

Introduction



Overview

The first edition of *The Royal Marsden Manual of Clinical Nursing Procedures* was produced in the early 1980s as a core procedure manual for safe nursing practice within The Royal Marsden Hospital, the first cancer hospital in the world. Implicit behind that first edition was the drive to ensure that patients received the very best care – expertise in carrying out clinical procedures combined with an attitude of respect and compassion.

Thirty years later these attitudes are still fundamental. The Chief Nurse Jane Cummings has ‘committed to make sure all patients receive the very best care with compassion and clinical skill’ (DH 2013). The values and behaviours of this compassionate practice are: *Care, Compassion, Competence, Communication, Courage and Commitment* – the 6Cs (DH 2013). This manual of clinical procedures focuses on bringing together current evidence, acting as an essential resource for practice and providing the theory underpinning *Competence*, one of the 6Cs.

This ninth student edition includes a range of new learning features throughout each chapter that have been designed to support student nurses as they use this manual to support learning in clinical practice. In line with the ninth professional edition, it focuses for the first time on procedures that are applicable in all areas of acute inpatient hospital care. (Procedures specific to the care of the cancer patient can be found in the new companion volume *The Royal Marsden Clinical Cancer Nursing Procedures*.) The Manual is informed by the day-to-day practice in the hospital and conversely is the corporate policy and procedure document for the adult inpatient service of the organization. It therefore does not cover all aspects of acute nursing practice or those relating to children’s or community nursing. However, it does contain the procedures and changes in practice that reflect modern acute nursing care.

Core to nursing, wherever it takes place, is the commitment to care for individuals and to keep them safe so that when and wherever the procedures are used, they are to be carried out within the framework of the Nursing and Midwifery Code, Appendix 1 (NMC 2015). In respect of clinical competency, the NMC Code states that you must:

- have the knowledge and skills for safe and effective practice without direct supervision
- keep your knowledge and skills up to date throughout your working life
- recognize and work within the limits of your competence (NMC 2015).

The Manual has been structured to enable nurses to develop competency, recognizing that competence is not just about knowing how to do something but also about understanding the rationale for doing it and the impact it may have on the patient.

Some of the procedures in the Manual will be newer for nursing. Developing new roles and taking responsibility for new procedures have obvious risks attached, and although every individual nurse is accountable for their own actions, every healthcare organization has to take vicarious liability for the care, treatment and procedures that take place. An organization will have expectations of all its nurses in respect of keeping patients, themselves and the environment safe. There are obvious ethical and moral reasons for this: ‘Nurses have a moral obligation to protect those we serve and to provide the best care we have available’ (Wilson 2005, p.118). Risk management has therefore become an integral part of day-to-day nursing work. For this reason, the risk management implications of the areas of practice have been integrated into each chapter.

Evidence-based practice

The moral obligation described above extends to the evidence upon which we base our practice. Nursing now exists in a healthcare arena that routinely uses evidence to support

decisions and nurses must justify their rationales for practice. Where historically, nursing and specifically clinical procedures were based on rituals rather than research (Ford and Walsh 1994, Walsh and Ford 1989), evidence-based practice (EBP) now forms an integral part of practice, education, management, strategy and policy. Nursing care must be appropriate, timely and based on the best available evidence.

What is evidence-based practice?

Evidence-based practice has been described by Sackett, a pioneer in introducing EBP in UK healthcare, as:

‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research’ (Sackett et al. 1996, p.72).

Despite the emphasis on research in EBP, it is important to note that where research is lacking, other forms of evidence can be equally informative when making decisions about practice. Evidence-based practice goes much wider than research-based practice and encompasses clinical expertise as well as other forms of knowing, such as those outlined in Carper’s seminal work (1978) in nursing. These include:

- empirical evidence
- aesthetic evidence
- ethical evidence
- personal evidence.

This issue is evident throughout this Manual where clinical expertise and guidelines inform the actions and rationale of the procedures. Indeed, these other types of evidence are highly important as long as we can still apply scrutiny to their use.

Porter (2010) describes a wider empirical base upon which nurses make decisions and argues for nurses to take into account and be transparent about other forms of knowledge such as ethical, personal and aesthetic knowing, echoing Carper (1978). By doing this, and through acknowledging limitations to these less empirical forms of knowledge, nurses can justify their use of them to some extent. Furthermore, in response to Paley’s (2006) critique of EBP as a failure to holistically assess a situation, nursing needs to guard against cherry-picking, ensure EBP is not brandished ubiquitously and indiscriminately and know when judicious use of, for example, experiential knowledge (as a form of personal knowing) might be more appropriate.

Evidence-based nursing (EBN) and EBP are differentiated by Scott and McSherry (2009) in that EBN involves additional elements in its implementation. Evidence-based nursing is regarded as an ongoing process by which evidence is integrated into practice and clinical expertise is critically evaluated against patient involvement and optimal care (Scott and McSherry 2009). For nurses to implement EBN, four key requirements are outlined (Scott and McSherry 2009).

