

Case Studies for Health, Research and Practice in Australia and New Zealand



**Southern Cross
University**

Nicola Whiteing
Lucy Shinnars
Nicole Graham
Dima Nasrawi

Donna Wilson
Anna Foster
Elicia Kunst
Jennene Greenhill

Case Studies for Health, Research and Practice in Australia and New Zealand

CASE STUDIES FOR HEALTH, RESEARCH AND PRACTICE IN AUSTRALIA AND NEW ZEALAND

NICOLA WHITEING; LUCY SHINNERS; NICOLE GRAHAM; DIMA NASRAWI; DONNA WILSON; ANNA FOSTER; ELICIA KUNST; AND JENNENE GREENHILL

Southern Cross University
Lismore, New South Wales



Case Studies for Health, Research and Practice in Australia and New Zealand Copyright © 2023 by Southern Cross University is licensed under a Creative Commons Attribution-ShareAlike 4.0 International License, except where otherwise noted.

This book was published via the Council of Australian University Librarians Open Educational Resources Collective. The online version is available at <https://oercollective.caul.edu.au/case-studies-for-health-research-and-practice-in-au-and-nz>

Disclaimer

Note that corporate logos and branding are specifically excluded from the Creative Commons Attribution Share-Alike 4.0 Licence of this work, and may not be reproduced under any circumstances without the express written permission of the copyright holders.

Copyright

Case studies for health, research and practice in Australia and New Zealand by Nicola Whiteing, Lucy Shinnars, Nicole Graham, Dima Nasrawi, Donna Wilson, Anna Foster, Elicia Kunst and Jennene Greenhill is licensed under a Creative Commons Attribution Share-Alike 4.0 Licence by Southern Cross University.

Cover (illustration) adapted from image by chiplanay on Pixabay.

Recommended citation (in APA 7 style)

Whiteing, N., Shinnars, L., Graham, N., Nasrawi, D., Wilson, D., Foster, A., Kunst, E., & Greenhill, J. (2023). *Case studies for health, research and practice in Australia and New Zealand*. Southern Cross University. Retrieved Month Day, Year, from <https://doi.org/10.25918/text.303>

Recommended attribution

Case studies for health, research and practice in Australia and New Zealand by Nicola Whiteing, Lucy Shinnars, Nicole Graham, Dima Nasrawi, Donna Wilson, Anna Foster, Elicia Kunst and Jennene Greenhill is licensed under a Creative Commons Attribution Share-Alike 4.0 Licence by Southern Cross University.

CONTENTS

How to use this book	1
About the authors	3
Acknowledgment of Country	vii
Accessibility statement	viii
<i>Accessibility features of the web version of this resource</i>	viii
<i>Other file formats available</i>	viii
Versioning	ix
Glossary of icons	x

Part 1 The Calos-Clark Family

1.1 Introduction to the Calos-Clark family	14
Jennene Greenhill and Anna Foster	
<i>Family genogram</i>	14
<i>Introduction to family and community</i>	14
1.2 Calos-Clark family case study 1: Total knee replacement	23
Jennene Greenhill and Anna Foster	
<i>Introduction to case study</i>	23
<i>Scenario</i>	23
<i>Case study 1 summary</i>	27
1.3 Calos-Clark family case study 2: Ethics and inclusion	28
Jennene Greenhill and Anna Foster	
<i>Introduction to case study</i>	28
<i>Scenario</i>	28
<i>Case study 2 summary</i>	30

1.4 Calos-Clark family case study 3: Jay's suspected dementia	32
Jennene Greenhill and Anna Foster	
<i>Introduction to case study</i>	32
<i>Scenario</i>	32
<i>Case study 3 summary</i>	35
1.5 Calos-Clark family case study 4: Climate emergency impacts Giani and Jay's health	36
Jennene Greenhill and Anna Foster	
<i>Introduction to case study</i>	36
<i>Scenario</i>	36
<i>Case study 4 summary</i>	39
<i>References</i>	39
1.6 Calos-Clark family summary	41
Jennene Greenhill and Anna Foster	
<i>Summary</i>	41
<i>Acknowledgements</i>	41
<i>Image attributions</i>	41

Part 2 Lucy's Story

2.1 Introduction to Lucy's story	45
Nicole Graham	
<i>Family genogram</i>	45
<i>Introduction to family and community</i>	45
2.2 Lucy case study 1: Trauma	48
Nicole Graham	
<i>Introduction to case study</i>	48
<i>Scenario</i>	48
<i>Case study 1 summary</i>	54
<i>References</i>	54

2.3 Lucy case study 2: Adolescent pregnancy	56
Nicole Graham	
<i>Introduction to case study</i>	56
<i>Scenario</i>	56
<i>Case study 2 summary</i>	60
<i>References</i>	60
2.4 Lucy case study 3: Mental illness diagnosis	62
Nicole Graham	
<i>Introduction to case study</i>	62
<i>Scenario</i>	62
<i>Case study 3 summary</i>	69
<i>References</i>	69
2.5 Lucy's story summary	70
Nicole Graham	
<i>Summary</i>	70
<i>Image attributions</i>	70

Part 3 The Shero Family

3.1 Introduction to the Shero family	73
Lucy Shinnars	
<i>Family genogram</i>	73
<i>Introduction to family and community</i>	73
<i>References</i>	79
3.2 Shero family case study 1: Medya develops ulcerative colitis	80
Lucy Shinnars	
<i>Introduction to case study</i>	80
<i>Scenario</i>	80
<i>Case study 1 summary</i>	84
<i>References</i>	85

3.3 Shero family case study 2: Medya needs a temporary stoma	86
Lucy Shinnars	
<i>Introduction to case study</i>	86
<i>Scenario</i>	86
<i>Case study 2 summary</i>	89
<i>References</i>	89
3.4 Shero family summary	91
Lucy Shinnars	
<i>Summary</i>	91
<i>Image attributions</i>	91

Part 4 The Lewis Family

4.1 Introduction to the Lewis family	94
Nicola Whiteing	
<i>Family genogram</i>	94
<i>Introduction to family and community</i>	94
4.2 Lewis family case study 1: Neurodiversity	99
Nicola Whiteing	
<i>Introduction to case study</i>	99
<i>Scenario</i>	99
<i>Case study 1 summary</i>	103
<i>References</i>	103
<i>Acknowledgements</i>	104
4.3 Lewis family case study 2: Sally goes into surgery	105
Nicola Whiteing	
<i>Introduction to case study</i>	105
<i>Scenario</i>	105
<i>Case study 2 summary</i>	108
<i>References</i>	108

4.4 Lewis family case study 3: John has a motorbike accident	110
Nicola Whiteing and Elicia Kunst	
<i>Introduction to case study</i>	110
<i>Scenario</i>	110
<i>Case study 3 summary</i>	113
<i>References</i>	113
4.5 Lewis family case study 4: John is transferred to the emergency department	114
Nicola Whiteing and Elicia Kunst	
<i>Introduction to case study</i>	114
<i>Scenario</i>	114
<i>Case study 4 summary</i>	118
<i>References</i>	118
4.6 Lewis family summary	119
Nicola Whiteing	
<i>Summary</i>	119
<i>Image attributions</i>	119

Part 5 The Rossi Family

5.1 Introduction to the Rossi family	122
Dima Nasrawi and Donna Wilson	
<i>Family genogram</i>	122
<i>Introduction to family and community</i>	122
5.2 Rossi family case study 1: Maria Rossi - heart failure	127
Dima Nasrawi and Donna Wilson	
<i>Introduction to case study</i>	127
<i>Scenario: Maria's diagnosis of chronic cardiac failure</i>	127
<i>Case study 1 summary</i>	132
<i>References</i>	133

5.3 Rossi family case study 2: John Rossi - Myocardial infarction, coronary artery bypass grafting (CABG) surgery	134
Dima Nasrawi and Donna Wilson	
<i>Introduction to case study</i>	134
<i>Scenario</i>	134
<i>Case study 2 summary</i>	138
<i>References</i>	138
<i>Suggested readings</i>	138
5.4 Rossi family case study 3: Elisabeth Rossi - Strong family history of heart disease: health promotion	139
Dima Nasrawi and Donna Wilson	
<i>Introduction to case study</i>	139
<i>Scenario</i>	139
<i>Case study 3 summary</i>	141
<i>Suggested readings</i>	142
5.5 Rossi family summary	143
Dima Nasrawi and Donna Wilson	
<i>Summary</i>	143
<i>Image attributions</i>	143
Review statement	145

HOW TO USE THIS BOOK

Case studies in healthcare are a great way to improve education by bringing learning to life. They are powerful and effective learning strategies. By bringing real world problems into student learning, case studies invite active participation and innovative solutions to problems. As students work together to discuss the cases, they can apply clinical reasoning when responding to the health and wellbeing of the people in each case study.

This book consists of case studies that encourage creative problem-solving, higher-order critical thinking, promote learner involvement, and immediate use of newly acquired knowledge and skills. While these case studies are all fictional, some are inspired by true stories. The authentic contexts are designed to expose students to various viewpoints from multiple sources and help them understand why people may have different health outcomes.

This book was designed to facilitate an integrated approach to a new Bachelor of Nursing curriculum, underpinned by a transformative, place-based approach to learning. The case studies draw from our creative faculty team's extensive professional clinical experiences, forming a series of part, each introducing a fictional family. Each part includes a series of case studies about the family members. Alongside each case study are questions requiring students to analyse data to reach a conclusion. Each case study is informed by current evidence and educational practice knowledge. Thinking points encourage students to consider broader implications, stretching their thinking about how policies or other resources might be considered and applied. Students can explore their role, as well as how their clinical interventions are underpinned by professional values and practice requirements by professional and/or registering bodies.

The case studies in this book offer opportunities for various healthcare disciplines to develop or adapt questions to meet their needs. They can be used as a toolkit for planning and delivering education and training to support student learning. The case studies can supplement lectures, tutorials, or assigned readings and in small groups, these case studies can facilitate collaborative communities of practice, promoting problem-solving skills and communication.

Case studies are valuable for developing interprofessional practice. When students from various health disciplines work together to explore a case, they will work through different opinions, methods, and perspectives, learning about, with, and from each other.

These case studies can also be used beyond problem-solving. Students can be asked what they might do in a similar situation and think about what could have been done differently.

Acknowledgments

The development of this open education resource would not have been possible without the work done by the authors and our colleagues, families, friends, students, and the people we have cared for who inspire us. We would also like to thank our incredible team of Southern Cross University

librarians for their support and guidance throughout this project. Thank you to the copyeditor, who provided valuable feedback and advice to ensure we delivered a book structured for readability, and many thanks to our peer reviewers, who ensured our case studies were contemporary and appropriate for practice.

*I wondered how this was created,
Then I remember the many hours spent,
In deep discussion, debate, and contemplation,
Through a myriad of life's confronting moments,
The inspiration to create together, we persevered,
And words danced across our blank screens,
A tapestry of nursing expertise and wisdom,
Shared to inspire a new generation.*

~Poem by Jennene Greenhill~

ABOUT THE AUTHORS



Photo: © All rights reserved

Associate Professor Nicola Whiteing is Course Coordinator (Interprofessional) at Southern Cross University. Nicola has worked as an academic since 2000 in both the United Kingdom and Australia. Nicola has a PhD from Central Queensland University and is a Senior Fellow of Advance Higher Education (previously the Higher Education Academy). Nicola has extensive experience in teaching and learning and curriculum design. Nicola teaches in both the nursing programs as well as coordinating the interprofessional portfolio of units across the wider Faculty of Health. Nicola's research interests include teaching and learning, curriculum, workforce development and capacity building with a particular focus on regional, rural and remote areas.

ORCID



Photo: © All rights reserved

Lucy Shinnars is a Lecturer at Southern Cross University. Lucy is a credentialed intensive care nurse of more than 20 years and more recently, a nursing academic. Lucy is an emerging voice in health and technology and technology research, completing a PhD that explored healthcare professionals' perceptions of artificial intelligence (AI) in the delivery of care. Lucy has a well established publication record and participates in collaborative research projects which empower healthcare professionals to harness the power of technology and aim to bridge the divide between health and technology.

LinkedIn

ORCID



Photo: © All rights reserved

Nicole Graham is a Lecturer at Southern Cross University. Nicole has a background in inpatient and community mental health nursing. Nicole has experience in interdisciplinary education and nursing leadership in a tertiary hospital and health service. Nicole also has experience in the coordination and review of transition to practice mental health programs. Nicole is a credentialed mental health nurse and is currently pursuing a PhD exploring trauma-informed care and interdisciplinary and lived experience mental health workforce. Nicole's passion is cultivating a suitably qualified and skilled workforce to optimise the care of people who experience mental illness as well as enhancing the transition to practice experience for health discipline students.

[LinkedIn](#)

[ORCID](#)



Photo: © All rights reserved

Dima Nasrawi is a Lecturer and Course Coordinator at Southern Cross University. Dima has experience in various clinical care settings in Australia and overseas. Dima has taught at the tertiary level since early 2017 across nursing programs (years 1-3). Dima has completed various postgraduate studies and is a fellow of the Higher Education Academy. Dima is also a unit assessor across nursing programs and coordinates the Bachelor of Nursing – Enrolled Nurse to Registered Nurse pathway. Dima is completing her PhD in the area of inpatient rehabilitation following cardiac surgery, holds a well-established publication record and participates in research collaborations on a national and international scale.

[LinkedIn](#)

[ORCID](#)



Photo: © All rights reserved

Donna Wilson is a Lecturer at Southern Cross University. Donna has a clinical background of over 12 years in ICU nursing and has completed postgraduate studies that support her critical care nursing and educator specialties: Graduate Certificate, Graduate Diploma, and Master of Advanced Practice. Donna has worked in tertiary education since 2018 and has 5 years' experience in leadership roles of unit assessing in the undergraduate and postgraduate nursing education spaces. Donna is completing her PhD in the area of innovation in mobile technology that supports undergraduate nursing students in the work-integrated learning environment, and is immersed in the processes of writing, publishing and presenting her PhD work. Donna has experience in innovative education design, particularly utilising mobile technology to link theoretical concepts to the clinical environment. Donna is currently unit assessing, and teaching into the undergraduate and master of nursing programs.

LinkedIn

ORCID



Photo: © All rights reserved

Anna Foster is a Lecturer (Teaching Scholar) Southern Cross University. Anna has an 18-year background in intensive care nursing, surgical ward nursing and midwifery. Anna has completed postgraduate studies in various areas, including academic practices. Anna has been teaching in the tertiary environment since 2012, after returning from the UK, where she worked as a nurse educator with a large London-based trust. Anna has worked at Southern Cross University as a placement coordinator, lecturer, unit assessor, and course coordinator of the Enrolled Nurse to Registered Nurse Pathway Program. Anna has an interest in climate change, climate health, and workforce adaptation and resilience in the face of climate risk. Anna hopes to commence her PhD in the near future with a focus on this area.

LinkedIn

ORCID



Elicia Kunst is a Lecturer (Teaching Scholar) at Southern Cross University. With nearly 20 years' clinical experience in emergency care, Elicia's qualifications include Master of Advanced Practice (Nursing), Graduate Certificate in Health Professional Education (Nursing), Bachelor of Naturopathy (Health) and Bachelor of Nursing.

ORCiD

Photo: © All rights reserved



Professor Jennene Greenhill is Chair of Nursing at Southern Cross University. Jennene leads a young dynamic team across 3 campuses spanning the border of Queensland and New South Wales. Her national and international profile in rural health is a result of social accountability research and transformative education that aims to change health service culture, improve clinical practice and build the health workforce. Jennene has led several large research grants including NHMRC and Department of Aged Care Services (DACs) grants for innovation in aged care. Jennene was previously Professor of Rural Health, University of Western Australia, leading the national evaluation of the regional training hubs. Jennene was also director of the award-winning Flinders University Rural Health, initiated the Masters of Clinical Education, and was appointed by

the health minister as deputy chair of the South Australian Health Performance Council. In Jennene's role as the national chair of FRAME (Federation of Rural Academic Medical Educators), she collaborated with others passionate about rural health to influence policy change.

LinkedIn

ORCiD

ACKNOWLEDGMENT OF COUNTRY

The authors gratefully acknowledge the Traditional Custodians of the lands upon which we live, learn, teach, research, and write. We pay our respects to Elders past, present and future, and recognise that Aboriginal and Torres Strait Islander Peoples are Australia's first storytellers, artists, communities and creators of culture. We recognise their continuing connection to the land and waters and acknowledge that they never ceded sovereignty.

ACCESSIBILITY STATEMENT

Accessibility features of the web version of this resource

The web version of this resource has been designed with accessibility in mind by incorporating the following features:

- It has been optimised for people who use screen-reader technology:
 - all content can be navigated using a keyboard
 - links, headings, and tables are formatted to work with screen readers
 - images that convey information have alt tags
- Information is not conveyed by colour alone.

Other file formats available

In addition to the web version, this book is available in a number of file formats including PDF and EPUB (for eReaders). Select a file format from the 'Download this book' drop-down menu on the book homepage.

This accessibility statement is adapted from the BCcampus Accessibility Toolkit, which is licensed under a Creative Commons Attribution 4.0 licence.

VERSIONING

This page provides a record of changes made to this resource. Each set of edits is acknowledged with a 0.1 increase in the version number. The downloadable export files for this resource reflect the most recent version.

Version	Date	Change
1.0	25 October 2023	Resource published in the CAUL OER Collective Collection

GLOSSARY OF ICONS

An A-Z list describing the icons used throughout this book.



Cardiovascular



Case studies



Clinical reasoning



Cultural safety



Endocrine



Evidence-based practice



Infection prevention and control



Introduction



L – Legal



Medication safety



Mental health



Musculoskeletal



Neurological



Objectives



Person-centred care



Preventing, minimising and responding to adverse events



Reflective practitioner



Reproductive



S – Social



Self care and resilience



Summary



T – Technology



Teamwork and collaborative practice



Therapeutic communication



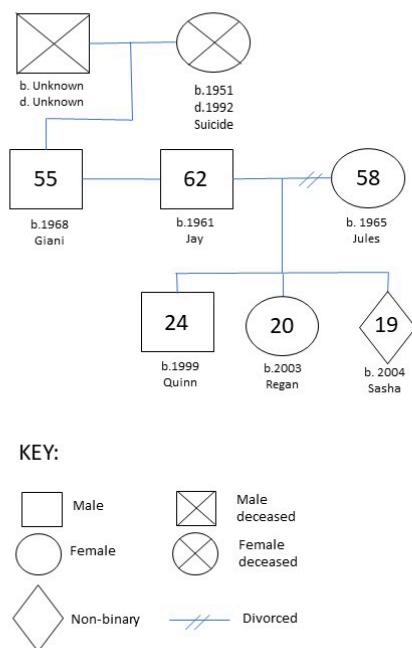
Thinking point

PART 1 THE CALOS-CLARK FAMILY

1.1 INTRODUCTION TO THE CALOS-CLARK FAMILY

Jennene Greenhill and Anna Foster

Family genogram



Calos-Clark family genogram

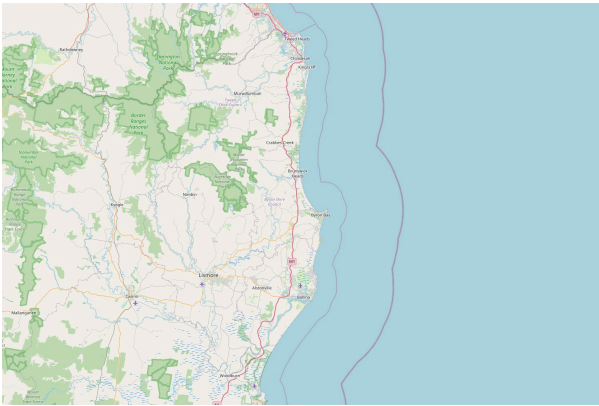


Introduction to family and community

This part provides a series of case studies about an older gay couple, named Jay and Giani. They moved to northern New South Wales soon after they met to establish a lifestyle that suits their values and enhances their wellbeing. They set up a beautiful home in an inclusive community and were very actively involved in social and community events.

This part illustrates how both men experience life changing health concerns and the challenges they face in navigating the health system in a regional area. The part begins with a section outlining family background, history and relationships, with a brief overview of their lifestyles as they transition to retirement. This is followed by 4 case studies including: 1) a total knee replacement, 2) complex issues in equity and inclusion, 3) dementia, and 4) climate emergencies affecting health outcomes.

The Calos-Clark family



Brunswick Heads map

Giani Calos (56) and Jay Clark (62) are cisgender men in a same-sex relationship who met 16 years ago at an event hosted by mutual friends in Sydney. At the time of their meeting, Jay had recently left his marriage to his wife Jules, whom he had been with since he was 25. Jay had felt for some time he was gay and had come out to Jules resulting in tension and eventual separation. When he met Giani, who was originally from Ecuador, it was his first real same-sex relationship. He says he found his soulmate when they met at a music festival in Sydney. On the other hand, Giani

thought Jay a bit boring at first and took several weeks to warm to him. They are now a deeply loving couple and strongly committed to each other.

Shortly after getting together, they felt called to have a sea-tree change and make the move to a more rural setting. They each felt a bit burnt out by the Sydney scene and moved to Brunswick Heads in an area known as the 'rainbow region' of northern NSW. Upon moving to Brunswick Heads, the couple developed a block of land on Riverside Crescent, originally purchased by Jay and Jules. Now owned solely by Jay, it has a beautiful view of the Brunswick River and the forest that surrounds the block. They brought in a Queenslander house they had saved from demolition in Beenleigh. They had it lifted to create storage and covered parking underneath for their primary vehicles and Jay's vintage car. They lovingly restored the house to its original 1930s federation style condition, and it is now their pride and joy.

Giani and Jay are extremely happy following the move to Brunswick Heads. Giani became a spiritual healer following a life changing retreat in the Byron Hinterland 10 years earlier. Jay retired from teaching music in high schools about 3 years ago, and since then, he and Giani have opened Natural Rhythms, a business that offers private music lessons and spiritual healing. They are very popular in the area and have created a great reputation in the community. Their social circle is extensive. Giani and Jay consider themselves activists and agents of change. They work closely with local community organisations in a small town that is becoming more supportive, running fundraisers, often raising money in unconventional ways, such as drag bingo events, for the benefit of the LGBTIQ+ community.

Calos family members

Katarina Calos: 32 years old at time of death

Thiago Calos: age unknown when he married Katarina



Katarina and Thiago

Katarina, Giani's mother, was born in Ecuador to older parents. She was the youngest child of 10 and was frequently left alone with her older siblings, as her parents both had to work full time. Her family considered her 'spacey'. While her father, Iberto, often berated her for daydreaming, her mother, Lucina, loved her deeply and encouraged her creativity. Katarina had hopes of either being a doctor or a nurse when she grew up. Her father worked as a subsistence farmer. Her mother was part of the Panama hat trade, weaving hats for export to New York. In winter, Katarina's father travelled to the coast to find work, as the crops did not grow during the cold season. The older children were capable of maintaining the livestock in his absence.

Katarina met Thiago when she was 14. Thiago was the grandson of their neighbour and visited each summer. The details of their early relationship are unknown. What is known, however, is that Katarina did not like Thiago at first, staying away from the neighbour's farm while he was there. She only grew to really love him after their marriage. When Katarina was 15, she told her older sister Livvia that she might be pregnant. When it became clear she was indeed pregnant, her father forced Katarina to marry Thiago, despite her begging not to as she wanted to continue her education.

When Katarina gave birth to Giani at 16, she and Thiago settled into parenthood uneasily. Katarina often resented that Thiago was able to leave home to go to work for the day while she was at home with the baby, weaving hats like her mother. Katarina eventually got the hang of it and when Giani was about 2 years old, she found she really loved being a mother. She started doing small jobs outside of the home, taking Giani with her.

When Katarina was 20 and Giani 4 years old, Thiago went to the coast with Katarina's father to find work over winter. But Thiago never returned. It later transpired that Thiago had been having an affair with a local woman, telling her he planned to migrate to Los Angeles and she was to join him. Neither Katarina nor the other woman ever heard from Thiago again. Around this time Katarina discovered she was pregnant again, but miscarried the baby at 23 weeks, her fourth miscarriage since Giani's birth. Katarina sunk into a heavy depression following the loss of this last baby, a depression that lasted for 4-5 years. During this time, Giani was largely attended to by his grandmother and aunt Betina. While Giani did his best to keep his mother's spirits up, there were long periods of time when Katarina was unable to get out of bed or go to work.

The bills piled up during this period. However, when Giani was nearing 10, Katarina seemed to improve, and she was able to work again. Giani remembers the next 5 years as an extremely happy time, surrounded by his mother's loving family. Tragedy struck Katarina at age 31 when she was

diagnosed with multiple sclerosis. At the same time, Katarina's sister Betina and her mother, who had both raised Giani for a long period of time during Katarina's period of depression, were killed in an accident on the family farm. Katarina again sunk into a heavy depression, from which she never recovered. At the age of 32, Katarina committed suicide in her family home, leaving Giani to be cared for by his grandfather, Aunt Livvia and her husband Calos.

Giani Calos (aka 'Monty Carlo'): 56 years old



Giani

Giani was born to Katarina and Thiago Calos in Ecuador. English is Giani's second language. He has an accent and sometimes finds it difficult to read and write in English. At age 25 Giani came out as gay. His grandfather disowned him but his aunt Livvia continues to be a strong presence in his life at the age of 84. Giani worked in the oil industry in his 20s, like his uncle Calos, Giani's self-adopted father.

At age 27, Giani migrated to Spain from Ecuador during an economic crisis where the unemployment rate was 15%. When Giani was unable to get a job in the oil industry in Spain, he migrated the following year to Australia to work in the mining industry. He later relocated to Sydney and joined a cabaret. At age 30, Giani opened an art gallery in Oxford Street and later opened a drag bar 100 metres down the road.

That's where Giani created his drag persona 'Monty Carlo'. She became a big part of Giani's life and has been there to help him through a number of difficult situations. Monty Carlo and Jay host regular bingo nights, which have been helping to raise funds for research and community services for those living with health problems like HIV and their families.



Monty Carlo

Giani has a past history of smoking, but quit 5 years ago after losing a close friend to cancer. His GP has recently prescribed an ACE inhibitor, perindopril, for hypertension. While Giani's blood pressure was previously under control with diet and exercise, he has lost a lot of mobility more recently due to a bad knee. He is now awaiting a total knee replacement.

Giani has a large extended family with lots of relatives in Melbourne and Sydney, whom he lived with when he migrated to Australia. As he had significant trauma following his mother's suicide when he was 16 years old, he sometimes experiences periods of depression that require intensive cognitive behavioural therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs). In general, though, he is able to self-manage with good nutrition, sleep and exercise and aims to live a healthy lifestyle. He is a vegetarian and loves his garden. He has always been a professional performer and is an excellent dancer.

Clark family members

Jay Clark: 62 years old



Jay

Jay was born in Melbourne but his birth parents are unknown. Jay was adopted to a childless couple at the age of 6 months. He had a very happy upbringing, first with his adoptive parents Martha and Rob, and then 3 years later with his adopted twin sisters Maggie and Hope. He is unaware of any family medical history.

Jay loved music as a child and had hoped to perform professionally. He later decided he would have greater stability in life if he pursued a teaching career like his father Rob. This worked out very well for Jay. Becoming a music teacher allowed him to keep his passion for music, while passing this onto many generations of students who thought he was the best teacher they ever had. Jay moved to North Sydney in his mid-20s and lived and worked there until he met Giani. Jay has now been retired from teaching for about 3 years.

