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Nutrition
Intervention and support

Role of REVNs in horse performance

Mastering negotiation
Business tips and tricks

BVNA launches collaborative pet behaviour hub via portal

The BVNA has launched a "Behaviour Hub" for its members, designed to allow veterinary nurses to collaborate, share resources and discuss matters relating to pet behaviour.

Available via the BVNA membership portal, the forum will include monthly topics, general discussions and signposting towards further training and CPD.

The first month's topic provides information on how veterinary nurses can pursue an interest in animal behaviour, enabling them to integrate this knowledge into their role as an RVN in practice and feel empowered to make positive change for patients' emotional welfare.

Nikki McLeod, BVNA honorary treasurer and Behaviour Hub project lead, said: "Knowledge of animal behaviour is essential to our role as veterinary nurses and the wider veterinary team.

"Having this understanding has an enormous positive impact on the emotional well-being of our patients while in our care. However, we also know that it can be tricky to find accessible, reliable sources of information and advice surrounding pet behaviour."

The project complements the ongoing collaboration between the BVNA and the Animal Behaviour and Training Council (ABTC) in delivering a Learning Pathway in Behaviour.

Scan the QR code to access the portal. More details on the BVNA and ABTC Learning Pathway in Behaviour is available via the BVNA website.

Calendar arrival

The *VN Times* calendar is released this month, championing animal rescue and rehab involving VNs.

Animals like Dinky (**pictured inset**) that had been victim of multiple injuries and mutilation, but now lives happily in a home with a new guardian. Thank you to RVN Robyn Lowe and her team for saving Dinky.

Meanwhile, this month's cover image is from Wildlife Aid, which works all year round to support the care, rehabilitation and education surrounding wildlife.

Senior vet surgeon's plea to end sexual abuse of animals 'taboo'

The veterinary sector must do more to highlight and tackle the "taboo subject" of animals being sexually abused, according to a senior clinician.

A new campaign for action, including legislative reform, is expected to be launched in the coming weeks following a hard-hitting discussion of the topic at the London Vet Show.

The initiative is set to be led by the Animal Related Crime Working Group, whose founder members include IVC Evidensia group head of animal welfare David Martin.

'Massive correlation'

Addressing delegates at the 14 November session, he warned of a "massive correlation" between the abuse of animals and children and argued it was "about time" the professions began to speak out about the issue.

He said: "As a profession, the sexual abuse of animals is a taboo subject. But we need to stop treating it as a taboo subject. We need to be more willing to talk about this, to be more willing to stand up and diagnose this where it is occurring."

Although current published data appears limited, a total of 27 people are known to have been convicted of having sexual intercourse with an animal – a specific offence under the Sexual Offences Act 2003 – in England and Wales between 2007-16.

But other types of sexual activity are not covered by the present legislation and an online petition demanding the outlawing of all sexual contact with animals failed to reach the 10,000-signature threshold required for a formal response from the then UK Government before it was closed in early 2021.

Although group leaders say they recognise the challenges of building support for change by discussing such a disturbing topic, Dr Martin argued that the law didn't make sense in its present form, particularly because of the sector's previous failure to engage with it.

He said: "It looks like it was written in Victorian times. That is because the veterinary profession does not talk about the really, really serious sexual abuse of animals."

As well as widening the law's scope to cover all types of sexual activity, Dr Martin said increased sentencing powers, including the capacity for offenders to be banned from keeping animals under the Animal Welfare Act 2006, were also necessary.

But he cautioned: "That is only going to happen if the veterinary profession takes its head out of the sand and does something about it."

Highlighted findings

Dr Martin highlighted the findings of previous research that indicated 38 per cent of convicted child sex offenders reported being involved in the sexual abuse of animals and 73 per cent of offenders found to be in possession of indecent images of children also had material depicting the sexual abuse of animals.

A separate study found that 85 per cent of charges for possession of extreme pornographic images also related to animals.

He further warned of a need for greater understanding of the issue among police and highlighted a case where a dog had remained with an abusive owner for three years as officers were not aware that they could seize the animal.

He said: "We have got to train our police officers to realise the powers they have under the Animal Welfare Act."

Speaking from the floor, RSPCA chief vet Caroline Allen said her organisation's officers did not have the same seizure powers that their counterparts in Scotland did, though they can alert police to cases.

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Vet nurse reprimanded over animal theft cases

An RVN who admitted stealing animals she thought were suffering has been reprimanded and warned about her future conduct after an RCVS disciplinary hearing.

Committee members concluded there was "no useful purpose" in imposing a harsher penalty on Shakira Free Miles, due to the recognised low risk of further offending.

But newly published documents of the case also showed the panel rejected her submissions, which it felt "indicated a wish to provide ethical justification for her actions".

The committee said it accepted people may have "deeply held personal convictions", but insisted that didn't "justify breaking the law in order to uphold those convictions".

Crown Court

The disciplinary case was heard around a year after Miss Miles pleaded guilty to six charges of theft, plus one of attempted theft, at Reading Crown Court in October 2023.

She was subsequently given an 18-month community order, including unpaid work and rehabilitation activity, in February this year.

Giving evidence, she told the committee she had believed the animals were suffering at the time of the incidents and would either "die or continue to suffer without intervention".

A report outlining the case acknowledged the sentencing judge's remarks that Miss Miles and her co-defendants had been motivated by their personal beliefs, rather than personal gain.

But the committee still concluded that the convictions rendered her unfit to practise because of a "real risk of harm" to the animals involved and the potential for the offences to bring the profession into disrepute.

Later, in a separate document dealing solely with the question of sanction, Miss Miles was said to have told the committee she felt she had "never swayed from promoting animal welfare".

The paper added: "The respondent also expressed that ethical veganism is a protected characteristic under the Equality Act, and she should not be discriminated against, having already told the committee that she is a vegan."

She added that, while she had not physically taken all of the animals involved, she had personally covered the cost of any veterinary care that had been required.

Animal welfare

But the panel said it "did not accept or see the relevance" of the comments relating to ethical veganism and warned that Miss Miles "gave the impression" of believing that intending to protect welfare justified her actions even while accepting she was wrong to have committed the offences.

However, it also stressed its function was not to "police" her views but to consider whether those views risked either animal welfare or public confidence in the profession.

The report said that despite Miss Miles' profile, the committee had not been shown evidence of "any real risk" arising from her views in either area.

The warning and reprimand will remain on Miss Miles' record indefinitely.

Louise Hosford (centre left) with (from left) *Coronation Street* actor Antony Cotton and Vets Now's Racheal Marshall and Tricia Colville.

Legacy grant given to inspiring leader

Vets Now's Louise Hosford has become the sixth winner of a bursary in memory of vet nurse Louise O'Dwyer.

A principal nurse manager who works at an emergency and critical care clinic in Sheffield, Mrs Hosford was named the bursary winner at a gala dinner hosted as part of the Vets Now ECC Congress, which was held in Leeds from 7 to 8 November.

A new Louise O'Dwyer bursary winner is announced each year at congress with the award open to all vet nurses within Vets Now.

The bursary offers an extra £2,000 CPD allowance for the winner who is the candidate who best demonstrates their commitment to making a difference in their chosen discipline, while furthering Miss O'Dwyer's legacy of sharing learning.

Louise Hosford said: "I'm absolutely over the moon to have been awarded the Louise O'Dwyer bursary – and am incredibly grateful for the support and opportunity provided by Vets Now.

"I have worked in practice for some 26 years now and was lucky enough to attend several of Louise's emergency and critical care nursing lectures at a variety of veterinary conferences over the years. Her lectures were inspiring and full of humour."

Louise O'Dwyer was one of the world's leading emergency and critical care veterinary nurses and a huge influence on the thousands of vet professionals who encountered her through her lectures, practical guide books and journal papers.