- 1 To be aware of what EBN means.
- 2 To know what constitutes evidence.
- 3 To understand how EBN differs from evidence-based medicine and EBP.
- 4 To understand the process of engaging with and applying the evidence.

We contextualize our information and decisions to reach best practice for patients and the ability to use research evidence and clinical expertise together with the preferences and circumstances of the patient to arrive at the best possible decision for that patient is recognized (Guyatt et al. 2004).

Knowledge can be gained that is both propositional, that is from research and generalizable, and non-propositional, that is implicit knowledge derived from practice (Rycroft-Malone et al. 2004). In more tangible, practical terms, evidence bases can be drawn from a number of different sources, and this pluralistic approach needs to be set in the context of the complex clinical environment in which nurses work in today's NHS (Pearson et al. 2007, Rycroft-Malone et al. 2004). The evidence bases can be summarized under four main areas.

- 1 Research
- 2 Clinical experience/expertise/tradition
- 3 Patient, clients and carers
- 4 The local context and environment (Pearson et al. 2007, Rycroft-Malone et al. 2004)

Grading evidence in The Royal Marsden Manual of Clinical Nursing Procedures

The type of evidence that underpins procedures is made explicit by using a system to categorize the evidence which is broader than that generally used. It has been developed from the types of evidence described by Rycroft-Malone et al. (2004) in an attempt to acknowledge that 'in reality practitioners draw on multiple sources of knowledge in the course of their practice and interaction with patients' (Rycroft-Malone et al. 2004, p.88).

The sources of evidence, along with examples, are identified as follows.

- 1 *Clinical experience (E)*
 - Encompasses expert practical know-how, gained through working with others and reflecting on best practice.
 - *Example:* (Dougherty 2008: E). This is drawn from the following article that gives expert clinical opinion: Dougherty, L. (2008) Obtaining peripheral vascular access. In: Dougherty, L. & Lamb, J. (eds) *Intravenous Therapy in Nursing Practice*, 2nd edn. Oxford: Blackwell Publishing.
- 2 *Patient (P)*
 - Gained through expert patient feedback and extensive experience of working with patients.
 - *Example:* (Diamond 1998: P). This has been gained from a personal account of care written by a patient: Diamond, J. (1998) *C: Because Cowards Get Cancer Too*. London: Vermilion.
- 3 *Context (C)*
 - Can include audit and performance data, social and professional networks, local and national policy, guidelines from professional bodies (e.g. Royal College of Nursing [RCN]) and manufacturer's recommendations.
 - *Example:* (DH 2001: C). This document gives guidelines for good practice: DH (2001) *National Service Framework for Older People*. London: Department of Health.
- 4 *Research (R)*
 - Evidence gained through research.
 - *Example:* (Fellowes et al. 2004: R). This has been drawn from the following evidence: Fellowes, D., Wilkinson, S. & Moore, P. (2004) Communication skills training for healthcare professionals working with cancer patients, their families and/or carers. *Cochrane Database of Systematic Reviews*, 2, CD003751. DOI: 10.1002/14651858.CD003571.pub2.

The levels that have been chosen are adapted from Sackett et al. (2000) as follows.

- 1 **a** Systematic reviews of randomized controlled trials (RCTs)
- b** Individual RCTs with narrow confidence limits
- 2 **a** Systematic reviews of cohort studies
- b** Individual cohort studies and low-quality RCTs
- 3 **a** Systematic reviews of case-control studies
- b** Case-control studies
- 4 Case series and poor-quality cohort and case-control studies
- 5 Expert opinion



Box 1.1 Levels of evidence

- 1a Systematic reviews of RCTs
- 1b Individual RCTs with narrow confidence limits
- 2a Systematic reviews of cohort studies
- 2b Individual cohort studies and low-quality RCTs
- 3a Systematic reviews of case-control studies
- 3b Case-control studies
- 4 Case series and poor-quality cohort and case-control studies
- 5 Expert opinion

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RCTs, randomized controlled trials.

Source: Adapted from Sackett et al. (2000). Reproduced with permission from Elsevier.

The evidence underpinning all the procedures has been reviewed and updated. To reflect the current trends in EBP, the evidence presented to support the procedures within the current edition of the Manual has been graded, with this grading made explicit to the reader. The rationale for the system adopted in this edition will now be outlined.

As we have seen, there are many sources of evidence and ways of grading evidence, and this has led us to a decision to consider both of these factors when referencing the procedures. You will therefore see that references identify if the source of the evidence was from:

- clinical experience and guidelines (Dougherty 2008: E)
- patient (Diamond 1998: P)
- context (DH 2001: C)
- research (Fellowes et al. 2004: R).