Jay met Jules when he was 25. Jules worked in the front office of the school where Jay was working as a music teacher in North Sydney. Jay loved that Jules was a funny and irreverent sort of person, as he had been quite serious for most of his life. They dated for about 8 years before getting married and some years later had their first child, Quinn now aged 24, followed 4 years later by Regan now 20 and then Sasha now 19 years old. About the time Regan was born, Jay began to explore his attraction to men and pushed aside his sexual needs for the marriage and family. However, when he discussed this with Jules, she did not receive it well. Given her response, Jay decided to let it go and they went on to have another child, Sasha. By the time Sasha was 2 years old, Jay decided he needed to be true to both himself and Jules and asked for a separation.

After commencing his relationship with Giani following a few flings with other men, Jay's separation from Jules became very hostile. Jules had often felt Jay was deceiving her about his reasons for unhappiness in the marriage. This was confirmed for her when he began his relationship with Giani. On the other hand, Jay believes he had been very forthcoming about his feelings during the marriage. They split their assets 50/50, but had to sell the family home in Manly to liquidate their joint assets. Jay bought out Jules' stake in the block of land in Brunswick Heads. Jules was then

forced to rent a 3-bed bungalow in Revesby, a long distance from her workplace and the rent has recently increased.

The breakdown of the relationship led to ongoing conflict with Jules, who still feels she was taken advantage of both during the marriage and after their separation. While Jay maintains a very strong relationship with his 2 younger children, Regan and Sasha, his relationship with Quinn is very strained, an ongoing point of contention between Jay and Jules. Although Jay has spent many years trying to bridge the gap with his oldest son, Quinn is not receptive to a closer relationship. He is very protective of his mum and blames his father for her struggles in later life.

Given the children were so young when Giani and Jay became involved, they have been raised with Giani in their lives from a very early age. Regan and Sasha have a very close relationship with Giani, love him dearly, and call him 'papi'. Giani considers the 3 children to be his and is very proud of their achievements and who they have grown up to be. This is very upsetting for Jules, as she sees Giani as the man who broke up her marriage. Quinn refused to stay with Giani and Jay after the age of 12 and insisted instead on his father seeing him in Sydney for their visitation. Quinn refuses contact with Giani and will not attend family events if he knows Giani will be there. This has created conflict between the siblings, who believe their mother has influenced Quinn's opinion of Giani.

Lately Jay has been struggling with his memory, and Giani has noticed some personality changes. They initially put this down to exhaustion from setting up the business but are now considering consulting a doctor.

Jules Clark: 58 years old



Jules

Jules was born in Sydney and had a middle-class Australian upbringing. She completed her retail training certificate at age 20, and later went on to complete her training in office work. She worked in a number of temporary positions in offices in central Sydney, before applying for and getting the position in the front office of the school where she met Jay.

Jules was 21 when she met Jay and they dated for some years. Her friends used to tease her that she would never get Jay to propose, but he finally did after 8 years of dating. They

eloped to Tasmania to get married 3 months later. When Jules was 41, she was blindsided when Jay said he was gay and wanted to separate. When they separated, Jules was very angry. Although she had known for some time that Jay was gay, she didn't think he would ever leave her. During the separation, they had to sell the home Jules and Jay had bought in the early years of their relationship, during a downturn in the housing market, losing money on their purchase price. Once all the assets had been sold, all that was left was a block of land in Brunswick Heads they had purchased to build an investment property. Given Jules was left with very little financially at the end of the marriage, she jumped at the chance to sell her half of the property to Jay so she could afford to rebuild her life. However, she was devastated to part with it. She had always seen the investment property as her nest egg in retirement.

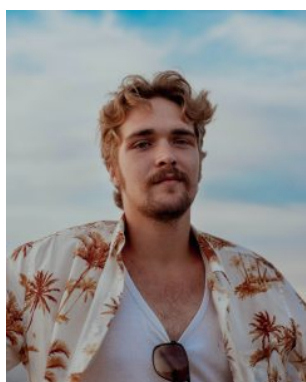
Jules still lives in Sydney with her child Sasha. She is very close with Quinn who she leaned on during the separation. She also enjoys a close loving relationship with her other 2 children, Regan and Sasha, although they disagree with her stance on Giani. They elect not to discuss Giani in the family setting to avoid conflict.

Jules has been struggling financially since the separation, because she had stopped working to be a stay-at-home parent during the marriage and did not have any superannuation prior to having children. She always worked in casual jobs during the years of their relationship because Jay was the breadwinner. Jules was told last month by the GP practice where she has been an office manager for the last 2 years, that after merging with a larger practice down the street, they will need to cut her hours to 20 hours per week so they can keep as many staff as possible. She also discovered in the last 6 months that the practice she worked at previously for 10 years had been faking deposits into her superannuation account, and she has been left with nothing. She does not have the money to pay the legal fees to take the case to court which is the only option her lawyer could suggest.

Jules has recently been told the rent on the 3-bed bungalow she has lived in for the last 16 years is going to be increased. Jules is in no financial position to buy her own property, but also can't afford the rent increase. One-bed flats in the area are the only option she can see at the moment, but she is not wanting to downsize her life that much, as Sasha is still living at home, and feels she was cheated out of income during the marriage.

She has had to continue to be strong for the last 16 years and get the kids through their education. Now that all the children have good jobs, except Sasha who is still completing university, she feels it is time to focus on her needs.

Quinn Clark: 24 years old



Quinn

Quinn was Jules and Jay's first child. He is a very serious and well-liked young man. When his parents separated, Quinn was nearly 8 years old and his entire world fell apart. His mother, who was previously happy, fun and full of laughter, became sad and serious. His father moved nearly 800km away a year later to start a new relationship with a man.

Quinn's mother gained full custody during school terms, and his dad had access for one week each school holiday and 3 weeks over the Christmas break. Jay paid \$250 child support per week. When Quinn was 12, he refused to go to Brunswick Heads to see his dad anymore and cut off all contact with Giani. From that time, Jay came to Sydney for a week every 3 months. During those weeks Quinn stayed with Jay at Jay's sister place.

Quinn became more and more resentful of his father as he watched his mother struggle while Jay and Giani lived an idyllic life in Brunswick Heads. Quinn now has minimal contact with his father and none with Giani. He feels the couple cheated his mother and their family out of a happy life; he blames them entirely for the disruption to his childhood.

Aside from the strained relationship with his father, Quinn got good grades at school, despite a diagnosis of dyslexia at age 10. He completed numerous sessions with a speech therapist and managed to develop successful strategies for reading and writing. After graduating, Quinn took an apprenticeship as an electrician. He loves his job and is considering returning to university to study electrical engineering. He is dating a woman called Clare and they are very happy, recently returning from a trip to New Zealand.

Regan Clark: 20 years old



Regan

Regan was only 4 years old when her parents separated. She does remember some occasions from her childhood when her parents were together, but for the most part, unlike Quinn, she mostly remembers them being apart. Regan loves her visits to Jay and Giani during the school breaks and adores it when Monty Carlo is around. Regan feels right at home in Brunswick Heads and has developed a good social circle in the town over the years. She is currently sharing a flat with a girlfriend she met when she was 10 in Brunswick Heads.

While Regan is saddened by her mothers' feelings towards Jay and Giani, she doesn't blame her; she has watched her mother financially struggle for the last 16 years. Regan learned in her early teens it was best not to bring up the subject of Giani as it would send her mother into a spin. Regan shares a loving bond with her mother, although at times she worries her mother takes on too much to try and keep them afloat. Regan's relationship with both her father and Giani is both serious and light-hearted. She considers herself lucky to have two amazing dads and a very loving mum.

Regan is in her final year of university, studying a Bachelor of Arts in international policy. She hopes to become an ambassador in the future and recently was awarded an internship with the United Nations in New York. It was a highly coveted position, only awarded to 3 people per year. Regan now works as a model to make ends meet. She has been lucky to travel all over the world with her modelling. However, her priority is to use her modelling social media profile for her work on equality and climate change.

Sasha Clark: 19 years old



Sasha

Sasha is Jules and Jay's youngest child, only 2 years old when their parents separated. Sasha has no memory of their separation at all, and only knows them apart. Sasha loves their parents equally, and feels they have mostly been able to keep out of the conflict, using the same strategies as Regan. They spent an extended period of time with Giani and Jay in years 11 and 12 when they did a transfer of study arrangement between their Sydney school and one in Byron Bay. At that time Sasha wanted to study marine biology and it was around then that they came out as non-binary. Now in their first year of university studying a Bachelor of Laws (honours), they are so far managing their study load quite well. They managed to get a scholarship to study their degree, which was a relief to them as they were worried about financially burdening their mother. Sasha is very close with Giani and talks to him several times per week on the

phone. They feel that Giani is the one they would go to in a crisis and that Giani understands them the most.

1.2 CALOS-CLARK FAMILY CASE STUDY 1: TOTAL KNEE REPLACEMENT

Jennene Greenhill and Anna Foster

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Describe the anatomy and physiology of the knee and conditions associated with the need for a total knee replacement (TKR).
- Explain appropriate nursing care for patients who undergo total knee replacement surgery.
- Identify strategies to prevent complications and preoperative and postoperative care.
- Describe the importance of pain relief in the rehabilitation of the patient undergoing a total knee replacement.

Scenario

Giani is now 68 years old and has been a dancer and professional performer for 25 years. Over the last 10 years, he has had several injuries and has been experiencing increasing arthritic pain in his left knee. After multiple visits to his GP for ongoing treatment and monitoring, as well as regular acupuncture and massage, the pain has become unbearable. As a result, 2 years ago he was referred to an orthopaedic surgeon, Dr Kim, who placed him on a waiting list for knee surgery. The pain was beginning to affect his fitness and activity levels as well as his mental health. The doctor said that if knee pain is preventing him from undertaking adequate regular exercise, then the benefit of total knee replacement (TKR) is substantially increased. Furthermore, the procedure

would prevent him from being in a high-risk group. Giani and Jay both know how dangerous it is to be immobile and neither wants a sedentary lifestyle.

Prior to admission, Dr Kim took a medical history and blood tests to gather information about Giani's general health and the extent of his knee pain and ability to function. He undertook a physical examination to assess the range of motion in Giani's knee, as well as stability, strength, and overall leg alignment. Giani also had x-rays and a magnetic resonance imaging (MRI) scan to determine the extent of damage and deformity in his knee. Jay and Giani had to drive one hour to Lismore or Tweed Heads for most of these appointments.

Giani and Jay talked to some of their friends who had had this operation. They wanted to learn about what was involved the procedure, the pros and cons and risks. Their friend Murphy told them how he had a rapid reduction in swelling in the knee about 6-8 weeks post-op but needed to have quite a lot of rehab to work on his strength and bending. Their friend Carla had swelling in her knee for nearly 6 months, which improved with ice and elevation at the end of the day, and was able to get back into swimming 6 weeks post-op. At 12 weeks Carla added in bicycle riding around town and found that was an excellent way for her to build mobility and range of movement in her knee. Ted, Jay's brother-in-law, said it was the best thing he had ever done, after his knee was hurt during a motorcycle accident; now he is driving, walking, swimming, and playing golf again, all within 3 months of the operation. He had his knee replaced 15 years ago and will probably be looking at another replacement in the next few years. The average replacement lasts 10-20 years, and Ted is hopeful he will be a candidate for the minimally invasive procedure next time.

After considering all the positives and negatives of the procedure, Giani decides to proceed with the surgery. He is worried about the recovery and the scarring, but ultimately, he and Jay want Giani to return to his previously levels of mobility. Monty loves to dance! Giani and his surgeon discuss using a minimally invasive technique, which allows for a shorter incision, hopefully less pain during his recovery and a speedier recovery overall. Given Giani is fit, younger in terms of knee replacements, and very willing to complete an extensive rehabilitation regime, his surgeon feels he is a good candidate for the minimally invasive procedure. They are aware, as always, of the risk of blood clots, bleeding and infection, but hope that Giani should have an uneventful recovery.

Giani is admitted to the hospital on the day of his surgery. The nurse greets him and goes through the admission process, saying 'you will be soon seen by a member of the anaesthetics team. After surgery, you will wake up in the recovery room, where you may remain for several hours. After you properly wake up, you will be moved to your hospital room'. Giani's TKR is performed and the surgery takes 1.5 hours. After surgery, he is monitored in recovery for 3 hours until the effects of the anaesthesia wear off. He is transferred to the ward, visited by the surgeon and told that all went smoothly. If all continues to go well, he will stay in the hospital for 2 nights.

Giani has a nerve block in place on return to the ward, which leaves the area feeling numb to start with. He is told about his patient-controlled analgesia (PCA) to help with pain after the block wears off. He is also told he has had a peri-articular injection (PAI) of local anaesthesia that will control much of his pain post-op. The PCA allows Giani to control his pain relief, with regular paracetamol and anti-inflammatory medications to augment it.

Giani's postoperative orders stated:

- Complete vital signs every 30 minutes for 2 hours, then hourly while the PCA was in situ, then per pathway.
- Provide oxygen via nasal prongs to keep SpO₂ > 95%. Encourage deep breathing and coughing, and use of trifold.
- Assess foot for temperature, pulse, capillary refill, movement, swelling and pain.
- Encourage ankle pumps and static contractions as able with pain relief.
- Monitor drainage from site and output into drains – document same.
- Indwelling catheter in situ for 24 hours, remove once mobile, and commence trial of void – monitor output on fluid balance chart.
- Physiotherapy to commence on day one with mobilisation to chair and to shower.
- Start ice on knee day one.
- Patient controlled analgesia (PCA) in situ with morphine for 24 hours. Monitor use and supplement with regular paracetamol and anti-inflammatories.
- DVT prophylaxis and regular IV antibiotics as charted.
- X-ray of knee for alignment 24 hours postoperative.
- Haemoglobin and clotting levels check day one.



Knee post-op

Giani's initial recovery is uneventful. He finds the PCA and regular oral analgesia are adequate to control his pain. He has TED (thrombo-embolus deterrent) stockings on his legs to help avoid clotting. He has inflatable sleeves called sequential compression devices (SCDs), that intermittently compress his legs to help move the blood out of the calves. Giani's wound is closed with staples on the surface and covered with a waterproof dressing. He has a small bellovac drain in his knee that drains blood and other fluids from the surgical site.

Giani's PCA is stopped and removed 24 hours after the procedure and Giani commences oral analgesia. He requires some opioid medications (codeine) for a week, as well paracetamol and anti-inflammatories to minimise pain before physio and sleep. Giani experiences some nausea with his oral analgesia. His medical team reassures him it is common for people to experience some nausea and loss of appetite

several weeks after surgery and give him an antiemetic medication to help. The nursing team explain that a balanced diet with protein is important to help wound healing and restore muscle strength and that regular small meals can help with the nausea.

Giani starts his physiotherapy exercises within the first 24 hours to help develop movement and function. The physio team help him learn exercises to do several times a day to improve mobility and strengthen the knee. A graduated walking program slowly increases his mobility.

After the drain is removed on day one of Giani's recovery, he has an x-ray of his knee to check the alignment of the joint and ensure it is straight.



Knee x-ray

The physiotherapist and occupational therapist meet with Giani again on day 2 of his recovery. They discuss his plans for discharge home and his care in the community. They make suggestions for home modifications including safety rails in the shower, handrails on the stairs, stable chairs for resting and securing all loose carpets and surfaces.

Giani is discharged home, where Jay will care for him, 72 hours after his procedure.



Case study questions

1. How does age and the change in normal exercise impact on the anatomy of the knee?
2. What preoperative checks are most important for Giani?
3. What is the role of family members in care planning for a patient undergoing a total knee replacement and how do you involve them to optimise health outcomes?
4. What role does pain management play in Giani's quality of care, both immediately after surgery and during his ongoing recovery?
5. How can the nursing team encourage the patient to take actions to prevent clots, both in the immediate postoperative period and on discharge home?
6. What are the primary signs of infection that Giani and Jay will need to observe? What should they do if they notice any of these signs once discharged home?



Key information and links to other resources



Thinking Point

Thinking about patient's wellbeing, mental health and body image can become an important factor in their recovery. Often patients have gone from being very physically active to a largely immobile person, which can have an impact on self-identity.



Case study 1 summary

After 5 months Giani is walking daily and able to climb stairs without any pain or stiffness. He hopes to be back on stage soon, doing his weekly drag bingo as Monty Carlo.

Giani and Jay are extremely happy with the outcome. They have returned to volunteering at the local youth centre and attended Mardi Gras.

1.3 CALOS-CLARK FAMILY CASE STUDY 2: ETHICS AND INCLUSION

Jennene Greenhill and Anna Foster

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Align your personal and professional ethics in nursing.
- Identify core ethical principles that apply to practice.
- Appreciate the importance of inclusion and equity in nursing.
- Reflect on how to advocate for communities and individuals under your care.

Scenario

Following Giani's operation, Jay was with Giani most of the afternoon. They had 2 visitors in the evening, their friends Teal and Harper, one non-binary and the other trans. They are fellow performers, both flamboyant and funny. When they arrived with a large basket of snacks and a bunch of rainbow balloons, they said, 'Hey girl, how are you feeling? Ready to "partaay" yet?' They laughed and joked to cheer up Giani. He was a bit tearful when they left.

After they left, Jay went to the kitchen to make he and Giani a cup of tea. While there, he overheard 3 nurses talking in the nurses' station, 2 senior RNs and one 20-year-old graduate RN. One of the senior RNs said, 'Did you see those visitors in room 3? I'm not saying I don't accept them, but I just wish they would be a bit quieter'. The other senior RN chuckled and agreed, saying, 'I'm glad

I'm not on that side of the ward tonight. I don't know why they need to be so overt?' The graduate nurse was silent for some time during this conversation, until Jay heard her say to the other nurses, very quietly, that those comments weren't appropriate. She said, 'I don't want to upset you both, but are you aware those kinds of comments are now illegal, as they are homophobic?' One of the senior nurses replied, 'Ahh come on, if they didn't want to be discussed they wouldn't be so out and loud. They must want the attention to behave like that'. She laughed with the other senior nurse. Jay could hear the nervousness in the young nurse's voice. As she walked past him in the tea room, he could see she was close to tears.

Jay and Giani grew up during a time when being gay was a criminal offence. Jay had heard these kinds of comments for years and couldn't believe it was the responsibility of a 20-year-old to educate fellow colleagues on inclusive language. The following morning, he complained to the nurse unit manager (NUM) who was shocked. She apologised to both Jay and Giani. She took a considerable amount of time to listen and talk with Jay about the incident, took many notes and later completed an incident report on the situation. She then contacted HR, who advised her to inform the assistant director of nursing in writing, including an action plan. The action plan covered individual counselling for the 2 nurses and broader education for the whole interprofessional team.

The NUM went back to Jay after the counselling session and closed the loop by informing Jay of the outcome of the incident reporting and process. When she told Jay about the education session coming up, he offered to come back as a volunteer to help educate the staff on how to care for LGBTIQ+ patients and about discrimination, inclusion and equity. The NUM was grateful for Jay's offer, however the hospital employed an academic from a nearby university who had undertaken research in this field, and Jay assisted to deliver a series of staff education sessions.



Case study questions

1. How would you feel in this situation, overhearing commentary like this about the people you love?
2. How could such behaviours and attitudes impact on the quality and safety of patient care?
3. What does the legislation say regarding legal rights and anti-discrimination for LGBTIQ+ peoples?
4. What escalation tools are available for junior staff to interact with senior staff in difficult situations?
5. What do the Registered Nurse Standards for Practice say about how the rights of LGBTIQ+ individuals can be protected?
6. In what ways does this case study shape your own future professional identity?

7. How would you demonstrate professionalism in this type of scenario?



Key information and links to other resources

- **LGBTIQ+ Health Australia**
- **Rainbow Health Australia: Research & resources:** This website has resources to help individuals and organisations to develop services that are inclusive for LGBTIQ+ staff and clients.



Thinking Point

Think about how we communicate with each other as health professionals in the clinical environment. We are often guilty of discussing patients in a less than professional way when we think we are alone with other healthcare practitioners. If this were your family member you overheard being discussed in this way in an environment that should be safe for all patients and families, what would you do after hearing these comments? Would you feel safe leaving your loved one receiving care from a health professional after they expressed opinions like these? What could they (or you) do differently to ensure they were providing safe responsive care to their patient, and their patient's families and friends?



Case study 2 summary

While Giani and Jay are extremely disappointed that this had happened at all, they appreciate the way the nurse unit manager took their concerns seriously and dealt so promptly with the issue. Jay returned to the ward 2 weeks later to help provide education on the history of healthcare in the gay community by sharing his personal experiences. The education sessions provided insights about what the community has overcome to get to this point of greater equality and what needs to happen to continue this journey towards respect for LGBTIQ+ patients, families and friends. The 2 nurses involved approached Jay and Giani at a later point after the counselling they received. Each

separately apologised for their role in distressing Jay and Giani. Jay approached the graduate nurse on a later shift when she was again caring for Giani to thank her for her attempt to intervene and stop the cycle.

1.4 CALOS-CLARK FAMILY CASE STUDY 3: JAY'S SUSPECTED DEMENTIA

Jennene Greenhill and Anna Foster

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Develop an understanding of the early symptoms of dementia.
- Understand a holistic approach to managing dementia.
- Explore the roles of the interdisciplinary team in diagnosing and managing dementia.
- Identify the safety issues involved in a dementia diagnosis.

Scenario

Giani is due for discharge home from hospital following his total knee replacement on Friday, 3 days after his operation. The evening before, Jay arranges to pick up Giani from the side of the ambulance bay at the hospital at 10 am. Giani completes his discharge and heads to the meeting place. Jay does not arrive at 10 am. Concerned he won't be able to stand for long, Giani calls Jay to see how far away he is and finds that Jay is in the middle of making scones for morning tea with the next-door neighbour. Jay has no recollection of the arrangement to collect Giani. He says he thought Giani was not due for discharge for several days. Giani elects to catch an Uber home, rather than rely on Jay.

Giani has noticed that Jay has become more forgetful than usual. Initially Giani had put this down to

the stress of opening the new business and the long days involved. He had thought Jay just needed a break and a good rest. When Giani arrives home, he finds Jay has forgotten the scones which are now burnt in the oven. Meanwhile, Jay is outside weeding their vegetable garden.

The following afternoon when Giani is due to see their GP for review of his knee wound, he suggests to Jay he should also see the GP about his forgetfulness. Although Jay is quite reluctant, Giani books the appointment and convinces Jay to see the GP as they are going there anyway. As Jay parks his 1964 Rover, he has a minor accident with another patient exiting the car park. He becomes irate, yelling and accusing them of backing into the front of his car. Giani took several minutes to calm Jay down and thought maybe this uncharacteristically short temper was one of his symptoms.

The GP, their long-time doctor, listens to Giani's concerns about Jay. The doctor sees that Jay is still emotional from the car incident and asks Jay whether he has noticed other changes in his mood or his usually calm demeanour. Jay admits he has been a lot more irritable lately and sometimes becomes anxious about the smallest things. The GP explains these could be behavioural symptoms of dementia and notes the impairment of ADLs (activities of daily living). He undertakes a series of tests and begins the initial steps for cognitive assessment, including a mini-mental state exam, and is alarmed at the results. He tells Jay and Giani to return 3 days later for another appointment and for more testing. It is apparent Jay has been masking his symptoms for a very long time.

After extensive testing, it is determined that Jay is experiencing the early stages of dementia.



Case study questions

1. How might a diagnosis of dementia change Giani and Jay's relationship?
2. Being gay and having dementia is referred to as 'a double whammy'. What do you think this means?
3. Before his diagnosis Jay burnt the scones. What are the safety considerations around the home for someone with a diagnosis of dementia?
4. How does the interdisciplinary team ensure the living situation is safe for Jay and Giani with this diagnosis?
5. A diagnosis of dementia is life changing. How should clinicians break life-changing news to patients?
6. What is the role of the aged care assessment team (ACAT) in the case of a dementia diagnosis?
7. How would other health professionals be involved in the diagnosis, care planning and treatment?

8. What support will Giani need to manage Jay's responsive behaviours?

Key information and links to other resources

The patient journey in dementia is complex, but the journey of care with regards to being gay may require additional support.

- Cramer, P., Barrett, C., Lambourne, S., & Latham, J. (2015). *We are still gay ... An evidence based resource exploring the experiences and needs of lesbian, gay, bisexual and trans people living with dementia*. Australian Research Centre in Sex, Health and Society, La Trobe University. <https://www.dementia.org.au/sites/default/files/NATIONAL/documents/Dementia-Narrative-Resource.pdf>



Thinking Point

While living with dementia is very challenging for everyone, one glimmer of light comes from the benefits of music and the arts. Jay and Giani are both talented musicians and performers, so think about how they might respond to the calming influence of beautiful music. There is an emerging body of evidence that music helps preserve memories, for example see:

- Beard, R. L. (2012). Art therapies and dementia care: A systematic review. *Dementia*, 11(5), 633-656. <https://doi.org/10.1177/1471301211421090>
- Kuot, A., Barton, E., Tiri, G., McKinlay, T., Greenhill, J., & Isaac, V. (2021). Personalised music for residents with dementia in an Australian rural aged-care setting. *Australian Journal of Rural Health*, 29(1), 71-77. <https://doi.org/10.1111/ajr.12691>
- Hamiduzzaman, M., Kuot, A., Greenhill, J., Strivens, E., Parajuli, D. R., & Isaac, V. (2020). *The nexus of 'music, mind, and well-being': Effects of harmony in the bush music intervention for residents with advanced dementia in Australian rural nursing homes*. Research Square. <https://doi.org/10.21203/rs.3.rs-67641/v1>



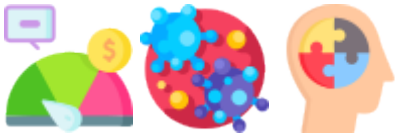
Case study 3 summary

The couple are even more stressed when it comes to light that Jay has symptoms of dementia. They have a supportive general practitioner who helps them to navigate the complexities of the community assessment and support services. This case study highlights the role of the general practitioner as a linchpin and gateway to other vital, specialised assessment and community health services. Many services are finding ways to support families from diverse backgrounds and some residential facilities are able to provide tailored services for the LGBTIQ+ communities.

1.5 CALOS-CLARK FAMILY CASE STUDY 4: CLIMATE EMERGENCY IMPACTS GIANI AND JAY'S HEALTH

Jennene Greenhill and Anna Foster

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Understand the impacts climate emergencies can have on acute and chronic conditions.
- Consider the changing distribution of illnesses associated with climate events.
- Articulate the role of the nurse in caring for and advocating for people experiencing climate emergencies.

Scenario

As Jay and Giani return home after discharge following Giani's total knee replacement, they prepare to launch their legal battle to protect their home and assets from Jules and Quinn.

The lawyer suggests having their house and belongings valued in case they need to sell in the future. They move everything out of the garage and out from under the house to prepare it for valuation. Jay places everything on the back lawn himself, as Giani is unable to assist during his recovery. Jay's plan is to either dispose of the items or sell them. Jay heads inside for lunch. He forgets he was going through the items and doesn't get them sorted.

Before any of their possessions can be moved, sold or put away, a very slow-moving east coast low hits the region. This is followed by a second east coast low a week later that remains almost stationary off the coast. Torrential rain continues for 3 weeks, leading to record flooding across the northern rivers region. The flooding is unlike anything previously experienced where they live in Brunswick Heads, not usually a flood prone area: the yard and lower level of the house are flooded with a combination of storm water runoff filled with debris and flood water from Simpsons Creek containing untreated sewage overflow from the flood damaged sewage plant. The water takes 5 days to fully recede, while Giani and Jay are trapped in the house with bottled water, a portable gas stove, and, luckily, a well-stocked pantry.

Cut off by the flooding, Giani's community nursing team and his physiotherapist are closed, which has meant he has not been able to continue with his postoperative mobility work. He is also unable to access his community nurse to receive the appropriate wound care. Jay is due to be assessed by an aged care assessment team (ACAT) team for support during his progressing dementia, but this has also been postponed as the team's offices were destroyed in the flooding. While the team intends to reschedule, they are not certain when that will be.

