

# Case study of health issues for older adults



The purpose of this case study is to reflect on the journey of care experienced by an older adult during an acute hospital admission. An evaluation of the care given will be carried out by examining the available research.

The aim of the study is to demonstrate the application of nursing research into everyday practice. It will evaluate the role of the multi-disciplinary team in addressing the physical, psychological and social needs of patients.

The author is a Specialist Stoma Care nurse working in a department of colorectal surgery within the NHS in Scotland. Within the multi-disciplinary team the stoma nurse has a unique role. Porrett and McGrath (2005) suggest they are “ key to the clinical management of patients with a stoma”.

To fulfil the requirements of the assignment I requested the assistance of a patient with whom I had developed a close working relationship whilst he was a hospital inpatient. I have maintained contact with this gentleman since discharge.

In accordance with the Nursing and Midwifery Council Code - Standards of conduct, performance and ethics for nurses and midwives (2008), to maintain client confidentiality, all names have been changed and no reference has been made to vocation. For the purpose of this assignment the client will be known as “ Tom”.

Tom is an 84 year old retired grammar school headmaster. He lives in Georgian house on the outskirts of a small town. He moved here when he retired 20 years ago. Tom lives with his wife “ Jean” whom he has been

married to for 62 years. They have a son and two daughters who all live within a one hour drive of his home and they all visit regularly.

Tom is the primary carer for his wife, following her diagnosis with Alzheimer's disease a number of years ago. Over time this role has become more practical and demanding as her condition has deteriorated. He has minimal social work support. He is a very practical, capable and fiercely independent man who arranged and financed his wife's respite care in a local nursing home prior to his admission to hospital.

Tom remains very active; he runs his home, he continues to drive a car and is a keen gardener.

## **Past Medical History**

Tom suffers from Diverticular disease and has an enlarged prostate although neither has required on-going treatment. He suffers from mild hypertension which is treated with Bendroflumethiazide. This complies with the British Hypertension Society recommendations (Brown et al, 2003; Williams et al 2004). He does not drink alcohol or smoke cigarettes. Tom has Osteoarthritis which is eased by Paracetamol taken as required but he remains in generally good health.

Earlier this year, Tom visited his GP when he experienced fresh rectal bleeding with associated altered bowel habit. When initial treatment for haemorrhoids was unsuccessful and symptoms persisted Tom was referred urgently to his local hospital (SIGN, 2003; NICE, 2004; ISD, 2008). A flexible sigmoidoscopy and pathology confirmed a rectal cancer. Colorectal Cancer is the third most common cancer in both man and women (ISD, 2009).

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Following a positive cancer diagnosis patients have further investigations to establish staging of the disease (SIGN, 2003; Association of Coloproctology, 2007; QIS, 2008). Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI) scans revealed the tumour was circumferential and isolated to the rectum and there was no evidence of metastatic spread of the disease. His case was discussed at the weekly multi-disciplinary team (MDT) meeting and it was recommended that he undergo primary surgical total mesorectal excision (TME) (Heard et al, as cited in Rutten et al, 2008).

Malignant tumours are staged according to the tumour, node and metastasis (TNM) system of classification (Jass and Sobin, 1989; Sobin et al, 2010).

Rectal cancers are classified using The Dukes system (Dukes, C 1932 as cited in Haq et al, 2009; Libutti et al, 2008). Pathology and Radiological review diagnosed T3 disease; a locally invasive tumour.

## **Major Health Issue**

Treatment options were discussed with the Consultant surgeon at an outpatient clinic appointment. It was decided that an Anterior Resection would be the best surgical approach to resect the tumour and a minimally invasive laparoscopic assisted approach would be beneficial. The implications of surgery and the possibility of a temporary stoma were also discussed at this stage (Schiffmann et al, 2008) Arrangements were made for Tom's admission for elective resection of his tumour.

Surgery which results in any change in self-image can impact greatly on an individual. The formation of a stoma not only threatens self-image but

fundamentally alters the way the body functions (Bekkers et al, 1996; Black, 2004).

The main focus of this case study are the acceptance and management of the stoma which became necessary for Tom during his hospital admission, the associated psychological impact of a cancer diagnosis the complications which hampered Tom's treatment and how this relates to and impacts on his care management and recovery. The case study covers the 4 weeks of Tom's hospital admission.

