

Multi-disciplinary care management in orthopaedic ward



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The purpose of this assignment is to explore, discuss, and analyse multi-disciplinary care management of a patient admitted to an orthopaedic ward. It will look at how collaboration with other agencies and disciplines takes place. In addition, their role in the rehabilitation and discharge planning. It will conclude if the special needs of the patient were met which will be discussed throughout the assignment.

This assignment will contain reference to Gibbs (1988) reflective cycle along with Webb (1992) who agrees it is appropriate and acceptable to write in the first person, when giving a personal opinion.

The patient cared for in this assignment was a woman admitted to an orthopaedic ward after falling over in her home, with a possible fractured neck of femur. Fractured neck of femur is the most common traumatic condition requiring admission to orthopaedic wards. It is currently approaching epidemic proportions among older people, especially women (Audit Commission 1995). The names of the staff and hospital will remain anonymous to maintain confidentiality. This is in conjunction with clause 5. 1 of the Nursing and Midwifery Council's Code of Professional Conduct (NMC 2002). In addition, a pseudonym of ' Mrs. H' will be used to name the patient.

Mrs. H is a fifty-seven year old woman, who has Type II diabetes controlled by tablets and diet. Since she was a child, she was diagnosed as having learning difficulties. A learning difficulty/disability is a significantly reduced ability to understand new or complex information (DOH 2001). Due to social issues, Mrs. H was labelled as a complex discharge from admission. Smith

supports this and states discharge planning starts on admission (Smith 2002).

Mrs. H was admitted to the ward after an assessment was carried out in the Accident and Emergency Department. Mrs. H's fracture was confirmed by an x-ray, which identified an extracapsular fracture. The surgical house officer decided to book her for emergency surgery with dynamic hip screws (DHS), which are used to internally fix the fracture. DHS are designed so that the shoulder of the screw presses against the edge of the screw hole and applies pressure at the fracture site (Dandy & Edwards 1998). After surgery, Mrs H was transferred onto an elective orthopaedic joint replacement ward where I was placed.

The ward follows Roper's model of nursing as well as a care pathway for total hip and knee replacements. These pathways have been defined as a multidisciplinary outline of anticipated care, placed in an appropriate time frame, to help a patient with a specific condition or set of symptoms moving progressively through a clinical experience to a positive outcome (Roberts & Reeves 2003). Roper's model of nursing is the most commonly used in the UK, particularly in adult nursing (Kenworthy et al 2002). This model focuses on twelve activities that " people engage in to live"(Roper et al 1995). It focuses on the client as an individual engaged in the living throughout his or her lifespan, moving from dependence to independence, according to different circumstances. The concepts underlying the model are the progression of a patient along a lifespan, dependence, and independence continuum, the activities of daily living and influencing factors, and lastly <https://assignbuster.com/multi-disciplinary-care-management-in-orthopaedic-ward/>

individuality (Roper et al 1995). However, the goals of orthopaedic nursing is to return the patient to mobilise fully and weight bear independently, hence, self-caring. Therefore, Kenworthy et al (2002) suggests that when working with patients with learning difficulties, nursing models may need adapting to cater for long-term problems. Kenworthy et al (2002) also suggest that Orem's (1985) model of nursing is integrated with Roper's (1995), which is widely used in the fields of rehabilitation and community care. Despite this, this ward adheres only to Roper's (1995) model.

When Mrs H initially arrived on the ward, her patterns of activities were assessed, evaluated, and documented by the nurse. The problems identified were used to formulate a plan of care. This involves referrals to other agencies and disciplines. A multidisciplinary approach to rehabilitation and discharge planning is fundamental and includes the following: A named nurse, health care assistant, physiotherapist, radiographer, catering staff, social worker, occupational therapist, dietician, and psycho geriatrician. Other health team members involved in her care were community based health

professionals such as her general practitioner who would be involved after discharge. The adult nurse could facilitate health promotion for people with learning difficulties. This could involve a member of the community learning disabilities team, a learning disabilities nurse. The role of the learning disabilities nurse is to liaise with hospital administration staff to plan client's care needs on admission and discharge (Simpson 2002). However, there is shortage of learning disabilities nurse in the UK (UFI limited 2000).

Nevertheless, the nurse could adhere to the protocol for admission to hospital for adults with learning disabilities, which is being piloted in some hospitals at present (Robson 2000). Therefore, by using Mrs. H as an example of a learning disabilities patient, requiring specialist nursing. The ward could devise its own protocol. Similarly, by looking at the government's white paper for Learning Disabilities (LD) published in March 2001, its aims are to challenge discrimination and improve access to health and a better quality of life for people with LD (DOH 2001). The idea that nurses could discriminate against disabled patients may seem preposterous (Scullion 1996). However, some may play a part in what Miller (1995) calls 'hospital induced dependency'. Biley (1994) suggests that far from being user-friendly, hospitals may be particularly hostile to disabled people. Hannon supports this and points out people with learning disabilities are vulnerable and frightened on admission to hospital (2003).