After her death in 2019 Vets Now (http://www.vets-now.com/) launched the Louise O'Dwyer Bursary as a tribute to Miss O'Dwyer's passion for her role in ECC and the culture of shared learning she helped to create.

Racheal Marshall, head of clinical nursing at Vets Now, added: "It was important to all of us at Vets Now to find a way of honouring Louise's work and to keep her memory alive. The Louise O'Dwyer bursary is our way of thanking her for all that she contributed to the Vets Now family and the veterinary community."

IN BRIEF

Firework action

A survey by equine charity Redwings has found 97 per cent want more regulations restricting use of fireworks. A total of 179 people completed an online survey during the Your Horse Live three-day event in Warwickshire, with 81 per cent saying they were worried about the impact of fireworks on their horse and 65 per cent reported experience of a horse being nervous or agitated. Injury or illness was reported by 21 per cent, escape by 8 per cent and death by 4 per cent of respondents.

Fostering scheme

The Dogs Trust pet fostering scheme has seen a 140 per cent rise in referrals to use its specialist support in the past five years. The Freedom Project, which supports those fleeing domestic abuse, has received 2,303 referrals so far this year, compared to 955 in the whole of 2019.

Drainpipe dilemma

"John", a female black cat living in Somerset, required a fire service rescue after getting stuck in a drainpipe connected to her owners' garage. Having snuck out on Friday, she was found with her head poking out the pipe in the ceiling on Saturday morning.

Free CPD

Short on CPD? Natures Menu is providing eight hours' free CPD for vets and nurses. The online course can be taken in stages to gain further knowledge to support clients who may be choosing to feed a raw diet. Scan the QR code to find out more.

Charity trek

StreetVet volunteers and supporters have raised in excess of £23,000 by trekking 100km across the Sahara desert. The vital funds will be used to support the care of animal companions on the street with their rough sleeping companions.

Mastering negotiation – business planning tips for RVNs

Debbie Gray RVN, outlines the challenges veterinary nurses may face when trying to effect change in a practice, and shares some strategies to help achieve success

Nothing is more frustrating as a veterinary nurse than being denied the ability to purchase a piece of equipment or kit that you know would not only have significant benefits to patient outcomes, but would also make the practice operate more effectively and allow you to be more efficient in your role.

Veterinary nurses are at the forefront of patient care and instrumental in achieving successful patient outcomes. So, why are we often denied such pieces of kit? A basic infusion pump can cost as little as £500 and a multiparameter monitor can start in the region of £1,000, and the benefits they bring far outweigh the investment.

Ever-increased access to new equipment and technology exists that saves time and avoids repetitive tasks. However, it isn't just about convenience; it increases productivity and translates to money saved, and leads to improved patient care by allowing the nursing team to devote time to more complex patient care.

So, how do we get beyond the no?

Perhaps we need to think about the way we "pitch" for these products and how we can best use our skills and knowledge to build a solid business case, and demonstrate the return on investment.

It is easy to sit back and think, "well that's not my job" – it's something the practice manager or clinical director should do. However, veterinary nurses are on the front line delivering the care to the patients and are instrumental in communicating the significant benefits that investment would bring.

Everyone, including managers and practice owners, is challenged with the complexities of daily tasks and running the business. Approaching the negotiation with a solution to a problem is often more beneficial than presenting just the problem.

From a personal perspective it also reflects your ability to take initiative and responsibility for improving practice, and demonstrates an understanding of the business element of veterinary practice. Furthermore, the experience you gain from doing such tasks will enable you to provide evidence when it comes to performance reviews for senior roles or progressing wider in the industry.

So, where do we begin?

A good place to start negotiations is to have solid evidence to support and back your ideas. Well-structured research and documented evidence in a proposal is far harder to say no to than something verbally expressed as a suggestion or opinion. Auditing can be one option to help gain evidence to support your pitch.

Audits

The following are steps on conducting audits.

1 Understand the problem

Begin with identifying the real problem or the gap in equipment requirement. For example, if you do not have a multiparameter or infusion pump, document the challenges it causes, the increased time that procedures take or the manual work that could be automated.

For example, an infusion pump would allow for accurate delivery rates and prevent accidental free flow of fluids, or a syringe driver would allow for precise and continuous dosing.

2 Gather the evidence

Get the team on board to help monitor specific situations over time and record the frequency of issues to evidence the impact of the problem.

Consider parameters that can easily be measured – that is, time, clinical

continued on page 6

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Mastering negotiation

– continued from page 4

parameters or patient outcomes and document the findings. Create a specific template that everyone uses to make collating the information easier.

3 Build the case

Use the data to demonstrate how the equipment could help improve efficiency or patient care.

You may have recorded that it takes the nurse a total of 10 minutes to administer a specific dose of medication from start to finish; however, to set up the syringe driver would only take 2 minutes, which reflects a time-saving benefit of 80 per cent, plus improves the accuracy in drug delivery.

Return on investment and cost per use

Return on investment (ROI) is a financial performance measure that can also be included in the proposal. ROI compares the profit or loss from an investment, such as purchasing the equipment to its initial cost. You should also consider how often the equipment will be used, if all staff will be able to use it or if they will need to undertake additional training.

To calculate the ROI, you compare the financial gains or savings generated by the equipment against its initial cost. **Panel 1** shows the ROI formula.

Example

Let's consider the example – you have identified that having an oscillometric blood pressure machine would be beneficial and would like the practice to purchase one. Currently, nurses are manually measuring blood pressure on a conscious cat. It may routinely take 2 nurses 10 minutes and may also cause a degree of stress to the cat. However, a modern, quiet, automated machine will require just one nurse, and readings can be obtained within five minutes, the cat will be less stressed and client satisfaction is likely to improve. **Panel 2** considers the calculation.

Getting the evidence

It could be argued that the aforementioned is speculation if you do not already have a machine to monitor the time saved. This is where you can make use of loan equipment and trial periods.

Some equipment suppliers will offer a free trial period, with no commitment to purchasing, for you to test the product. This is an effective way to get a good understanding of the equipment, make comparisons (if necessary), ensure it is fit for purpose and gather the evidence.

Cost per use

Calculating the cost per use of any equipment request can also be included in the proposal. This is a simple and effective way to reflect that purchasing equipment is not just a one-time cost, but a long-term investment. It demonstrates that you have considered the financial implications and it supports growth for the practice.

Using the same example, the cost of the blood pressure machine is £1,500. You use the machine 10 times each day and the practice is open 20 days a month (10 × 20 = 200 uses a month).

200 × 12 (months) = 2,400 uses annually. Divide the number of uses by the cost of the equipment:

2,400 ÷ 1,500 = £1.60 per use

This cost can also be factored into the cost of the procedure, which is an alternative way of recovering investment costs.

Once you have completed your first audit, don't be afraid to think outside the box of the alternative ways in which the equipment can further benefit the practice. Maybe with the time saved you can offer a new service such as nurse-led senior pet clinics?

You can then incorporate further calculations to reflect the potential revenue generation from the clinics, which in turn helps justify the equipment expense.

The proposal

Create a documented proposal and include all the key points. It should be concise and easy to read; think about breaking it into sections – for example, challenges faced (supported with data as evidence), the proposed solutions (purchase of equipment and staff CPD), cost analysis (ROI and cost per use) and the benefits (financial, patient outcomes and customer satisfaction).

Use visual aids such as graphs and bar charts to present data and make interpretation easy, and consider the language used, so rather than"'we need this equipment", think about using "by investing in the blood pressure monitor we could save £4,500 annually, which would give us time to run senior pet clinics and generate an additional x per cent more revenue on nurse clinics".

Try to pre-empt questions that may be asked by including them in the proposal, and always be prepared for questions. Book a time to meet the person you will pitch to so that they give you, and the proposal, their full attention. Remember, if you do not get an immediate answer to ask when you can expect to hear a response and do not be afraid to follow up for an answer.