## **Discussion of the Care Received**

### Pre-Operative Assessment

Tom attended for a pre-operative assessment prior to his appointed admission date. Here he was seen by an anaesthetist and a nurse to establish fitness for surgery. In addition to past medical history a full physical examination, blood tests to check renal function and full blood count and an electrocardiograph (ECG) are carried out. This verifies risk factors including the presence of any co-morbidity which could affect treatment; Tom's hypertension was noted. The collection and recording of baseline blood pressure, pulse, respirations and temperature readings were documented. This enabled Tom's care to be planned prior to admission to hospital.

### Initial Care

I first met Tom on his day of admission when he was given additional pre-operative information and counselling on the possibility of stoma formation and a prospective site marked on his abdomen (Erwin-Toth, 2003). During

our initial meeting it was apparent that Tom wanted to avoid a stoma at all costs and should it be necessary he felt it would impact greatly on his daily life and ability to adequately care for his wife. Tom was reassured that although the chances he would require a stoma were low, all patients admitted for anterior resection were sited as a precaution. Indeed he appeared to be more concerned about his wife's welfare than that of his own. His primary concern was the length of stay in hospital as he had been forced to make alternative arrangements for her care in a local nursing home.

The preferred Laparoscopic assisted anterior resection was performed the following day. The surgery went well and he did not require a stoma. Initially Tom was nursed in the surgical high dependency unit; this enabled close monitoring of his condition and response to treatment (Dunn and Schmitz, 2005 as cited in Tulloch et al, 2007). As Tom did not have a stoma he was not routinely seen by the team but his recovery was monitored additionally by the colorectal CNS who assisted in supporting him following his cancer diagnosis.

#### MDT Outcome

Tom's case was discussed at the weekly multi-disciplinary meeting when results of detailed pathology investigations were available; this took place approximately one week following surgery. The results confirmed earlier suspicions of T3 disease; more specifically pT3 N0 – Dukes B well differentiated adenocarcinoma with extramural vascular invasion (Appendix 1). Pathology also confirmed the tumour had been completely excised and

circumferential margins were clear. On discussion at the MDT meeting, the pathological evidence indicated a curative resection of the tumour. There is no clinical evidence that chemotherapy treatment would be of any additional benefit it was decided that Tom should be followed up at the surgical clinic only (Gill and Scholefield, 2005; Midgley et al, 2000; Morris et al, 2007; Petersen et al, 2002). McMillan et al (2008) highlighted age; sex, Dukes stage and need for adjuvant therapy are important indicators on survival rates.

### Complications

It however came to light that, after initially making good progress Tom's recovery had suffered a number of setbacks. He had developed a fever which was assumed secondary to retention of urine (for which he was catheterized) or a superficial wound infection and he began vomiting. The medical team arranged a CT scan. It confirmed the presence of a paralytic ileus which accounted for Tom's vomiting and revealed a collection resulting from a leak in the anastomosis, the probable source of infection. A naso-gastric tube was passed to drain stomach contents and decompress the air in the small bowel to alleviate Tom's symptoms of nausea and vomiting. Intravenous antibiotics- Cephtriaxone and Metronidazole; were given to treat the infection but the only possible treatment option to address this problem was further surgery.

Research has shown anastomotic leak occurs in 3-19% of cases (Lyall, et al, 2007; Khan et al, 2007).

### Further Treatment

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Tom underwent a further Laparotomy, Hartmann's procedure with peritoneal washout and insertion of a rectal drain the following day. The procedure was explained by the surgeon but as there is no stoma care cover over weekends Tom was not sited for a stoma and he had no further specialist counselling to prepare him for this. Tom was again nursed in the high dependency unit following surgery. Due to the complications of his initial operation and subsequent second operation Tom required additional medical support to assist his recovery. Intravenous Colloid infusion failed to maintain adequate blood pressure so Inotropes - Noradrenaline and Dopexamine were commenced. This helped support renal function and improved urine output.

Although afebrile, an increased white cell count indicated further evidence of sepsis; intravenous antibiotics and Paracetamol continued. Tom continued to show signs of paralytic ileus - no bowel sounds heard, no activity from his stoma and moderate drainage from the naso-gastric tube; he began to develop generalised body oedema on his second post-operative day. This was due to low blood albumen. In an attempt to address his poor nutritional state and promote healing Total Parenteral Nutrition (TPN) was commenced.

