

Administration of colonoscopy reflective account



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This essay aims to provide a reflective account of the author's personal and professional experience of a patient being admitted for a colonoscopy. To achieve this, a model of reflection will be used and a rationale provided to support this choice.

The main point of discussion is communication and advocacy. Advocacy is central to communication and part of a caring nurse-client relationship (Arnold & Boggs, 2003). The author as a newly appointed nurse on the Endoscopy Unit, will reflect upon how they could have been a better advocate for the patient in question. Ethical and legal issues will be examined. Finally implications for practice will be discussed.

Using a model of reflection allows the nurse to re-appraise the care they have delivered to a patient/client and in doing so can evaluate the effectiveness of that care (Basford & Slevin 1995), thus with the intention of influencing future practice for the better. Before starting the reflection process it will be more helpful for the professional to have a guideline or framework from which to work from (Palmer, Burns and Bulman 1994). Palmer et al (1994) view the process as something that is dynamic and they advise a cyclical style model using questions to provide a format for reflection. It is for these reasons that the Gibbs Reflective Cycle has been chosen (Gibbs 1998) for this essay.

In accordance with the Nursing and Midwifery Council standards on respecting confidentiality in practice, all names and locations have been made anonymous (NMC 2008). As this is a reflective essay the author will refer to herself as " I " where appropriate.

The reflective cycle is divided into six sections each with their own key questions. These are:

Description: What happened?

Feeling: What were you thinking and feeling?

Evaluation: What was good or bad about this experience?

Analysis: What sense can you make of the situation?

Conclusion: What else could you have done?

Action Plan: If it arose again what would you do?

(Gibbs 1998)

These areas for reflection provide the main topics for the rest of this assignment. When the practitioner has developed an action plan they can then return to the beginning of the cycle with the extra knowledge they have obtained from the first reflective experience (Gibbs 1998). It is here though with the description of the incident that the reflective cycle will begin.

The following situation led me to question my actions when admitting a patient for a colonoscopy.

The patient a 43 year-old male was referred for a colonoscopy by his GP following a three-week history of fresh rectal bleeding, anal itching (pruritus ani) and a change in bowel habit. Two weeks prior to the scheduled test, a pack containing a letter of appointment was sent to the patient by the endoscopy administration staff. Enclosed were two sachets of Picolax bowel
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preparation, full instructions for usage, highlighting the need to follow instructions precisely to ensure clarity of view and aid diagnostic accuracy. Included with this pack was a pre-endoscopy questionnaire to enable the nurse to assess the patient's general state of health and identify any potential risk factors or complications, which may arise.

A booklet was in this pack explaining the procedure, reasons for the test, complications and risks and what to expect during the test. The booklet stated other available investigations in order that he could make an informed decision and enable him to give informed consent for the test to go ahead. The Nursing and Midwifery Council (NMC) (2008) state that before any treatment or care is given to the patient, consent must be obtained. The BSG (2008) warn that consent issues are a major source of problems, sometimes leading to both complaints and litigation throughout the NHS. Therefore valid and robust consenting is now a required standard for the Endoscopy Global Rating Scale (GRS, 2009) which is a tool that enables endoscopy units to assess how well they provide a patient-centred service. Information in the booklet covered the option of sedation and the need for appropriate after-care. A consent form was enclosed for him to sign at home, providing the patient had read, understood and agreed to under-go the procedure.

A morning appointment was made for the patient and he arrived at the unit by himself. He was greeted by myself, I checked his personal details. This is in accordance with the BSG (2008) guidance for obtaining a valid consent for elective endoscopic procedures as it states that identity checks at key stages in the procedure are essential as some patients have even been known to undergo procedures intended for another due to loss of autonomy and

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anxiety which can result when entering the hospital. When this information was confirmed he was made to feel comfortable in the preparation room.

The patient was clearly anxious. He was looking down a lot and he had his arms folded. He spoke very quickly and with a quiver in his voice one of the first things he said to me was, " please knock me out for this". I explained to the patient that although we could give him some sedation which would make him feel more relaxed, he would still be awake as it would be unsafe to " knock him out" for the test. The sedation used for all endoscopic procedures is " conscious sedation". This has been defined as:

" A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drug and techniques used to provide conscious sedation should carry a margin of safety wide enough to render loss of consciousness unlikely". BSG (2003, p3).

He explained that he saw on the consent form that sedation would be offered and he interpreted this to be a general anaesthetic. I further explained to him that although the patient may feel sleepy, he would be conscious throughout the test and he would be able to talk to us. Cotton and Williams (2003) agree, believing that the desired effect of the sedation on the patient is sleepy, relaxed but rouse able. The patient clearly expressed a preference for sedation and it was established that the patient's wife could collect him after his procedure and would remain with him over the next 24 hours. It is a requirement that any patient undergoing a procedure with sedation should

be accompanied home by a responsible adult who will remain with them for 24 hours as sedative effects are known to remain in the body system for up to this period of time (Royal College of Surgeons, 1993).