During the flooding, the town's infrastructure is badly damaged and Giani and Jay find themselves cut off from town water. They learn that the council is prioritising the repairs to this infrastructure, including the sewerage station. In the meantime, they decide to drink water from the tank Jay had installed in the back garden to water their vegetables. As they are unsure if the tank is contaminated by flood water, they decide to have the water tested. They call a local recovery volunteer hub, which assigns them a volunteer expert to undertake a microbiological test for faecal and total coliforms before they drink the water in 2 days' time.

After most of the water recedes, Giani and Jay attempt to start cleaning up their house site. They consider themselves quite lucky to escape with minimal damage to the house, mostly a heavy growth of mould and water damage to the living room from a leak in the tin roof. Both their cars are destroyed, and, having floated into the front yard, are now immovable. Their front stairs are badly damaged after being hit by a shipping container in the floodwater. It now rests on their neighbour's lawn. As they can't hose without water, they sweep what they can and pile the worst of the junk at the front ready for council collection. While Giani has limited mobility, he helps as much as he can, although the broom proves difficult. He has limited ability to lift objects and gets covered with the mud in the yard. He rinses himself off with tank water.

Several days later, Giani notices his knee appears swollen and red. He ignores it so he can keep supporting Jay with the clean-up. Some of their neighbours have returned and are able to assist with moving some of the heavier objects to the front of the home. Unfortunately, because so much debris has collected, their street is largely impassable. Giani becomes aware that Jay seems very confused, as well as complaining of a headache, fatigue and a sore neck and calls the Byron Bay hospital. The hospital is overwhelmed with high patient numbers and suggests contacting a GP or visiting one of the pop-up health clinics in the recovery centre. Giani also starts to feel unwell. He is short of breath, with a slight temperature, headache and muscle soreness. He puts these symptoms down to the clean-up work of the last week. He also wonders if he has perhaps caught Covid, as it is rife among volunteer groups.

Jay's confusion continues to worsen over the next 2 days. Giani becomes very concerned that Jay is not drinking enough and seems to have developed a rash. As Giani is also feeling extremely unwell, has constant nausea and some vomiting, he calls a friend from his dance group to take them both to the Tweed Hospital emergency department. The doctor on call assesses them both, takes vital signs, undertakes blood tests, a chest x-ray for Giani and has a nurse remove the soiled dressing on his knee. When exposed, the wound has broken down and started to dehisce (part or split) and there is some discharge. The nurse swabs and cleans the wound and the doctor sends the discharge for analysis, along with a blood test. The medical team suspect Giani may have an infection in the knee, and possibly leptospirosis which has been seen in the area after the floods. Jay is investigated for suspected Ross River virus from a mosquito bite.



Case study questions

1. If you were a primary care nurse, what role would you play in getting access to an assessment?
2. How do you gain access to reliable information on the distribution of climate illnesses as a nurse working in an area prone to climate emergencies?
3. How do climate emergencies impact distribution of illnesses?
4. What services may be available to support people with post-surgical care if they are not able to see their regular care providers? Consider the benefits of interprofessional health practice.
5. What are some of the greatest health risks associated with climate emergencies such as flooding, fire or storms?

Key information and links to other resources

Extreme weather events are on the rise due to the effects of human driven climate change. The planet relies on a very delicate balance of warming of the atmosphere from the sun's radiation. It is either being absorbed by the planet, which reflects that heat back to the atmosphere, where gases such as water vapour and carbon dioxide reside, absorbing the reflected heat, warming the planet, or cooling through the radiation energy from the sun being reflected back by aerosols in the atmosphere (Hanna & McIver, 2018).

While the natural warming effect is needed to keep the planet habitable, over the past few centuries since the industrial revolution, the balance has been disrupted (McDermott-Levy et al., 2019). Human factors (anthropogenic) affect this balance, as greenhouse gases, such as carbon dioxide

and methane, through the burning of fossil fuels, create a blanket-like effect around the planet as they absorb heat, blocking the ability of the planet's surface to eject heat (Costello et al., 2009).

As the warm atmosphere can hold more moisture, this means we see more extreme weather events such as cyclones, and storms that lead to flooding, amongst other events.

Some reading that may assist your understanding of the science behind climate change and the effects on health:

- McDermott-Levy, R., Kolanowski, A. M., Fick, D. M., & Mann, M. E. (2019). Addressing the health risks of climate change in older adults. *Journal of Gerontological Nursing*, 45(11), 21–29. <https://doi.org/10.3928/00989134-20191011-04>
- NSW Health: Infectious diseases fact sheets – this site will assist your understanding of conditions such as leptospirosis and Ross River virus.



Case study 4 summary

Giani had to have a surgical washout of his infected knee the day after his admission and undergo a treatment protocol with penicillin. In the meantime, the local community, led by Giani's drag bingo crew, rallied to clean up Giani and Jay's property and rebuild their stairs to improve access. The town water has also been restored and the volunteers were able to hose their home and property down and remove most of the mud.

Giani and Jay were discharged home from their hospital stay within days of each other. During Jay's admission, while he received intravenous fluids and pain relief, he mainly required rest. During the stay, Jay was linked with the social worker and ACAT, who completed their comprehensive assessment and started to put community services in place for Giani and Jay. Thankfully this also included some short-term links with the locum community health team who were working from the recovery hub. At this time, there are no indications that Jay can't stay at home with Giani as his carer, with additional support while Giani recovers from his knee operation.

References

- Costello, A., Abbas, M., Allen, A., Ball, S., Bell, S., Bellamy, R., Friel, S., Groce, N., Johnson, A., Kett, M., Lee, M., Levy, C., Maslin, M., McCoy, D., McGuire, B., Montgomery, H., Napier, D., Pagel, C., Patel, J., ... Patterson, C. (2009). Managing the health effects of climate change: Lancet and University College London Institute for Global Health Commission. *The Lancet*, 373(9676), 1693–1733. [https://doi.org/10.1016/S0140-6736\(09\)60935-1](https://doi.org/10.1016/S0140-6736(09)60935-1)
- Hanna, E. G & McIver, L. J. (2018). Climate change: A brief overview of the science and health impacts for Australia. *Medical Journal of Australia* (208)7, 311-315. <https://doi.org/10.5694/mja17.00640>

McDermott-Levy, R., Kolanowski, A. M., Fick, D. M., & Mann, M. E. (2019). Addressing the health risks of climate change in older adults. *Journal of Gerontological Nursing*, 45(11), 21–29. <https://doi.org/10.3928/00989134-20191011-04>

1.6 CALOS-CLARK FAMILY SUMMARY

Jennene Greenhill and Anna Foster

Summary

This part has focused on the health of Jay Clark and Giani Calos, a gay couple living in Brunswick Heads. The first case study is on the health impact following Giani having a total knee replacement that has a significant impact on Giani's active lifestyle and career as a drag queen. The second case study concerns equity and inclusion as the couple experience unprofessional, discriminatory behaviour from 2 nursing staff. Case study 3 involves Jay's rapid decline as they find out he has dementia and the couple need to navigate the complex community care processes to get support. The fourth and final case study reveals the major challenges as the heavens open and major floods cause a devastating climate emergency. Jay and Giani's health and wellbeing are at risk from these unpredictable major life events. As health professionals we need to be clinically skilled to optimise postoperative healing while being cognisant of the wider professional expectations as we encounter diverse people from all walks of life. The health impacts of climate change are going to continue to be a major priority for the future and we all need to consider how we can lead positive change for the wellbeing of individual, our communities and the planet!

Acknowledgements

The authors acknowledge the expert guidance of Professor Mark Hughes, Professor of Social Work at Southern Cross University, who reviewed this part.

Image attributions

Images not individually attributed are listed below in order of appearance in the part:

Chapter 1.1

Brunswick Heads map by OpenStreetMap is licensed under CC BY-SA 2.0

Katarina and Thiago image by Jonathan Borba on Pexels

Monty Carlo image by Esnehyder Mckullens on Pexels

Giani image by SHVETS production on Pexels

Jay image by Marcus Aurelius on Pexels

Jules image by gabananda on Pixabay

Quinn image by Pexels User on Pexels

Regan image by Pexels on Pixabay

Sasha image by Jeffrey Read on Pixabay

Chapter 1.2

Knee post-op image by Stephen Van Vorst is licensed under CC BY-SA 2.0

Knee x-ray image by Stephen Van Vorst is licensed under CC BY-SA 2.0

Icons

All icons in this part are from Flaticon and are listed below in order of first appearance in the part:

Introduction: Introduction icons created by Freepik – Flaticon

Musculoskeletal: Muscle icons created by Victoruler – Flaticon

Evidence-based practice: Analysis icons created by Uniconlabs – Flaticon

Objectives: Objective icons created by Uniconlabs – Flaticon

Case studies: Case study icons created by Flat Icons – Flaticon

Teamwork and collaborative practice: Communication icons created by Freepik – Flaticon

Thinking point: Creativity icons created by Freepik – Flaticon

Summary: Summary icons created by Freepik – Flaticon

Person-centred care: People icons created by Freepik – Flaticon

Therapeutic communication: Team icons created by Freepik – Flaticon

Cultural safety: People icons created by Freepik – Flaticon

Reflective practitioner: Self esteem icons created by Freepik – Flaticon

Neurological: Neurology icons created by Freepik – Flaticon

Preventing, minimising and responding to adverse events: Low risk icons created by Freepik – Flaticon

Infection prevention and control: Infection icons created by Freepik – Flaticon

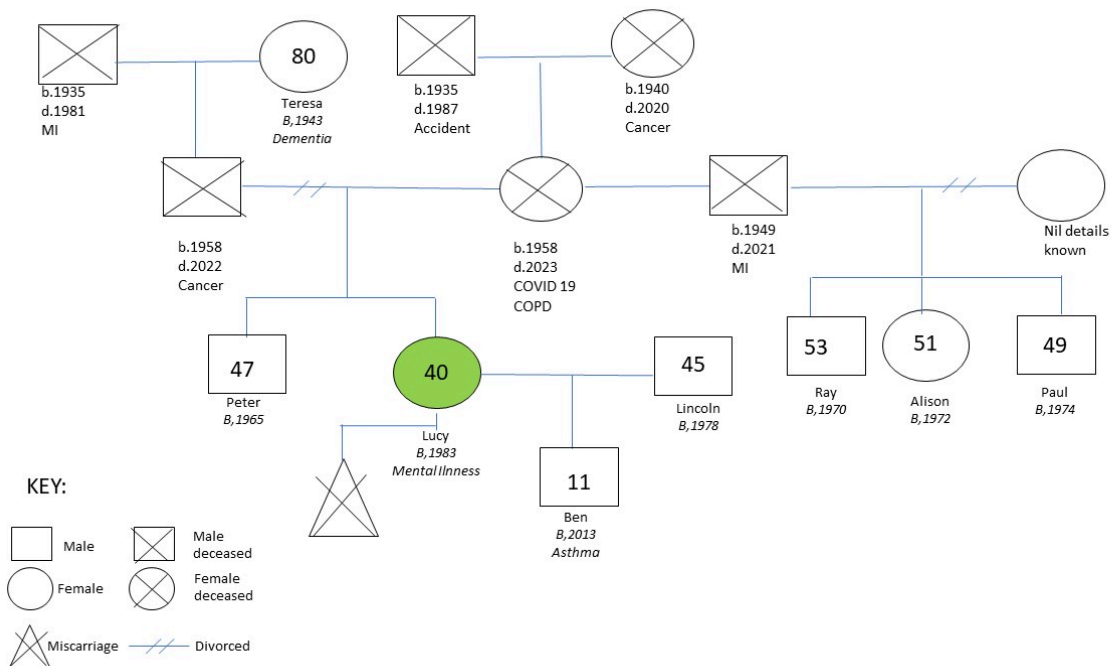
Clinical reasoning: Think icons created by Freepik – Flaticon

PART 2 LUCY'S STORY

2.1 INTRODUCTION TO LUCY'S STORY

Nicole Graham

Family genogram



Lucy's family genogram



Introduction to family and community

This part provides a series of case studies about Lucy, a Registered Nurse aged 40, who lives with mental illness. Lucy is born in Victoria, Australia in Bairnsdale, a small country town in East Gippsland. In her early years, Lucy is raised by her mother and father, both of whom emigrate to Australia in 1970 from England in the Assisted Passage Migration scheme, commonly termed 'Ten Pound Pom'. Lucy's mother works as a finance manager and her father is a publican at the local hotel. Lucy has an older brother who is ten years her senior. When Lucy is seven, her parents separate and her mother moves out of the family home. She lives next door with Lucy, while her brother (aged 17 at the time) stays with their father, having commenced his first job as a retail salesperson.



Bairnsdale

After approximately 12 months, her mother moves with Lucy to a neighbouring seaside town, Lakes Entrance, into a house owned by a professional fisherman. Lucy's mother becomes romantically involved with the fisherman, and, not long after, she marries him. Lucy's family expands to include a stepfather and three adult step-siblings. When she turns 13, Lucy is told that she, her mother and stepfather are moving from Victoria to Bundaberg, Queensland. This move limits her time with her biological father and brother to once or twice per year during school holidays. Lucy finalises her schooling at the end of year 10 just prior to turning 15, at which time she moves out to live in a caravan with an older boyfriend, aged 21, and his best friend.

As there are few opportunities for work living in a small coastal town in Queensland, Lucy is unemployed and is supported by her 21-year-old boyfriend, who receives unemployment benefits. The relationship between Lucy and her partner is complex and dependent. Lucy became pregnant at 16, which ended in a miscarriage. As a survivor of considerably complex life events, Lucy realises her life needs redirection. She seeks out opportunities for new friendships with the hope that she can re-establish herself, and separate from her boyfriend. After many intense emotional ups and downs, later diagnosed as bipolar affective disorder, Lucy experiences a series of life events that will forever impact her.



Lucy

In her early twenties, Lucy meets a man online and takes the opportunity to quickly end her relationship with her first boyfriend to move in with this new man, who has a stable home on the Gold Coast. Lucy is living carefree, without a solid plan. She joins her new partner in business. Two children later, she decides to study to become a Registered Nurse, a career goal she has had since childhood. She is a natural carer and quickly adjusts to the new role. She moves into the speciality of Emergency Nursing. A fast workplace, it matches well with

her endless energy and desire to work in an area faced with its own complexities and rapid turnaround. As a successful health professional, Lucy still lives with the impact of her history of trauma, the complexities of managing her wellness and her professional responsibilities. The treating team's diagnosis of mental illness is forever redefining as she experiences life challenges.

Her experiences of workplace bullying and the challenges of shift work, not to mention her anxiety and borderline personality vulnerabilities, all continue to impact her wellbeing.

2.2 LUCY CASE STUDY 1: TRAUMA

Nicole Graham

Introduction to case study



Lucy has experienced multiple traumas throughout her life, starting in infancy and extending into her adult life. If you compare her experiences against the Adverse Childhood Experiences study (ACES), Lucy scores incredibly highly across all three types of ACES: abuse, neglect and household dysfunction (Felitti et al., 1998). Lucy has experienced family domestic violence, sexual abuse and intimate partner violence. She is a survivor of a miscarriage during her teenage years and was separated from her biological sibling at an early age.



Learning Objectives

By the end of this case study, you should be able to:

- Identify the traumatic experiences Lucy has experienced.
- Classify the experiences according to abuse, neglect and/or household dysfunction.
- Identify what impact these experiences could have on Lucy's physical and mental wellbeing.

Scenario

Despite Lucy feeling loved by her mother, she recalls the moment she was told that her father did not want a second child, particularly not a daughter. Although she remembers affection from her father, she describes it as 'distant'. At the time when Lucy lived with parents, her father was dependant on alcohol and socialised with many members of the community. He was well respected amongst his peers, who described him as a 'character' and a 'good bloke.' He managed the local hotel and spent much of his time drinking with his regular customers. He would often drive home drunk, smelling of

stale beer. His character often altered in the privacy of his own home. Although Lucy's father was disengaged from her and her mother, he appeared to have a strong relationship with Lucy's brother.

Lucy recalls the arguments and yelling that were ever present in the family home. She would seek comfort and safety in the company of her brother during these times. Hearing threats of violence towards her mother was very stressful for her. Even though Lucy was young at the time, recalling memories from 5 to 7 years of age, she remembers being afraid of her father. She also remembers herself as a quiet child, interested in listening to the conversations of adults. Some of the conversations she remembers were when friends would advise her mother to leave her father, as he was often physically violent to the women with whom he was having extramarital affairs.

Lucy was aware of her father's 'special friends,' some of whom were kind and caring towards her. She recalls sitting in their kitchens or playing on their swings while he privately spoke with them. This occurred often, usually after he had collected Lucy from school when her mother was working. Even at an early age (between 5 and 7), Lucy knew that something was not right. She had promised her father never to tell her mother about these meetings because he had threatened to discipline her if she did. As an adult, Lucy now understands her father was having extramarital affairs with more than one woman in town. Lucy remembers once overhearing a conversation between her mother and a neighbour, who was also the local nurse. Lucy heard the nurse tell her mother that a woman had presented to the hospital after a significant physical assault and that Lucy's father was the perpetrator. The police had advised the patient not to pursue the issue further as Bairnsdale was a small town and everyone knew her father. Lucy recalls her mother being upset that Lucy had overheard the conversation. She told Lucy not to tell her father what she had heard as her mother was worried he would do the same to her.

Lucy recalls having mixed feelings about her dad. He was nice sometimes, often giving her chocolate and treats from work and working in the garden with her. At other times, she was afraid of his violence when he was drunk and was worried he would not approve of her. When he started to spend less time tending to the garden with Lucy, her father would exaggerate the time spent together in public. Lucy describes feeling alone and different from the relationships her peers had with their fathers.

At 7 years of age, Lucy's parents separated after increasingly loud verbal altercations between them, which always upset Lucy. Lucy and her mother moved into the house next door, the vacant home of a family friend. Her father became increasingly volatile and would turn up drunk to the house Lucy and her mother lived in. Lucy recalls having to lock the doors and being woken at night by all the yelling. At one point her mother whispered to Lucy to go over the road to their neighbour (the nurse), and call the police, as her father was threatening to kill them. Lucy recalls feeling safe in the nurse's home and welcomed her offer to stay there while the police attended to the call. Lucy fell asleep in the nurse's arms and woke startled from a nightmare. She dreamt her mother had been killed. The nurse provided comfort, support and reassurance that her mother would be fine.

This was when Lucy's mother realised they needed to find a home a safe distance from her father. Lucy recalls discussions between her mother and her close friend, where the initial plan was to relocate to a small Victorian rural town two hours away. However, there were challenges. Due to the

remoteness of the village, it was too far for Lucy to get to primary school and Lucy's mother would not be able to continue working. Fate stepped in and another option emerged. Lucy's mother was connected through her friend to a fisherman who was looking for a housekeeper. This meant free rent in exchange for someone to attend to the house and cook meals. Lucy's mother was very keen to take up this opportunity and the location was perfect: a large home in a seaside town. There was a good school and the town was close enough to maintain contact with Lucy's brother, who had chosen to remain living with his father. Lucy was 8 years old when she moved to Lakes Entrance, Victoria.



Lakes Entrance

After this move, life became less complicated. Lucy felt safe and liked her new school and bedroom. While she missed her brother and father, life was more stable, with no more fighting or yelling. After living there for a couple of months, her mother and the fisherman began a relationship. He had three adult children, 2 of whom were male aged 25 and 19, and one female aged 17, who moved back home around one year after the relationship started. Lucy recalls increasing conflict, as she became the target of nasty comments and later physical injuries through rough play. Lucy also recalls the oldest watching pornography loudly in the common lounge room. If her mother was home at the time, she would take Lucy out so she would not be exposed to inappropriate material. Her mother assured Lucy that the fisherman's children just needed time to adjust to the new relationship and that things would soon settle down. As Lucy moved towards 10 years old, things got worse before they got better. Lucy recalls feeling embarrassed about her developing body, enduring early puberty with comments every day from her new step siblings. The taunts made her very self-conscious of her body and she became quieter and more withdrawn. Her mother was busy within the new relationship and Lucy felt abandoned. She longed for her brother and life with her father did not seem so bad now. She begged to return to live with her brother. This was the signal to her mother that things were not going well.

Within a day of Lucy telling her mother about her desire to return home to her father, her mother took her away on a mini holiday. They took a trip to a farm to spend time with her mother's best friend. Lucy loved the farm and remembers how much she enjoyed spending time in the milking shed and helping with the cows. Towards the end of the holiday, her mother told Lucy that things had changed at their home in Lakes Entrance. The older children had been asked to move out and Lucy's mother wondered how Lucy would feel about going back. Lucy recalls saying she did not want to, but also

remembers the look on her mother's face when she said this. When Lucy saw how upset her mother was, she changed her mind and told her mum she would be ok about going back. Lucy's mother assured her that things would be better and she would be safe in the house.

Things were indeed better when they returned. After her visit to the farm, Lucy asked if she could have pets. Her mother agreed, and Lucy now had a dog, a cat and a rabbit, which she adored. Lucy was much happier and more settled now. The other children only visited the house occasionally and Lucy recalls that she did not have a great deal of interaction with them. School was going well and Lucy was now able to visit her brother, who had moved to Melbourne City for work. Then, when her mother told her they were moving to Queensland, Lucy was shocked. Her first concern was for her pets. Lucy was told they could only take their cat. Lucy recalls feeling numb and still into adulthood wonders what happened to her beloved pets.

Moving to the small coastal town of Bundaberg in Queensland was a positive experience for Lucy for the first three years, during which time she experienced no significant issues. As Lucy developed into a young woman, young men began to take interest. Lucy enjoyed the attention and began to date. When Lucy was 14, a friend of her mother and stepfather, a man in his forties, spent a lot of time complimenting Lucy on her developing body. He often commented that he wished he were younger so he could date her. One evening, as her parents sat in the lounge room, he followed her to her bedroom, claiming he needed to use the bathroom. This man then inappropriately and, uninvited, touched Lucy. Lucy remembers that she did not respond, again felt numb inside, and revisited that sense of being unsafe. He stopped when she turned away. Later, a different older male friend of the family also sexually abused her.

After this, Lucy spent more time outside the home with her friends. She started to miss school, preferred to drink with male friends and became sexually active. Her mother intervened and took her to see a counsellor where Lucy disclosed the experiences she had with her parents' friends. While her mother was informed, she took no further action. Lucy is convinced her parents did not believe her and instead saw her as a rebellious teenager. When Lucy's mother attempted to put firmer rules in place, Lucy pushed back and, when she turned 15, moved into a shared caravan with her boyfriend Lucas, who was 6 years older. The new relationship she had with her boyfriend was strong and it was not long after that she discovered she was pregnant. Unfortunately, it was a nonviable intrauterine pregnancy, which ended in a spontaneous abortion. Lucy felt abandoned and distressed. She did not tell anyone, apart from Lucas, about this loss. She continued for some time as though nothing had happened and that her pregnancy was progressing as normal.

Lucy experienced intimate partner violence when Lucas would drink, much like her mother had experienced. She was convinced that things would improve once they had a child together. During this time Lucy was very much isolated with minimal friends and little support from family.



Case study questions

1. Can you identify the Adverse Childhood Events (ACEs) Lucy experienced?
2. Can you identify other events in Lucy's life that could also have contributed to the trauma she experienced?
3. If you were providing support and care for Lucy, what could you do to ensure you do not contribute to re-traumatising her?
4. What impacts do you think Lucy's life experiences could have on her relationships?
5. As Lucy is a Registered Nurse working in the speciality of Emergency Nursing, what professional risks could be involved?
6. When a person survives childhood and ongoing trauma, how do you think this could impact a person's wellbeing, both physically and emotionally?

Key information and links to other resources

Lucy has experienced significant trauma throughout her childhood and into adulthood. Trauma-informed care (TIC) is founded on the recognition of the impact of trauma on both physical and mental health. Speck et al. (2023) recommend six TIC principles that need to be demonstrated when providing care for a woman with past trauma. These include:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment
6. Cultural, historical and gender issues

There are several interventions that can support these principles. The emphasis is on ensuring the person is provided the opportunity to maintain control over their care and life decisions, as well as utilising peer support (Speck et al., 2023). The resources listed below can offer further support and assistance to developing further skills in TIC.



Organisations providing information relevant to this case study

- Centers for Disease Control and Prevention: Adverse Childhood Experiences
- Blue Knot Foundation: National centre of excellence for complex trauma
- Bravehearts
- Domestic Violence Prevention Centre



Thinking point

Healthcare workers place the care of the service user and their family at the forefront. It is not unusual for a healthcare worker to have had personal experience of trauma, being exposed to professional traumatic adverse experiences and events, or the experiences of the people they care for (Morris et.al, 2022). The healthcare worker role can contribute to experiences of compassion fatigue, burn out and secondary traumatic stress (Morris et.al, 2022; Wolotira, 2023). It is essential for healthcare workers to embed strategies to mitigate the effects of trauma.

Read the following article and identify techniques to add to your self-care and resilience toolbox:

- Wolotira, E. A. (2023). Trauma, compassion fatigue, and burnout in nurses: The nurse leader's response. *Nurse Leader*, 21(2), 202–206. <https://doi.org/10.1016/j.mnl.2022.04.009>



Thinking point

LGBTIQ+ individuals experience barriers to affirmative care and disproportionately experience higher rates of trauma (Zhou et al, 2023). Reflect on your local area population and the care they may receive. Identify the health services in your area that provide affirmative and trauma-informed care. Review the following resources and identify strategies that could be implemented.

- Say It Out Loud: Practice considerations

Language is incredibly important in providing affirmative trauma-informed care. Often the terms we use to describe people of diverse backgrounds are inadequate or incorrect. Say It Out Loud also offers a language guide. Review the following document and reflect on your understanding of each term and the importance that language has on providing trauma-informed care.

- ACON Trans-affirming language guide



Case study 1 summary

Through this case study you have had the opportunity to learn more about Lucy's traumatic experiences throughout her lifespan. These events have significantly affected Lucy and her relationships. You have been able to identify these events and considered how you would incorporate trauma-informed care into your practice. There are some helpful resources that are available to not only support Lucy in her recovery but also you as a health professional.

References

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine*, 14(4), 245-258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Morris, D., Svetlicic, J., Grice, D., Turner, K., & Graham, N. (2022). Collaborative approach to supporting staff in a mental healthcare setting: "Always There" peer support program. *Issues in Mental Health Nursing*, 43(1), 42–50. <https://doi.org/10.1080/01612840.2021.1953651>
- Speck, P. M., Robinson, L. S., Johnson, K., & Mays, L. (2023). Care for women with past trauma using trauma-informed care. *Advances in Family Practice Nursing*, 5(1), 119–135. <https://doi.org/10.1016/j.yfpn.2022.11.002>
- Wolotira, E. A. (2022). Trauma, compassion fatigue, and burnout in nurses: The nurse leader's response. *Nurse Leader*, 21(2), 202-206. <https://doi.org/10.1016/j.mnl.2022.04.009>
- Zhou, C., Szwed, S., Wickersham, M., McDarby, M., Spellun, J., & Zonana, J. (2023). The patient population of a no-cost, student-run LGBTQ+ mental health clinic: A case for equitable and

trauma-informed care. *Journal of Gay & Lesbian Mental Health*. Advance online publication. <https://doi.org/10.1080/19359705.2023.2183536>

2.3 LUCY CASE STUDY 2: ADOLESCENT PREGNANCY

Nicole Graham

Introduction to case study



Lucy is familiar with trauma and her life has changed in such a brief period. Now living with her older partner, she is excited to learn she is pregnant shortly after her 16th birthday.