To minimise associated potential risk of pressure sores Tom was nursed on a therapeutic air mattress.

Tom was self-administering Morphine for pain relief via a patient controlled analgesia (PCA) pump and was receiving additional oxygen therapy via nasal cannula.

The complications Tom experienced and his subsequent treatment left him very weak and somewhat bewildered. He was experiencing a great deal of



pain but was reluctant to use the PCA as it made him feel nauseated and he felt he was unable to think clearly. Poor post-operative pain control can lead to further complications such as chest infection (McDonnell, et al, 2005).

Following review by the acute pain team his regime was subsequently changed from Morphine Sulphate to Ketamine. It has proved to be effective in improving pain scores when treating chronic post-operative pain (Visser, 2006).

As his general health had always been good Tom had not experienced these symptoms before, he had never needed or relied on such care and he became increasingly frustrated that he was unable to control his body and he became withdrawn. He began to question why his treatment had become problematic and found it difficult to accept the reality of his situation. This manifested itself particularly with regards to his body oedema and the newly formed stoma. He refused to acknowledge its existence and ignored it completely.

Initially, the stoma team's involvement was minimal. Tom's general health and increased medical and nursing support meant it was inappropriate to begin any form of teaching stoma management. Nursing staff were caring for and assessing the stoma but expressed concerns that he was finding the presence of the stoma difficult to cope with he had expressed feeling of revulsion whenever the pouch was drained or changed. As a new stoma patient this was a particularly difficult and frightening time for Tom, as he has lost control over a basic bodily function (Black and Hyde, 2004; Thorpe, McArthur and Richardson, 2009). Maslow (1968, 1971) as cited in Bohart (2007) described a hierarchy of human needs, ranging from food and water,

graduating through the need for safety and belonging to self-esteem and self-awareness. Tom's issue with his diagnosis and treatment are illustrated within this model (Appendix 2).

It was decided I was best place to assist Tom; he was familiar with me from our discussions prior to the initial surgery. The first challenge was to encourage Tom to engage with me and to look at the stoma. He reluctantly gave consent but was unable to see the stoma due to his distended abdomen. It was then decided that he would aim to touch the stoma through his hospital gown. This was a huge step for Tom but with encouragement and support he managed this.

Research (Burch, 2005; Metcalf, 1999; O'Connor, 2003; White, 1998) has indicated preparation through early education of practical skills and coping strategies result in more favourable outcomes for all new stoma patients, regardless of age. This however was difficult for Tom due to the emergency nature of his second operation.

Traditionally the stoma care pouch change procedure has been taught through an experiential learning approach (Metcalf, 1999; Readding, 2005; O'Connor, 2005). Combining Bloom's (1956)(Appendix 3) acquisition of skills and Kolb's learning cycle (1984)(Appendix 4) approach to teaching was appropriate as much of stoma care is practical, hands on care and encourages the participation of the learner in their own education (Quinn, 2000; Young and Paterson, 2007; Bradshaw, 2007).

White (1997, cited in Benjamin, 2002) recommends when teaching stoma care management the elements should be broken down into small

manageable sections and revising what was previously learned before introducing new information. The patient will find goals easier to achieve and ensure they are self-caring prior to discharge. As a retired teacher himself he responded well to this particular approach, it worked well and Tom began to make good progress with managing his stoma.

Through daily contact with Tom we worked through practical stoma management skills. Additional practice and support for Tom was provided by ward staff. This ensured he became more confident with self-care. I also made myself available to offer emotional support, practical guidance and advice. We discussed many aspects of life with a stoma to increase Tom's knowledge on the subject and, in turn, boost his confidence. Indeed, Black (2000) suggests counselling is essential if the new stoma patient is to cope with this new way of life.

The complications Tom suffered prolonged his hospital admission. He worried that he would not cope with the stoma on discharge and be well enough to continue caring for his wife. A hospital social worker helped alleviate his anxieties; with her help and that of his family arrangements were made to extend "Jean's" respite care at the nursing home to allow Tom some time to convalesce. This helped reduce his stress and anxiety levels and allowed him to concentrate on his own recovery.