If there is no written evidence to support a clinical experience or guidelines as a justification for undertaking a procedure, the text will be referenced as an 'E' but will not be preceded by an author's name.

For the evidence that comes from research, this referencing system will be taken one step further and the research will be graded using a hierarchy of evidence. The levels that have been chosen are adapted from Sackett et al. (2000) and can be found in Box 1.1.

Taking the example above of Fellowes et al. (2004) 'Communication skills training for healthcare professionals working with cancer patients, their families and/or carers', this is a systematic review of RCTs from the Cochrane Centre and so would be identified in the references as: Fellowes et al. (2004: R 1a).

Through this process, we hope that the reader will be able to more clearly identify the nature of the evidence upon which the care of patients is based and that this will assist when using these procedures in practice. You may also like to consider the evidence base for other procedures and policies in use in your own organization.

Structure of the Manual

The chapters have been organized into four broad sections that represent as far as possible the needs of a patient along their care pathway. The first section, *Managing the patient journey*, presents the generic information that the nurse needs for every patient who enters the acute care environment. The second section of procedures, *Supporting the patient with human functioning*, relates to the support a patient may require with normal human functions such as elimination, nutrition and respiration. The third section, *Supporting the patient through the diagnostic process*,

includes procedures that relate to any aspect of supporting a patient through the diagnostic process, from simple procedures such as taking a temperature to preparing a patient for complex procedures such as a liver biopsy. The final section, *Supporting the patient through treatment*, includes the procedures related to specific types of treatment or therapies the patient is receiving.

Structure of chapters in the student edition

The structure of each chapter is consistent throughout the book.

- **Learning outcomes:** each chapter starts by identifying what the reader can expect to have achieved after working through the chapter and completing the learning activities within it.
- **Overview:** as the chapters are larger and have considerably more content, each one has an overview to guide the reader, informing them of the scope and the sections included in the chapter
- **Learning activities:** each chapter includes a range of learning activities that encourage both reflection in, and on, practice. These include 'learning in practice' activities where students are asked to consider issues within their own practice environment, 'scenarios' that ask the student to consider what they would do in a given situation and 'case studies' where students work through questions to identify how a particular patient case may be managed. See Box 1.2.
- **Definition:** each section begins with a definition of the terms and explanation of the aspects of care, with any technical or difficult concepts explained.
- **Anatomy and physiology:** each section includes a discussion of the anatomy and physiology relating to the aspects of nursing care in the chapter. If appropriate, this is illustrated with diagrams so the context of the procedure can be fully understood by the reader.
- **Related theory:** if an understanding of theoretical principles is necessary to understand the procedure then this has been included.
- **Evidence-based approaches:** this provides background and presents the research and expert opinion in this area. If appropriate, the indications and contraindications are included as well as any principles of care.
- **Legal and professional issues:** this outlines any professional guidance, law or other national policy that may be relevant to the procedures. If necessary, this includes any professional competences or qualifications required in order to perform

the procedures. Any risk management considerations are also included in this section.

- **Pre-procedural considerations:** when carrying out any procedure, there are certain actions that may need to be completed, equipment prepared or medication given before the procedure begins. These are made explicit under this heading.
- **Procedure:** each chapter includes the current procedures that are used in the acute hospital setting. They have been drawn from the daily nursing practice at The Royal Marsden NHS Foundation Trust. Only procedures about which the authors have knowledge and expertise have been included. Each procedure gives detailed step-by-step actions, supported by rationale, and where available the known evidence underpinning this rationale has been indicated.
- **Problem solving and resolution:** if relevant, each procedure will be followed by a table of potential problems that may be encountered while carrying out the procedure as well as suggestions as to the cause, prevention and any action that may help resolve the problem.
- **Post-procedural considerations:** care for the patient does not end with the procedure. This section details any documentation the nurse may need to complete, education/information that needs to be given to the patient, ongoing observations or referrals to other members of the multiprofessional team.
- **Complications:** any ongoing problems or potential complications are discussed in a final section which includes evidence-based suggestions for resolution.
- **Illustrations:** colour illustrations have been used to demonstrate the steps of some procedures. This will enable the nurse to see in greater detail, for example, the correct position of hands or the angle of a needle.
- **Summary of learning and reflection on practice:** at the end of each chapter there is a series of questions for students to work through. 'Learning for practice' then draws on students' individual learning from the chapter, asking them to identify five key points that they will be able to apply to their clinical practice.
- **Key points:** each chapter ends with a number of key points that draw together essential learning points from the chapter content.
- **References and reading list:** the chapter finishes with a combined reference and reading list. Only recent texts from the last 10 years have been included unless they are seminal texts. A list of websites has also been included.