Learning Objectives

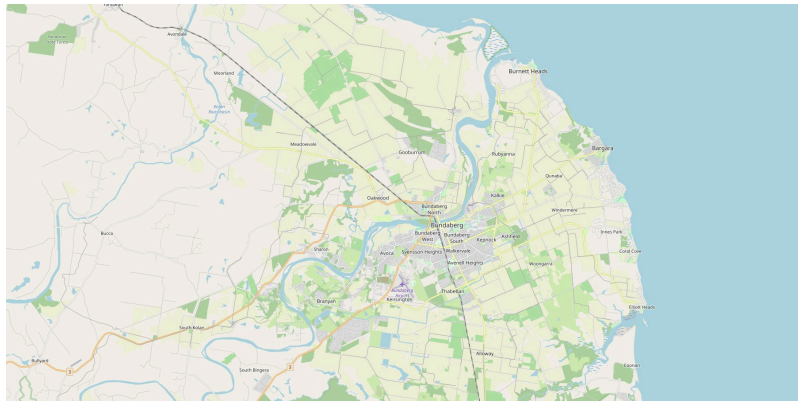
By the end of this case study, you should be able to:

- Identify the biological, social, and psychological impacts of a pregnancy during adolescence.
- Explore the health risk factors that may present.
- Consider the psychological impact on a young woman who experiences the loss of pregnancy.

Scenario

As we mentioned in the previous case study, Lucy met her partner Lucas at 15. He was 21 at the time. Lucy as a young adolescent was physically well developed and she felt mature for her age. Within only a short couple of months, at 15 and 4 months of age, Lucy realised she was pregnant. She was excited at the thought of becoming a mum; she loved children and wanted to have someone who would love her unconditionally. She told her partner Lucas, who was supportive. When Lucy told her mother, she was met with concern and advice that pregnancy is not easy at 15. Lucy recalls not taking on her mother's advice to have a termination. When she attended her first

ultrasound, she left incredibly happy with the image of early pregnancy. With the little money she had she purchased second hand baby clothing. She was happy and was proud to tell people she was expecting her first child.



Bundaberg map

Lucas was concerned about money and the need to move into a bigger place. They were living in a shared caravan with one other man, a friend of Lucas', with no privacy or room to move. Lucy and Lucas were confined to a bed and outdoor area within the caravan park. The caravan park itself was run down and considered 'rough.' Lucas, who worked for a local council as a labourer, would spend his time drinking after work. The more he drank, the more frustrated he became at their living conditions. Lucas had the support of his family, who also welcomed the news of Lucy's pregnancy. His parents offered to rent them a holiday house they owned in Bundaberg for a small amount of money each week. The plan was for Lucy and Lucas to marry and eventually buy the home.

Lucy felt increasingly happy. Her life was coming together, just as she imagined it. At 8 weeks gestation, Lucy and Lucas moved into the house. Shortly after moving, Lucy noticed spots of blood on her underwear. She did not know what to do nor who to call. Lucas took her to the local hospital. During the consultation, she overheard a nurse say it would be a blessing if she lost the baby as she was so young. Lucy felt judged and angry. She insisted that Lucas take her home. The doctor stopped her as she was getting changed and talked Lucy into agreeing to an examination and further advice. The doctor referred her for an ultrasound and conducted an internal examination, confirming that the pregnancy was still viable with a strong foetal heartrate of 150 beats per minute. The doctor advised Lucy that she needed prenatal care and referred her to the midwifery unit. The doctor also encouraged her to reconnect with her parents for support from family. Lucy recalls she did not really take on board the information and left the hospital before the midwife came to see her.

Over the next 3 weeks Lucy felt full of energy. Life was returning to normal. She remembers it as an intense feeling of energy and restlessness. She began an intense exercise regime and ran twice a day. She also had difficulty sleeping, with many thoughts going through her mind. She used this time to craft and made items out of recycled materials, often going through her neighbour's recycling bin for additional craft supplies. Her energy allowed her to prepare a nursery, which she decorated with abstract art and crafted decorative items. Lucas would often tell her to rest and that she needed to care for herself and baby. Lucy said she was doing just that and would often argue with Lucas that he did not understand that being pregnant brought intense energy.

This feeling changed around the 11-week gestation period when Lucy described a different feeling. She had been running when she experienced a pain, much like menstruation pain. It was different from the previous spotting. Lucy alerted a passer-by who called an ambulance. At the hospital, Lucy was advised that she was experiencing a spontaneous abortion and that she may require a dilation and curettage. Lucy refused to believe she had lost her baby and discharged herself against medical advice. Lucas picked her up and took her home. Lucy recalls feeling devastated and went to bed, a place she would remain for weeks. Lucy's pregnancy had spontaneously aborted, with no further complications. Her room was dark, she stopped talking to Lucas and spent hours sleeping. She recalls Lucas getting agitated and telling her to get out of bed and eat. At one point he dragged her into a cold shower and slapped her across the face. Lucy recalls feeling like life had ended. She had no energy.

Lucas eventually called a doctor who attended Lucy at their house. The doctor prescribed amitriptyline, an antidepressant, and told Lucy it was normal to experience grief after a pregnancy loss. Within what she describes as days, Lucy felt an intense surge of energy. She was happy the medication worked so quickly. She had not told anyone she had lost her baby and continued as normal. Lucas didn't understand, but respected Lucy's wishes. She attempted to become pregnant again so no-one would know. Lucy was upset each month she did not become pregnant. Lucy knew this could not continue as people were asking her about her health and that of the baby. She told her family and friends about the tragedy of losing the baby around the time she would have been 7 months pregnant. She offered no explanation to her family and friends, nor gave any details about the timing. She asked that they not speak of it again.



Case study questions

1. Identify the biological, social, and psychological stressors for both Lucy and Lucas.
2. What health education might have supported Lucy during her pregnancy and at the time she presented to hospital?
3. Given Lucy's prior history of trauma, what engagement strategies might help develop and maintain a therapeutic relationship?
4. After the pregnancy loss, what further support might be beneficial to both Lucy and Lucas?



Key information and links to other resources

Galeotti et al. (2022) recognise in a scoping review that miscarriage can have both short- and long-term emotional impacts for both men and women. They further suggest that hospitals and staff need to act to improve the emotional support of women and men who are experiencing a tragic loss of pregnancy. Lack of compassion, insensitive communication, excessive wait times for assessment, procedures, treatment and lack of privacy were the key contributors of stress and anxiety for both parents (Galeotti et al., 2022). The resources below can help clinicians become more trauma-informed when faced with the tragedy of miscarriage.

Sources of information relevant to this case study

- Raising Children: Teenage pregnancy: A guide for parents of pregnant teenagers
- Sands miscarriage, stillbirth & newborn death support: A father's grief
- Beyond Blue



Thinking point

Young parents experience higher rates of stereotyping and discrimination. The Australian Human Rights Commission (2017) conducted a project investigating the rights and needs of young parents and their children, finding that young parents and their children are very vulnerable to poorer physical health and have elevated risks to their emotional and social wellbeing. Despite these challenges, the report finds that young parents are very motivated to provide the best care for their children (Australian Human Rights Commission, 2017).

Review the data in the report and document the significant challenges encountered by young parents. Identify how many barriers could be overcome with the support of an interdisciplinary health care team.

- Australian Human Rights Commission. (2017). *The rights and needs of young parents and their children: A summary of key findings from the Children's Rights Report 2017*.
<https://humanrights.gov.au/our-work/publications/summary-childrens-rights-report-2017>



Thinking point

There has been an increase in stories of pregnancy loss in the media, which is potentially encouraging more people to discuss their own individual experiences (Budin, 2021). Queensland Health has developed a Clinical Care Guideline (2022) for early pregnancy loss, which highlights not only the physical health assessment and treatment response, but also psychological support and sensitive handling of foetal tissue and/or remains.

Review the clinical care guidelines in relation to a presentation like Lucy's; identify the clinical care recommendations; and reflect on how you could enhance the process through taking a trauma-informed approach.

- Queensland Health. (2023). *Queensland clinical guidelines: Translating evidence into best clinical practice*. <https://www.health.qld.gov.au/qcg>



Case study 2 summary

Through this case study you have had the opportunity to learn more about both Lucy's and Lucas' pregnancy experiences and traumatic loss. You have learned how this event had a significant impact on Lucy's mental health. You have been able to identify the variety of impacts across physical, social, and psychological wellbeing and considered how you may need to adapt your engagement strategies to suit individual needs.

References

- Australian Human Rights Commission. (2017). *The rights and needs of young parents and their children: A summary of key findings from the Children's Rights Report 2017*. <https://humanrights.gov.au/our-work/publications/summary-childrens-rights-report-2017>
- Budin, W. C. (2020). In This Issue-Confronting Pregnancy Loss. *The Journal of Perinatal Education*, 29(1), 3–5. <https://doi.org/10.1891/1058-1243.29.1.3>
- Galeotti, M., Mitchell, G., Tomlinson, M., & Aventin, Á. (2022). Factors affecting the emotional wellbeing of women and men who experience miscarriage in hospital settings: A scoping review. *BMC Pregnancy and Childbirth*, 22, Article 270. <https://doi.org/10.1186/s12884-022-04585-3>

Queensland Clinical Guidelines. (2022). *Early pregnancy loss* (Document number MN22.29-V6-R27). https://www.health.qld.gov.au/__data/assets/pdf_file/0033/139947/g-epl.pdf

2.4 LUCY CASE STUDY 3: MENTAL ILLNESS DIAGNOSIS

Nicole Graham

Introduction to case study



Lucy has experienced the symptoms of mental illness during her lifespan; however, it was not until her early twenties that she was formally diagnosed with bipolar affective disorder. In the case study below, we explore the symptomology that Lucy experienced in the lead up to and post diagnosis. Lucy needs to consider her mental illness in relation to her work as a Registered Nurse and as she continues to move through the various stages of adulthood.



Learning Objectives

By the end of this case study, you should be able to:

- Identify and consider the symptoms of mental illness.
- Develop an understanding of contributing biopsychosocial stressors that may exacerbate the symptoms of mental illness as experienced by Lucy.
- Critically analyse the professional, ethical, and legal requirements and considerations for a registered health professional living with chronic illness.

Scenario

Lucy's small group of friends describe her as energetic and 'a party person'. Although she sometimes disappears from her social group for periods of time, her friends are not aware that Lucy experiences periods of intense depression. At times Lucy cannot find the energy to get out of bed or

even get dressed, sometimes for extended periods. As she gets older, these feelings and moods, as she describes them, get more intense. She loves feeling high on life. This is when she has an abundance of energy, is not worried about what people think of her and often does not need to sleep. These are the times when she feels she can achieve her goals. One of these times is when she decides to become a nurse. She excels at university, loves the intensity of study, practice and the party lifestyle. Emergency Nursing is her calling. The fast pace, the quick turnaround matches her endless energy. The fact that she struggles to stay focused for extended periods of time is something she needs to consider in her nursing career, to ensure it does not impact negatively on her care.

Unfortunately, Lucy has experienced challenges in her career. For example, her manager often comments on her mental illness after she had openly disclosed her diagnosis. It is challenging for her to hear her colleagues speak badly about a person who presents with mental illness. The stigma she hears directed at others challenges her. She is also very aware that it could be her presenting to the Emergency Department when she is unwell and in need of further support. Lucy is constantly worried that her colleagues will read her medical chart and think she is unsafe to practice.

While the symptoms that cause significant distress and disruption to her life began in her late teens, they intensified after she commenced antidepressant medication after the loss of her child. She subsequently ceased taking them due to side effects. These medications particularly impact on her ability to be creative and reduce her libido and energy. By the time she turns 18, she notices more frequent, intense mood swings, often accompanied by intense feelings of anxiety. During her high periods, Lucy enjoys the energy, the feeling of euphoria, the increased desire to exercise, her engagement with people, and being impulsive and creative. Lucas appreciates her increased libido. However, during these periods of high mood, Lucy also has impaired boundaries and is often flirtatious in her behaviour towards both friends and people she doesn't know. She also increases her spending and has limited sleep. Lucas is often frustrated by this behaviour, leading to fights. On occasion Lucas slaps her and gets into fights with the people she is flirting with. These periods can last days and sometimes weeks, always followed by depressive episodes.

When she is in the low phases of her mood, Lucy experiences an overwhelming sense of hopelessness and emptiness. She is unable to find the energy to get out of bed, shower or take interest in simple daily activities. Lucas gets frustrated and dismisses Lucy's statements of wanting to end her life as 'attention seeking'. Lucy often expresses the desire to leave this world when she feels this way. When Lucas seeks support from the local general practitioner, nothing really gets resolved. The GP prescribes the medication; Lucy regains her desire to participate in life; then stops the medication due to side effects which extend to gastrointestinal upsets, on top of the decrease in libido and not feeling like herself. When Lucy is referred to a psychologist, she does not engage for more than one session, saying that she doesn't like the person and feels they judge her lifestyle. When the psychologist attempts to explore a family history of mental illness, Lucy says no- one in her family has it and dismisses the concept.

The intense ups and downs are briefly interrupted with periods of lower intensity. During these times, Lucy feels worried about various aspects of her life and finds it challenging to let go of her anxious thoughts. There are times when Lucy has symptoms like racing heart, gastrointestinal upset and

shortness of breath. She spends a great deal of time wanting her life to be better. Her desire to move on from Lucas and to start a new life becomes more intense. Lucy is confident this is not a symptom of depression; it is just that she is unhappy in her relationship. Lucy starts to consider career options, feeling that not working affects her lifestyle, freedom and health. As she explores different options on the internet, Lucy comes across a chat room. Using the chat name 'Foxy Lady 20', she develops new friendships. She finds herself talking a lot with a man named Lincoln who lives on the Gold Coast.



Gold Coast

After a brief but intense period talking with Lincoln online, Lucy abruptly decides to leave Lucas and her life in Bundaberg to move in with Lincoln. Lincoln, aged 26, 5 years older than Lucy, owns a modest home on the Gold Coast and has stable employment at the local casino. Their relationship progresses quickly and within a month Lincoln has proposed to Lucy. They plan to marry within 12 months.

Lucy is now happy with her life and feels stable. She decides to pursue a degree in nursing at the local university. Lucy enrolls and makes many new friends, enjoying the intensity of study and a new social scene. Her fiancé Lincoln also enjoys the social aspects of their relationship. During university examination periods, Lucy experiences strong emotions. At the suggestion of an academic she respects, she makes an appointment with the university counselling service. After the first 3 appointments, Lucy self-discovers, with the support of her counsellor, that she might benefit from a specialist consultation with a psychiatrist. She comes to recognise that her symptoms are not within the normal range experienced by her peers. Lincoln is incredibly supportive and attends the appointments with Lucy, extending on the information she provides. Lucy reveals information about her grandmother, who was considered eccentric, and known for her periods of elevated mood and manic behaviour. The treating psychiatrist suggests Lucy may be living with bipolar affective disorder and encourages her to trial the medication lithium.

Lucy does not enjoy the side effects of decreased energy, nausea and feeling dazed and ceases taking the lithium during the university break period. This causes Lucy to again experience an intense elevation of her mood, accompanied by risk-taking behaviours. Lucy goes out frequently, nightclubbing and being flirtatious with her friends. She becomes aggressive towards a woman who

confronts Lucy about her behaviour with her boyfriend in the nightclub. This is the first time Lucy exhibits this type of response, along with very pressured speech, pacing and an inability to calm herself. The police are called. They recommend Lucy gets assessed at the hospital after hearing from Lincoln that she has ceased her medication. Lucy is admitted for a brief period in the acute mental health ward. After stabilising and recommencing lithium, Lucy returns to the care of her psychiatrist in the community. The discharge notes report that Lucy had been previously diagnosed with bipolar disorder, may also be experiencing anxiety related symptoms, and have personality vulnerabilities.

Lucy is in the final year of her university studies when she has a professional experience placement in the emergency ward. Lucy really enjoys the fast pace, as well as the variety of complex presentations. Lucy feels it matches her energy and her desire for frequent change. After she completes her studies, Lucy applies and is successful in obtaining a position at the local hospital. Throughout her initial graduate year, Lucy balances life with a diagnosis of mental illness as well as a program of her own self-care. She finds the roster patterns in particular incredibly challenging and again becomes unwell. She goes through a period of depression and is unable to work. During this period, Lucy experiences an overwhelming sense of hopelessness and considers ending her life. Again, she requires a higher level of engagement from her treating team. Lucy agrees she is not fit to work during this time and has a period of leave without pay to recover. She has disclosed to her manager that she has been diagnosed with a mental illness and later discusses how shift work impacts her sleep and her overall mental wellbeing.

Over time, Lucy develops strategies to maintain wellness. However, she describes her relationship with the Nursing Unit Manager as strained, due to her inability to work night shift as her medical certificate shows. Lucy says she is often reminded of the impact that her set roster has on her colleagues. Lucy also feels unheard and dismissed when she raises workplace concerns, as her manager attributes her feelings to her mental health deteriorating. Lucy has a further period when her mental health deteriorates. However, this time it is due to a change in her medication.

As Lucy and Lincoln have a desire to have a child, Lucy was advised that she cease lithium in favour of lamotrigine, to reduce the risk of harm to the baby. Lucy ceases work during the period when her mental health deteriorates during the initial phase of changing medication. Lucy recommences lithium after she ceases breastfeeding their son at 4 months, with good effect and returns to work.



Case study questions

1. Consider the symptoms that Lucy experiences and indicate whether they align with the

suggested diagnosis.

2. Identify the biopsychosocial contributing factors that could impact mental health and wellness.
3. Review and identify the professional disclosure requirements of a Registered Nurse who lives with mental illness in your local area.
4. Identify self-care strategies that Lucy or yourself as a health professional could implement to support mental health and wellbeing.



Thinking point

Sometimes people do not agree with a diagnosis of mental illness, which can be incorrectly labelled as 'denial' by health professionals. It is possible that the person is unable to perceive or be aware of their illness. This inability of insight is termed anosognosia (Amador, 2023). The cause of anosognosia in simple terms can be due to a non-functioning or impaired part of the frontal lobe of the brain, which may be caused by schizophrenia, bipolar disorder or other diseases such as dementia (Kirsch et al., 2021).

As healthcare workers will likely care for someone who is experiencing anosognosia, it is important to reflect on how you may work with someone who does not have the level of insight you would have hoped. Below is a roleplay activity whereby you can experience what it might be like to communicate with someone experiencing anosognosia. Reflect on your communication skills and identify strategies you could use to improve your therapeutic engagement.

Role play activity – Caring for a person who is experiencing anosognosia

Learning objectives

1. Demonstrate therapeutic engagement with someone who is experiencing mental illness
2. Identify effective communication skills
3. Reflect on challenges and identify professional learning needs

Resources required

- Suitable location to act out scene.
 - One additional person to play the role of service user.
-

Task

Two people assume role of either service user or clinician. If time permits, switch roles and repeat.

Background

- Lucy has been commenced on lithium carbonate ER for treatment of her bipolar disorder.
- Lucy is attending the health care facility every week, as per the treating psychiatrist's requests.
- The clinician's role is to monitor whether Lucy is experiencing any side effects.

Role 1 – Clinician

- Clinician assumes role of health care worker in a health care setting of choice.
- Lucy has presented and your role is to ask Lucy whether she is experiencing any side effects and whether she has noticed any improvements in her mental state.

Role 2 – Lucy who lives with bipolar

- Lucy responds that she does not understand the need for the tablets. She also denies having a mental illness. Lucy says she will do what she is told, but does not think there is anything wrong with her. Lucy thinks she is just an energetic person who at times gets sad, which she describes as 'perfectly normal.' Lucy is not experiencing any negative side effects, but says she would like clarification about why the doctor has prescribed this medication.
-

Post role play debrief

Reflect and discuss your experiences, both as Lucy and as the clinician. Identify and discuss what was effective and what were the challenges.

Identify professional development opportunities and develop a learning plan to achieve your goals.

Additional resources that might be helpful

- Australian Prescriber: Lithium therapy and its interactions
- LEAP Institute: The impact of anosognosia and noncompliance (video)

Key information and links to other resources

Fisher (2022) suggests there are large numbers of health professionals who live with mental illness and recognise the practice value that comes with lived experience. However, the author also notes that as stigma is rife within the health care environment, disclosing mental illness can trigger an enhanced surveillance of the health professional's practice or impede professional relationships (Fisher, 2022).

It is evident that the case studies derived from Lucy's life story are complex and holistic care is essential. The biopsychosocial model was first conceptualised in 1977 by George Engel, who suggests it is not only a person's medical condition, but also psychological and social factors that influence health and wellbeing (Engel, 2012).

Below are examples of what you as a health professional could consider in each domain.

- **Biological:** Age, gender, physical health conditions, drug effects, genetic vulnerabilities
- **Psychological:** Emotions, thoughts, behaviours, coping skills, values
- **Social:** Living situation, social environment, work, relationships, finances, education

Developing skills through engaging in reflective practice and professional development is essential. Each person is unique, which requires you as the professional to adapt to their particular circumstances. The resources below can help you develop understanding of both regulatory requirements and the diagnosis Lucy is living with.



Organisations providing information relevant to this case study

- Rethink Mental Illness: Bipolar disorder
- Australian Health Practitioner Regulation Agency (AHPRA): Resources – helping you understand mandatory notifications
- Australian Health Practitioner Regulation Agency (AHPRA): Podcast – Mental health of nurses, midwives and the people they care for

- Black Dog Institute: TEN – The essential network for health professionals
- Borderline Personality Disorder Community
- National Institute of Mental Health (NIMH): Anxiety disorders



Case study 3 summary

In this case study, Lucy's symptoms of mental illness emerge in her teenage years. Lucy describes periods of intense mood, both elevated and depressed, as well as potential anxiety-related responses. It is not until she develops a therapeutic relationship with a university school-based counsellor that she realises it might be beneficial to engage the services of a psychiatrist. After she is diagnosed with bipolar affective disorder she engages in treatment. Lucy shares her experience of both inpatient and community treatment as well as her professional practice requirements in the context of her mental illness.

References

- Amador, X. (2023). Denial of anosognosia in schizophrenia. *Schizophrenia Research*, 252, 242–243. <https://doi.org/10.1016/j.schres.2023.01.009>
- Engel, G. (2012). The need for a new medical model: A challenge for biomedicine. *Psychodynamic Psychiatry*, 40(3), 377–396. <https://doi.org/10.1521/pdps.2012.40.3.377>
- Fisher, J. (2023). Who am I? The identity crisis of mental health professionals living with mental illness. *Journal of Psychiatric and Mental Health Nursing*. Advance online publication. <https://doi.org/10.1111/jpm.12930>
- Kirsch, L. P., Mathys, C., Papadaki, C., Talelli, P., Friston, K., Moro, V., & Fotopoulou, A. (2021). Updating beliefs beyond the here-and-now: The counter-factual self in anosognosia for hemiplegia. *Brain Communications*, 3(2), Article fcab098. <https://doi.org/10.1093/braincomms/fcab098>

2.5 LUCY'S STORY SUMMARY

Nicole Graham

Summary

This part provides case studies focused on Lucy, a Registered Nurse who lives with mental illness. Throughout Lucy's lifespan, she experiences many adverse childhood experiences, a history of partner abuse and ongoing workplace stigma and biased behaviours. These experiences impact her relationships, negatively affect her mental wellbeing and highlight the importance of trauma-informed care in health professional practice. Lucy has brief periods of safety, often overshadowed by experiences of abuse or significant loss. Her symptoms of intense elevated or depressed mood, often overshadowed by life circumstances, are eventually diagnosed in her early twenties. Lucy willingly engages in both inpatient and community treatment. She goes on to have a successful career in the Emergency Department, with continuing assessment of her fitness to practice and a requirement to ensure a balance of work and self-care.

Image attributions

Images not individually attributed are listed below in order of appearance in the part:

Chapter 2.1

Bairnsdale image by Ralf Genge on Pixabay

Lucy image by Van3ssa Zheki Dazzy on Pixabay

Chapter 2.2

Lakes Entrance image by Mark Wyld on Pixabay

Chapter 2.3

Bundaberg map by OpenStreetMap is licensed under CC BY-SA 2.0

Chapter 2.4

Gold Coast image by Nathan Cowley on Pexels

Icons

All icons in this part are from Flaticon and are listed below in order of first appearance in the part:

Introduction: Introduction icons created by Freepik – Flaticon

Mental health: Mental health icons created by Freepik – Flaticon

Person-centred care: People icons created by Freepik – Flaticon

Therapeutic communication: Team icons created by Freepik – Flaticon

Cultural safety: People icons created by Freepik – Flaticon

Preventing, minimising and responding to adverse events: Low risk icons created by Freepik – Flaticon

Objectives: Objective icons created by Uniconlabs – Flaticon

Case studies: Case study icons created by Flat Icons – Flaticon

Teamwork and collaborative practice: Communication icons created by Freepik – Flaticon

Thinking point: Creativity icons created by Freepik – Flaticon

Summary: Summary icons created by Freepik – Flaticon

Reproductive: Uterus icons created by Freepik – Flaticon

Self-care and resilience: Peace icons created by Freepik – Flaticon

Clinical reasoning: Think icons created by Freepik – Flaticon

Evidence-based practice: Analysis icons created by Uniconlabs – Flaticon

Medication safety: Health insurance icons created by Freepik – Flaticon

Reflective practitioner: Self esteem icons created by Freepik – Flaticon

S – Social: Society icons created by Freepik – Flaticon

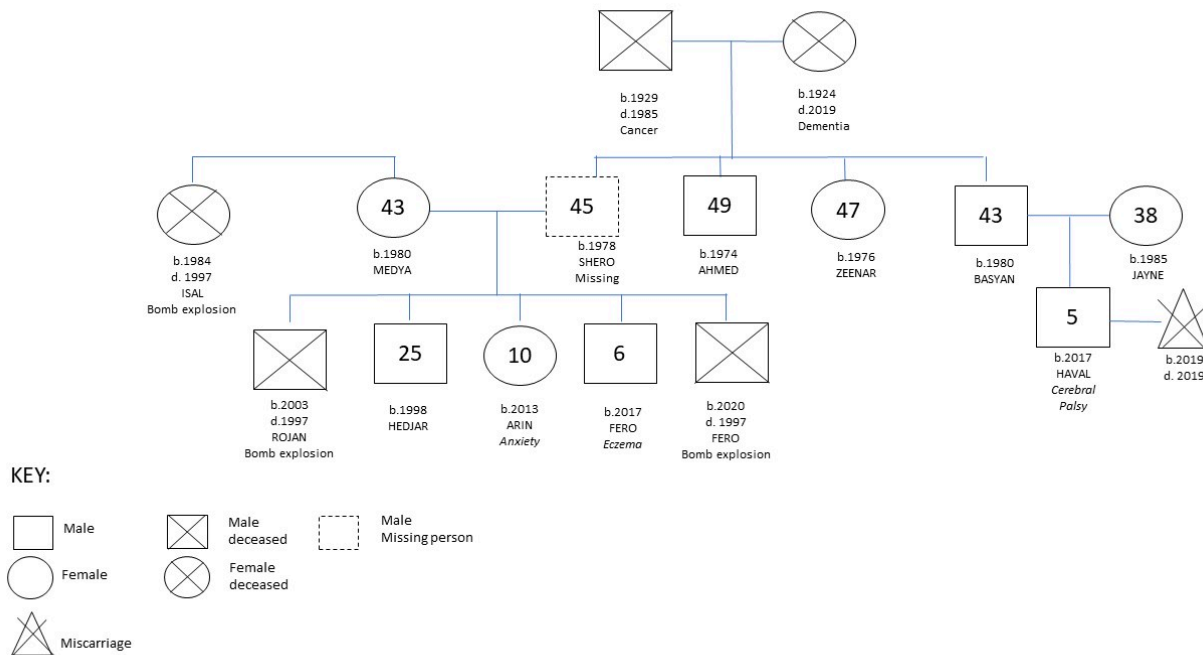
L – Legal: Political icons created by Freepik – Flaticon

PART 3 THE SHERO FAMILY

3.1 INTRODUCTION TO THE SHERO FAMILY

Lucy Shinnars

Family genogram



Shero family genogram



Introduction to family and community

This part provides case studies about an Iraqi refugee family of 4, Medya and her 3 children, Hedjar, Arin and Fero. The United Nations resettled them in the seaside town of Coffs Harbour after they escaped from Iraq, making a very difficult journey to Lebanon for safety. They took some time to settle into their new surroundings after the family was rescued. Still, they have now learned the language and have begun rebuilding their lives. They have developed a deep connection to the Coffs community and continue to heal and recover from the trauma they witnessed. This part illustrates how one family experiences life as refugees in Australia, the challenges they face navigating the healthcare system with English as a second language, and their journey of recovery from trauma. The part begins with a section that outlines the family's background, history and relationships, followed by a brief overview of their lifestyles. The part describes 2 case studies: 1) Medya develops ulcerative colitis, and 2) Medya has a temporary stoma.