Norris and Spelic (2002) reported that it can take a year or more to adapt and accept a stoma. Although the operation performed giving Tom his stoma is reversible as time passed and he began adapting to this new situation Tom came to realise the stoma was aiding his recovery and would enable him to

return to some semblance of normality. As he became more confident and competent at pouch changing and generally managing the stoma Tom decided he did not wish to proceed with a reversal operation and instead keep the stoma.

The stoma care nurse is one of only a few health professionals able to offer continuity of care between hospital and the community. Discharge planning was essential. O'Connor (2005) recommends that it begin from the first visit and should be supported by on-going assessment. On discharge Tom was visited at home. This was an ideal way to offer on-going support, education and advice.

## Evaluation

Reflection is an integral part of professional nursing to ensure quality of care for patients.

Nurses follow an analytical approach to patient care on a daily basis in order to best meet their medical, psychological and social requirements. Analysis allows us to take a detailed look at the care given to patients by healthcare professionals over the course of a patient's journey of care.

Evaluation of Tom's care has led me to reflect on the decisions made. Sadly, it is fair to say that Tom's journey of care was problematic. All investigations were carried out within the recommended timescale (SIGN, 2003; NICE, 2004; ISD, 2008). They indicated Tom's rectal tumour could be resected using a laparoscopic approach. The clinical evidence shows multiple benefits: minimally invasive procedure allowing early mobilisation, faster recovery and

reduced hospital stay (Sharma et al, 2010). Surgery however does not come without risks which were explained to Tom. Weighing benefit against risk both Tom and his surgeon felt this approach was suitable for Tom's needs considering his complex social needs, age and wish to avoid a stoma.

Unfortunately, Tom experienced a recognised complication, namely anastomotic leak which happens to a small percentage of people who have colorectal surgery (ref). When he showed symptoms of this he was appropriately treated with antibiotics and a Computerised Tomography (CT) scan was arranged. This confirmed the problem but also necessitated a further emergency operation and a stoma. This unsurprisingly had a profound effect on Tom both physically and psychologically. He had little time to prepare for this and no additional specialist stoma care support as this took place over a weekend. This would have allowed him to be more fully prepared for the stoma and perhaps avoided the levels anxiety and depression he experienced.

Given this particular set of circumstances this could not have been avoided.

During the close teaching process effective communication is invaluable in developing a therapeutic relationship with patients as we strive to provide them with emotional support and advice. It allows us to continually assess their individual needs. Regular daily contact to teach stoma management skills proved beneficial. This also allowed time to discuss coping strategies and talk through any concerns Tom had. The aim of education is empowerment. This period of education provided Tom with the skills and knowledge to care independently for his stoma. It is important to note that

this patient journey did not end on discharge. He was visited at home where support and education continued.

Tom's post-operative complications were as a direct result of the second operation and he was treated appropriately based on the clinical evidence; Tom responded well and began to progress. His psychological issues took longer to address.

Both Tom and his surgeon could have chosen a different course of treatment. It would possibly have meant a temporary or permanent stoma from the outset which he was clear he wished to avoid. His main reason that he felt it would impact on his ability to care for his wife.

On balance, Tom got best possible treatment. The decisions both he and the healthcare team made can all be justified. With the benefit of hindsight different decisions would undoubtedly resulted in a different course of treatment but may have resulted in a similar outcome – namely some form of stoma. There is also no guarantee that Tom would have not suffered other setbacks but we can only speculate on this.

## **References**

Bekkers, M. J. T. M., van Knippenberg, F. C. E., van den Borne, H. W. and van Berge-Henegouwen, G. P. (1996) Prospective evaluation of psychosocial adaptation to stoma surgery: The role of self-efficiency. *Psychosomatic Medicine*. Vol. 58(2), pp183-191.

Benjamin, H. C. (2002) Teaching the stoma care routine to a patient with low vision. *British Journal of Nursing*. Vol. 11(19), pp1270-1276.

Black, P. (2000) *Holistic Stoma Care*. London: Bailliere Tindall.

Black, P. (2004) Psychological, sexual and cultural issues for patients with a stoma. *British Journal of Nursing*. Vol. 13(12), pp1270-1276.

Black, P. and Hyde, C. (2004) Caring for people with a learning disability, colo-rectal cancer and stoma. *British Journal of Nursing*. Vol. 13(), pp970-975.