What other tools are available to help?

If you're new to auditing, RCVS knowledge has a wealth of information on its website to support clinical audits in practice. A checklist can be used for planning and completing the audit. Donview Veterinary Centre (RCVS, 2024) provides a good example of a clinical audit and the purchase of new equipment.

It identified that patients were being returned to kennels with low body temperatures after procedures. The body temperatures of 31 patients were recorded, which provided data showing that 58 per cent were hypothermic postoperatively.

The team discussed methods of improving patient care and a new standard operating procedure was implemented, and the practice invested in a fluid warmer, forced air warmer and thermo-blocker for the prep room table. The original data was then used as a benchmark to measure and reflect the improvement made.

CPD

CPD and training is available on these topics, but we are all guilty of doing the CPD that we really enjoy rather than doing CPD that develops different skills and knowledge. Progressing in your career and the direction you take is your choice; however, being able to demonstrate transferable skills is a huge asset that puts you in good stead to progress to a wide range of non-clinical roles within the profession.

In summary, there is no set way that you should approach negotiations. Your place of work, the culture and internal process are all different. Therefore, you need to determine the approach that works best for the investment required.

If proposals are rejected, be open to feedback and try to understand why that decision was taken. It might mean that you can negotiate on tweaking the proposal from purchasing two infusion pumps, to buying one now and the other in six months. Feedback is also essential for learning how to adapt future proposals.

To finish where we started, veterinary nurses are at the forefront of leading and can be highly influential. While our initial thoughts are often on improving patient welfare and outcomes, we must present proposals with a business mindset and demonstrate revenue profitability and opportunities for practice growth. If we all had our way, we would have access to all the new and fancy equipment, but veterinary practices must operate as a business to continue to offer services for veterinary care.

Panel 1. Return on investment (ROI) formula

$$\text{ROI} = \left(\frac{\text{Total benefit (or saving)} - \text{cost of equipment}}{\text{Cost of equipment}} \right) \times 100$$

Panel 2. Example calculation

2 (nurses) × 5 (patients daily) at 10 minutes (monitoring time) = 100 minutes

versus

1 (nurse) × 5 (patients daily) at 5 minutes (monitoring time) = 25 minutes

Total time saved = 100–25 = 75 minutes per day

Let's assume the blood pressure machine is £1,500. We have already calculated that our labour savings are 75 minutes per day (above). If the nurse's salary is £15/hr, the daily labour saving would be £18.75 per day.

$$75 \text{ minutes} \times \left(\frac{15}{60} \right) = £18.75$$

If the practice is open 20 days per month = 20 × £18.75 = £375 per month

Annual savings (benefit) = £375 × 12 (months) = £4,500

If we plug this into the return on investment calculation = (£4,500–£,1500) ÷ £1,500 = 2 × 100 = 200% ROI

This means the investment of the blood pressure monitor pays for itself within a year and generates an additional return on the initial purchase cost, that's without the additional benefits of improved patient outcomes.

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RCVS (2024). Knowledge award 2022 champion post-operative temperature audit, bit.ly/3O9KzDL (accessed 30 October 2024).

DEBBIE GRAY

Debbie is chief learning and development officer for the WSAVA. She holds a certificate in education, and is completing a master's in business administration. Debbie spent several years in practice before moving into education and teaching. Throughout her career, she has developed numerous CPD initiatives, e-learning courses and curricula. More recently she was associate director for a veterinary supply company and gained a diploma in leadership and operational management. Debbie continues to serve on various educational boards in the veterinary profession and is passionate about progression of the vet nurse role.

BEVA inside tack

Insights into the world of equine vet nursing

Role of equine nurses in poor performance workup

Cassie Woods BSc(Hons), CertNCS(RVN Cons), RVN, discusses how the use of REVNs can help further improve and provide the optimum care and support to sports horses

The role of the REVN varies between practices, with the skills used daily depending on the caseload and the type of the clinic (hospital or ambulatory).

Sports horse work plays a large part in the caseload of many practices, from amateur competition riders to world-class professionals, we are presented with performance-related concerns on a daily basis.

It has recently been considered that dedicated equine practices would be unlikely to survive without the continuation of sporting disciplines involving the use of horses (Webb, 2024).

When considering the role of the equine nurse, many immediately think of in-patient care, theatre work, neonatal nursing and general clinic work. However, the role of the nurse in the sports horse workup is just as important.

With discussions around social licence and the use of horses in sport, the use of REVNs can aid to further improve and provide the optimum care and support to the equine athlete, bringing a different perspective on the role.

It's not just trotting up and lungeing

When horses are initially presented, a member of the team will be required to trot up and lunge the horse for assessment. While this is an important part of the process, it is not the only way to get involved. Instead, this role can be carried out by veterinary technicians and grooms, meaning nurses can use their skills more effectively, making the process run smoother.

Throughout this article, references will be made to Schedule 3 procedures that are within the remit of the REVN. Clarification of these procedures has recently been outlined by BEVA, which has further recognised the skills nurses should be using in practice (BEVA, 2024).

To enable us to use the privilege of Schedule 3, nurses must remain within the remit of their role, working under the direction of the veterinary surgeon and not making a diagnosis.

Initial assessment

During the initial phase of the workup, nurses can be used by assisting the veterinary surgeon with key aspects.

Firstly, RVNs can acquire a detailed history on admit, making notes of key findings and giving feedback to the treating vet.

They can also carry out an initial clinical exam and take any required samples. RVNs can fit and set up the gait analysis equipment, and provide a helping hand with ensuring the correct data is obtained.

During the lameness workup process, RVNs under Schedule 3 guidance can perform nerve blocks under the direction of the veterinary surgeon – a skill that not all clinics will require their nurses to use, but the option is there for those that want to explore it.

Diagnostics

Once an area of interest has been localised, RVNs can carry out the required x-rays, leaving the treating vet to start on another case or catch up on paperwork.

Ultrasonography is a tool that veterinary surgeons like to often do in real time; however, it is a skill an RVN can develop as long as they are not making a diagnosis.

In many practices, RVNs are fundamental in the acquisition of MRI and CT advanced imaging, which again is an important role of the nurse and adds a further challenge and advancement of skills (Hall, 2022).

Performance cases may not always be orthopaedic based. Nurses should be competent to set up and use the mobile ECG machines, enabling the vet to simply watch and observe the findings.

Gastroscopy is a common cause of poor performance (Franklin, 2010) and again under Schedule 3 guidelines this is a role that nurses can carry out, if they are

continued on page 8

Image: skumer/ Adobe Stock

Role in poor performance workup –

continued from page 7

not making a diagnosis. This procedure, again, is something many veterinary surgeons like to see in real time.

However, the nursing team should be confident to pass and drive the gastroscope when required.

Airway endoscopy is another common procedure carried out when looking at performance-related respiratory issues. This can vary from respiratory noise, cough, epistaxis, and head shaking (Massie, 2023).

Nurses should be confident to pass and drive the scope when required, and prepare the patient and equipment for sample collections such as tracheal washes and bronchoalveolar lavage.

Carrying out the associated laboratory work following sample collection is an avenue that can also be opened to nurses wanting to develop their laboratory skills. In turn, this enables quicker results for our patients.

Overground endoscopy may also form part of the poor performance workup, with nurses able to fit and set up the equipment for the veterinary surgeon.

Dentistry plays a crucial role in any horse, pony or donkey, but animals that are asked to work on a contact or are stabled more may present more often with dental related conditions (Carmalt, 2006).

Nurses can be involved in dental workups and dental-related procedures, but with regards to any rasping of teeth, they should follow the BEVA guidelines as to which category they fall into (BEVA, 2024a; BEVA, 2024b).

