Gibbs reflective cycle 1988 nursing essay

I am a Paramedic registered with the health professions council and this essay will look reflectively at an incident I attended during the course of my duties. The assignment will look at the moral, ethical and legal aspects of pre-hospital care with which I was challenged during this particular emergency. Confidentiality has been maintained at all times and names of individuals have been changed, I have also gained permission from the family of the patient and for the purposes of this essay I will call the patient Mr Taylor (HPC 2008)

To analyse this critical incident I will use Gibb’s reflective cycle. (1988).

Description

As a Rapid response Paramedic working for the Ambulance service I attend life threatening emergencies during my tours of duty, I work alone and am frequently dispatched to jobs as a solo resource that is without ambulance back up. The incident on which I wish to reflect occurred part way through a shift that had been up to then quiet. I received a call to attend a patient who had collapsed and was semi-conscious. On arriving I was met by a lady who was obviously distressed and she showed me to the patient who turned out to be the lady’s husband, he was around 50 years old and was by this time unconscious with poor respiratory effort, I quickly requested a backup ambulance via radio and continued with my assessment of the patient and attempted to gain a history of his condition and what had happened that day. His wife told me that Mr Taylor had been well until 8 weeks before when he visited his doctor for abdominal pain and some rectal bleeding. The GP had sent him for tests at the local hospital within a couple of days he had

been diagnosed with numerous tumours throughout his body, Bowel, liver & lung and was told it was terminal , he had been given between 3 and 6 months to live. Overall he had still been active and reasonably well until a couple of days before, when he started to deteriorate , that day she had been shopping and when she arrived home had found him in bed semi-conscious and with difficulty breathing. By this time I had gained some observations and placed oxygen on Mr Taylor. My back up ambulance arrived and I did a clinical handover to the paramedic on board it was at this point that Mrs Taylor called me to one side and told me that he wanted to pass away at home and not in hospital, he had expressed a wish not to be resuscitated, she explained that as she was alone with her son living in the south she felt she needed some help when she found him. I asked about a the Do Not Attempt Resuscitation (DNAR) paperwork and she told me there wasn’t any. I explained our position as Health Care Professionals and in the absence of the DNAR we had to act in his best interests. She again reiterated his wishes not to be taken to hospital or resuscitated. As my colleagues continued to assist the patient I contacted our on call Advanced Paramedic for advice , I was asked to verify there was no DNAR in situ with the patients palliative care team first, then if this was the case to contact the patients GP to see if he or she would attend as a matter of urgency. After confirming the absence of a DNAR I contacted the GP who was extremely understanding and attended within 15 minutes. Mr Taylor passed away within minutes of the GP attending.

Feelings

Situations that deal with someone losing their life are always hard to deal with and cause an array of emotions, in this case sadness, that this lady was losing her husband of 30 years and he was only 50, frustration and irritation of paperwork that should have been in place but was not. The Health professions council (HPC) list one of my duties as a registrant as , “ act within the limits of my knowledge, skills and experience and if necessary , refer the matter to another practioner” (standards of conduct performance and ethics, p3 2006) on this occasion we did this and it is On occasions like this when there is a group of health care professionals I try to include everyone in the descsicon making process and it was agreed it would be wrong to ignore a person’s wishes in these circumstances. His wishes had been explained to me by his wife, his palliative team and his general practioner. The Lasting memory for this lady and her family would be that her life partner died at home with his wife, exactly as he had wished.

Evaluation

As with any emergency situation our priority is safety and ensuring we are aware of any potential danger on scene, and performing dynamic risk assessments during the emergency. My responsibility for safety covers myself, colleague, patient, relatives and any further agencies requested to attend scene. The health and safety at work act (1974) states I should take reasonable care for my own health and safety and also that of others who could be affected by my acts or omissions. On this occasion everything was safe.

Looking at the incident I feel there were lots of positives , these include fast and effective communication with the patients relative, and fast assessment of the scene, decision makimg was also quick and effective and minimised any further upset and stress to the patients wife. Conversations with our own AP and the Palliative care staff and GP all fell into place on this job and this is not the norm , we often encounter difficulties contacting various agencies within the NHS .

Negatives included understanding of the DNAR side of our advanced decisions policy. I’m sure most HPC’s would agree that with so many modern policies and proceadures we cannot be expected to know everything , let alone little used sections of certain policies.

Morally I was challenged too as my professional guidelines state that in the absence of a DNAR then you must commence resuscitation (JRCALC). 2006).

Analysis