Bloom, D. S. (1956) *Taxonomy of educational objectives: the classification of educational goals. Handbook 1: Cognitive domain*. London: Longmans.

Bohart, A. C. (2007) Chapter 5. In: Cooper, M., O'Hara, M., Schmid, P. F and Wyatt, G. (eds.) *The Handbook of person centred Psychotherapy and Counselling*. Basingstoke: Palgrave Macmillan.

Bradshaw, M. J. (2007) *Effective Learning: What Teachers Need to Know*. In: Bradshaw, M. J. and Lowenstein, A. L. (eds.) *Innovative teaching strategies in nursing and related health professionals*. 4th Edn. Sudbury, Massachusetts: Jones and Bartlett.

Brown, M, J., Cruickshank, J, K., Dominiczak, A, F., MacGregor, G, A., Poulter, N, R, Russell, G, I., Thom, S. and Williams, B. (2003) Better blood pressure control: how to combine drugs. *Journal of Human Hypertension*. Vol. 17(2), pp81-86.

Burch, J. (2005) Exploring the conditions leading to stoma forming surgery. *British Journal of Nursing*. Vol. 14(2), pp94-98.

Clinical Outcomes of Surgical Therapy Study Group (2004) A comparison of laparoscopically assisted and open colectomy for colon cancer. Vol. 351(9), pp933-934.

Erwin-Toth, P. (2003) Ostomy Pearls. A concise guide to stoma siting, pouching systems, patient education, and more. *Advances in Skin & Wound Care*. Vol. 16(3), pp146-152. Available URL: <http://journals.lww.com/aswcjournal/toc/2003/05000>. [Accessed 10th July, 2010].

Gill, T. S. and Scholefield, J. H. (2005) Update on adjuvant therapy in colorectal cancer. In Taylor, I. and Johnson, D. C. (eds.) *Recent advances in surgery*. London: Royal Society of Medicine Press, pp153-164.

Haq, A. I., Schneeweiss, J., Kalsi, V. and Arya, M. (2009) The Dukes staging system: a cornerstone in the clinical management of colorectal cancer. *The Lancet: Oncology*. Vol. 10(11), pp1128.

Information Services Division Scotland (2008) NHS Scotland [Online] New Cancer Waiting Times. Available URL: <http://www.isdscotland.org/isd/5013.html> [Accessed 28th July 2010].

Information Services Division Scotland (2009) NHS Scotland [Online] Cancer statistics: Colorectal cancer. Available URL: <http://showcc.nhsscotland.com/isd//1425.html#Cancer%20of%20the%20colon> [Accessed 28th June 2010].

Jass, J. R., and Sobin, L. H. (1989) *Histological typing of Intestinal Tumours: (WHO International Histological Classification of Tumours)*. 2nd ed. Berlin: Springer-Verlag.

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Khan, A. A., Wheeler, J. M. D., Cunningham, C. George. B., Kettlewell, M. and Mortensen, N. J. McC. (2007) The management and outcomes of anastomotic leaks in colorectal surgery. *Colorectal Disease*. Vol. 10(6), pp587-592.

Kolb, D. A. (1984) *Experiential Learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall.

Libutti, S. K., Saltz, L. B. and Tepper, J. E. (2008) Chapter 39: Section 12 Colon Cancer. In: DeVita, V. T., Lawrence, T. S. and Rosenberg, S. A. (eds.) *Cancer: principles & Practice of Oncology*. 8th Edn. [Online]. Philadelphia: Lippincott Williams & Wilkins. Available: Books@Ovid [31st July 2010].

Lyll, A., McAdam, T. K., Townend, J. and Loudon, M. A. (2007) Factors affecting anastomotic complications following anterior resection in rectal cancer. *Colorectal Disease*. Vol. 9(9), pp801-807.

Metcalf, C. (1999) Stoma Care: empowering patients through teaching practical skills. *British Journal of Nursing*. Vol. 8(9), pp593-600.

Midgley, R. S. Young, A. M. Ferry, D. R. and Kerr. D. J. (2000) In: McArdle, C. S. Kerr, D. J. and Boyle, P. (eds.) *Colorectal Cancer*. Oxford: Isis Medical Media, pp190.

Morris, E. J. A., Maughan, N. J., Forman, D., and Quirke, P. (2007) Who to treat with adjuvant therapy in Dukes B/ Stage II colorectal cancer? The need for high quality pathology. *Gut*. Vol. 56(10), pp1419-1425.