The Shero family



The Shero family

Medya and her family are refugees from Baghdad, Iraq. They live in the beautiful seaside town of Coffs Harbour on the mid-North Coast of New South Wales. Medya, the mother of this family, is 43 years old and has 3 surviving children, Hedjar aged 25, Arin aged 10, and Fero aged 6.

Six years earlier, this family's village was attacked by the militant groups Islamic State of Iraq and the Levant (ISIL). Medya, who was pregnant at the time, lost 6 family members, including her sister (pictured in the family photo) and 2 children, her daughter Denah, aged 3, and her son Rojan, aged

15. As their village was destroyed during the fighting, the family was forced to live in a run-down flat with limited electricity and access to drinkable water. They had to rely on food aid from international volunteer agencies. When Medya's husband joined the army to fight on behalf of their people, the Yazidis, living and supporting her remaining 2 children became very difficult on her own. They lived in extreme poverty. Medya had to work long hours, carting dangerous building rubble to the rubbish site, to provide enough money to buy food or medicine. The United Nations supported the family by ensuring the village had clean drinking water, blankets and basic food supplies. However, Medya's family lived in a small room with barely enough food to share. If her kids became unwell, she had to risk her life to seek medical help.



Iraq map

The situation worsened when her son Hedjar was attacked and shot 3 times in the leg and arm while he was praying. While he survived the attack, he was left with an acute brain injury with intermittent seizures and this event forced Medya and her children to leave her husband and escape through the mountains into Lebanon as refugees to seek medical support.

The walk through the mountains was extremely difficult. Medya often had to wrap her children's feet with clothes to help them walk, or hide them when they could hear militants approaching. After 9 days of travel they joined other refugees, but it took many weeks for Medya and her children to

recover from the ordeal. When she was 28 weeks pregnant, Medya thought she would lose her baby as she suffered much pain and bleeding. However, with medical attention and rest, her body recovered, and she remained pregnant. It was not until she would arrive in Australia that she would deliver her child.

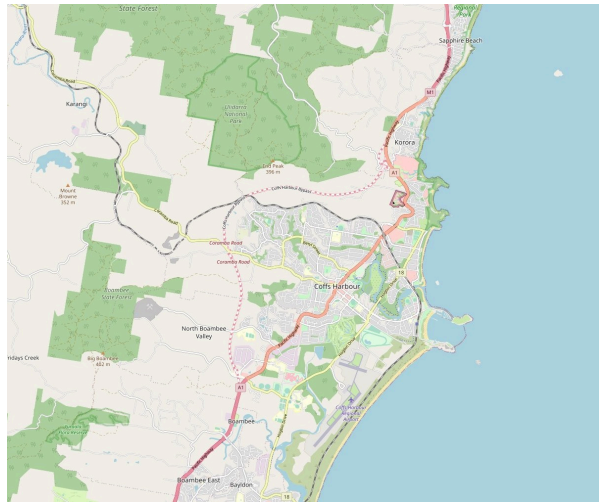


Children during war

Medya and her family were placed into a resettlement program by the United Nations High Commissioner for Refugees (UNHCR) and granted a humanitarian refugee visa 4 months later. They then boarded a flight to Sydney, Australia. After spending a month in a refugee facility, they were resettled in Coffs Harbour. Other Yazidis refugees were resettled in Wagga Wagga, Brisbane and Toowoomba. The Coffs Harbour community have been very welcoming to their people and Medya is grateful that she is living there with her children. Meanwhile, her husband and sister are still in Iraq. Medya does not know what happened to them or whether they are still alive. She is in contact with some of her family members who are living under extreme circumstances. Medya heard that thousands of women and girls were forced into sexual slavery by ISIL and thousands of men were killed. She prays every day for their safety.

One of the world's most threatened religious minorities, the Yazidis people are indigenous to Kurdistan and are predominately Kurdish-speaking. Yazidis people have a history of centuries of conflict with surrounding regions due to their unique religious beliefs, a combination of Judaism, Christianity, Islam and lesser-known Iranian religions (Allison, 2017). Their links to their homeland and ancestry are crucial to their faith. Yazidis society follows a caste system determined by birth and the Yazidis calendar is coloured by several festivals rich with culture and spirituality. They are often disadvantaged socially, economically, and educationally, having diverse religious customs that dictate how they interact with other established systems.

When they arrived in Australia, Medya was 32 weeks pregnant, Arin was 2 and Hedjar 17. The Multicultural Australia organisation and the case manager assigned to their relocation helped them when they arrived in Australia. Initially, they were housed in a motel on the outskirts of Coffs Harbour as it was difficult to find permanent accommodation. After 6 months, they moved to a small 3-bedroom house with a garden and leopard tree in the front yard. It was the most beautiful house Medya had ever seen. The family felt very lonely for some time, cut off by language and cultural barriers, however this changed when they connected with the Coffs Harbour community centre.



Coffs Harbour map

Shero family members

Medya: 43 years old



Medya

Medya is the matriarch of this family at 43 years old and identifies as female. Five weeks after they arrived in Australia, Medya delivered Fero at 37 weeks. Without family, the ability to speak English or drive, to get to hospital Medya had to call on the assistance of their case manager and 2 women from the community centre. Her experience was very different from the way she delivered her other babies in Iraq. It turned out that Fero was breech. Medya had not had any medical follow-ups with a doctor since very early in the pregnancy. Her delivery was traumatic, to the extent she sustained a fourth-degree perineal tear and post-partum haemorrhage. She had to undergo emergency surgery for repair of her anus. While Medya was very unwell after the birth, her new baby boy, Fero, was healthy, which gave her strength to recover from her surgery within 4 weeks. Her new friends at the community centre helped her by

supporting her eldest son Hedjar, who was looking after Ari and bringing her to the hospital to visit Medya each day.

It has now been 7 years since Medya and her family arrived and resettled. While Medya has learned enough English to get through the essentials of daily life, she speaks Kurdish strictly to her family so that her beloved country and family are not forgotten. She is amazed how quickly and easily her children have adopted Australian language and culture. Medya is an excellent cook and enjoys exploring and expanding her abilities through her interactions with other refugee women at the Coffs Harbour community centre. She volunteers in the kitchen when the community centre hosts community events. This centre has been central to the rebuilding of her life. She now believes there is hope for her children's future.

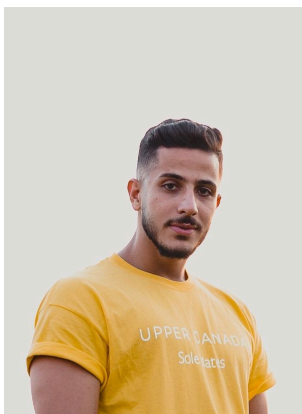
While there are very few Kurdish women Medya can share her hardship with, many other refugee

women in the centre talk about the trauma they have experienced. This provides her with a sense of deep connection with other refugees. In a recent reconnection with members of her husband's family who live in Lebanon, she learns they have heard no news of her sister or her husband. This is deeply troubling and upsetting for Medya. Now she has access to a Kurdish counsellor, which may help her talk about her experiences.

The repair of her anus and bladder has had long-term impacts on her bladder and bowel patterns and function, which is difficult for Medya to manage at times. Her strict religious practices and lack of representation by her husband make this more difficult as she does not feel confident to seek medical attention on her own. Medya has worked hard to find female specialists who can help and whom she feels able to trust with such a private aspect of her life.

Medya does not drive but knows the public transport system well now. She has taught her children to safely make their way to and from the local school. Her eldest son often takes her to where she must go when he is not working.

Hedjar: 25 years old



Hedjar

Hedjar is 25 years old and identifies as male. He is Medya's eldest son and has taken on the role of the head of the household to support his mother. He has witnessed so much over the past 8 years; he was only 17 at the time of their escape. Since resettling in Australia, he has worked hard to learn the language and find a way to support the family financially. For the last few years he has been working as a trolley collector at the local supermarket while he studied English at TAFE. After graduating, he enrolled in a bookkeeping course, which he is nearly finished. He hopes to study business at university in the near future, as he has always had a way with numbers and wishes to provide for his family. After he had saved enough to take driving lessons and get his driver's licence, he bought a small second-hand car. He is meticulous with keeping it clean and will tell off the children, especially Fero, if they do not respect it.

Hedjar's other passion is music. In Iraq he often played the oud with his father. Now he is working to save enough money to buy one. He wants to be reminded of his father and the special memories they shared playing music together. Since arriving in Australia, Hedjar quickly learned to play the guitar after finding an old one lying around at the community centre. Bill, one of the volunteers, is a rocker from the past with a passion for blues and roots. Bill has been teaching Hedjar the guitar for several years. They have a very strong friendship that is meaningful to both of them. Bill and Hedjar have formed a band with other locals from the centre and play small gigs and functions in Coffs Harbour. Hedjar's favourite is to play at weddings, as they remind him of the family gatherings they had at home in Iraq when he was a child.

Just before escaping for Lebanon, Hedjar began to have focal seizures and was diagnosed with post-traumatic epilepsy, a recurrent seizure disorder that can appear after head injury (Agrawal et. al., 2006). Medical staff suspect this occurred when he was attacked and shot in Iraq and did not receive the extensive medical care that such an injury requires. He has been on anti-epileptic

medication for 2 years and is currently stable and able to drive again, which is essential for the family. Prior to receiving his medication, Hedjar's epileptic events appeared to be triggered by stress and poor sleeping patterns. He usually finds it difficult to sleep restfully as he is still plagued by nightmares from his experiences in Iraq. He has not seen anyone for help with this yet because, while he and his mother often talk about what they went through, they prefer to be private about this. However, Hedjar has mentioned what happened to him to Bill, who has suggested he seek support through his connections in the community centre and that he would be willing to support him if he needed it. Hedjar is thinking about it.

Arin: 10 years old



Arin

Arin is 10 years old and a very sweet, intelligent, quiet little girl who is quite shy with strangers. Arin suffers from anxiety due to the years of disruption and danger she experienced as a very young child in Iraq. At one point the anxiety was so crippling that the family sought the support of a child psychologist, who has been working with Arin to manage it. She was only a toddler when they escaped Iraq. She suffered permanent damage to her feet and legs after fragments from a bomb blast damaged her muscles and skin. Arin was not treated until they arrived in Lebanon. This was the same bomb that killed 2 of her siblings and other family members. She suffered an incredible amount of pain as they could not often get access to, or afford medication to treat it. Arin is very self-conscious about her legs,

which have suffered muscle wasting and strictures where the skin has been burned and healed without treatment. Since arriving in Australia, she has had one surgery to release the skin around her knee and will likely need more surgery as she grows. At school she needs to use a wheelchair for most of the day. She does not like using her crutches as they draw attention to the way she walks.

Arin is a very good artist at age 10, which her teacher has noticed. The school put her forward to be a part of a community art program which she enjoys very much. As part of her counselling for her anxiety, she uses art to express her feelings. She is particularly good at drawing and painting; she will happily sit for hours making figurines out of plasticine or learning how to make earrings with her mother's Sudanese friends at the community centre. While she is well loved by her friends, she hasn't yet invited anyone to her house or been to a sleepover. Arin doesn't want to leave her family or have her friends see their home.

Fero: 6 years old



Fero

Fero is a cheeky little 6-year old who keeps the household lively. He was born prematurely at 37 weeks in Australia and his mother tells him he is a 'strong fighter'. He proudly tells the story of how he is the only one in his family who was born in Australia. Although he is meeting almost all his growth milestones, Fero has several allergies to contend with, namely asthma, eczema and an allergy to penicillin, which they discovered when he was a baby after he developed a severe rash on his chest. He has a strict bath and cream routine for his skin to try to reduce the redness and itching, which is a constant source of frustration for both him and his mother.

Fero started year one this year at the local public primary school. While he has taken it all in his stride, he is quite boisterous and finds it difficult to sit still in class. The teacher is working with Medya and Hedjar to decide whether they need to explore his behaviour more deeply. For example, he could have some attention-deficit hyperactivity disorder (ADHD). His favourite time at school is lunchtime and sports when he can run around and kick the footy.

While Fero loves the beach, he has not yet learned to swim. The family cannot afford swimming lessons other than what is provided through the school program. He wants to be a surf life saver when he grows up as well as a policeman. He adores his big brother Hedjar, following him whenever he can. He often tries to convince his brother to take him for a ride in his car, which Fero absolutely loves.

References

- Agrawal, A., Timothy, J., Pandit, L., & Manju, M. (2006). Post-traumatic epilepsy: An overview. *Clinical Neurology and Neurosurgery*, 108(5), 433-439. <https://doi.org/10.1016/j.clineuro.2005.09.001>
- Allison, C. (2017). The Yazidis. In J. Barton (Ed.), *Oxford research encyclopedia of religion*. Oxford University Press. <https://doi.org/10.1093/acrefore/9780199340378.013.254>

3.2 SHERO FAMILY CASE STUDY 1: MEDYA DEVELOPS ULCERATIVE COLITIS

Lucy Shinnars

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Understand the organisations that support inflammatory bowel disease (IBD) in Australia and internationally
- Consider the impact that IBD has on the mental wellbeing of IBD sufferers
- Articulate the role of interprofessional team members in promoting culturally sensitive, person-centred care

Scenario

Medya has had difficulty with her bowels since her son Fero was born. Her older son Hedjar doesn't really know much about it as his mother is very private. However, he sees her crying quietly in her bedroom one afternoon. She tells him she has had a lot of pain when she goes to the toilet, and now it's getting worse. After a few days of nausea and lack of appetite, she has now started vomiting overnight. Hedjar is aware that lately his mother has not been eating very much, has lost weight, and does not often leave the house. Obviously, because it is a very private matter for her, they have not discussed what has been happening until now. Medya agrees it is time to seek medical attention. She is embarrassed that she will have to take her son with her to assist with interpreting her private information to the doctor. After Hedjar offers to find one of her friends from the community centre to

come with her, she says no to this. He instead arranges an appointment for her at the local doctor's surgery. As her usual doctor is not there, he requests a female doctor so that his mother will feel more comfortable and less embarrassed.

They arrive at the local doctor's surgery and are ushered into the rooms. Although Medya is painfully shy, the doctor speaks gently and establishes that Hedjar can interpret for his mother and that she consents to this. Medya reveals that for the past 3 months she has had an increasingly difficult time with her bowels. Ever since Fero's delivery and the damage it has caused, her bowel motions have been loose; she has had to rush to the toilet to make sure she does not have an accident. However, the frequency of her bowels opening has increased in the last 2 months, which has meant she has had to stay close to home to ensure she doesn't have an accident. She tells the doctor she has started vomiting overnight and when she noticed blood on the toilet paper this morning, she felt very worried.

The doctor takes her vital signs, asks a series of questions about her past surgery after the birth, her recent bowel changes, her diet and the symptoms she has been feeling since the day before. She examines her abdomen, which Medya describes as more painful than usual, listens for bowel sounds which are very active and examines her old wounds on her perineal and rectal areas which appear red and inflamed. She decides to send Medya to the hospital to seek urgent attention for IBD exploration.



Case study questions

- Who are the local and international organisations that support the IBD community?
- What are the mental health impacts of people suffering with IBD?
- Who is in the interdisciplinary team caring for a patient with IBD?
- How do you provide culturally sensitive care to an IBD patient?

Key information and links to other resources



Australian organisations that support bowel disease

The latest research suggests that inflammatory bowel disease has increased in prevalence globally (Alatab et al., 2020). It is estimated that almost 10% of the Australian population experiences IBD

and the economic and social impacts of this disease are far reaching (Busingye et al., 2021). Both national and international organisations pursue research, education and funding and Australia has developed a national strategic action plan.

The International Organisation of Inflammatory Bowel Disease (IOIBD) conducts research that promotes the health of people with IBD worldwide and sets the direction for patient care and education. Access IOIBD publications [here](#).

In Australia, the Crohn's & Colitis organisation has been working for more than 35 years to provide support services, advice and encouragement to people living with IBD.

The IBD national action plan outlines a series of priority actions designed to improve cooperation between partners, individual and system outcomes.



Psychological health for patients with bowel disease

Research has shown that throughout the lifespan, people who suffer from IBD are more likely to suffer from depression, anxiety and low self-esteem (Byrne et al., 2017; Gralnek et al., 2021). Furthermore, inflammatory bowel disease has been identified as a significant driver of mental illness (Szigethy et al., 2021).

Due to the nature of this condition, people often experience recurrent symptoms which may interfere with their ability to attend social events, work or maintain meaningful relationships. Many people report feeling worried, anxious, embarrassed or ashamed, which can cause them to withdraw socially, reduce their activities or avoid certain situations, all of which lead to poor mental health (Kok et al., 2023; Szigethy et al., 2021). It is important that IBD sufferers understand the close link between the physiology of the body and mental health. If they experience more emergency hospital presentations or disease flares, there is a strong possibility that their mental health could be a contributor. Stress can increase gut sensations, muscle tension and the rate at which food is processed through the system (Szigethy et al., 2021).



Thinking Point

The Crohn's & Colitis Foundation has produced a series of videos designed to help patients understand more about the impact of this disease on mental wellbeing, offering tips and strategies that they can use.

- When to seek a mental health professional
- Anxiety and Depression with IBD
- Battling IBD negativity

Write down the key take-home messages you could convey to an IBD patient you are caring for.



Teamwork and collaborative practice

Given IBD's complex and chronic nature and the fact that it requires long-term care, it is important to understand the multidisciplinary care model needed for IBD patients.

A systematic review exploring healthcare professionals' roles in managing chronic gastrointestinal diseases in primary care (Prasad et al., 2020) found that gastroenterologists and nurses are the key practitioners who deliver specialised care to IBD patients. Other health professionals who have important roles to play include pharmacists, dieticians, surgeons, social workers, hypnotherapists, psychologists, general practitioners, physiotherapists and psychiatrists.



Thinking Point

Read the following article and write down the 4 main roles that a registered nurse plays when they engage with a patient with IBD:

- Prasad, S. S., Potter, M., Keely, S., Talley, N. J., Walker, M. M., & Kairuz, T. (2020). Roles of healthcare professionals in the management of chronic gastrointestinal diseases with a focus on primary care: A systematic review. *JGH Open*, 4(2), 221–229. <https://doi.org/10.1002/jgh3.12235>

Healthcare professionals require specialised training to care for IBD patients. Crohn's & Colitis Australia offers targeted education. See the Crohn's & Colitis support for health professionals' website for more details.



Cultural diversity

Healthcare professionals must be able to work and communicate effectively with people from different cultural backgrounds. While a patient-centred approach to IBD management is critical, culturally appropriate care is not commonly followed or understood. A study surveying IBD sufferers from South Asian communities in the United Kingdom suggests that mainstream care for people from some cultures and religions can have a significant impact on their health outcomes and experiences (Mukherjee et al., 2021). For example, having to avoid traditional foods may lead to health deficiencies; avoiding conversations about the disease or long-haul travel to see family may lead to feelings of isolation and inadequacy. However, you as a health professional should not make assumptions about the way your patient's cultural background or ethnicity may affect their experience. Instead, look to the evidence to find out and understand what those impacts are.

Healthcare professionals should consider:

- Is cultural competence integrated into care of IBD patients?
- Does the patient's family or community understand the disease or need education?
- Do the common concerns that impact the general IBD population significantly increase in a culturally diverse patient? Has the team created opportunities to explore this further?
- Has IBD information been provided in the patient's language?
- Have self-management strategies been co-created with the patient in a way that makes it possible for them to enjoy their cultural and religious traditions?
- Has the team invited an open and collaborative relationship with the patient and their community so all understand when to ask questions, seek advice and escalate care?



Thinking Point

Given that Medya is from Iraq, what other services could you access to assist her with understanding her treatment while ensuring that her cultural needs are also met?



Case study 1 summary

Medya is entering a new chapter of her life with a new diagnosis of inflammatory bowel disease. The

role of the nurse in supporting refugee patients is important and complex. As well as learning how to manage her symptoms and physical health, Medya must learn how to monitor and promote her mental wellbeing. Medya's cultural and religious needs should be addressed by an interdisciplinary team to promote a collaborative relationship and positive experience for her and her family.

References

- Alatab, S., Sepanlou, S. G., Ikuta, K., Vahedi, H., Bisignano, C., Safiri, S., . . . Naghavi, M. (2020). The global, regional, and national burden of inflammatory bowel disease in 195 countries and territories, 1990-2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet Gastroenterology & Hepatology*, 5(1), 17-30. [https://doi.org/10.1016/S2468-1253\(19\)30333-4](https://doi.org/10.1016/S2468-1253(19)30333-4)
- Busingye, D., Pollack, A., & Chidwick, K. (2021). Prevalence of inflammatory bowel disease in the Australian general practice population: A cross-sectional study. *PLoS One*, 16(5), e0252458. <https://doi.org/10.1371/journal.pone.0252458>
- Byrne, G., Rosenfeld, G., Leung, Y., Qian, H., Raudzus, J., Nunez, C., & Bressler, B. (2017). Prevalence of anxiety and depression in patients with inflammatory bowel disease. *Canadian Journal of Gastroenterology & Hepatology*, 2017, Article 6496727. <https://doi.org/10.1155/2017/6496727>
- Gralnek, I. M., Stanley, A. J., Morris, A. J., Camus, M., Lau, J., Lanas, A., Laursen, S. B., Radaelli, F., Papanikolaou, I. S., Cúrdia Gonçalves, T., Dinis-Ribeiro, M., Awadie, H., Braun, G., de Groot, N., Udd, M., Sanchez-Yague, A., Neeman, Z., & van Hooft, J. E. (2021). Endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage (NVUGIH): European Society of Gastrointestinal Endoscopy (ESGE) guideline – update 2021. *Endoscopy*, 53(3), 300–332. <https://doi.org/10.1055/a-1369-5274>
- Kok, K. B., Byrne, P., Ibarra, A. R., Martin, P., & Rampton, D. S. (2023). Understanding and managing psychological disorders in patients with inflammatory bowel disease: A practical guide. *Frontline Gastroenterol*, 14(1), 78-86. <https://doi.org/10.1136/flgastro-2022-102094>
- Mukherjee, S., Beresford, B., Atkin, K., & Sebastian, S. (2021). The need for culturally competent care within gastroenterology services: Evidence from research with adults of South Asian origin living with inflammatory bowel disease. *Journal of Crohn's and Colitis*, 15(1), 14-23. <https://doi.org/10.1093/ecco-jcc/jjaa117>
- Prasad, S. S., Potter, M., Keely, S., Talley, N. J., Walker, M. M., & Kairuz, T. (2020). Roles of healthcare professionals in the management of chronic gastrointestinal diseases with a focus on primary care: A systematic review. *JGH Open*, 4(2), 221-229. <https://doi.org/10.1002/jgh3.12235>
- Szigethy, E., Murphy, S. M., Ehrlich, O. G., Engel-Nitz, N. M., Heller, C. A., Henrichsen, K., . . . Allen, J. I. (2021). Mental health costs of inflammatory bowel diseases. *Inflammatory Bowel Diseases*, 27(1), 40-48. <https://doi.org/10.1093/ibd/izaa030>

3.3 SHERO FAMILY CASE STUDY 2: MEDYA NEEDS A TEMPORARY STOMA

Lucy Shinnars

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Understand the organisations that support stomal management in Australia
- Consider the implications that health complications have on a person's identity and their family
- Understand how you can support them as a healthcare professional

Scenario

Medya spends two weeks in hospital suffering ulcerative colitis. She loses a considerable amount of weight and does not respond well to the medicines prescribed to treat her symptoms. The gastrointestinal surgeon decides that for Medya's bowel to rest and heal, a temporary stoma must be formed so that she can put on some weight, get stronger and return to her family.

Hedjar stays with his mother to act as her interpreter. He finds most of the staff polite and patient once he explains that she does not understand much English. Medya tells Hedjar she is very worried about the children and does not want surgery. Hedjar reassures her that the doctors said it was very important and that if they did not operate, she may become unwell or even die. The stomal nurse visits Medya and her son to talk about how to care for the stoma after the operation.

The stomal nurse documents that Medya seems overwhelmed by the concept of surgery. Although her son Hedjar is very engaged and communicates well, the nurse records that the family will need ongoing support once Medya is discharged home. She talks with Hedjar about contacting a community nurse who can visit them regularly when they get home. Hedjar agrees that this is a very good idea.



Case study questions

1. What is the role of the stomal nurse throughout the journey of care?
2. How can you ensure that post-discharge care decreases psychological distress, promotes quality of life and prevents complications?
3. To deliver culturally safe care to Medya, what do you understand about the Shero family's social and cultural needs? Who else needs to be involved in the care of the Shero family?



The journey of care

It is common for inflammatory bowel disease (IBD) sufferers to require a temporary stoma if their symptoms cannot be managed, and the patient becomes unwell. The Australian Council of Stoma Associations represents 21 regional stoma associations nationally which support as many as 46,000 people living with a stoma or ostomy in Australia.

Like most health disruptions, a person who is given a stoma for the first time may be shocked by its impacts on many aspects of their life, such as their diet, living habits, travel arrangements, body image, sexuality and even clothing. Stress is a key contributor to poorer health outcomes for people who undergo stomal surgery (Ang et al., 2013). Modifiable factors such as family support, maintenance of social networks, education, spirituality, exercise and financial stability can all help to improve the quality of life of ostomy patients and reduce stress (Alenezi et al., 2021; Nam et al., 2019). As a registered nurse you can influence the patient's journey from when they have surgery, through recovery, and learning to care for themselves.

Postoperative care

While the journey of care is likely to commence in a tertiary organisation such as a hospital, the priority for postoperative education is to assist the patient to prepare for self-care (Ang et al., 2013).

Within a short period of time, they must be taught all the practical skills required for stomal care. A good education program will be comprehensive and respectful of the person's age, health literacy, cultural differences and personal preferences.



Thinking points

Watch these patients' experience of this type of surgery:

- Patient experiences with IBD surgery

Read this article which describes the stressors related to psychological health following stoma surgery:

- Ang, S. G. M., Chen, H.-C., Siah, R. J. C., He, H.-G., & Klainin-Yobas, P. (2013). Stressors relating to patient psychological health following stoma surgery: An integrated literature review. *Oncology Nursing Forum*, 40(6), 587–594. <https://doi.org/10.1188/13.ONF.587-594>

Post-discharge care

Once they are discharged from hospital, stomal patients are sent home with a vast amount of literature and samples, which can be confusing. If a patient's discharge has been poorly planned or rushed, it can create issues for them once they get home (Richbourg et al., 2007). Community-based nursing care is very important for a person with a stoma and is key to enhancing self-care, independence and a healthy recovery. Follow-up by a stomal nurse should aim to decrease psychological distress, promote quality of life and prevent complications (Schluter & Sinasac, 2020).



Thinking points

Based on these recommendations, consider the skills you will require as a registered nurse. How will you adjust these skills to meet the needs of an older person or a person like Medya who is culturally and linguistically diverse? The Journal of Stomal Therapy Australia offers many insightful publications about this specialty, the experiences of people with a stoma and the clinical practices required to support them.