This will depend on additional training they may have undertaken and extra qualifications. This, however, can be considered as a role for the equine nurse should they wish to carry out equine dentistry by obtaining further qualifications in equine dentistry through the British Association of Equine Dental Technicians.

Treatments

Nurses play a vital role in the treatment and management of performance-related conditions and can be involved throughout the process, from diagnosis and treatment to home care.

Orthopaedic

Joint injections

It is not appropriate for nurses to perform joint injections as this is considered as entering a body cavity, but they still should be involved in the procedure. Aseptic preparation of the area is a key element in infection prevention and control (Mitchell, 2017). This is something that nurses are well equipped to carry out.

During an ultrasound guided procedure, the RVN can also be involved by positioning the probe and obtaining an image for the veterinary surgeon administering the injection. Following joint injections, bandage application is a skill that RVNs can use for infection control and patient comfort.

Shockwave therapy

With training, nurses can carry out shockwave therapy under the direction of the veterinary surgeon.

Knowledge of anatomy and technique should be established prior to the nurse undertaking this alone.

Equine orthobiologics

Many options exist for regenerative biological therapies that we can use for the treatment of various orthopaedic conditions, such as platelet-rich plasma, interleukin-1 receptor antagonist protein and alpha-2 macroglobulin.

Preparation of these for use requires laboratory skills and asepsis – all that RVNs can carry out. Often, training can be provided from the supplying company, which enables the nurse to obtain the techniques in the preparation of the biological agent.

Following the guidance of Schedule 3, RVNs can prepare the patient and obtain any samples needed to start the process. This will often involve the insertion of an IV catheter and phlebotomy when directed to do so by the case vet.

Surgery

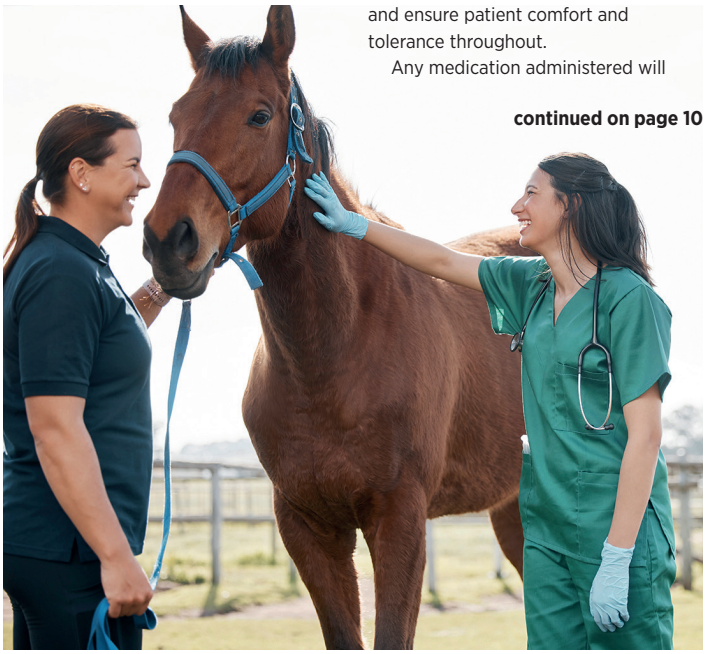
Nurses are essential to the smooth running of the theatre. During orthopaedic surgery, nurses should be involved in preparation of the patient, managing the theatre during the surgery or acting as a scrub nurse. Encouraging nurses to scrub into surgeries enables further skill development.

At the end of surgery, under Schedule 3 guidelines nurses can close the incisions when required. Nurses can also be involved in or, under specific circumstances, carry out equine anaesthesia, which are again skills that are day one skills for nurses, but should be further developed in practice.

For standing procedures such as impinging dorsal spinous process surgeries or dental extractions, nurses can set up and monitor a standing continuous regional infusion of sedation and ensure patient comfort and tolerance throughout.

Any medication administered will

continued on page 10



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Role in poor performance workup –

continued from page 8

have been prescribed by the case veterinary surgeon.

Postoperative care of the orthopaedic surgical patient involves clinical assessments, pain scoring and bandage changes as a minimum. Nurses can include some light physiotherapy and with further knowledge and training, develop rehabilitation plans for both surgical and non-surgical cases in consultation with the case vet and a physiotherapist.

RVNs with an interest in physiotherapy could consider additional training and qualifications around this area.

Injections

RVNs can be used in administering regular injections such as pentosan, which can be carried out at the clinic or at home incorporating the role of the ambulatory nurse (Woods, 2022).

Laser

An additional role that can be carried out by REVNs is the use of a class IV laser, which can be used under the direction of the veterinary surgeon to aid in the treatment of certain orthopaedic conditions.

Treatments for other performance-related conditions

Not all performance related issues stem from orthopaedic conditions.

Medicine conditions such as those concerning gastroenterology and respiratory systems can also be responsible, opening up more avenues for the role of the equine nurse – particularly those that also have a medicine interest.

Respiratory

A variety of conditions may need to be treated regarding the respiratory tract, ranging from surgery to medication administration and management changes.

RVNs, as previously mentioned, play a key role in any surgery – both during an operation and postoperatively.

A common condition for nurses to be involved in is the management of equine asthma. This can involve the use of medication administration and equipment demonstration. This is a good example of how the RVN can get involved in home care during ambulatory visits.

The demonstration and use of inhalers and nebulisers during a nurse visit also allows opportunity to study the home environment, and help with the improvement of its management. (Woods, 2022). For example, assessing ventilation, pollens and other environmental factors.

For the horse with gastric ulceration, nurses should firstly be involved with education around the diet and management with the owner. This can be a formulated plan, including a weight check and a feeding regime depending on the requirement and needs of the horse.

Owners are usually capable of self-administration of omeprazole via syringe, but when the injectable form is required, this can be another role of the nurse in an ambulatory form.

Throughout all the above the nurse can also play a key role in communication and support for the client during the process.

Overall, the use of equine nurses during poor performance investigations gives another opportunity for more involvement and job satisfaction for the REVN.

This should be considered not just in hospital settings, but also for those in ambulatory practices where the employment of an RVN working alongside a performance horse vet could be greatly beneficial to all parties involved.

Opportunities for nurses to support veterinary surgeons at sporting events should also be considered, where they can provide assistance and support as well as improving job satisfaction and variation in the role.

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VN Voice

BVNA The Voice of Veterinary Nursing

Baby steps of a newly qualified veterinary nurse

Declan Jones BVNA council member, CertAVN (Teaching, Coaching and Mentoring), RVN, reflects on his time as a newly qualified nurse

HAVING worked in the same practice for my entire career, it wasn't long after qualifying that I felt how I'm sure many newly qualified RVNs feel – that at some point, I should learn to spread my wings.

I'm sure there's some pretty imagery of a newly born butterfly to be found somewhere there; a whole world of opportunity and so many options to explore. But leaving your training practice – especially if it was a positive experience like mine – can be daunting.

Opportunities

The number of opportunities swimming around in my head was dizzying – the metaphorical "VN passport" is truly a blessing to our profession. Of course, I felt called to try them all, but I had to learn the hard way that there are just too many options to accomplish right away.

With that said, a few options really shone out through the haze for me – emergency and critical care, education and engaging with the BVNA.

Thinking about leaving everything I knew for ECC work weighed heavily on my mind. A braver person may not have had any trouble leaving the familiar, but I certainly did.

Everything I knew came from a single practice, and this led to all kinds of worries – one of the biggest concerns being "What if my development as a professional has been stifled in some way, and I have no clue?"

I could waltz into the big old world looking for an adventure with a suitcase full of swimwear, when the destination is the Arctic Circle.

Scary times

So, after talking with colleagues and friends, I looked for opportunities that gave the best of both worlds – the familiar and the scary. I can't be the only one who walks into a new practice for their first shift and thinks, "Oh dear, what on Earth have I done?"