McDonnell, A., Nicholl, J. and Read, S. (2005) Exploring the impact of Acute Pain Teams (APT's) on patient outcomes using routine data. Can it be done? *Journal of Research in Nursing*. Vol. 10(4), pp383-402.

McMillan, D. C., Hole, D. J., and McArdle, C. S. (2008) The impact of old age on cancer-specific and non-cancer-related survival following elective potentially curative for Dukes A/B colorectal cancer. *British Journal of Cancer*. Vol. 99(7), pp1046-1049.

National Institute for Clinical Excellence (2004) *Guidance on Cancer Services: Improving Outcomes in Colorectal Cancer*. London: NICE.

NHS Quality Improvement Scotland (2008) *Clinical Standards – Management of bowel cancer services* [Internet] Available URL:

<http://www.nhshealthquality.org/nhsqis/4118.html> [Accessed 28th July 2010].

Norris, J. and Spelic, S. (2002) Supporting adapting to body image disruption. *Rehabilitation Nursing*. Vol. 27(1), pp8-13.

O'Connor, G. (2003) Discharge planning in rehabilitation following surgery for stoma. *British Journal of Nursing*. Vol. 12(13), pp800-807.

Porrett, T. and McGrath, A. (2005) *Stoma Care Nursing*. Oxford: Blackwell Science.

Petersen, V. C., Baxter, K. J. Love, S. B. and Shepherd, N. A. (2002) Identification of objective pathologies prognostic determinants and models of prognosis in Dukes' B colon cancer. *Gut*. Vol. 51(1), pp65-69.

<https://assignbuster.com/case-study-of-health-issues-for-older-adults/>

Quinn, F. M. (2000) Principles and Practice of Nurse Education. 4th Edn. Cheltenham: Nelson Thornes.

Readding, L. M. (2005) Hospital to home: smoothing the journey for the new ostomist. British Journal of Nursing. Vol. 14(16 Stoma Supplement), ppS16-19.

Rutten, H. J. T., den Dulk, M., Lemmens, V, E. P. P., van de Velde, C. J. H., and Marijnen, C. A. M. (2008) Controversies of total mesorectal excision for rectal cancer in elderly patients. The Lancet: Oncology. Vol. 9(), pp494-501.

Schiffmann, L. Ozean, S. Schwarz, F. Lange, J. Prall, F. and Klar, E. (2008) Colorectal cancer in the elderly- surgical treatment and long-term survival. International Journal of Colorectal Disease. Vol. 23(6), pp601-610.

Scottish Intercollegiate Guidelines Network (2003) Guideline 67: Management of Colorectal Cancer. Edinburgh: SIGN.

Sharma, B. Baxter, N. and Grantcharov. (2010) Outcomes after laparoscopic techniques in major gastrointestinal surgery. Current Opinion in Critical Care. Vol. 16(4), pp371-376.

Sobin, L. H., Gospodarowicz, M. and Wittekind, C. (eds.) (2010) TNM Classification of Malignant Tumours. 7th ed. Oxford: Blackwell Publishing Ltd.

The Association of Coloproctology of Great Britain and Ireland (2007) Guidelines for the Management of Colorectal Cancer. 3rd ed. [Internet] Available URL: [http://www.acpgbi.org.uk/assets/documents/COLO\\_guides.pdf](http://www.acpgbi.org.uk/assets/documents/COLO_guides.pdf) [Accessed 28th July 2010].

<https://assignbuster.com/case-study-of-health-issues-for-older-adults/>

Thorpe, G., McArthur, M. and Richardson, B. (2009) Bodily change following faecal stoma formation: qualitative interpretive synthesis. *Journal of Advanced Nursing*. Vol. 65(9), pp1778-1789.

Tulloch, A., How, C., Brent, M., Chapman, R., Burns, B., and Pomery, S-M. (2007) Admission and discharge practices: High Dependency Unit audit outcome. *Contemporary Nurse: a journal for the Australian Nursing Profession*. Vol. 24(1), pp15-24.

Visser, E. J. (2006) Chronic post-surgical pain: Epidemiology and clinical implications for acute pain management. *Acute pain*. Vol. 8(2), pp73-81.