Teamwork and technology

The interdisciplinary team is essential to a healthy rehabilitation process. Stomal patients are faced with a variety of challenges when they recover from surgery at home. They may need to adjust what they eat, start an exercise rehabilitation plan, change their clothing style or be unable to drive or work for a period of time. For most people this requires the support of a range of healthcare professionals once they get home.

New technology presents us with innovative ways to communicate with our patients at home. Telehealth can connect with patients in our regional and remote communities (Weinstein et al., 2021). Mobile applications offer a way to monitor patients remotely or support patients to be independent in their decision-making (Wang et al., 2018; Zhang et al., 2020).



Thinking points

Make a list of the health disciplines that could be involved in Medya's care, given her background.

Companies like Convatec have developed mobile applications that can provide real-time information and support to patients with stomas. How do you think technology could support Medya and her family?



Case study 2 summary

The journey of care post-stomal surgery can be complex and challenging. As a registered nurse, either in the hospital or in the community, you can improve the journey of someone like Medya by understanding how to prepare them before they leave the hospital setting and effectively support them at home. Innovations and interdisciplinary models of care are key to successful rehabilitation in the future.

References

Alenezi, A., McGrath, I., Kimpton, A., & Livesay, K. (2021). Quality of life among ostomy patients:

- A narrative literature review. *Journal of Clinical Nursing*, 30(21-22), 3111-3123. <https://doi.org/10.1111/jocn.15840>
- Ang, S. G. M., Chen, H.-C., Siah, R. J. C., He, H.-G., & Klainin-Yobas, P. (2013). Stressors relating to patient psychological health following stoma surgery: An integrated literature review. *Oncology Nursing Forum*, 40(6), 587-594. <https://doi.org/10.1188/13.ONF.587-594>
- Nam, K. H., Kim, H. Y., Kim, J. H., Kang, K. N., Na, S. Y., & Han, B. H. (2019). Effects of social support and self-efficacy on the psychosocial adjustment of Korean ostomy patients. *International Wound Journal*, 16(Suppl. 1), 13-20. <https://doi.org/10.1111/iwj.13038>
- Richbourg, L., Thorpe, J. M., & Rapp, C. G. (2007). Difficulties experienced by the ostomate after hospital discharge. *Journal of Wound Ostomy & Continence Nursing*, 34(1), 70-79. <https://doi.org/10.1097/00152192-200701000-00011>
- Schluter, J. E., & Sinasac, P. A. (2020). Community stomal therapy services: A needs analysis and development of an evidence based model of care. *The Journal of Stomal Therapy Australia*, 40(1), 8-13. <https://doi.org/10.33235/jsta.40.1.8-13>
- Wang, Q. Q., Zhao, J., Huo, X. R., Wu, L., Yang, L. F., Li, J. Y., & Wang, J. (2018). Effects of a home care mobile app on the outcomes of discharged patients with a stoma: A randomised controlled trial. *Journal of Clinical Nursing*, 27(19-20), 3592-3602. <https://doi.org/10.1111/jocn.14515>
- Weinstein, R. S., Holcomb, M. J., Mo, J., Yonsetto, P., Bojorquez, O., Grant, M., . . . Cidav, Z. (2021). An ostomy self-management telehealth intervention for cancer survivors: Technology-related findings from a randomized controlled trial. *Journal of Medical Internet Research*, 23(9), e26545. <https://doi.org/10.2196/26545>
- Zhang, X., Gao, R., Lin, J. L., Chen, N., Lin, Q., Huang, G. F., . . . Li, H. (2020). Effects of hospital-family holistic care model on the health outcome of patients with permanent enterostomy based on the theory of 'Timing It Right'. *Journal of Clinical Nursing*, 29(13-14), 2196-2208. <https://doi.org/10.1111/jocn.15199>

3.4 SHERO FAMILY SUMMARY

Lucy Shinnars

Summary

This part provides a series of case studies of an Iraqi family who have come to Australia as refugees. The case studies focus on Medya, the mother of this family, who has experienced a range of gastrointestinal issues as a result of a traumatic birth and other health issues. The family is comprised of Medya and her 3 children Hedjar, Arin and Fero. They live in Coffs Harbour NSW.

The part illustrates the diverse nursing considerations required when working with families from different cultural and religious backgrounds. The 2 case studies include 1) Medya develops ulcerative colitis and 2) Medya needs a temporary stoma. The case studies explore psychological health for patients with bowel disease, the importance of teamwork and collaborative practice and considerations of cultural diversity. It also follows the journey of care for a patient undergoing bowel surgery and introduces the idea of how technology can support teamwork.

Image attributions

Images not individually attributed are listed below in order of appearance in the part:

Chapter 3.1

Coffs Harbour map by OpenStreetMap is licensed under CC BY-SA 2.0

Iraq map image by Lara Jameson on Pexels

The Shero family image by David Mark on Pixabay

Children during war image by Welcome to All! on Pixabay

Medya image adapted from photograph by David Mark on Pixabay

Hedjar image adapted from photograph by Amir Babaei on Pexels

Arin image adapted from photograph by Abdulmomn Kadhim on Pixabay

Fero image adapted from photograph by Abdulmomn Kadhim on Pixabay

Icons

All icons in this part are from Flaticon and are listed below in order of first appearance in the part:

Introduction: Introduction icons created by Freepik – Flaticon

Endocrine: Endocrine system icons created by Freepik – Flaticon

Teamwork and collaborative practice: Communication icons created by Freepik – Flaticon

Clinical reasoning: Think icons created by Freepik – Flaticon

Person-centred care: People icons created by Freepik – Flaticon

Cultural safety: People icons created by Freepik – Flaticon

Objectives: Objective icons created by Uniconlabs – Flaticon

Case studies: Case study icons created by Flat Icons – Flaticon

Mental health: Mental health icons created by Freepik – Flaticon

Thinking point: Creativity icons created by Freepik – Flaticon

Summary: Summary icons created by Freepik – Flaticon

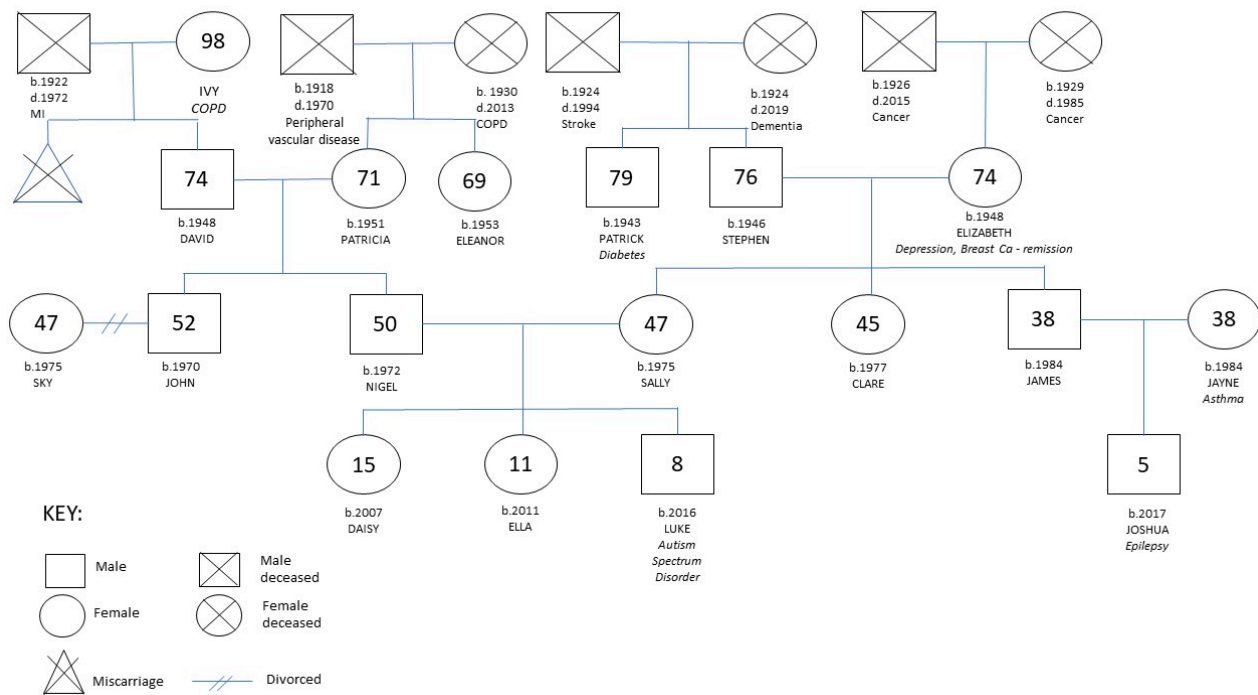
T – Technology: Technology icons created by Freepik – Flaticon

PART 4 THE LEWIS FAMILY

4.1 INTRODUCTION TO THE LEWIS FAMILY

Nicola Whiteing

Family genogram



Lewis Family Genogram



Introduction to family and community

Nigel (50) and Sally (47) live in Currumbin, Queensland with their 3 children Daisy (15), Ella (11) and Luke (8). Nigel and Sally met at university when they were both studying business degrees. Nigel was born in Australia and has always lived around the Gold Coast area. His parents live just two streets away and his sister lives in nearby Elanora. They are a very close family. Sally was born in England, but moved to Melbourne when she was 3, due to her father's work as an aeronautical engineer. Her parents decided to move back to England when Sally graduated from university 25 years ago. Sally decides to stay and see where her relationship with Nigel might lead. Sally's parents try to come out to Australia every other year, however they are getting older and find the journey hard. While Nigel and Sally try to go back every second year, financially they are finding this difficult. Sally's parents are fit and well but are becoming slower as the years go by.

Nigel and Sally's house is a two-storey Queenslander, which they have spent the last 10 years

renovating. They now have the house just as they want and are proud to have friends and family over. The children each have their own bedrooms, as well as a rumpus room which is home to Luke's precious collection of cars, diggers and tractors.

Sally



Sally majored in events management at university. Before having children, she worked full-time for a sports events company, a job she loved. Since having children, Sally has not worked. She has always regretted not going back to work sooner and is now concerned whether it will be possible for her to get back into the industry. She volunteers at the canteen at the local primary school her younger 2 children attend. Sally has a good circle of friends, with whom she regularly goes to the gym and meets up for lunch, walks and book club. She is also a member of the local church and actively helps in the youth program. Sally is fit and well, takes pride in her appearance and is a great believer in using natural, complementary and lifestyle medicines.

Sally

Nigel



Nigel majored in accounting and is now a partner in an accountancy firm in Brisbane. He stays away in a rented apartment Monday to Wednesday to save on travelling time. He works long hours, but the income is good. Nigel enjoys playing soccer in his spare time and helps coach the local under-12s team with his best mate Craig. When he is able to 'escape' the business of life with 3 children, he also enjoys the odd round of golf.

Nigel

Daisy



Daisy

Daisy is 15 years of age and is fit and well. Her parents describe her as a ‘typical teenager’. She is in year 9 at the local state high school, does well academically and has a good circle of friends. As Daisy went through her teenage years, Sally felt as though she and her friends were drifting apart, which upset her. Daisy used to dance until last year, when she gave up, wanting to spend more time with her friends. She plays the flute and was successful in gaining a place on the Music Excellence Program at school. Nigel believes she should be studying more, a topic that often ends in an argument at home. Daisy enjoys going to the cinema with friends and hanging out at the church youth club on a Friday night.

Ella



Ella

Ella is a bubbly 11-year old who is particularly close to her mother. Ella is always busy, with her mum taking her to various activities throughout the week, including 3 dance classes and music tuition (Ella plays the piano). She also plays netball on Saturday mornings in the winter season and basketball in the summer season. Ella’s favourite part of the day, though, is when she and Sally snuggle in bed together and read before lights out. Ella attends a local state primary school and is in year 5. She loves school and throws herself into all areas of school life. Since Ella started year 5, Sally has noticed she is struggling more academically and is concerned she may be losing confidence.

Luke



Luke

Luke is 8 years old and the baby of the family. As Nigel always wanted a son whom he could take to the footy and play rough and tumble with, he was delighted when their third (and final) baby was a boy. Luke loves cars, diggers and tractors and will sit and play for hours, organising them on his road map into their different colours. If he sees roadworks when he is out walking, he has to stop and watch, often providing the family with a number of facts about the diggers he sees.

As Luke was growing up, Sally always had a niggling feeling there was something ‘different’ about him. When she would try to talk to Nigel about it, he would brush it off, saying ‘he’s just a boy’. When Luke started pre-school at aged 4, however, one of the

teachers suggested that Nigel and Sally take Luke to see a clinical psychologist. The teacher had reported Luke did not make eye contact and found it difficult to build social relationships with his peers. Luke would get frustrated easily if things were not 'just so', which further exacerbated his difficulties in making friends. The teachers would often say that Luke was in his 'own little world', not unhappy, but not the smiley child they remembered Ella as being.

Nigel found the suggestion that Luke should see a psychologist incredibly difficult and remained adamant that nothing was wrong. When the appointment came up, Nigel said he had to be in Brisbane overnight, which meant Sally had to attend the appointment with Luke without Nigel. After a number of visits, Luke was diagnosed with autism spectrum disorder (ASD). Sally felt relieved to finally have a diagnosis and was not, as Nigel said, 'imagining something that wasn't there'. Nigel has found the diagnosis extremely difficult to accept and has drifted further and further away from his son.

John



John

John Lewis is 52 and is Nigel's brother. He lives a pretty relaxed lifestyle in Broadbeach on Queensland's Gold Coast. He loves living near the beach and surfing; you will usually find him out at one of the famous surfing breaks on a good day or enjoying the local café scene on days when the surf is not so good. John owns and operates a cleaning business and sub-contracts work cleaning shops and offices after-hours. John is single and lives alone in a second-storey unit. It is one of the older style units with an external staircase and shared balcony to a single entrance.

John was married to Skye (now aged 47), but they divorced 10 years ago. They have minimal contact, with the occasional text message at Christmas or on their birthdays. John has a few mates that he catches up with for a surf or coffee. He doesn't have any other hobbies or activities other than

his regular motorbike rides.

David and Patricia



David and Patricia

Nigel's father David is 74 and is a retired maths teacher. While he leads an active life, just recently he has noticed he is more breathless when playing a round of golf, often having to have a nap in the afternoon after playing. Nigel's mother Patricia (71) or 'Patsy' as she likes to be called, is full of life. Nigel often says that Patsy is where Ella gets her personality from. Patsy's social life is everything to her; she is part of the Queensland Country Women's Association, the local bridge club, church, plays golf and engages in a number of other activities. Whilst she has a busy social life, nothing is more important to her than

her family; she will readily drop everything if Nigel or the children need her. Patsy insists on seeing them all at least weekly and will often pop in without warning with a meal for everyone. Patsy is fit and well and is slightly frustrated that her husband's increasing tiredness changes their social arrangements on occasion.

Stephen and Elizabeth



Stephen and Elizabeth

Sally's father, Stephen (76), likes a quiet life now he is retired. He enjoys modelling and reading and potters around the garden. Despite living in Australia for so long, England is still his home and he doesn't like to stray far from his home country. Sally's mother, Elizabeth (74), was diagnosed with stage I breast cancer 8 years ago. Following chemotherapy, she is now in remission, but has suffered with depression ever since. She doesn't want to take medication despite her GP's recommendation. Instead she tries to manage it with herbal remedies and exercise. Elizabeth misses Sally and they speak

on FaceTime twice a week. Sally has an older sister (51) who also returned to England with her parents following the breakdown of her marriage. Sally and her sister are not as close as they once were following a disagreement about Sally not moving back to England with the rest of the family. Sally rarely speaks with her sister and keeps up with the news through her mum.

4.2 LEWIS FAMILY CASE STUDY 1: NEURODIVERSITY

Nicola Whiteing

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Articulate what resources are available to support individuals with autism spectrum disorder (ASD) and their families.
- Discuss ways in which nursing practice may need to change to accommodate people with a different style of thinking.
- Define the different style of thinking someone with ASD has compared with someone without ASD.
- Discuss which health professionals may contribute to caring for someone with ASD and how the interprofessional team can collaborate to promote person-centred care and positive outcomes.

Scenario

Sally worries that Luke is lonely without any friends. He was the only child not invited to a birthday party last weekend. Luke's pre-school teachers have discussed with Nigel and Sally how he struggles to build social relationships with his peers. Last week, Luke was playing on the mat with his cars, lining them up in 'car parks' according to their colour. One of the other children (Theo) sat next to Luke and picked up one of the cars and 'parked' it in another area. Luke said "No" and put

the car back in its spot. Theo moved it again and Luke got increasingly agitated and upset, pushing Theo away. The teacher came over and suggested Theo play with the diggers in another area. Theo moved away, upset he could not join in Luke's game. Luke continued to place his cars in the coloured car parks, ensuring all of the wheels were aligned. Luke's teacher talked calmly to Luke to explain that Theo wanted to play with him and was now feeling sad. All the time, Luke continued with his cars, not looking at his teacher and not acknowledging Theo or that he was upset.

Sally has bought Luke a Spiderman costume as a surprise for the upcoming book week. On the morning of the parade, Sally surprises Luke with his costume. Luke refuses to wear it saying, "I am Luke, I am not Spiderman". As Luke becomes increasingly upset, Sally puts the costume in his bag, drops him at day-care, telling the teachers where his costume is. When all of the other children are changing into their costumes, ready to go to the 'big school' for the parade, Luke again refuses to dress up, despite the excitement from his peers at being a policeman, a fireman or a nurse. While his teachers try to encourage him, Luke chooses to sit in the corner of the room with his cars. He does not want to leave the pre-school room to go to the parade.

Luke is due to start at the primary school where his sister Ella goes in 5 months' time. Sally is worried how Luke will cope at school. When she tries discussing with Nigel how to plan to help Luke before he starts, Nigel does not feel this is necessary, saying 'he'll be fine once he starts school with all the other kids.



Case study questions

1. Following Luke's diagnosis of autism spectrum disorder (ASD), how might different members of the interprofessional team work with him and his family to support him?
2. Nigel is struggling with his relationship with Luke following his diagnosis of ASD. Why do you think this may be?
3. In what ways could Nigel and Luke work towards improving their relationship?
4. Drawing on the information in the scenario, how is Luke's style of thinking different from that of a child without ASD?
5. As a nurse, how may your practice need to change to ensure person-centred care if you were looking after Luke in a healthcare setting?

Key information and links to other resources



Australian organisations that support Autism Spectrum Disorder

The following websites have some excellent resources, including a number of videos and patient stories that you might find valuable to explore:

- Autism Spectrum Australia
- Autism Awareness Australia



Reasonable adjustments for people with Autism Spectrum Disorder

Spectrum Disorder

Healthcare systems pose a number of challenges for people with ASD. Some of these challenges are based within systems or organisational structures, while others are created through healthcare professionals' lack of understanding about how to provide person-centred care to someone with ASD (Maloney et al., 2021). This gap in health care provision and the problem of how to address the needs of patients with ASD is significant in the light of increased mortality and morbidity amongst those with ASD (Wilson et al., 2021; Croen et al., 2015). As healthcare practitioners, we have a responsibility to ensure we understand what reasonable adjustments we can make to assist people with ASD access and use healthcare effectively. Reasonable adjustments are positive measures that can be implemented at a variety of levels within an organisation to ensure equity in healthcare (Maloney et al., 2021).



Thinking points

Read the following paper by Wilson et al., (2022) and reflect on the questions that follow:

- Wilson, N. J., Pracilio, A., Kersten, M., Morphet, J., Buckely, T., Trollor, J. N., Griffin, K., & Cashin, A. (2021). Registered nurses' awareness and implementation of reasonable adjustments for people with intellectual disability and/or autism. *Journal of Advanced Nursing*, 78(8), 2426-2435. <https://doi.org/10.1111/jan.15171>

Questions:

1. Why is it important to adjust our care for patients who have a diverse thinking and

information processing style, such as ASD?

2. In what ways, if any, have you applied reasonable adjustments in your practice when you have cared for someone with ASD?
3. What changes would you now make to your practice following reading the article by Wilson et al., (2022)?



Addressing the needs of the whole family

The number of people (children and adults) being diagnosed with ASD is increasing globally (AIHW, 2017, Mullen et al., 2021). In 2015, an estimated 164,000 people had an autism diagnosis in Australia, equating to approximately one in every 150 people (Australian Bureau of Statistics [ABS], 2016). This is up from an estimated 64,400 people in 2009. While it is not clear why prevalence rates are increasing, more acceptance, awareness and better diagnostic services could contribute to this acceleration (Nyrenius et al., 2022; Davidovitch et al., 2021).

Research shows that having a child with ASD leads to increased stress on families and a poorer quality of life (Bonis, 2016; Vasilopoulou & Nisbet, 2016). The relationships between siblings can also be affected (Coffman et al., 2021; Perlman & Howe, 2023). Despite significant impacts on the entire family, interventions and treatments still focus predominantly on the needs of the child with ASD rather than on the family as a whole. Research also shows that intervention programs with the whole family unit can improve the child's personal care, adaptation to change and decrease anger and meltdowns (Mullen et al., 2021). Parents also report being less stressed, experiencing an improvement in mood, developing an increased confidence and ability to manage their child and having less parental conflict and greater relationship happiness (Mullen et al., 2021; Manohar et al., 2019; Tellegan & Sanders, 2014).



Thinking point

If you were to design a support program for the Lewis family, what would you want to achieve and what would you include in your program? Read one or 2 of the following papers to learn more about some of the intervention programs that have taken place globally. Consider which strategies have worked well, which have limitations, and why this may be.

- Mullen, A., Boyd, K., & McConkey, R. (2021). The impact of a brief home-based intervention on families with a child with Autism Spectrum Disorder. *Journal of Developmental and Physical Disabilities*, 33, 693-708. <https://doi.org/10.1007/s10882-020-09768-4>
- Manohar, H., Kandasamy, P., Chandrasekaran, V., & Rajkumar, R.P. (2019). Brief parent-mediated intervention for children with Autism Spectrum Disorder: A feasibility study from South India. *Journal of Autism and Developmental Disorders*, 49, 3146-3158. <https://doi.org/10.1007/s10803-019-04032-x>
- Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trial evaluating a brief parenting program with children with Autism Spectrum Disorders. *Journal of Consulting and Clinical Psychology*, 82(6), 1193-1200. <https://doi.org/10.1037/a0037246>



Case study 1 summary

This case study has provided you with the opportunity to consider diverse thinking and information processing styles for people with ASD. You have reflected on changes you may need to make to the care you provide to ensure you embed reasonable adjustments and carry out person-centred care when nursing someone who has ASD. You have had the opportunity to consider the needs of the family and family relationships when one (or more) family members have ASD.

References

- Australian Bureau of Statistics. (2016). *Disability, ageing and carers: Summary of findings, 2015*. <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features12015?OpenDocument=>
- Australian Institute of Health and Welfare. (2017, April 5). *Autism in Australia*. <https://www.aihw.gov.au/reports/disability/autism-in-australia/contents/autism>
- Bonis, S. (2016). Stress and parents of children with autism: A review of literature. *Issues in Mental Health Nursing*, 37(3), 153-163. <https://doi.org/10.3109/01612840.2015.1116030>
- Coffman, M. C., Kelso, N., Antezana, L., Braconnier, M., Richey, J. A., & Wolf, J. (2021). Understanding of ASD by siblings is associated with warmth and hostility in the sibling relationship. *Journal of Child and Family Studies*, 30, 1577-1585. <https://doi.org/10.1007/s10826-021-01945-z>
- Croen, L. A., Zerbo, O., Qian, Y., Massolo, M. L., Rich, S., Sidney, S., & Kripke, C. (2015). The

- health status of adults on the autism spectrum. *Autism*, 19(7), 814-823. <https://doi.org/10.1177/1362361315577517>
- Davidovitch, M., Shmueli, D., Rotem, R. S., & Block, A. M. (2021). Diagnosis despite clinical ambiguity: Physicians' perspectives on the rise in Autism Spectrum Disorder incidence. *BMC Psychiatry*, 21, Article 150. <https://doi.org/10.1186/s12888-021-03151-z>
- Maloney, M., Hennessy, T., & Doody, O. (2021). Reasonable adjustments for people with intellectual disability in acute care: A scoping review of the evidence. *BMJ Open*, 11, Article e039647. <https://doi.org/10.1136/bmjopen-2020-039647>
- Manohar, H., Kandasamy, P., Chandrasekaran, V., & Rajkumar, R.P. (2019). Brief parent-mediated intervention for children with Autism Spectrum Disorder: A feasibility study from South India. *Journal of Autism and Developmental Disorders*, 49, 3146-3158. <https://doi.org/10.1007/s10803-019-04032-x>
- Mullen, A., Boyd, K., & McConkey, R. (2021). The impact of a brief home-based intervention on families with a child with Autism Spectrum Disorder. *Journal of Developmental and Physical Disabilities*, 33, 693-708. <https://doi.org/10.1007/s10882-020-09768-4>
- Nyrenius, J., Eberhard, J., Ghaziuddin, M., Gillberg, C., & Billstedt, E. (2022). Prevalence of Autism Spectrum Disorders in adult outpatient psychiatry. *Journal of Autism and Developmental Disorders*, 52, 3769-3779. <https://doi.org/10.1007/s10803-021-05411-z>
- Perlman, J., & Howe, N. (2023). Mothers' perceptions of the sibling relationship when one child has Autism Spectrum Disorder. *Journal of Child and Family Studies*, 32, 965-976. <https://doi.org/10.1007/s10826-022-02495-8>
- Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trial evaluating a brief parenting program with children with Autism Spectrum Disorders. *Journal of Consulting and Clinical Psychology*, 82(6), 1193-1200. <https://doi.org/10.1037/a0037246>
- Vasilopoulou, E., & Nisbet, J. (2016). The quality of life of parents of children with autism spectrum disorder: A systematic review. *Research in Autism Spectrum Disorders*, 23, 36-49. <https://doi.org/10.1016/j.rasd.2015.11.008>
- Wilson, N. J., Pracilio, A., Kersten, M., Morphet, J., Buckely, T., Trollor, J. N., Griffin, K., & Cashin, A. (2021). Registered nurses' awareness and implementation of reasonable adjustments for people with intellectual disability and/or autism. *Journal of Advanced Nursing*, 78(8), 2426-2435. <https://doi.org/10.1111/jan.15171>

Acknowledgements

The authors acknowledge the expert guidance of Professor Andrew Cashin, Professor of Autism and Intellectual Disability at Southern Cross University, who reviewed this case study.

4.3 LEWIS FAMILY CASE STUDY 2: SALLY GOES INTO SURGERY

Nicola Whiteing

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Identify the risk factors for developing breast cancer.
- Articulate the role of the nurse and other interprofessional team members in promoting a person-centred approach to the care of Sally and her family as she undergoes surgery.
- Discuss the role of the nurse and the relevance of considering natural and lifestyle therapeutic choices.
- Discuss safe surgical practice for a patient undergoing a mastectomy.

Scenario

Sally is showering when she finds a small lump in her right breast. After her mother's experience of breast cancer Sally is scared to go to the GP and convinces herself it is just due to her cycle and it will go away. After 3 months the lump is still there and her right breast has some slight dimpling. Sally makes an appointment with her GP, and, following an ultrasound, tomogram and a biopsy, Sally is diagnosed with Stage III breast cancer.

Sally undergoes chemotherapy and hormone therapy to shrink the tumour prior to surgery. Sally has also been taking fish oil and vitamin E. Unfortunately, these therapies do not shrink the tumour

sufficiently to allow for breast-conserving surgery (a wide local excision). As a result, Sally is admitted to hospital for a mastectomy, in which the whole right breast will be removed.

Following surgery, Sally undergoes radiotherapy and continues with hormone therapy. Sally and the rest of the family have a long journey ahead of them.