At this point, I as a newly appointed staff nurse on the unit was unsure whether the consent form that the patient had signed was valid as he originally thought that he was going to have a general anaesthetic when he had signed the form. I had been trained in taking consent which is documented in my e-portfolio as regards the national GIN training programme (Gastrointestinal in Nursing Training Programme), but was unsure what to do in this instance as I had never experienced the situation before. My initial thought was that it was not valid as the patient had a different perception of the test. I explained to the patient that I was just going to get some advice from my colleague (who had worked in the endoscopy unit for several years) as regards the validity of his consent form. I said that I would need to explain the situation to my colleague and he agreed to this joking that we did not both want to get into trouble from the headmaster and get a detention. I said that I would only be a couple of minutes and left the room to find advice.

I explained the situation to the nurse who was sat in recovery. The nurse said that the Endoscopist performing the procedure would go over consent again in the procedure room and not to worry about it. I expressed concern at this because I knew that consent must never be obtained in the procedure room. Guidelines readily available in relation to consent include British Society of Gastroenterology guidelines (BSG) (2008) and the Joint Advisory Group Guidelines (JAG) (2001). Both agree that consent should not be taken

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in the procedure room. Guidance on good practice in consent implies that all patients must have had adequate time to absorb and reflect upon new information. This is not achieved if consent is obtained at the last possible moment which is in the procedure room itself.

The nurse was dismissive and made unpleasant comments regarding men in general. There was a short distance between the nurse and the preparation room where the patient was so it is likely that the patient heard her remarks. I did not comment at this time even though I felt her remarks to be inappropriate. Luckily this gentleman was the first patient on the morning's list and as such, no other patients were in recovery to hear the comments. The nurse picked up the patient's notes and knocked on the preparation room door. I thought that I had better observe too as the nurse looked ready for a challenge.

The nurse was very brusque in manner and asked the patient if he had read the booklet which the unit has sent out for the test and the section regarding sedation. The patient said that he had read the booklet and indeed the section regarding sedation but there was no mention that he would be awake after he had been given the sedative and assumed therefore that he would be asleep. The nurse then got a copy of the booklet. As she was flicking through trying to find the page with the relevant sedation information on, she said "it clearly states in the booklet that if sedation is given, the patient will be awake throughout the test". However, when she got to the page regarding sedation there was no mention of this. It just stated that sedation would be offered prior to the colonoscopy but if the patient decided to have sedation that it was essential that someone was

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available to stay escort the patient home and stay with them overnight. The nurse went bright red, but did not apologise to the patient and said that she was going to “ have words” with the administration staff and left the procedure room.

I felt guilty that I had not challenged the nurse regarding her rude manner with the patient at the time but felt intimidated and unable to voice my opinion, I also felt I had failed in my duty of care. I thought that the nurse had made a big deal when there was no need. I apologised unreservedly for my colleague’s attitude and said that I would take steps to make sure that the booklet was clearer. I then realised that my original question regarding the consent form had not even been answered. I asked the patient if it was okay if I asked another colleague their opinion. The patient said yes but “ not that do-lally nurse” and said that he would be making a complaint regarding her attitude. I then found the endoscopist who was actually going to be undertaking the patient’s test and asked them about the consent issue. They said that the consent form was fine as long as I reiterated that the patient would be awake and that they fully understood the test. The Endoscopist said that they would discuss the consent form with the patient again prior to the procedure as this is normal practice.

I went back into the preparation room and said that the consent form was not a problem and that we would discuss it further. I spoke to the patient in a reassuring way, trying to compensate from his previous treatment from my colleague. I asked the patient if he understood the test he was about to have and its related risks. When I felt like the patient had a clear understanding of the procedure I asked him if he had any questions regarding the procedure,

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the patient replied he had no further questions. He added that he was even more nervous now after the experience with the nurse but just wanted it to be over as quickly as possible. I began to explain the procedure that he was going to undergo and asked if he knew why the GP had referred him for this procedure and relayed the benefits of viewing the bowel in this way. The patient was happy that a diagnosis might be forthcoming from this test. I then reiterated the possible risks of the procedure to the patient explaining that they were rare but never the less very real. The patient said that he understood the risks involved but wanted to go ahead with the test to obtain a diagnosis of his problems.