Development

I was fortunate to be given the opportunity to complete out-of-hours work in a local hospital, while continuing to work in the same old practice – with development prospects to become a clinical supervisor (or clinical coach) in sight. And for me, that was perfect.

The support network around me was incredible, both "home" and "away" as it felt. The new people I was meeting each shift in my new venture would always be willing to teach and have a good laugh.

So, my message for anyone thinking about spreading their wings is go for it. Just don't be averse to taking some baby steps.

Declan started working in a small independent practice in 2014 as a veterinary care assistant, and is yet to leave them in peace and move on with his relentless singing.

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Nutritional considerations – intervention and carer support

Lizzie Bradley-Covey RVN, in part two of her article, covers undernutrition and overfeeding, continuous rate infusion versus bolus feeding and correct parenteral nutrition use

Abstract

Nutrition is a vital part of our nursing practice. Significant evidence shows early enteral nutrition reduces hospitalisation times and improves survival rates for a range of clinical conditions. We have to consider the best way to provide nutrition on a patient basis, completing a nutritional assessment to provide a contextualised approach.

In this article (read part one on feeding tubes in *VNT*24.11), the author will explore the prevalence and risks of undernutrition and overfeeding, and consider the strategies to encourage oral feeding, contemplate the risks and benefits associated with continuous rate infusion versus bolus feeding, and lastly consider the correct use of parenteral nutrition.

Panel 1. Standardised terms for changes in food intake as suggested by Johnson and Freeman (2017)

Adequate food intake
Voluntary consumption of sufficient calories to maintain or gain (if underweight) bodyweight and condition

Hyporexia
Inadequate food intake to maintain bodyweight (if ideal weight) or gain weight (if underweight)

Anorexia
Complete absence of voluntary food intake

Dysrexia
Abnormal patterns of food intake, for example, changing dietary preference/intake regularly, creating an increased risk of hyporexia

Undernutrition in hospitalised humans has an estimated prevalence from 25 per cent to 50 per cent (Barker et al, 2011; Kelly et al, 2000; Lew et al, 2017), the prevalence of undernutrition in hospitalised cats and dogs varies from 25 per cent to 65 per cent (Brunetto et al, 2010; Remillard et al, 2001; Chandler and Gunn-Moore, 2004).

Molina et al (2018) found the average energy intake of 500 hospitalised dogs was only 23.9 per cent of their resting energy requirement (RER), with 84 per cent of dogs consuming less than 25 per cent of their RER, and only 3.4 per cent consumed their RER.

A total of 16 per cent did lose weight and 18.4 per cent hanta decline in body condition score (BCS) – especially older patients and those with a higher BCS on admit.

Death was associated with lower BCS and lower energy intake. Brunetto et al (2010) found energy intake has a positive association with discharge from hospital, and patients with a lower BCS had a lower hospital discharge rate compared to ideal or overweight BCS.

Those receiving voluntary food intake have the highest hospital discharge rate, with those receiving parenteral nutrition having the lowest. This may show a difference in survival to discharge due to severity of disease, as those receiving parenteral support were more likely to be critically ill than those that were voluntarily eating.

A more specific UK study looking at mechanically ventilated dogs identified only 31 per cent received nutrition within 72 hours of no caloric intake (Greensmith and Chan, 2021).

Undernutrition in hospitalised patients is "stressed starvation" (Delaney, 2006; Gagne and Wakshlag, 2015), which is different to a healthy patient being starved for a procedure, "simple starvation". Stressed starvation means the patient is in a hypermetabolic state (Robben et al, 1999) due to inflammation and sympathetic stimulation (Michel et al, 1997; Center et al, 2011), increasing energy loss and protein breakdown (**Panel 1**).

This in turn causes a negative energy and nitrogen balance (Robben et al, 1999). This loss of muscle affects immunity, wound healing and overall survival (Freitag et al, 2000; Baez et al, 2007).

Reduced food intake is important when considering quality of life in patients – especially those with chronic conditions such as congestive heart failure, cancer or chronic kidney disease. Reduced appetite occurs in

continued on page 14

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Nutrition considerations

– continued from page 12

20.9 per cent to 92.3 per cent; however, this varies from anorexia to "reduced appetite" (Johnson and Freeman, 2017).

The lack of standardised terms for percentage intake can make nutritional assessment challenging. Therefore, the terminology stated in **Panel 1** has been suggested by Johnson and Freeman (2017) to improve clarification of terms.

Early enteral nutrition

Early enteral nutrition is associated with an improvement in survival rates and reduced length of hospitalisation (Liu et al, 2012). This has been evidenced in critically ill patients with canine parvovirus (Mohr et al, 2003), haemorrhagic gastroenteritis (Will et al, 2005) and septic peritonitis (Liu et al, 2012).

Remillard et al (2001) found an association with a low-energy intake during hospitalisation and increased mortality rates. Critically ill patients have a high risk of malnutrition due to catabolism from the increased stress hormones and inflammatory mediators. They also are at high risk of hypoalbuminaemia, which is best managed through nutrition, although human albumin is available for severe cases (Mazzafero and Edwards, 2020).

The majority of these patients are inappetent or unable to eat due to a combination of factors such as nausea, ileus (commonly due to opioids) or reduced mentation and recumbency, putting them at increased risk of aspiration pneumonia (Remillard et al, 2001).

Jensen and Chan (2014) stated the importance of early enteral nutrition in humans with pancreatitis, although previously it was thought to be preferred to avoid the enteral route.

The same is now considered true in our dogs and cats, although a combination of contextualised approaches may be required. Therefore, nutritional support should be provided alongside antiemetics and prokinetics as deemed necessary, and the method chosen should be based on risk:benefit analysis. Voluntary food intake can also be encouraged through management of stress in the hospital environment and use of appetite stimulants (Dumont et al, 2023).

Some patients may be "pseudo-anorexic" where they are interested in food, but unable to eat orally – for example, jaw fractures or neurological issues causing absent gag (Taylor et al, 2022). In these cases, a proactive approach to nutrition, providing long-term sustenance, is required.

Nutritional assessment

Each patient is an individual, and we should be providing contextualised care to all patients according to their disease processes, temperament, breed, life stage, activity level, neuter status and owner wishes (National Research Council, 2006; Bermingham et al, 2010).

The nutritional assessment should be regarded as the fifth vital assessment, after temperature, pulse and respiration, and pain (Freeman, 2011) – especially identifying those at risk of malnutrition or that will require feeding intervention (Taylor et al, 2022).

Table 1 is a nutritional assessment table with a range of considerations for each patient when determining what assisted feeding route is required, if any (Chan, 2020).

The nutritional assessment should include dietary history, clinical history, a physical examination that includes BCS/muscle condition score (MCS) and assessment of coat quality, assessment of any recent weight loss/gain and clinicopathological parameters such as electrolytes, albumin and creatine kinase (Chan, 2020).

Patients should be reassessed throughout hospitalisation, as the patients' clinical status, appetite, BCS and MCS change (Michel, 2015).

Cats have a higher protein requirement than dogs, with the recommended protein intake for critically ill cats consisting of 60g/1,000kcal to 80g/1,000kcal (Eirmann and Michel, 2014; Chan, 2015). This is higher than the normal recommended intake due to increased protein losses that occur during illness.

Glutamine is an amino acid that provides energy for enterocytes and the provision of additional glutamine can improve protection in the intestinal mucosa. Additional fatty acids can improve immune function, and zinc is found to have a positive effect on wound healing and preventing proteolysis (Robben et al, 1999).

Cats also have a higher requirement of macro-nutrients such as retinol, arachidonic acid, vitamin D and taurine. While dogs also require these vitamins, they can metabolise and extract these more effectively from plant-based sources (Morris, 2002).