The nurse carried out most nursing interventions, including measurement of blood pressure, pulse, respiration, and temperature. This procedure was carried out every half hour for two hours until Mrs. H's cardiovascular observations were stable. This was increased to four hourly intervals (NHS Trust 2002). The nurse also monitored her pain score, sedation score, and pain site. She checked all intravenous drips for leakage. Wound dressings were observed for strike through.

Mrs. H arrived back on the ward with a patient controlled Analgesia (PCA) pump. It is a method of pain relief, which allows patients to control their own pain by using an electronically operated pump (NHS Trust 1998). By using a <https://assignbuster.com/multi-disciplinary-care-management-in-orthopaedic-ward/>

pain assessment tool, nurses play a major role in assessing and managing pain (Watt-Watson et al 2001). The administration of prescribed analgesia was offered, and local policies regarding pain relief were implemented (Alexander et al 2000). However, Watt-Watson et al (2002) states many nurses distrust patients self-reporting of their pain, which suggest that they have their own benchmark of what is an accepted level before analgesic is necessary. McCaffrey disputes this and notes pain is what the patient says it is and exists when he or she says it does (McCaffrey & Beebee 1989). The nurse would ask Mrs. H if she would like any pain relief and on most occasions, she replied ' Yes'. The Nursing & Midwifery Council (NMC) guidelines for mental health and learning disabilities (MH & LD 2002) state it is important to devote as much time as it is necessary to explain issues to clients (nmc. org. uk 2002). This suggests that the nurse should ask if they have any

pain and explain it is not always necessary to agree to accept pain relief. The NMC guidelines for MH & LD also state people with learning disabilities have a fluctuating state of competence (nmc. org. uk 2002).

Due to poor mobility and being a diabetic, Mrs H was at risk of developing pressure sores. Using the hip replacement care pathway as a tool, the nurse and health care assistant turned her every two hours using an immoturn. This is a metal frame to help move the patient, it elevates pressure, ensuring no discomfort or soreness is experienced (NHS 2002). Because older patients are at risk of a deep vein thrombosis following surgery, the use of an anti-coagulant ' clexane' was used (Collins 1999), the nurse encouraged leg and circulatory exercises to be commenced post operatively. Due to a previous <https://assignbuster.com/multi-disciplinary-care-management-in-orthopaedic-ward/>

low blood haemoglobin, a full blood count was taken, along with urea and electrolytes and liver function tests (Collins 1999). Blood glucose monitoring was carried out and documented at appropriate times. Mrs. H's consent was not always sought to carry out the blood glucose monitoring procedure. The NMC MH & LD guidelines (nmc. org. uk 2002) suggest that certain environments force the learning disabilities client to feel forced to make certain decisions. They go on to suggest if a person has been appointed as guardian of the client, matters of consent should be discussed with that person (nmc. org. uk 2002). The diabetic nurse was not involved as the nurses on the ward were managing Mrs H's diabetes through tablets and monitoring of her diet.

Using the ward's care plan as a tool to reassess Mrs H's problems, it was evident that by the third day post operatively her dietary intake was poor. Due to this, and the fact Mrs H was a diabetic, a referral to the dietician was made.

The dietician advised both the catering staff and the nursing staff what type of diet was appropriate. The nurse would sit with Mrs. H and talk through what was available on the food menu. Mrs. H would deny that she had chosen the meal when it arrived. The NMC MH & LD guidelines outline learning disabilities clients may be highly suggestive, thus most likely to agree to choices from those in positions of authority (nmc. org. uk 2002). They also suggest an advocate would promote the client's right to choose and decide for themselves (nmc. org. uk 2002).

On the third day after Mrs. H operation, the physiotherapist came to teach her how to use a walking frame, which should progress to walking with two sticks. The physiotherapists play an important part in the patient's rehabilitation process by encouraging limb movement (Cuthbertson et al 1999). After mobilising on the stairs with the physiotherapist, a referral to the occupational therapist was made. The role of the occupational therapist was to assess the patient and decide if any aids are needed to help the patient manage safely and independently at home. Both the physiotherapist and occupational therapist agreed that Mrs. H was fit enough to go home. The multidisciplinary team (MDT) recognised the benefit of family centred care and involved Mrs H's family (Wright & Leahey 1994). This resulted in the family expressing

concern over the squalid conditions of her home. Mrs. H's home had not been cleaned for some time; she chose to leave left over food all over the house. This resulted in an infestation of maggots and bluebottles. In addition, the house was poorly maintained, with no heating and hot running water.