I stated that if the patient was going to have sedation, then he should not drive or operate any machinery and should not sign any legally binding documents as the side effects from the sedation would still affect him for twenty four hours. I explained that the endoscopist would endeavour to complete the investigation however, if complications were to occur such as patient distress or poor bowel prep that the test would be abandoned. During a Gastrointestinal Endoscopy and Related Procedures Course at The University of Sheffield (Feb 2010, SNM 2215/3232) it was suggested that the guideline for informed consent was signified by the acronym EMBRACE, Explanation of the procedure, Motive for the procedure, Benefits, Risks, Alternatives, Complications and side Effects of the procedure. I believe that these guidelines were fully complied.

Following the taking of a medical history and completion of a further in-depth health check questionnaire to ascertain any condition or reason to which sedation would be contraindicated such as elderly patients who may have

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significant co-morbidity and even in younger patients, the presence of heart disease, cerebrovascular disease, lung disease, liver failure, anaemia, shock and morbid obesity (BSG, 2003). It became evident that sedation would be an option. I explained to the patient that a nurse would be with him continuously throughout the procedure and would encourage him to breathe through any discomfort he may feel, or to push some of the air out of his bottom to relieve any pain. The patient's blood pressure, pulse and saturations were taken and all were within acceptable limits. This provides a good baseline of the patient's observations for the procedure itself and can determine any changes that may occur as a result of the cardio or respiratory depression that may be induced by sedation. Pascarelli (1996) states that during the procedure, the nurse's primary responsibility is to monitor the patient's vital signs along with communication with the endoscopist, administration of medications and emotional support to the patient. Clarke (1994) warns that patients who undergo invasive procedures are usually anxious and their vital signs are commonly elevated however the sedation lessens the anxiety, and all of the vital signs decrease therapeutically to that patient's resting level.

The sedation of choice in my workplace is intravenous Midazolam. Midazolam is a benzodiazepine reputedly well suited for use in endoscopy. It has an amnesic affect causing a reduction in memory recall. Clarke (1994) agrees saying that the goal of IV conscious sedation is some degree of amnesia. Patients will occasionally remember some parts for example, the initial introduction of the colonoscope. It is for this reason clear written discharge instructions are given to the patient prior to discharge, with a contact

telephone number in the event of any problems and this was explained to the patient. Sedation may be indicated for many reasons. In the main these may include allaying of fears regarding a procedure, and aims to facilitate compliance with repeat procedures as a result of the amnesic affects induced. In many cases it assures co-operation and eases difficulties for the endoscopist and generally provides a rapid, safe return to the normal activities of daily living.

The patient was asked to undress from the waist down and to put on the gown provided. When the patient was ready he was taken by myself into the procedure room and introduced to the endoscopist and the appointed staff nurses where the issues of consent and sedation would once more be discussed with the patient as it is the endoscopist's ultimate responsibility.

Throughout the experience, I felt that several important issues had been highlighted. One issue is that of the booklet that is sent out to the patients prior to the test. I believe that individual patient's perspectives regarding the effects of sedation may vary greatly, from a mild sedative to a general anaesthetic. I conclude this to result from the individual interpretation of patient information received and relatives and friends giving a distorted image of their own experience due to the amnesic affect of the sedation. I would advocate good effective communication skills are paramount in allaying misconceptions and fears and the giving of a realistic overview is therefore essential.

It was clear that there needed to be some improvement of the explanation of conscious sedation as I felt that is merely skimmed the surface explaining

that the option of sedation was there and that there needed to be someone to escort the patient home and stay with them overnight. I felt that it needed to be clearer in the fact that it needs to mention that the patient will not actually be anaesthetised and furthermore that amnesia is a common side effect from the sedation given. This has subsequently been mentioned to the ward sister and the booklet has been updated to clarify conscious sedation.

Perhaps one of the most obvious issues is that of the attitude of the other nurse. The BSG (2008) state that the patient must not be put under any pressure and have sufficient time to digest the information in order for consent to be valid. I felt that the attitude of the nurse in question did put pressure on the patient and caused further anxiety for the patient. I felt that the nurse spoke to the patient in a degrading way and showed a lack of professionalism. The Nursing and Midwifery Council (NMC 2008) state that nurses must treat people as individuals and respect their dignity, must not discriminate and must treat people kindly and considerately. This was not the case in the above example.

The Equality and Human Rights Commission (2008) state that no matter your circumstances you should always be treated fairly and with respect when using healthcare services. The Department of Health (2008) cite the UK Human Rights Act in their guidelines about human rights in healthcare when they state that people have an absolute right not to be treated in a degrading way. This means that it is unlawful for the NHS organisations to act in a way that is incompatible with the human rights act. Endoscopy nurses and indeed all NHS staff should be thinking about their practice and how their response to a situation may impact on a patient or client's human

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rights. If the patient had chosen to complain (as he said he was going to do) about the nurse's attitude towards him, then the nurse may have well been in trouble.