Cats also tend to eat frequent small amounts – especially those that hunt outdoors (Bradshaw, 1996). They are also crepuscular and therefore feeding at dawn and dusk may be more suitable (Bowen, 2018) and an important consideration with turning off or dimming lights of hospitalised patients at night to allow for natural behaviours.

Where possible, cats especially should be offered the same diet they are receiving at home, as neophobia is a common issue. Therefore, presenting cats with unfamiliar tastes or textures in a hospital environment may increase inappetence and food aversion (Zoran and Buffington, 2011). Therefore, sourcing a dietary history is important to continue feeding a familiar diet (Taylor et al, 2022).

In the author's experience, we often jump to what we think will be the most appetising food for our cats, such as fish or chicken, or warmed wet food, but often cats will be used to a dry biscuit diet at home, and she often finds when this is offered it will stimulate some cats to start eating.

When planning the RER, the aim is to stabilise the nutritional status of the hospitalised patient, not to increase weight or body condition back to normal. Therefore, we approach this conservatively, with gradual reintroduction of food in those that have been anorexic for more than three days to prevent refeeding syndrome.

Reintroducing the food over three days, with 1/3 RER on the first day, followed by 2/3 day two and full RER day three, reduces the risk of re-feeding syndrome (Chan, 2020); however, in some patients that have been anorexic for longer periods, the reintroduction may need to be more conservative, occurring over several days (Cook et al, 2021).

RER calculation should use the following formula and be calculated according to current bodyweight, regardless of BCS:

$$\text{RER} = 70 \times \text{bodyweight (kg)}^{0.75}$$

There can be further adjustment to RER by a maximum of 10 per cent every three to four days based on weight gain/loss, which should be assessed every day (Taylor et al, 2022).

Certain patients will have additional requirements to RER – for example, neonates, depending on age, should receive two to three × RER and patients with catabolic conditions such as burns or tetanus require additional calories (Birkbeck et al, 2020).

Table 1. Nutritional assessment table to determine the risk of malnutrition and requirement for feeding intervention from Chan (2020)

Parameter	Low risk	Moderate risk	High risk
Food intake <80% RER for <3 days	✔		
Food intake <80% RER for 3-5 days		✔	
Food intake <80% RER for >3 days			✔
Presence of weight loss		✔	
Severe vomiting/diarrhoea			✔
BCS <4/9			✔
Muscle mass score <2			✔
Hypoalbuminaemia		✔	
Expected course of illness <3 days	✔		
Expected course of illness 2–3 days		✔	
Expected course of illness >3 days			✔

RER = resting energy requirement, BCS = body condition score.

The number and size of feeds is also affected by the amount of food required by the patient. A high-calorie diet, but suitable to the patients' specific requirements (for example, puppy, renal, hepatic, gastrointestinal [GI] and so on) should be chosen. For a cat, the maximum bolus per feed ranges from 5ml/kg to 15ml/kg (Taylor et al, 2022).

Newer specific liquid diets are becoming available (Kathrani and Parkes, 2022) that can be tube fed to treat IBD. Although this study only had a small sample of five, this diet effectively resolved anorexia in these patients, with some improvements in albumin, globulin and cholesterol levels, although these were not statistically significant.

For pancreatitis a difference in diet exists between cats and dogs, with dogs recommended to have a low-fat GI diet, whereas cats have improved response to hydrolysed diets (Cridge et al, 2024).

Refeeding syndrome

Refeeding syndrome can be avoided with conservative reintroduction of food after a prolonged period of starvation. Refeeding syndrome is found to happen in humans even after short periods of starvation (Mehler et al, 2010); however, it is more likely in cats that have been missing (and assumed starved) for more than three weeks (Cook et al, 2021).

Main signs include depression, coma, weakness, haemolytic anaemia, glycaemic deregulation and severe electrolyte derangements – especially hypokalemia and hypophosphatemia due to the sudden surge of insulin causing electrolyte uptake into the cells. Thiamine deficiency also exhibits similar signs, and is a risk in a starved or malnourished cat (Cook et al, 2021).

At-risk cats should be identified as those that have been missing, likely to have had no food intake and have significant loss of body condition. Electrolytes should be assessed and any derangements treated prior to starting feeding. For these patients to be gradually reaching the RER across 4 to 10 days; with a maximum 20 per cent increase each day, electrolyte and/or thiamine supplementation may also be required (Chan, 2015).

Overfeeding

Overfeeding – even to underweight patients – can cause significant problems such as hyperglycaemia and GI stress; vomiting and diarrhoea (Ramsey, 2012). Overhydration may also occur – especially in patients receiving fluids and oral food/water, therefore monitoring for these signs as well as keeping a clear record of fluid ins and outs is important.

Signs of overhydration are increased skin turgor, tachypnoea, dyspnoea, pulmonary crackles and nasal discharge. This is especially a concern in patients with increased risk of overload, such as cardiac disease or anuric/oliguric renal disease patients (Taylor et al, 2022).

Bolus versus continuous feeding

Bolus feeding is preferred in stable patients as it simulates the normal feeding pattern the patient would have. Most patients will tolerate small, but frequent, meals; however, in humans, normotension is preferable when bolus enteral feeding. It is preferable to do constant rate infusion (CRI) feeding in hypotensive or borderline hypotensive patients, to prevent vasodilation within the GI tract worsening hypotension (Singer et al, 2019).

CRI feeding also reduces the rate of vomiting and patients reach caloric targets quicker compared to bolus feeding (Klaus et al, 2009). However, Campbell et al (2010) and Rado-Blozonva (2023) found no significant difference in GI complications between those fed continuously and those fed intermittently.

This study also compared the percentage of prescribed nutrition delivered (PPND) between the two methods. Those fed continuously received a slightly higher PPND (99 per cent) compared to bolus fed (92.9 per cent); however, this was not statistically significant. Patients receiving a CRI must be positioned upright with their head/neck extended to reduce the risk of regurgitation and aspiration (Taylor et al, 2022).

Parenteral nutrition

Enteral nutrition should always be considered first, as this has the most beneficial effect on gut barrier function, which could reduce the risk of bacterial or endotoxin translocation (Mohr et al, 2003). Some cases may be too high risk for enteral nutrition due to aspiration,

continued on page 16

Nutrition considerations

– continued from page 15

or persistent vomiting/regurgitation despite anti-emetics; therefore, parental nutrition can be considered (Liu et al, 2012).

Ideally, a portion of the nutrition will still be provided enterally to still gain the benefits from enteral nutrition (Preiser et al, 2015). Adverse effects exist that are associated with parenteral nutrition, such as the risk of bacterial infection in an often already immunocompromised patient, and the requirement of a central line to provide total parenteral nutrition, which requires a general anaesthetic for placement, as well as being a more expensive option (Perea, 2012).

The most common disease process requiring parenteral nutrition is pancreatitis and the most common complication is hyperglycaemia, lipaemia and hyperbilirubinaemia (Queau et al, 2011; Chan et al, 2002).

Chronic kidney disease in dogs, hepatic lipidosis in cats and a longer duration of insufficient calorie intake prior to parenteral nutrition had a negative association with survival. Therefore, a proactive approach to nutrition as discussed earlier is vital to improve outcome.

Patients that had received both enteral and peripheral parenteral nutrition had higher survival rates than those just receiving peripheral parenteral nutrition. Positive survival factors included longer duration of parenteral nutrition, enteral feeding in cats and enteral feeding in dogs with respiratory disease (Chan, 2002).

Peripheral parenteral nutrition is also an option for patients that are unable to have a jugular catheter and require short-term nutritional support (for example, prior to placement of a longer-term feeding tube solution), or have additional requirements in addition to enteral feeding. The solutions are lower in osmolality, but this also means they are lower in energy and protein (Chandler et al, 2000); however, a high risk of infection remains with this method.