This book is intended as a reference and a resource, not as a replacement for practice-based education. None of the procedures in this book should be undertaken without prior instruction and subsequent supervision from an appropriately qualified and experienced professional. We hope that *The Royal Marsden Manual of Clinical Nursing Procedures* will continue to be a resource to deliver high-quality care that maximizes the well-being and improves the health outcomes of patients in acute hospital settings.

Conclusion

It is important to remember that even if a procedure is very familiar to us and we are very confident in carrying it out, it may be new to the patient, so time must be taken to explain it and gain consent, even if this is only verbal consent. The diverse range of technical procedures that patients may be subjected to should act as a reminder not to lose sight of the unique person undergoing such procedures and the importance of individualized patient assessment in achieving this.

When a nurse
Encounters another
What occurs is never a neutral event
A pulse taken
Words exchanged



Box 1.2 Key to learning activities

- **Learning in practice:** these activities enable students to consider issues within their own practice environment, encouraging exploration and discussion with mentors and colleagues.
- **Scenarios:** students are asked to consider what they would do in a given clinical situation.
- **Case studies:** students work through questions to identify how a particular patient case may be managed.
- **Summary of learning and reflection on practice:** at the end of each chapter there is a series of questions for students to work through. 'Learning for practice' then draws on students' individual learning from the chapter, asking them to identify five key points that they will be able to apply to their clinical practice.
- **Key points:** each chapter ends with a number of key points that draw together essential learning points from the chapter content.

Where applicable, the answers to the questions are provided at the end of each chapter.

A touch
 A healing moment
 Two persons
 Are never the same
 (Anon in Dossey et al. 2005)

Nurses have a central role to play in helping patients to manage the demands of the procedures described in this Manual. It must

not be forgotten that for the patient, the clinical procedure is part of a larger picture, which encompasses an appreciation of the unique experience of illness. Alongside this, we need to be mindful of the evidence upon which we are basing the care we deliver. We hope that through increasing the clarity with which the evidence for the procedures in this edition is presented, you will be better able to underpin the care you deliver to your patients in your day-to-day practice.

REFERENCES

- Carper, B. (1978) Fundamental patterns of knowing in nursing. *ANS Advances in Nursing Science*, 1(1), 13–23.
- DH (2001) *National Service Framework for Older People*. London: Department of Health.
- DH (2013) *Compassion in Practice*. NHS Commissioning Board. Leeds: Department of Health.
- Diamond, J. (1998) *C: Because Cowards Get Cancer Too*. London: Vermilion.
- Dossey, B.M., Keegan, L. & Guzzetta, C.E. (2005) *Holistic Nursing: A Handbook for Practice*, 4th edn. Sudbury, MA: Jones and Bartlett.
- Dougherty, L. (2008) Obtaining peripheral vascular access. In: Dougherty, L. & Lamb, J. (eds) *Intravenous Therapy in Nursing Practice*, 2nd edn. Oxford: Blackwell Publishing.
- Fellowes, D., Wilkinson, S. & Moore, P. (2004) Communication skills training for health care professionals working with cancer patients, their families and/or carers. *Cochrane Database of Systematic Reviews*, 2, CD003751.
- Ford, P. & Walsh, M. (1994) *New Rituals for Old: Nursing Through the Looking Glass*. Oxford: Butterworth-Heinemann.
- Guyatt, G., Cook, D. & Haynes, B. (2004) Evidence based medicine has come a long way. *BMJ*, 329 (7473), 990–991.
- NMC (2015) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: Nursing and Midwifery Council.
- Paley, J. (2006) Evidence and expertise. *Nursing Enquiry*, 13(2), 82–93.
- Pearson, A., Field, J. & Jordan, Z. (2007) *Evidence-Based Clinical Practice in Nursing and Health Care: Assimilating Research, Experience, and Expertise*. Oxford: Blackwell Publishing.
- Porter, S. (2010) Fundamental patterns of knowing in nursing: the challenge of evidence-based practice. *ANS Advances in Nursing Science*, 33(1), 3–14.
- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A. & McCormack, B. (2004) What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1), 81–90.
- Sackett, D.L., Rosenberg, W.M., Gray, J.A., Haynes, R.B. & Richardson, W.S. (1996) Evidence based medicine: what it is and what it isn't. *BMJ*, 312(7023), 71–72.
- Sackett, D.L., Strauss, S.E. & Richardson, W.S. (2000) *Evidence-Based Medicine: How to Practice and Teach EBM*, 2nd edn. Edinburgh: Churchill Livingstone.
- Scott, K. & McSherry, R. (2009) Evidence-based nursing: clarifying the concepts for nurses in practice. *Journal of Clinical Nursing*, 18(8), 1085–1095.
- Walsh, M. & Ford, P. (1989) *Nursing Rituals, Research and Rational Actions*. Oxford: Heinemann Nursing.
- Wilson, C. (2005) Said another way. My definition of nursing. *Nursing Forum*, 40(3), 116–118.