Case study questions

1. What are the risk factors for developing breast cancer? Considering the background information in this case study, what factors put Sally at more risk of developing breast cancer?
2. From the information provided in the case study, consider what concerns Sally may have prior to her admission to hospital. Which of these can you address as a nurse and which may need the involvement of other members of the interprofessional team?
3. As the registered nurse looking after Sally, what pre-operative, peri-operative and post-operative care will she require? It would be helpful to access a surgical nursing text to answer this question.

Key information and links to other resources



Australian organisations providing information on cancer

A number of different organisations provide resources and supports for both healthcare practitioners, patients and families. These are just a few:

- The Cancer Council
- Breast Cancer Network Australia
- McGrath Foundation
- Cancer Australia



Complementary and natural / lifestyle therapies

The use of complementary and lifestyle medicine is increasing globally at a rapid rate (Steel et al., 2018; Frass et al., 2012). A study by Steel et al., (2018) finds that 63.1% of the adult Australian population have used some sort of complementary medicine. More patients are choosing to supplement conventional healthcare with other methods as a way of addressing issues not met by conventional medicine or psychological aspects of care (Hall et al., 2018; Leach, 2016). With an increase in the use of complementary therapies (CTs), nurses need to have an awareness of their use so they can encourage informed decision-making and improve patient safety (Hall et al., 2018; Lindquist et al., 2018; Cooke et al., 2012).

Sally is an advocate for complementary and natural lifestyle approaches to health. Research demonstrates the positive effects natural and lifestyle therapies can have on cancer and a person's wellbeing. These include supplements such as vitamin E and/or selenium, therapies such as music therapy, meditation, relaxation, stress management, yoga and tai chi as well as exercise (Singh et al., 2018; Greenlee et al., 2017; Larkey et al., 2015).



Thinking points

1. Consider your role as a surgical nurse in managing Sally's care. What do you think is your role in supporting Sally's choice of using natural and lifestyle approaches?
2. What advice might you give to Sally as she prepares for surgery?
3. What should you consider as Sally prepares for discharge in relation to natural and lifestyle approaches, including the use of supplements?



Family impact

A cancer diagnosis will have a significant impact on all members of the family.



Thinking points

1. How might Sally's diagnosis and admission to hospital affect other members of the family?
2. What strategies might be useful in helping family members manage these effects?
3. Based on what you know about the Lewis family and the information provided above, what interventions may be appropriate to ensure the wellbeing of each family member? (Remember to take a holistic approach and consider their physical, psychological, social, cultural and spiritual wellbeing).
4. Based on your answers to the questions above, which professionals would be important when it comes time to form the interprofessional team? What might the roles and responsibilities of each professional be?



Case study 2 summary

Through this case study you have had the opportunity to learn more about Sally, her diagnosis of breast cancer and her treatment. A diagnosis such as this has a significant impact on not only Sally but the wider family as well. In considering a person-centred approach to care, you have reflected upon and considered the needs of all family members and how your role as a nurse and member of the interprofessional team can contribute to care.

References

- Cooke, M., Mitchel, M., Tiralongo, E., & Murfield, J. (2012). Complementary and alternative medicine and critical care nurses: A survey of knowledge and practices in Australia. *Australian Critical Care*, 25(4), 213-223. <https://doi.org/10.1016/j.aucc.2011.12.055>
- Frass, M., Strassl, R. P., Friehs, H., Müllner, M., Kundi, M., & Kaye, A. D. (2012). Use and acceptance of complementary and alternative medicine among the general population and medical personnel: A systematic review. *Oschner Journal* 12(1), 45-56.
- Greenlee, H., DuPont-Reyes, M. J., Balneaves, L. G., Carlson, L. E., Cohen, M. R., Deng, G., Johnson, J. A., Mumber, M., Seely, D., Zick, S. M., Boyce, L. M., & Tripathy, D. (2017). Clinical practice guidelines on the evidence-based use of integrative therapies during and after breast

cancer treatment. *CA: A Cancer Journal for Clinicians*, 67(3), 194-232. <https://doi.org/10.3322/caac.21397>

Hall, H., Brosnan, C., Cant, R., Collins, M., & Leach, M. (2018). Nurses' attitudes and behaviour towards patients' use of complementary therapies: A mixed methods study. *Journal of Advanced Nursing*, 74(7), 1649-1658. <https://doi.org/10.1111/jan.13554>

Larkey, L. K., Roe, D. J., Weihs, K. L., Jahnke, R., Lopez, A. M., Rogers, C. E., Oh, B., & Guillen-Rodriguez, J. (2015). Randomized controlled trial of qigong/tai chi easy on cancer-related fatigue in breast cancer survivors. *Annals of Behavioural Medicine*, 49(2), 165-176. <https://doi.org/10.1007/s12160-014-9645-4>

Leach, M. (2016). Profiling the Australian consumer of complementary and alternative medicine: A secondary analysis of national health survey data. *Alternative Therapies in Health and Medicine*, 22(4), 64-72.

Lindquist, R., Tracy, M. F., & Snyder, M. (Eds.) (2018). *Complementary and alternative therapies in nursing* (8th ed.). Springer Publishing Company.

Singh, B., Spence, R. R., Steele, M. L., Sandler, C. X., Peake, J. M., & Hayes, S. C. (2018). A systematic review and meta-analysis of the safety, feasibility, and effect of exercise on women with stage II+ breast cancer. *Archives of Physical Medicine and Rehabilitation*, 99(12), 2621-2636. <https://doi.org/10.1016/j.apmr.2018.03.026>

Steel, A., McIntyre, E., Harnett, J., Foley, H., Adams, J., Sibbritt, D., Wardle, J. & Frawley, J. (2018). Complementary medicine use in the Australian population: Results of a nationally-representative cross-sectional survey. *Scientific Reports*, 8, Article 17325. <https://doi.org/10.1038/s41598-018-35508-y>

4.4 LEWIS FAMILY CASE STUDY 3: JOHN HAS A MOTORBIKE ACCIDENT

Nicola Whiteing and Elicia Kunst

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Understand the process of primary and secondary survey.
- Apply comprehensive assessment to a patient case.

Scenario



Motorbike

John is a recreational motorbike rider who is the proud owner of a hybrid sports bike and a cruiser motorcycle. John is a safe and mature rider who wears safety gear at all times. While on a weekend ride with a group of friends through the Gold Coast hinterland, John's bike is clipped by a car; he is knocked off the bike and slides several metres through gravel and into a metal guardrail at moderate speed and impact. A passer-by calls the paramedics and police, who arrive at the scene within 10 minutes.

Primary survey by paramedics

John is rapidly assessed by paramedics using the DRABC mnemonic:

- Danger
- Response
- Airway
- Breathing
- Circulation

After ensuring their own safety and that of the patient and other bystanders, the paramedic team assesses John's level of consciousness using the alert, verbal, pain, and unresponsive (AVPU) scale (Janagama et al, 2022). John is found to be alert with a normal level of responsiveness. The paramedics then assess John's airway for signs of obstruction. John is found to have normal breath sounds and no obvious airway obstruction. In line with Queensland Ambulance Service policy, the paramedics remove John's helmet using a two-operator process that provides support at the mandible and occiput and reduces the risk of destabilising and cervical spine injury. John is breathing in a regular pattern, with equal chest wall movement bilaterally. John's respiratory rate is 22 breaths per minute. In assessing circulation, John's blood pressure is 118/86 and he is found to have adequate central and peripheral perfusion.

The initial treatment involves protecting the cervical spine (also known as the C-spine) in case of vertebral injury, which may result in spinal instability and damage to the spinal cord. The paramedics apply a cervical collar to limit movement and support the C-spine. They establish intravenous access with an 18g peripheral cannula (PIVC) into the left arm antecubital fossa.



Secondary survey by paramedics

The paramedics gather further information about the accident, including information from bystanders, and conduct a more focused assessment. This head-to-toe physical assessment includes a more comprehensive history, including pain assessment and vital signs. John complains of moderate pain in his lower back and abdomen, radiating into the right groin. There are no visible deformities of the head, neck or chest. John does report some tenderness over the right clavicle on palpation. Auscultation of the chest reveals undiminished heart and lung sounds, with no additional sounds. Inspection of the abdomen shows some bruising and extensive grazes from the right hip into the right lower quadrant. John experiences moderate pain on palpation and passive movement of the hip. There is no obvious deformity of the lower limbs. John's boots are removed to assess for rotation or shortening of the legs; however, both legs are naturally positioned and of equal length.

John's vital signs remain stable.

- Respiratory rate: 22, bilateral equal chest movement

- SpO₂: 97% on room air
- Blood pressure: 124/ 89
- Heart rate: 96, regular
- GCS:15 (E4, V5, M6)



Prepare for transport to hospital

Using spinal precautions, the paramedics recruit bystanders to help them transfer John to the spinal board which is then lifted onto a stretcher. John's pain worsens on movement, intensifying in the right hip and radiating from the right groin down into the leg. The pain is spasmodic or cramping in nature; John says that the pain score is now 8 out of 10. Paramedics administer intravenous fentanyl in 25 microgram increments and inhaled methoxyflurane (Penthrox) until the pain is more manageable.

When John failed to arrive at the meeting point, two of his friends rode back and arrived at the scene. One of his friends (Mark) agreed with the police that he would contact Nigel to let him know what had happened. On receiving Mark's phone call, Nigel said he would come to the hospital straight away.



Case study questions

1. Fentanyl is an effective opioid analgesic for managing short-term or acute pain. What are the benefits of using fentanyl for the type of pain that John is experiencing? What are some of the risks of opioid analgesia?
2. In the initial phase, John would need to be monitored for signs of sedation. How do we assess the level of sedation?

Key information and links to other resources

- Emergency Care Institute NSW: Maintaining cervical spine precautions
- Trauma Victoria: Pre-hospital triage



Thinking point



Clinical evidence has questioned the use of spinal immobilisation in both pre-hospital and in-hospital care, especially the use of the rigid cervical collar.

Undertake a search of the literature and find out the risks of using a rigid cervical collar to minimise cervical spine movement following an acute injury



Case study 3 summary

This case study explores the pre-hospital care provided to John before he is transferred to the emergency department (ED). The primary and secondary survey has been presented and you have had the opportunity to consider pain relief and the use of spinal immobilisation in line with current evidence. In the next case study, you will follow John's story as he is admitted to the ED.

References

Janagama, S. R., Newberry, J. A., Kohn, M. A., Rao, G. V. R., Strehlow, M. C., & Mahadevan, S. V. (2022). Is AVPU comparable to GCS in critical prehospital decisions? – A cross-sectional study. *The American Journal of Emergency Medicine*, 59, 106–110. <https://doi.org/10.1016/j.ajem.2022.06.042>

4.5 LEWIS FAMILY CASE STUDY 4: JOHN IS TRANSFERRED TO THE EMERGENCY DEPARTMENT

Nicola Whiteing and Elicia Kunst

Introduction to case study



Learning Objectives

By the end of this case study you should be able to:

- Understand how care is prioritised through the process of triage.
- Outline an A to G assessment.

Scenario

John is transported to the nearest tertiary hospital emergency department (ED). While en route from the accident scene to the ED, the paramedics notify the ED of the details of the accident and their assessment and ask if the hospital is able to accept care of John. This ensures there is capacity and resources available to provide good patient care. The paramedics continue to monitor John's pain and assess his condition during transport. On arrival at the ED, the paramedics provide further details to the triage nurse about John's condition and the treatment they provided. The triage nurse conducts their own rapid assessment. Based on the Australasian triage scale (ATS), the nurse allocates John to category 3, based on the adult physiological predictors scale. While maintaining spinal precautions, John is transferred from the ambulance stretcher to the ED bed.

Function of triage

Triage is an essential function that underpins the delivery of care in all EDs. The triage process allows a number of people with a range of conditions to present to the ED at the same time. Triage requires a reliable and consistent process to ensure the available resources are used to minimise the risk of clinical deterioration from delayed care. Although triage systems may function in slightly different ways depending on local factors, effective triage systems share the following important features:

- A single-entry point for all incoming patients (ambulant and non-ambulant), to ensure all patients go through the same assessment process.
- A physical environment that is suitable for undertaking a brief assessment. This should include easy access to patients that balances clinical, security and administrative requirements, as well as the availability of first aid equipment and handwashing facilities.
- A systematic patient process that facilitates the flow of patient information from point of triage through to ED assessment, treatment and discharge.
- Responsive data for activity in the ED, including systems for alerting the department of incoming patients from emergency services to facilitate efficient resource allocation.

John's triage

The nurse assesses John as he presents to the ED. An initial quick assessment involves assessing for safety and checking John is physiologically stable enough to allow for assessment. Once he is assessed as stable, the nurse takes him through the systematic 'A to G' assessment framework:

- Airway: checking for John's patency and potential for obstruction.
- Breathing: looking at his respiratory rate and effort, assessing his pulse oximetry, considering the potential for oxygen or ventilatory support.
- Circulation: assessing central perfusion, his blood pressure and heart rate, assessing risk to circulation due to blood loss, vasodilation or constriction, or other haemodynamic instability.
 - As time permits, this includes looking at factors that affect cardiac output, including cardiac rhythm. Initially, cardiac output and rhythm can be assessed using a basic assessment like palpating a pulse for regularity and strength, then subsequently assessing the cardiac rhythm using continuous cardiac monitoring. A 12 lead ECG provides a static picture of the electrical activity across a wider section of the myocardium, or cardiac muscle.
- Disability: considering factors that limit or affect John's normal function, like injury, pain or other physical limitations.
- Exposure: observing him for other injury, skin integrity, and considering issues that affect his temperature; assessing him for hypothermia, hyperthermia, and fever.

- Fluids: considering John's risk of fluid deficit or overload and the potential need for intravenous access (including peripherally inserted venous cannulation (PIVC) or other central venous access device (CVAD) such as a portacath or peripherally inserted central catheter (PICC).
- Glucose (and other electrolyte disturbance): assessing his blood glucose level if this is a risk factor and considering the potential for other metabolic disorders.

John's airway remains patent without any signs of wheeze or distress that might indicate partial obstruction. His breathing is regular and even, with no signs of respiratory distress. The respiratory rate is 18 and pulse oximetry shows an SpO₂ of 96% on room air. Blood pressure is 112/ 72, his heart rate is 92 and the cardiac monitoring shows a normal sinus rhythm. At rest, John appears comfortable as he lies on the bed; he is not grimacing or wincing or holding an affected part of his body. John says his pain is currently 6 out of 10 at rest when he is asked for his pain score. However, when he is moved to the other bed, John does cry out in pain, reporting his pain score as 10 out of 10. John states the pain is on his right side, throughout his lower back, radiating laterally to the hip and down into the right leg. The triage nurse notes the paramedics administered intravenous fentanyl pre-hospital as well as inhaled methoxyflurane (Penthrox).

On examination, the nurse notes bruising and some swelling over John's right hip and lower flank. There is also swelling over the right clavicle. The cervical collar remains in place and the team, made up of medical and nursing staff, continue with spinal precautions. Nursing staff remove John's remaining clothing and he is dressed in a hospital garment to allow for a more thorough physical examination. John's privacy is maintained as much as possible by drawing curtains around the cubicle and using garments and blankets to cover him.

After further assessment, the team notes that John has an 18g PIVC in the left arm antecubital fossa. This appears to be intact with no signs of redness or swelling. At this point, John says he needs to go to the toilet to pass urine. However, as the team suspects there may be potential for cervical spine injury, which has not yet been comprehensively assessed, they assist him to use a urinal bottle. As John is embarrassed and uncomfortable to pass urine in this way, the nurse provides reassurance. Then the team takes a venous collection of bloods to gather a baseline of haematology, including haemoglobin, biochemistry, renal function indicators and electrolytes.

John is assessed by the emergency doctors. Further investigation includes a radiograph or x-ray of the pelvis and both hips, the right clavicle and shoulder, and a chest x-ray to check for undetected trauma to the cardiac structures, airway structures and bony structures. The radiography also takes images of his cervical and thoracic spine because of the risk associated with how the injury occurred (the mechanism of injury) (State Insurance Regulatory Authority NSW, 2014, p. 17). The urine collected by the nurse is tested using ward urinalysis that looks for the presence of blood, which can be an indicator of renal system trauma.

John is found to have sustained a closed pelvic fracture as a result of a vertical shear injury. The x-ray shows a fracture through the superior pubic ramus. John is cleared of underlying gastrointestinal or vascular system trauma through a computer assisted tomography (CT) scan of the abdomen. The x-ray also shows he has a fractured right clavicle. When John is cleared for cervical spine injury, which means the cervical spine has not sustained any injury, the team removes the cervical collar.

While John is allowed to raise the head of the bed so he can sit in a slightly inclined position, raising the bed head above 30 degrees creates pain in his pelvis. John is given further analgesia and is referred to the orthopaedic team for management of his injuries.

Nigel arrives at the emergency department

On arrival at the ED, Nigel speaks with a receptionist who tells him to take a seat in the waiting area. Nigel has not had any information regarding how John is, with Mark just telling him that he “has a collar on his neck and is in a lot of pain”. Nigel is worrying about how they will all cope if John has a spinal injury. After half an hour, a member of the medical team comes out to speak with Nigel. He discusses with him John’s injuries and what will now happen. Nigel is feeling great relief that John is going to be OK and goes to sit by his bedside to wait with John until the orthopaedic team arrive.

Planning for discharge

In conjunction with John, the orthopaedic team plan for conservative management of his injuries. This means that they support function and encourage rest to allow the bones to heal without surgical intervention. John will need support with mobility, activities of daily living, and managing pain. Nigel and Sally have suggested that John moves in with them while he is recovering from his accident. John is reluctant to do so, however acknowledges that he is going to need help from someone and agrees to move in with Nigel ‘just for a short time’. Nigel, Sally and John arrange to meet with the interprofessional team so they can ensure everything is organised for his discharge.



Case study questions

1. John has a closed fracture. How does this terminology describe the nature of the fracture and damage to surrounding tissues? How does a closed fracture differ from an open or compound fracture? Consider the risk of further injury through secondary complications, management and implications for recovery from the injury.
2. After a short stay in hospital and a week in a rehabilitation centre, John is discharged back to Nigel and Sally’s house. He uses a single crutch on his left arm to support his mobility due to his fractured right clavicle. Consider John’s social factors: how can he be supported on discharge to return to normal function?
3. John was reluctant to move in with Nigel and Sally. Could he have been safely discharged to his own home? If so, who is able to support him with things like transport, meal preparation,

shopping, laundry, cleaning? Job insecurity and financial stress can often occur after serious injury or illness – consider what support we can provide or recommend for John



Thinking points

The Australasian triage scale (ATS) is one of many triage processes in use worldwide. While this uses a 5-point scale to objectively prioritise patient care, some other scales use a 3 or 4-point scale. Have a look at some of the other triage processes that are used, and compare this to the ATS. List the strengths of a few different systems from countries that have a comparable healthcare system to Australia's, for example, the United Kingdom, the United States, Germany, France or Canada.

John's brother Nigel was called and he waited in the ED waiting room while John was triaged. Nigel asks the receptionist about the triage process and questions why John is not immediately seen by a medical doctor on arrival to the ED. Explain the process of triaging or prioritising patients to Nigel, and why it is important in providing efficient and effective emergency care.



Case study 4 summary

This case study has given you the opportunity to learn more about the use of systems that aid the triage of patients. You have also seen how the A-G assessment is applied to John's presentation. John did not require surgery and was able to be discharged with conservative treatment. Patients that live alone may experience significant obstacles in their recovery, not only their physical recovery but also in social, emotional and financial aspects of their life.

References

State Insurance Regulatory Authority NSW. (2014). *Guidelines for the management of acute whiplash-associated disorders for health professionals* (3rd ed.). <https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/whiplash-resources/SIRA08104-Whiplash-Guidelines-1117-396479.pdf>

4.6 LEWIS FAMILY SUMMARY

Nicola Whiteing

Summary

This part focuses on the care of the Lewis family who live in Queensland. The case studies focus on different members of the family, namely Luke, Sally and John. While each case study has a central character at its core, each scenario demonstrates the impact an individual incident, such as an accident or a diagnosis, can have on the wider family. The ripple effect caused by the circumstances discussed in these case studies can be significant. It is essential that healthcare professionals consider these circumstances when they care for an individual. It is only through taking a holistic approach to care that we can truly achieve the delivery of person-centred practice.

Image attributions

Images not individually attributed are listed below in order of appearance in the part:

Chapter 4.1

Sally image by Karolina Grabowska on Pexels

Nigel image by Nathan Cowley on Pexels

Daisy image by Владимир Васильев on Pexels

Ella image by Liliana Drew on Pexels

Luke image by RDNE Stock project on Pexels

John image by Antoni Shkraba on Pexels

David and Patricia image by Matheus Bertelli on Pexels

Stephen and Elizabeth image by BOOM on Pexels

Chapter 4.4

Motorbike image by Dawid Cedler on Pixabay

Icons

All icons in this part are from Flaticon and are listed below in order of first appearance in the part:

Introduction: Introduction icons created by Freepik – Flaticon

Person-centred care: People icons created by Freepik – Flaticon

Therapeutic communication: Team icons created by Freepik – Flaticon

Teamwork and collaborative practice: Communication icons created by Freepik – Flaticon

Objectives: Objective icons created by Uniconlabs – Flaticon

Case studies: Case study icons created by Flat Icons – Flaticon

Thinking point: Creativity icons created by Freepik – Flaticon

Summary: Summary icons created by Freepik – Flaticon

Medication safety: Health insurance icons created by Freepik – Flaticon

Evidence-based practice: Analysis icons created by Uniconlabs – Flaticon

Musculoskeletal: Muscle icons created by Victoruler – Flaticon

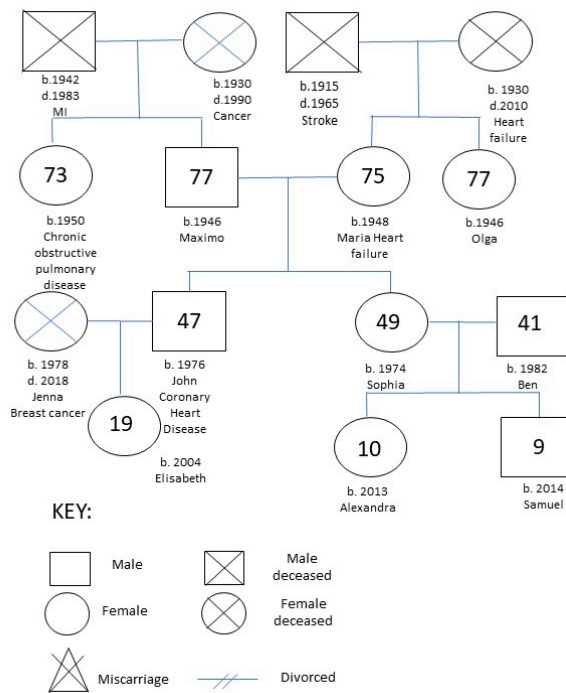
Clinical reasoning: Think icons created by Freepik – Flaticon

PART 5 THE ROSSI FAMILY

5.1 INTRODUCTION TO THE ROSSI FAMILY

Dima Nasrawi and Donna Wilson

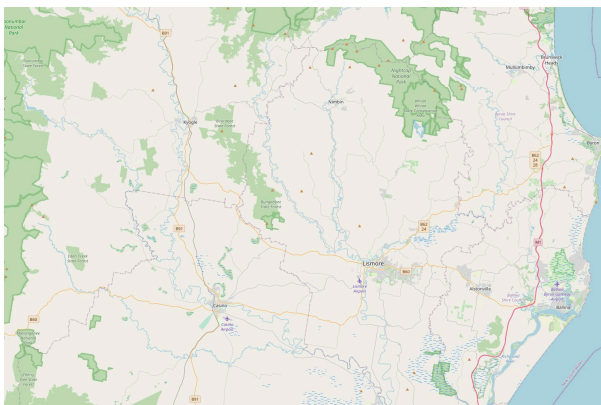
Family genogram



Rossi family genogram



Introduction to family and community



Corndale map

This part provides a series of case studies of an Australian family with a Mediterranean/European background who had a history of cardiac conditions. The family consists of 3 generations who live together: Maria and her husband Maximo, their son John, and John's daughter Elisabeth. Maria and Maximo migrated from Italy to Australia almost 50 years ago as newlyweds to Corndale, a small village outside Lismore. John and Elisabeth are first and second generation Australian. Unfortunately, Elisabeth lost her mother 5 years

ago due to breast cancer. Maria and Maximo also have a daughter named Sofia, who lives interstate.

This part illustrates the complexities that can arise within families who live with chronic cardiac conditions and present with multiple risk factors. This part showcases health promotion strategies and details how to navigate the Australian healthcare system. The part starts with a section outlining the family's background, its medical and surgical history and associated risk factors. This is followed by 3 case studies: 1) heart failure diagnosis and management; 2) myocardial infarction and an escalation to coronary artery bypass grafting surgery; and 3) cardiac risk factors and health promotion strategies.

The Rossi family

Maria and Maximo Rossi



Maria and Maximo

Maria and Maximo met in the Italian town of Agugliano near the seaside city of Ancona. They were married just prior to emigrating to Australia in their mid-20s. They started their married lives on a dairy cattle farm in the northern New South Wales (NSW) village of Corndale, just outside of the city of Lismore. Maximo had existing contacts locally when they first arrived, with an uncle, aunt and 2 young cousins already residing on another farm in the area. Like many in Australia, the northern rivers of NSW region boasts a proud heritage of Italian immigrant families. Maria and Maximo have been lifetime members of the Italo-Australian Club in Lismore,

where they have grown strong connections and relationships with other local Italian and Australian families over the decades.

Maria and Maximo grew up in the Catholic faith and have continued to observe Catholic traditions and practices within the Parish of Saint Carthage's Cathedral in Lismore. Between their local farming community, the Italo-Australian club and the Saint Carthage's Parish, the Rossi's have lived a life surrounded by an extended and supportive community. Maria and Maximo gained Australian citizenship several decades ago and are very proud 'Italian Australians', enthusiastically embracing both cultures as their own.

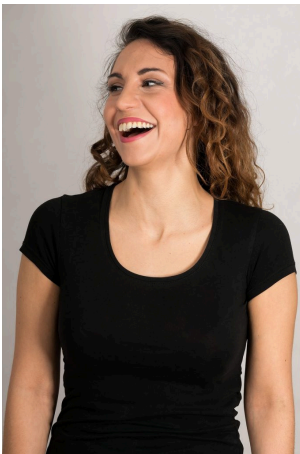
About 6 months after moving to Australia, Maria was delighted to discover she was pregnant with their first child. Their first-born child was a daughter, whom they called Sofia. Their second child, a son named John, came along 2 years later. Maria and Maximo would have dearly loved to have had many more children, but unfortunately Maria suffered complications and several miscarriages following John's birth and underwent a hysterectomy in her early 30s.

Maria is now 75 years old after migrating to Australia with her new husband Maximo (now 77 years old) at the age of 25. While English is her second language, she has a very good grasp of both spoken and written English. Maria's closest friends would describe her as kind, generous, clever,

and a fantastic cook with a great sense of humour. Maria spent many years working part-time as a carer for the elderly retired nuns from the Catholic Presentation Convent of the Sisters, who resided in Presentation House behind Saint Carthage's Cathedral. When Sofia and John attended school, the cathedral was right next door. They would love to come and visit the elderly Sisters after school and meet their 'mamma' Maria.

Along with her husband Maximo, Maria is a farmer, not just a farmer's wife! She has always fulfilled farming duties, from milking cows, feeding the cattle, moving cattle to higher ground when it floods, to ensuring water troughs are filled during the dry times. She used to be responsible for the farming books and records but was more than happy when John took over that job many years ago after his studies, moving it all onto the computer! Maria was fascinated by the computer when it landed in the home office all those years ago and has developed her own skills; from playing games of solitaire in the early days, to googling for facts and, more recently, online shopping. In this way she is quite unlike her husband Maximo, who has never taken to the digitisation of the world around him. To this day he maintains a handwritten journal of weather and rainfall from the first year they moved to the farm in Corndale. Maria and Maximo have taken a step back from managing the farm, and are enjoying this new chapter of looking after their health and ageing together.