Appetite stimulants

Three appetite stimulants are licensed for veterinary use: mirtazapine, capromorelin and cyproheptadine. Appetite stimulants may be appropriate for patients showing interest in food, but not eating, or those that are eating, but not ingesting sufficient calories. They are not indicated in critically ill patients, or those with acute vomiting or nausea (Taylor et al, 2022).

Mirtazapine reduces nausea and vomiting, working similarly to ondansetron (de Boer, 1996), as well as being an appetite stimulant; however, some studies have found it did not increase return of appetite (Brunet et al, 2022).

It is available as a transdermal formulation, which makes it much easier to administer to an inappetent patient (Buhles et al, 2018). It has been found to significantly increase bodyweight, as well as having reduced the adverse effects due to slower absorption (Poole et al, 2019).

Mirtazapine at higher doses is associated with side effects such as hyperexcitability, vocalisation and tremors, due to serotonin syndrome (Ferguson et al, 2016; Quimby, et al, 2011).

A newer appetite stimulant called capromorelin is a ghrelin receptor agonist (Rhodes et al, 2017). A freedom of information summary (US Food and Drug Administration, 2020) found cats receiving capromorelin had significant weight gain; however, common adverse effects are vomiting, hypersalivation and lethargy (Wofford et al, 2018). Transient bradycardia and hypotension have been reported, making it unsuitable in hospitalised, and especially critically ill, cats (Taylor et al, 2022).

A further appetite stimulant is cyproheptadine; however, this is not licensed in cats or dogs, and its efficacy is anecdotal (Agnew and Korman, 2014).

Anti-emetics and pro-kinetics

As well as appetite stimulants, it is important to also relieve nausea and vomiting in these patients. The three main anti-emetics licensed for use in veterinary patients are maropitant, metoclopramide and ondansetron (Kenward et al, 2017). The first line anti-emetic is maropitant, which binds to neurokinin receptors in the brain to inhibit nausea centrally.

Ondansetron binds to 5HTP receptors in the brain, and is found to be the most effective emetic for managing chemotherapy-related nausea and vomiting (Kenward et al, 2017). Metoclopramide is a good option in patients that are suffering from delayed gastric emptying and ileus, which is common in our critically ill patients due to drug therapy, electrolyte abnormalities, pancreatitis and hepatic lipidosis (Yalcin and Keser, 2017).

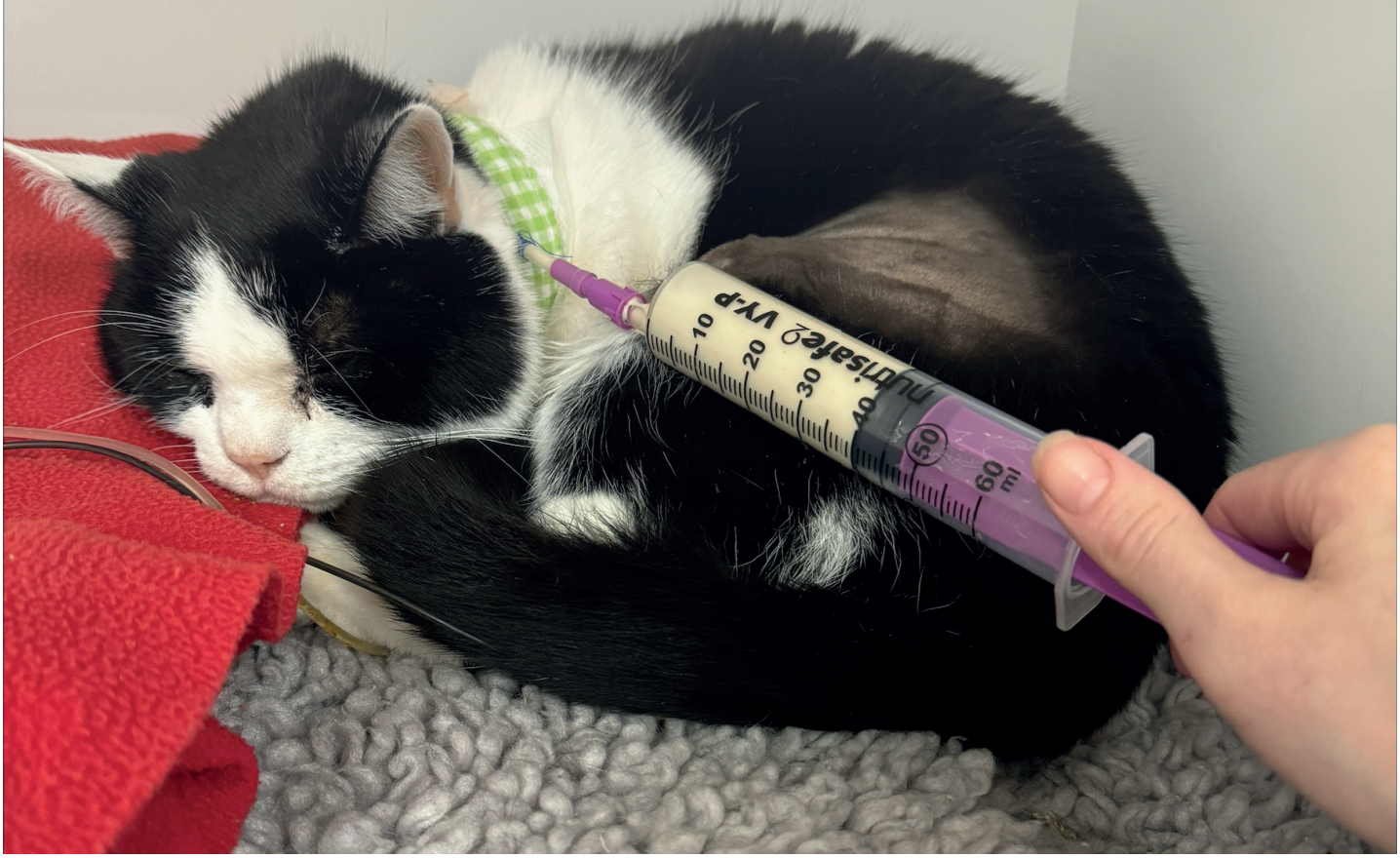
Cisapride is also an effective prokinetic, stimulating gastric emptying and reducing oesophageal reflux – especially in cats – but is only available as an oral formulation, therefore its effectiveness may vary depending on gastric emptying (Whitehead et al, 2016).

Further considerations

Stress is a significant factor in the hospitalised cat, leading to inappetence (Mills, 2014). We need to ensure we are using canine and feline-friendly practices throughout our patients' hospitalisation to minimise the detrimental effects of stress on the GI tract.

Regular pain assessment is paramount for administering sufficient analgesia, but not excessive, which may have adverse effects such as ileus and nausea (Gruen et al, 2022). Some patients may suffer more adverse effects than others from opioids. We need to consider our pain protocol on a patient basis, and observing any adverse effects, adjust accordingly.

Fluid deficits and electrolyte



derangements should also be corrected as dehydration may cause constipation and inappetence (Taylor et al, 2022).

Hypokalaemia has a correlation with reduced appetite (Phillips and Polzin, 1998) and ileus (Husnik and Gaschen,2021) and is a common occurrence in critically ill and especially inappetent cats (Hoehne et al, 2019). Furthermore, supplementation with cobalamin in cats with B12 deficiency may also improve appetite (Simpson et al, 2001; Kempf et al, 2017).

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LIZZIE BRADLEY-COVEY

Lizzie graduated from University of Bristol in 2013 and is working as a lecturer in veterinary nursing at Hartpury University. She is also a tutor on the CertVNECC course run by Vets Now. Prior to this, Lizzie worked in the ICU at Langford Vets (Bristol Veterinary School), with the latter two years as head ICU nurse. She achieved her CertVN(ECC) in 2016, and has recently been awarded a distinction in her APA teaching qualification. Lizzie lives in Weston-super-Mare with her wife, two sons, a chihuahua, a cat and a tortoise.