The

main concern expressed by the MDT was hundreds of rubbish bags, which surrounded most of the house, causing blockage of the stairs and doorways.

Due to Mrs. H's learning disability, a cognitive assessment was requested, and carried out by a psycho geriatrician. The nursing admission form contradicts this decision, in which Mrs. H states that she knew why she was in hospital and what her treatment was. However, as mentioned earlier, people with learning disabilities have a fluctuating state of competence

(nmc. org. uk 2002). The psycho geriatrician confirmed that Mrs. H did have <https://assignbuster.com/multi-disciplinary-care-management-in-orthopaedic-ward/>

the capacity to decide where she lived. Nevertheless, Mrs H's social worker was very concerned about home circumstances. Based on these facts, the ward nurse contacted the community liaison nurse to arrange a case conference. Unfortunately, this was delayed by two weeks due to the social worker taking annual leave. The nursing staff was told that there was no other social worker available to take over this case. This may be explained by the fact that there is currently a shortage of qualified social workers nationwide (Simpson 2002). Most days, Mrs. H would spend time sitting in her chair and would only mobilise when going to and from the toilet. Over the weekend, Mrs H did not receive any visitors. She then became tired mobilising back from the toilet. She began to shout loudly and insisted she was in pain. As it was visiting time, all the visitors stopped to stare at her. The nurses responded to this by transporting her back to her bed in a wheelchair. This behaviour continued for a couple of days. This prompted an x-ray referral, which confirmed no change. This was recorded on the care pathway as a variance. Any variance from the anticipated care pathway is recorded outlining what occurred differently, why and what was done instead (Onslow 2003). Mrs. H was encouraged to mobilise as much as she could but she would still shout in pain. The NMC guidelines for MH & LD (nmc. org. uk 2002), however, suggest a lack of individual stimulation could be the reason and exacerbate the problems associated with some challenging behaviours.

Eventually a case conference was arranged. The issues highlighted were although Mrs. H has the help of daily home carers visiting twice a day and <https://assignbuster.com/multi-disciplinary-care-management-in-orthopaedic-ward/>

belongs to a lunch club, she had a history of falls. Mrs. H was mobilising around the home with a zimmer frame, due to a right fractured neck of femur in 1999. The MDT reached a decision and the aim is to get Mrs. H to agree to a home visit. After careful negotiations with Mrs H and members of the MDT, a home visit took place. The outcome of the home visit was sheltered accommodation would be safer. Pritchard & Pritchard (1994) suggests each member of the team demonstrates a clear understanding of his or own functions and recognises a common interest. This common interest was the well being of the patient. Mrs. H was asked to visit the sheltered housing available and asked to make a decision. Mrs. H decided she wanted

to go home. The occupational therapist made a list of recommendations, such as rails on her front door, additional help to tend to the coal fire or alternate heating and an electrician to come and fix the light in Mrs. H's bathroom. Unfortunately, the social worker involved with Mrs. H's case went on annual leave for a further two weeks. Mrs. H is now still in hospital awaiting her social worker's instructions on her discharge. According to the Guardian newspaper, every day across England, about 5, 000 people of all ages are unnecessarily stuck in acute hospital beds because no follow up care is available in the community (Waters 2003). This is still happening in spite of in 2003, the government introduced the community care (Delayed Discharges Act). This act, effective from January 2004, stipulates social services departments will be fineable and will have to pay the NHS up to £120 per day to cover the cost of a blocked bed (Batty 2003).

On reflection, (Gibbs 1988) I felt there was evidence of good multi-disciplinary team collaboration. Mrs. H was given good care and emphasis was placed on her rehabilitation and discharge planning. However, on further analysis, utilisation of other agencies/disciplines could have been made. Due to staff shortages, and no alternative social worker being available to be Mrs. H's advocate, then the community learning disabilities could have been involved. As this was not possible, the nurse as a health facilitator could have made herself and the multidisciplinary team aware of the government white paper, learning disabilities a strategy for the 21st century (DOH 2001). Conversely, one member of the nursing staff could have offered to participate in training

courses for the care management of people with learning disabilities (NHS Careers 2000).

Overall, the nursing staff implemented good care. Nevertheless, the nursing staff by using Mrs. H as an example of a complex discharge can learn from this. They could put in place policies to deal with other learning disabilities patients.

Finally, the NMC (2002) clause 2. 4, stipulates that as a registered nurse, you must promote the interests of your clients. This includes helping individuals and groups, including the multidisciplinary team, to gain access to health and social care. More importantly, “ you must respect the interests of patients irrespective of their ability” (NMC 2002) clause 2. 2.