Sofia Rossi



When Sofia grew up, she studied law at Southern Cross University in Lismore, before taking a job interstate in Queensland. She met her husband Ben through her work and moved to Melbourne with him when their 2 children (Samuel and Alexandra) were still very young. She is now 49 and has a wonderfully fulfilling life and career in Melbourne, where she has lived for over 20 years. She travels home to visit her family on the farm 2 to 3 times a year.

Sofia

John Rossi



John

John, now a 47-year-old male, grew up and studied agricultural science at the University of New England in Armidale, NSW, before returning to his family farm to live with his parents after the loss of his wife 5 years ago. He currently works locally as an agricultural scientist with the Department of Primary Industries of NSW (DPI). John chose this career specifically so he could support his parents and continue the legacy of the farm they have established.

When he was 27 years old, John married his wife Jenna in a beautiful ceremony at St Carthage's Cathedral. He and Jenna renovated and extended the original Corndale farmhouse, which enabled them to live comfortably and privately on the same property as Maria and Maximo. Jenna adored her in-laws and was a very much-loved part of the Rossi

family. John and Jenna welcomed their only daughter Elisabeth in the first year of marriage, before encountering a period of fertility difficulties. When Elisabeth was 6 years old, her mother was diagnosed with breast cancer. Following surgery, several years of treatment, a period of remission and a cancer relapse, Jenna succumbed to the disease 8 years after her initial diagnosis when her daughter was 14 years old.

John has been the main carer for his daughter Elisabeth and has raised her on the Corndale farm with the support of his mum and dad. He also manages the running of the farm with the support of his now elderly father Maximo. He is not only passionate about farming, but also a hardworking and caring man who gives back to the community that helped his parents establish a life in Corndale.

Recently, John has been feeling stressed and overwhelmed from years of looking after his daughter and helping out on the land. He has not taken time to grieve and has tried to continue to live his life as normal. In the last 2 months, John has been experiencing health problems, significant weight loss and a desire to be alone. His family now feel very concerned as he is managing his health alongside his job with the DPI and the farm.

Elisabeth Rossi



Elisabeth

Elisabeth is now 19 years old and has very recently started studying to become a primary school teacher at the local Southern Cross University campus in Lismore. She is your quintessential Australian 19-year-old, who loves the beach, social media, and hanging out with her friends. Her dream is to live and work in Italy for a year or 2 after she completes her studies. She has been working on her Italian language skills with her nonna and nonno Maria and Maximo. Despite her Italian heritage, Elisabeth grew up in a primarily English-speaking household.

5.2 ROSSI FAMILY CASE STUDY 1: MARIA ROSSI - HEART FAILURE

Dima Nasrawi and Donna Wilson

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Identify associated risk factors with the development of chronic cardiac failure.
- Identify the impact of a chronic cardiac failure diagnosis.
- Discuss required lifestyle modifications for patients living with a cardiac failure diagnosis.
- Identify required self-management strategies to manage cardiac failure diagnosis with a specific focus on rural health.
- Discuss the role of the nurse managing a cardiac failure diagnosis.

Scenario: Maria's diagnosis of chronic cardiac failure

Early last month, Maria began to experience some light-headed episodes, heart palpitations and dizziness at home. She did not report these symptoms to her family or visit a doctor, as she believed it was just 'a part of ageing'. She believed she could manage with an improvement in her hydration and additional rest. However, last week her husband Maximo finds her after a fall. Maria has collapsed in the dining room and sustains a small bleeding laceration above her left eyebrow. Maximo realises she has likely hit her head on the edge of the chair as she collapsed. As Maria is semi-conscious when Maximo finds her, he calls out to their son John for help. Both John and Elisabeth rush to assist and Elisabeth immediately calls for an ambulance.

When the ambulance arrives, the paramedics explain to Maria's family that it looks like her heart is not working properly. They say that whilst it does not look like a heart attack, they believe she needs to be urgently transported to the local hospital in Lismore, about 20 minutes away by road. Later that day, Maria's family are informed that she is in a serious condition, with a new diagnosis of heart block.



Thinking point

The hospital staff start Maria on an isoprenaline infusion, which has a mode of action known as a 'beta-agonist', which relaxes the muscles of the airways. This drug increases cardiac output via positive chronotropic and inotropic actions. Cardiac automaticity and atrioventricular nodal conduction are improved under this drug, which can also improve coronary blood flow.

With the isoprenaline infusion underway, Maria is airlifted to a larger hospital just over one hour away from Lismore by road. This tertiary facility specialises in complex cardiac care. On arrival, Maria is transferred urgently to the cardiac catheterisation laboratory (CCL) where she is diagnosed with complete heart block, leading to the need for emergency pacemaker implantation. The cardiac team inform Maximo and John that the infusion has played a big part in saving her as it keeps her heart reasonably stable, long enough for her to be delivered safely to the cardiac facility.

Reflective Questions

- Can you imagine how Maria and her family would have felt during the transport stage of her care?
- As a healthcare professional, how could you offer support to Maria and her family during this stage?



Thinking point

Maria's pacemaker procedure occurs almost 5 hours after she is found on the floor in the dining room. If Maria lived in a city, she would likely have reached the CCL procedure table within the

hour. However, systems in place in her local area enable the swift escalation and retrieval to occur, resulting in Maria accessing the life-saving procedure.

Unfortunately, in the 2 days after the pacemaker implantation, Maria continues to experience palpitations and develops symptoms of shortness of breath, fatigue and swelling in the legs.

Further diagnostic tests reveal Maria is experiencing heart failure with reduced ejection fraction. This results in a new diagnosis of atrial fibrillation with ventricular pacing. Maria's condition is treated with diuretics, ACE inhibitors and beta-blockers. In addition, she receives some short-term non-invasive ventilation with biphasic positive airway pressure (BiPAP) to assist with her shortness of breath, due to acute pulmonary oedema (APO).

With appropriate treatment and management, Maria's symptoms improve. She is discharged from the hospital with a referral to the local heart failure community management team, a cardiac rehabilitation program, and a plan for follow-up with her cardiologist. Her condition remains stable; however, she now lives with a new chronic cardiac condition and a reduced overall functionality when it comes to activities of daily living.

Reflective Questions

- Have you considered the impact of living rurally on patients, in terms of accessing life-saving health care services? Maria received this treatment far from home, how would this affect her?
- This situation was a life-threatening situation for Maria. As a healthcare professional, it is always important to consider regular debriefs and self-care strategies, have you considered any of these yet?



Thinking point

Maria travelled just over 100 kms to receive care and treatment in a tertiary hospital facility. The local city of Lismore has a range of healthcare facilities, including a major hospital. She can also access local support via the community health team as well as rural healthcare initiatives and virtual care such as telehealth. Maria and Maximo may benefit from additional in-home support. As an Australian example of additional support in the community for the aged, 2 types of assessments are offered by the Australian government to determine the needs and eligibility for specific types of care.

The first is a home support assessment conducted by a regional assessment service (RAS). This

assessment is recommended if only low-level support is required to maintain independence at home and it is part of the Commonwealth home support programme.

The second is a comprehensive assessment conducted by an aged care assessment team (ACAT). This assessment is recommended if the care needs exceed what the Commonwealth home support programme can provide. ACAT assessments cover the following care options: home care packages, short-term care options, and aged care homes.



Case study questions

1. What were Maria's risk factors for developing chronic cardiac failure?
2. Now that Maria has a chronic cardiac failure diagnosis, what do you think could be the impact that this diagnosis has on Maria, Maximo, John and Elisabeth?
3. Now that Maria is going to be living with the diagnosis of chronic cardiac failure, what are some of the lifestyle modifications she and the family will need to be aware of?
4. Maria and her family live about one hour from the cardiac hospital and specialist care providers, and 20 minutes away from the community healthcare providers in Lismore. Given that she lives rurally, out of town on a farm, what sort of self-management strategies could she and her family put in place?
5. How can nurses make a difference to Maria's experience of managing her cardiac failure condition? Consider the role of the nurse in Maria's journey.



Key information and links to other resources

- Heart Foundation (Australia)
- Australian Commission on Safety and Quality in Healthcare: Fourth Australian atlas of healthcare variation – Section 2.2 heart failure
- Australian Institute of Health and Welfare: Heart, stroke and vascular disease: Australian facts
- Australian Government My Aged Care: Prepare for your assessment
- NSW Health virtual care



How to assess the cardiac system

Subjective Data:

- Ask the patient about their level of comfort, whether they have any pain and what is normal for them.
- Discuss with the patient about their medical and surgical history.
- Discuss with the patient their nutrition and diet: ask them about their appetite, their diet and whether they are experiencing any nausea.

Objective Data:

- Observe
- Listen: use a stethoscope
- Palpate
- Weigh the patient and record the body mass index (BMI)
- Diet: review the food intake of the patient, and if there is none, commence a food chart
- Observe bowel patterns
- Review the patient's medication history to see if any bowel medications have been commenced.

Now, before we pick up a stethoscope to perform a cardiac assessment, let's review how and where to auscultate, and consider what the sounds we hear will be telling us. Watch the video below which demonstrates how to conduct a physical cardiac assessment:

- Heart Sounds: An Advanced Assessment | Physical Examination | Lecturio Nursing



What is heart failure?

Activity: Watch this video for a great visual explanation for 'What is heart failure?'

- What is heart failure? | Circulatory System and Disease | NCLEX-RN | Khan Academy

Heart failure often arises from heart attack and coronary heart disease, although there are various other factors contributing to its occurrence. People living with heart failure are often also dealing with chronic ailments and comorbidities like lung disease or diabetes. Your heart can become weakened, damaged or stiffened due to underlying conditions that can lead to the development of heart failure, such as:

- Old age
- Chronic conditions: for example, diabetes, HIV and thyroid conditions
- Coronary heart disease and myocardial infarction
- Damaged heart tissues and muscle: cardiomyopathy, causes can include infection, alcohol abuse and certain medications; myocarditis caused by inflammation of the heart muscle
- Heart valve disease
- Cardiac arrhythmias
- Congenital heart disease
- High blood pressure
- Pregnancy: extra strain may cause damage to the heart (Heart Foundation, n.d.)

Symptoms of heart failure can be different for each person which range from serious to mild. The most common symptoms include:

- Chest pain
- Coughing, difficulty with breathing or shortness of breath, especially when doing physical activity, possible overnight waking due to difficulty with breathing
- Dizziness and/or heart pounding or racing (i.e. palpitations)
- Loss of appetite or nausea
- Swollen ankles or legs (i.e. oedema)
- Tiredness and/or weakness (Heart Foundation, n.d.)



Psychological health for patients with heart failure / cardiac disease

When considering ways to promote coping, resilience and improve quality of life, whilst reducing mortality and hospital readmission rates, it is crucial to consider the role of self-care. Many patients struggle to adhere to self-care advice, which may be due to a lack of motivation, knowledge, ability or support. Healthcare professionals play such an important role in supporting these patients with chronic cardiac conditions. This may be via education, assisting with making lifestyle changes, adhering to treatments, monitoring symptoms, responding appropriately to deteriorations, and linking patients to further resources and support agencies (Jaarsma, et al. 2021).



Case study 1 summary

Maria's case highlights the importance of monitoring patients who undergo cardiac interventions such as pacemaker implantation and for potential complications such as heart failure. Educating patients about their condition can ensure the best possible patient outcomes are achieved. Timely

diagnosis, appropriate treatment, and lifestyle modifications can significantly improve outcomes for patients with heart failure.

References

Heart Foundation. (n.d.). *What is heart failure?* <https://www.heartfoundation.org.au/bundles/your-heart/heart-failure>

Jaarsma, T., Hill, L., Bayes-Genis, A., Brunner-La Rocca, H.-P., Castiello, T., Celutkiene, J., Marques-Sule, E., Plymen, C. M., Piper, S. E., Riegel, B., Rutten, F. H., Ben Gal, T., Bauersachs, J., Coats, A. J. S., Chioncel, O., Lopatin, Y., Lund, L. H., Lainscak, M., Moura, B., ... Stromberg, A. (2021). Self-care of heart failure patients: Practical management recommendations from the Heart Failure Association of the European Society of Cardiology. *European Journal of Heart Failure*, 23(1), 157–174. <https://doi.org/10.1002/ejhf.2008>

5.3 ROSSI FAMILY CASE STUDY 2: JOHN ROSSI - MYOCARDIAL INFARCTION, CORONARY ARTERY BYPASS GRAFTING (CABG) SURGERY

Dima Nasrawi and Donna Wilson

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Identify associated risk factors with the development of chronic cardiac disease.
- Identify the impact of acute coronary disease.
- Discuss required lifestyle modifications for patients living with acute coronary disease.
- Identify required self-management strategies to manage acute coronary disease.
- Discuss the role of the nurse managing patients following cardiac surgery.

Scenario

John is a 47-year-old man, whose wife died 5 years ago. Recently he has been experiencing signs of health deterioration, including high blood pressure, cold sweats and radiating chest pain to his left arm. John has kept these signs and symptoms confidential, not sharing his health issues with the family. His signs are exacerbated by continual stress, anxiety, unresolved grief and the pressures of looking after his family's farm. He recently restarted smoking, as a coping mechanism against the stresses that he has in his life. At a recent community event, with people gathering in a well-known tavern to celebrate Easter Sunday after a church mass, John experiences an episode of shortness

of breath and crushing sensations of chest pain. His cousin Alberto rushes John to the emergency department of the nearest hospital (Lismore base). Upon arrival at the hospital, the emergency doctor sees on the electrocardiogram tracing that John has developed an elevated ST myocardial infarction, which requires emergency coronary artery bypass grafting surgery (CABGX4).

The family becomes really concerned about John's diagnosis, especially as they have always known him as a healthy, active man. John is transferred to a large tertiary hospital in Queensland so he can have his surgery within 24 hours. This news is very difficult and scary for Elisabeth. She is extremely concerned about her dad undergoing a complex surgery and very frightened about losing her father. Elisabeth starts to show signs of extreme anxiety, especially as she lost her mother at a young age. Maria, Maximo and Elisabeth decide to move to a hotel nearby so they can visit John and support him during his recovery from a complex surgery.

After his surgery John is transferred to the intensive care unit (ICU) for 48 hours. During his stay in the ICU, John struggles with his breathing due to his history of smoking. The healthcare team supports John to use an incentive spirometer and try some deep breathing exercises. He also requires a high flow of oxygen (45 litres at 45% of oxygen). During his stay at the hospital, John also experiences high levels of blood glucose. An ongoing diagnosis of coronary heart disease makes him very anxious about his surgical wound and recovery after discharge.

During visits by Elisabeth, Maria and Maximo in the post-operative phase, the family is concerned to see John connected to such an array of monitoring devices, which includes telemetry, drains, intra dwelling catheter, intra venous canula and isolated wires. The nursing and inpatient cardiac rehabilitation teams play an integral part in reassuring John and the family about discharge arrangements. On John's last day at the hospital, he is referred to an outpatient cardiac rehabilitation program and provided with 2 follow-up appointments with cardiac surgeons and the outpatient department.



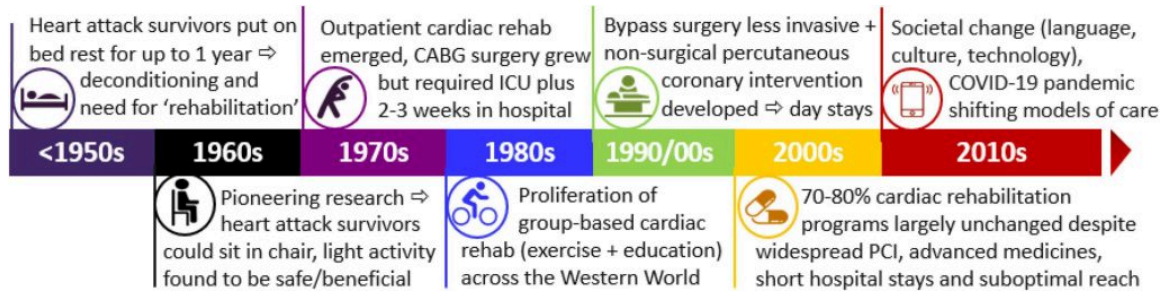
Thinking points

Cardiac rehabilitation history, inpatient, outpatient, long term:

The management of myocardial infarction (MI) has changed significantly since 1950. However, cardiac rehabilitation (CR) remains underutilised treatment. The figure below shows the history of CR:

Figure 1:

History of cardiac rehabilitation



Note: Timeline for cardiac rehabilitation from 'Historical context of cardiac rehabilitation: Learning from the past to move to the future' by J. Redfern et al., 2022, Frontiers in Cardiovascular Medicine, 9, p. 3. CC BY

Now patients who survive an MI not only require a reperfusion similar to what John has undergone, but also an inpatient cardiac rehabilitation intervention that starts pre-operatively, continues after surgery and then after discharge (Nasrawi et al. 2022).

- **Phase 1** cardiac rehabilitation focuses on introducing mobilisation to patients and required information for discharge and recovery.
- **Phase 2** is an outpatient hospital-based program that includes a group and runs for 6 to 12 weeks.
- **Phase 3** is known as the maintenance phase and is usually around 4 to 6 months where patients learn how to continue their exercise regime, risk factor modification and return to work and their daily lifestyle.



Thinking point

In Australia, 12,700 CABG procedures were performed between 2020 and 2021 (Australian Institute of Health and Welfare [AIHW], 2023.) Surgical intervention can lead to various adverse events, with hospital-acquired infections being the most common complications. Including patients in healthcare improvement is paramount and is supported by the Australian national safety and quality health service standards. This approach includes a collaboration between practitioners and the patient, the use of photographs to allow accurate evaluation and documentation of the wound healing process.



Case study questions

1. What local organisations support recovery after heart surgery?
2. Who in the interdisciplinary team cares for a patient during the inpatient cardiac rehabilitation phase after cardiac surgery?
3. Who in the interdisciplinary team cares for a patient during the outpatient cardiac rehabilitation phase after cardiac surgery?
4. What are the 3 phases of cardiac rehabilitation?
5. What is the impact of diabetes on wound care after surgery?
6. How do you provide culturally sensitive care for patients after cardiac surgery? (refer to the Shero family in Part 3 for additional information about cultural sensitivity)



Key information and links to other resources

- Heart Foundation: What is coronary heart disease?
- Heart Foundation: Find a cardiac rehabilitation service near you
- Diabetes Australia



What is a myocardial infarction?

John experiences a feeling of crushing chest pain or in medical terms an 'unstable angina'. His angina is associated with atherosclerosis plaque, thrombus and was not relieved by rest. The occlusion escalates to an ST-elevation myocardial infarction.

Symptoms of a myocardial infarction, or 'heart attack' can be different for each person, ranging from serious to mild. The most common symptoms include:

1. Pain or tightness in one of these areas: chest, arms, shoulders, neck or jaw.
2. Shortness of breath, feeling dizzy, sweaty or nausea.

For example, this flyer should be available in every household, especially in John's house, to detect

early signs and trigger an early response. The Heart Foundation website has many resources that can assist patients and families to manage coronary artery disease, including videos and flyers in various languages:

- Heart attack warning signs



Case study 2 summary

John's case covers the importance of early detection of signs of myocardial infarction and early management to improve health outcomes. While reperfusion therapy is vital to increasing chances of survival, cardiac rehabilitation, or, in more inclusive terms, secondary prevention, is essential to implementing lifelong preventative strategies.

References

- Australian Institute of Health and Welfare. (2023). *Heart, stroke and vascular disease: Australian facts*. <https://www.aihw.gov.au/reports/cvd/092/hsvd-facts/contents/treatment-and-management/hospital-care-and-procedures>
- Nasrawi, D., Latimer, S., Massey, D., & Gillespie, B. M. (2023). Delivery, barriers, and enablers to patient participation in inpatient cardiac rehabilitation following cardiac surgery: An integrative review. *Australian Critical Care*, 36(3), 420–430. <https://doi.org/10.1016/j.aucc.2022.01.007>
- Redfern, J., Gallagher, R., O'Neil, A., Grace, S. L., Bauman, A., Jennings, G., Brieger, D., & Briffa, T. (2022). Historical context of cardiac rehabilitation: Learning from the past to move to the future. *Frontiers in Cardiovascular Medicine*, 9, Article 842567. <https://doi.org/10.3389/fcvm.2022.842567>

Suggested readings

- Walker, R., Lin, F., Chaboyer, W., Latimer, S., Eskes, A., Clayton, C., Murphy, C., Sladdin, I., Bull, C., & Gillespie, B. (2020). Identifying surgical wound care priorities from the perspectives of clinicians and health consumers in an Australian private healthcare context: A case study. *Wound Practice & Research*, 28(1), 17–21. <https://doi.org/10.33235/wpr.28.1.17-21>

5.4 ROSSI FAMILY CASE STUDY 3: ELISABETH ROSSI - STRONG FAMILY HISTORY OF HEART DISEASE: HEALTH PROMOTION

Dima Nasrawi and Donna Wilson

Introduction to case study



Learning Objectives

By the end of this case study, you should be able to:

- Identify the impact of a chronic cardiac diagnosis within a person's immediate family.
- Identify the importance of early management of cardiac risk factors.
- Determine the importance of lifestyle modifications in improving health outcomes.

Scenario

Elisabeth lost her mother 5 years ago when she was only 14. She continues to grieve her loss, is very attached to her father and lives in constant fear of losing him. Her father's recent experience of a myocardial infarction has triggered painful memories from the time her mother was in hospital. As a result, Elisabeth has become more attentive to her family's medical history and is now curious to know more about her own cardiac risk factors. As she became more aware of the extent of her anxiety about losing her father, she realised she needed help with her mental health. She is now communicating with a psychologist through telehealth. As Elisabeth lives in a rural area with few friends close by within her age group, she feels quite isolated. Talking with her psychologist is the only source of support she has to help with her current emotional turmoil and state of mind.



Thinking points

The Heart Foundation Australia has developed many resources for people of all ages who are experiencing, or might have concerns about developing, heart disease. Elisabeth may benefit from accessing the Heart Foundation website to learn more about:

- Heart disease risk and risk minimisation strategies: Am I at risk?
- Young Hearts resources and podcast: Supporting young hearts podcast
- Healthy nutritional advice: Healthy eating to protect your heart
- Healthy exercise and lifestyle advice: Physical activity and your heart health

A young person in a similar position to Elisabeth may wish to access additional support services to manage their anxiety, such as speaking with a psychologist in person or via telehealth. In Australia, there are many public and private offerings for telehealth, and Elisabeth may do well to discuss her options with her general practitioner or community nurse.



Case study questions

1. Do you think Elisabeth currently presents risk factors for developing cardiovascular disease?
2. What type of risk factors for cardiovascular disease could Elisabeth develop in the future?
3. What self-management strategies could Elisabeth follow to reduce her risks of developing cardiovascular disease?



Key information and links to other resources

1. Heart Foundation: Supporting young hearts events – including great sessions supporting young individuals such as heart to heart and connecting heart, minds and people virtual

meetup.

2. Heart Foundation: Cardiovascular disease risk calculator – the calculator helps individuals and healthcare professionals calculate a person's risk of developing cardiovascular disease in the next 5 years.
3. NSW Health: Virtual care – one of many telehealth options available in the state of NSW, in Australia.



Healthy hearts: Pathophysiology of risk factors

- Risk factors for heart disease can be different for each person, ranging from serious to mild. It is important to remind Elisabeth that with self-management strategies she can improve her heart health.
- One way Elisabeth could reduce her risk of heart disease would be to make daily positive changes to her lifestyle, including regular exercise and healthy eating habits.
- Some non-modifiable risk factors for heart disease include age, sex, ethnicity and family history.
- It is important that Elisabeth has regular health checks to test her blood pressure, cholesterol levels and risk of type 2 diabetes.
- Regular check-ups by her general practitioner and being seen for a heart health check will help Elisabeth to detect early signs of cardiovascular disease.

Further resources regarding the modifiable risk factors can be found on the Heart Foundation website.



Case study 3 summary

Elisabeth could be facing a new set of health concerns as she deals with the changes in cardiac health for both her father and grandmother. This has brought up new anxieties of her own as she reflects on the pain of having lost one parent and her worries about her own cardiac health into the future. As health professionals, we can play a significant role in empowering individuals like Elisabeth to be proactive in looking after their own health through health promotion strategies and education. Armed with skills and knowledge to make sound decisions that can reduce her risk of developing cardiac illness, Elisabeth can not only reduce her anxieties about her health, but also contribute to her living a long, happy and healthy life.

Suggested readings

Heart Foundation. (n.d.) *Are you at risk of heart disease?* <https://www.heartfoundation.org.au/bundles/your-heart/are-you-at-risk-of-heart-disease>

5.5 ROSSI FAMILY SUMMARY

Dima Nasrawi and Donna Wilson

Summary

This part provides a series of case studies of an Australian family with a Mediterranean/European background who have experienced a range of cardiac conditions. The family is comprised of 3 generations living together on a farm in rural NSW. The case studies explore 3 family members in detail: Maria, her son John and John's daughter Elisabeth.

The part illustrates the complexities of families living with chronic cardiac conditions and presenting multiple risk factors. It also showcases health promotion strategies and how to navigate the Australian healthcare system. The 3 case studies explore:

1. Maria's heart failure diagnosis and management;
2. John's myocardial infarction and escalation to a coronary artery bypass grafting surgery; and
3. Elisabeth's cardiac risk factors and health promotion strategies.

These case studies highlight strategies that can optimise continuous management and care for patients through preventive cardiology.

Image attributions

Images not individually attributed are listed below in order of appearance in the part:

Chapter 5.1

Corndale map by OpenStreetMap is licensed under CC BY-SA 2.0

Maria and Maximo Rossi image by Sofia Shultz on Pixabay

Sofia Rossi image by ID 20257964 on Pixabay

John Rossi image by Jan Niepel on Pixabay

Elisabeth Rossi image by Sofia Antonacci on Pexels

Icons

All icons in this part are from Flaticon and are listed below in order of first appearance in the part:

Introduction: Introduction icons created by Freepik – Flaticon

Clinical reasoning: Think icons created by Freepik – Flaticon

Person-centred care: People icons created by Freepik – Flaticon

Therapeutic communication: Team icons created by Freepik – Flaticon

Cultural safety: People icons created by Freepik – Flaticon

Teamwork and collaborative practice: Communication icons created by Freepik – Flaticon

Cardiovascular: Cardiac icons created by AmethystDesign – Flaticon

Objectives: Objective icons created by Uniconlabs – Flaticon

Thinking point: Creativity icons created by Freepik – Flaticon

Case studies: Case study icons created by Flat Icons – Flaticon

Mental health: Mental health icons created by Freepik – Flaticon

Summary: Summary icons created by Freepik – Flaticon

REVIEW STATEMENT

Southern Cross University is committed to publishing high-quality open textbooks which meet the needs of students and educators. This book has been peer-reviewed by two academic subject experts from two institutions. The full-text was openly reviewed by each reviewer.

Reviews were structured around considerations of the intended audience of the book and examined the comprehensiveness, accuracy, and relevance of the content. Reviews were also focused on diversity of perspectives, longevity, clarity, consistency and structure.

The authors would like to thank the reviewers for the time, care, and commitment they contributed to the project. We recognise that peer reviewing is a generous act of service on their part. This book would not be the robust, valuable resource that it is were it not for their feedback and input.

Reviewers included:

- Dr Sam Lapkin, Associate Professor, Faculty of Health, Southern Cross University
- Professor Rhonda Nay, Emeritus Professor, School of Nursing & Midwifery, La Trobe University