The Ruby Goodhew foundation

Ruby Goodhew was an RVN who at 28 years of age died as a result of leukaemia. Having adopted Ruby at a young age, her mum recounts how passionate Ruby was about veterinary medicine and her journey to becoming an RVN

Ruby started life in London and had a difficult start. She had a looked-after status and was placed in permanent foster care with her maternal aunt and uncle.

The family relocated to Norfolk, and Ruby moved with her aunt, uncle and cousins following the loss of her mother. Though this was a difficult time in her life, Ruby was keen to embrace the country lifestyle.

Love of animals

Ruby always had a passion for caring for animals and by the time she was a young adult she owned her own ponies, cats and a dog. She was a keen horse rider and won several competitions as a young child.

All of Ruby's pets were rescue animals and she worked part-time alongside school studies to ensure she could financially maintain her horses in livery and keep them safe and well. This passion led her to want to train to be a vet.

Mid-way through her A-levels, Ruby realised that she was more a vocational student rather than an academic, and made the wise choice to switch to training to become a veterinary nurse. She embarked on this by first seeking a placement. This was more difficult than she imagined, and her first placement was a considerable distance from home.

As a newly qualified driver, Ruby struggled with the long days and challenges of being an inexperienced driver travelling to and from both work, and college in rural locations. She struggled with studies, holding down both her placement and a part-time job, and looking after her animals, but giving up was never an option.

Support network

While working as an SVN, Ruby began her training at Easton College and completed it at the Medivet Training College. Ruby had such an eagerness to learn and was so committed to the training. She flourished practically, but struggled with dyslexia and found written exams challenging.

She didn't pass first-time every time, but Ruby knew she had found her true calling and was devoted to qualifying. She often commented about colleagues/other trainees nurses and the challenges they faced. Most found the demand of working in busy practices, juggling shifts, nights and weekend work alongside study, and managing often on low incomes quite a pressure.

It became apparent to Ruby that while she was finding studying and working hard at times, she had the support of her family, which she needed – in particular financial support towards petrol, books, uniform, equipment and so on. She recognised that not all nurses had the advantages she had, in terms of support.

Ruby's happiest times were when she was working and she made good friends, who remained good friends throughout her life.

Becoming unwell

Ruby started to become unwell as she approached her final practical exams (OSCE) in the summer of 2018. Though suffering from severe flu-like symptoms, fatigue, fainting, bruising and nosebleeds, Ruby still managed to complete her OSCE, which required more than a three-hour drive to attend.

Just days later, Ruby was admitted to Addenbrooke's Hospital in a critical state and diagnosed with acute myeloid leukaemia. Immediately starting chemotherapy, her life changed forever.

Ruby's journey was long, extremely hard and not without complications. While undergoing intensive chemotherapy, she received the wonderful results that she passed her OSCE and opened her RCVS certificate and badge in her hospital bed. She was so proud to finally be an RVN and this news motivated her during difficult moments in her treatment, determined to return to the job she loved.

Return to work

Ruby was set to return to work as an RVN in autumn 2020, after more than two years of treatment. Sadly, one week before starting, Ruby relapsed and it was on the advice of her consultants that she reluctantly resigned from her job and feared that it was likely she would never work again.

Despite trauma, ill health, financial hardship and personal loss, she didn't give up. In a recovery period between relapse, Ruby was able to join the team at Terrington Veterinary Centre and fulfil the role she worked so hard to achieve.

Ruby was extremely passionate about patient welfare, improving industry standards and professional development. She especially had a love for emergency and critical care, for which she started studying for a certificate while unable to work.

Ruby showed support to those in training, eager to become a clinical coach to the next generation of students.

Excellent veterinary nurse

Ruby was grateful to go to work every day she could, but her health began to decline after a short time at Terrington.

In September 2022 she relapsed for a fourth time and began another cycle of aggressive treatment. While travelling back from Addenbrooke's one day, Ruby said: "If I hadn't had leukaemia I really think I could have been an excellent veterinary nurse. Not just 'good', but really good – someone who would get to the top of their game."

Legacy

After a five-and-a-half-year battle, on 28 October 2023 Ruby died at home with her family and husband at her bedside. She was 28 years old.

A huge part of Ruby's adult life was spent receiving treatment, but leukaemia did not define her. She always identified as a veterinary nurse, determined to get back to nursing her patients.

Ruby never got the chance to make the difference she wanted, but would be so proud to know she leaves a legacy – an opportunity to help others who may be experiencing some of the challenges she faced while in training.

Image: maklstock / Adobe Stock

BVNA The Voice of Veterinary Nursing

BULLETIN

During a recent discussion panel at BVNA Congress, RCVS policy and public affairs manager Ben Myring shared with us that the RCVS had received no reports of the "veterinary nurse" title being misused in the past year[1].

Yet, the preliminary results from the BVNA's recent Survey of the VN Profession show that 52 per cent of our respondents knew someone who is currently being referred to as a "veterinary nurse", despite not being registered with the RCVS – a figure that has remained roughly the same since our earlier Protect the Title survey undertaken in 2022 (48 per cent).

So why is it that, at the BVNA, our evidence tells a very different story – and what can be done about it?

Accountable

Given that the "veterinary nurse" title is not protected, it makes it very difficult to hold anyone accountable for using it.

It is against our professional codes of conduct for a vet or RVN to refer to someone as a "veterinary nurse" knowing they are not properly qualified and regulated. So those already registered with the RCVS can therefore be held accountable – but only when this is reported.

From our data, the misuse of the VN title is clearly a prolific problem. In those incidences where this is originating from vets and RVNs, we must report such breaches to the RCVS, which will also further strengthen the argument that protection of the VN title is needed in legislation.

Engagement

But, how can we engage positively with our own teams to start to reduce this figure of 52 per cent? Changes absolutely must start from within our own practices. Sometimes individuals are referred to as a "nurse", and they are inadvertently referring to themselves as such by the job title they have been given by their employer.

As RVNs, we need to be speaking to our practice leaders about the unintended consequences of using the term "nurse" in anyone's job title if they are not a student or RVN. Not only could this mislead the public, but it can also confuse team members who may not be entirely sure of individuals' roles and level of qualifications.

Advocate

For those RVNs in leadership roles within your practice, use your position to advocate for your nursing team – but at the same time, carefully support those that have been given a job title that may have to be adjusted.

Be transparent with your clients, let them know who is who in your practice and do the same for your team. Support each other and recognise the benefits of not only keeping your team members safe, and preventing them from being exposed to situations they didn't ask for. This includes vets, RVNs and those who may have titles that could be misleading.

It can be difficult to speak up – especially in a close-knit team. But if we are allowing those who are not qualified or registered to be identified as a "veterinary nurse" in practice, we are putting them at risk. Ultimately, by turning a blind eye, qualified members of the team are also putting themselves at risk, and consequently our patients.

When addressing these matters, it is very important to do so sensitively. It will more than likely not be down to that individual the tasks they are carrying out, or what they are referred to. However, we must also be mindful that these team members are ultimately working under the direction of a vet, meaning there could also be significant consequences for the vet if tasks are not delegated appropriately to qualified members of the team.

Lead the change

So, let us keep each other safe and act with kindness – but ensure our codes of conduct are clear.

While the BVNA is tirelessly campaigning to protect our title in law, we must also remember that we don't need to wait for legislative change before we start to make this positive change at a practice level.

Reference

1. Pitcher L (2024). RCVS makes plea for evidence as report reveals VN title misuse, www.vettimes.co.uk/?p=291631

> “Being able to talk to someone, who did not judge, was a huge step forward.”

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