White, C. (1998) Psychological management of stoma-related concerns. *Nursing Standard*. Vol. 12(36), pp35-38.

Williams, B., Poulter, N, R., Brown, M. J., Davis, M. McInnes, G, T., Potter, J. F., Sever, P. S. and Thom, S, M. (2004) Guidelines for the management of hypertension: report of the fourth working party of the British Hypertension Society, 2004- BHS IV. *Journal of Human Hypertension*. Vol. 18(3), pp139-185.

## **Bibliography**

Armstrong, E. (2001) Practical aspects of stoma care. *Nursing Times*. [Internet] Available URL: <http://www.nursingtimes.net/nursing-practice-clinical-research/practical-aspects-of-stoma-care/206160>. article (Accessed 12th July 2010).

Benner, P. (2001) *From Novice to Expert*. Commemorative Edn. New Jersey: Prentice-Hall.

<https://assignbuster.com/case-study-of-health-issues-for-older-adults/>

Borwell, B. (1997) Psychological considerations of stoma care nursing. *Nursing Standard*. Vol. 11(48) August, pp49-55.

Brown, H. and Randle, J. (2005) Living with a stoma: a review of the literature. *Journal of Clinical Nursing*. Vol. 14(1), pp74-81.

Burch, J. and Sica, J. (2008) Common peristomal skin problems and potential treatment options. *The British Journal of Nursing*. Vol. 17(17 Stoma Care Supplement), ppS4-S11.

NHS Quality Improvement Scotland (2008) Clinical Standards: Management of bowel cancer services. Edinburgh: QIS. Available URL : <http://www.nhshealthquality.org>.

Collett, K. (2002) Practical aspects of stoma management. *Nursing Standard*. Vol. 17(8) October, pp45-52.

Cronin, E. (2005) Best practice in discharging patients with a stoma. *Nursing Times*. [Internet] Available URL: <http://www.nursingtimes.net/nursing-practice-clinical-research/best-practice-in-discharging-patients-with-a-stoma/203531.article?sm=203531> (Accessed 12th December 2009).

Dewar, B. J., and Walker, E. (1999) Experiential learning: issues for supervision. *Journal of Advanced Nursing*. Vol. 30(6), pp1459-1467.

Dimond, B. (2006) Generalist and specialist nurses: caring for a patient with a stoma. *British Journal of Nursing*. Vol. 15(14), pp769-770.

Eschrich, S. et al. (2005) Molecular Dtaging for Survival Prediction of Colorectal Cancer Patients. *Journal of Clinical Oncology*. Vol. 23(15), pp3526-3535.

Fellows, J. (2009) Ostomy: general principles of management and patient teaching. *Journal of Wound Ostomy and Continence Nursing*. Vol. 36(2), pp200-201.

Fulham, J. (2008) A guide to caring for patients with a newly formed stoma in the acute hospital setting. *Gastrointestinal nursing*. Vol. 6(8), pp14-23.

Haugen, V., Bliss, D. Z. and Savik, K. (2006) Perioperative factors that affect long-term adjustment to an incontinent ostomy. *The Journal of Wound, Ostomy and Continence Nursing*. Vol. 33(5), pp525-535.

Hawkins, J. and Hollinworth, H. (2003) Living theory: Enhancing the psychological support of patients. *British Journal of Nursing*. Vol. 12(9), pp543-548.

Hyland, J. (2002) The Basics of Ostomies. *Gastroenterology Nursing*. Vol. 25(6) November/December, pp241-244.

Knox, M., Myers, E., Wilson, I., and Hurley, M. (2009) The impact of pre-operative assessment clinics on elective surgical case cancellations. *Surgeon*. Vol. 7(2), pp76-78.

Lee, J., Moore, H. and Asbury, N. (2008) Meeting the challenges: delivering interactive stoma care education. *British Journal of Community Nursing*. Vol. 13(4) April, pp154-159.

Lisbon, A. (2003) Dopexamine, Dobutamine, and Dopamine Increase Splanchnic Blood Flow: What is the Evidence? Chest. Vol. 123(5), supplement, pp460S- 463S.

Law, W. L. et al. (2006) Laparoscopic and Open Anterior Resection for Upper and Mid Rectal Cancer: An Evaluation of Outcomes. Diseases of the Colon & Rectum. Vol. 49(8), pp1108-1115.

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