This experience has made me question my future practice as a registered nurse and how I would deal with a similar situation. Arnold and Boggs (2003) suggest that an advocate is someone who speaks out; supporting a person so that their views are heard and their rights are upheld, with the sole purpose of maximising the patient's health. I was not assertive as I did not defend the patient and therefore did not fulfil my duty of care by becoming an advocate for the patient, ensuring he was treated with dignity and respect. I was worried about what may happen if I challenged the nurse's practice. I need to develop my assertiveness and be able to communicate confidently and effectively with both patients and health care professionals. It is quite easy for a nurse to be an advocate for the patient when there is no stress involved but it can be quite difficult when it goes against other health professionals (Kendrick 1994). In this instance there was a conflict between the patient's best interest and my fear of challenging the nurse. If I had been a more experienced nurse on the endoscopy unit and known the nurse involved in this situation better, I think I may have been able to foresee her reaction to the patient and perhaps may not have approached this particular nurse or used my communication skills together with advocacy to diffuse the situation.

Gates (1994) states advocacy is one of the main responsibilities nurses have; it is part of communicating on behalf of the patient and/or their families, acting as a mediator to express their needs and experiences. In health care,
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communication is fundamental to promoting the safe and effective care of patients. The Department of Health Knowledge and Skills Framework (KSF) (DoH 2004) is a competence framework to support professional development and career progression through the NHS and is about lifelong learning. It has core dimensions essential to providing quality care. Core dimension 1 (level 4) is concerned with communication. It states that the purpose of communication may include 'advocating on behalf of others'. In order for me to progress as a nurse on the endoscopy unit I need to be familiar with and work within the KSF and other guidelines.

On reflection, I feel that I did communicate with the patient well. Smith (1995) proposes that reflection does not necessarily entail an incident that was dramatic or negative; it could easily be something positive that a person finds they obtain valuable learning experience from. Communication with the patient has to be one of the most important aspects of nursing care. An integral part of this process is the way a nurse should use and understand body language (Wilkinson 1991). It is as vital a part of the communication process as speaking and should be treated as such. Body language can convey all human emotions either consciously or not and can show a person's true feelings regardless of what they have said (Pease 1984). I could tell by the way that the patient was communicating non-verbally that he was anxious. His facial expressions and posture showed the classic signs of someone being anxious (Teasdale 1995). Seeing this, perhaps I should have explained to the nurse beforehand that the patient was anxious so that she may have acted with a bit more respect towards the patient. It is clear that

good clear communication skills can improve patient satisfaction and compliance, thus reducing anxiety.

I believe that during the admitting process with the patient I did actively discuss the procedure with the patient. I felt that I gave the patient opportunity to ask questions and allay any fears he was harbouring. I sat beside the patient and spoke to him about the procedure in an informal and pleasant manner, giving him opportunity to voice any concerns that he had. I believe that the patient is at their most vulnerable and anxious upon entering the endoscopy unit and some encouraging reassurance makes the patient's experience less of an ordeal. It is my opinion that an assessment of a patient's personality and level of understanding regarding consent and sedation enables the development of a communication strategy accordingly thus providing a sound knowledge of the test, sedation offered and therefore informed consent.

This essay has allowed me to reflect upon my own practice and how I should have acted differently by standing up for the patient at the time, not allowing my own lack of confidence to prevent this. I understand that the care of the patient is my first concern and that I must work with others as a team to protect and promote the health and wellbeing of those in my care (NMC 2008). Perhaps with this understanding, I will be less anxious about feeling inferior around other professionals. I will articulate my professional judgement given a similar situation, using what I have been taught which is the best evidence based practice to rationalise my reasons for questioning their practice. I will aim to develop my assertiveness (as I realise that assertiveness does not come naturally to me) to speak out in the interests of

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the patient, whatever the situation. I will develop my ability to communicate with both patients and other professionals to offer them the opportunity to rationalise their own care delivery and reflect upon it. I believe these actions will enhance my professionalism and promote best practice, in the interest of the patient.

I had chosen to focus on communication and advocacy as these are areas in which I feel I need to work on. Gibbs (1998) reflective cycle was used in this assignment because it is a familiar tool that I have found to be useful and uncomplicated. Learning from an experience and then reflecting on that experience is an excellent way of improving the skills in my chosen profession (Kolb 1984). From my own personal point of view, I went into this assignment with some degree of emotional imbalance for the fact that I did not speak out for the patient but now I feel that I have gained in several areas. I feel my reflective skills have increased and with it my confidence regarding tackling such situations again. Also I feel more relaxed with the idea of reflecting uncomfortable incidences because I can see the benefits in doing so.