

The renal unit at mater dei hospital nursing essay

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INTRODUCTION In this assignment I am going to discuss end stage renal disease, ESRD. I will be going through the pathophysiology of the illness and the psychosocial implications that this condition may bring about. My essay will include patient's experiences that I have witnessed on the Renal Unit at Mater Dei Hospital. The kidneys are bean-shaped organs, each about the size of a fist. They are located near the middle of the back, just below the rib cage, one on each side of the spine. The kidneys are responsible for the filtration of blood from extra water and waste products from metabolic reactions in the body, which is later excreted as urine after being stored in the bladder. They also help to keep the right balance of electrolytes in the bloodstream necessary for life. Moreover, the kidneys release three hormones, namely erythropoietin, renin and calcitriol. Erythropoietin (EPO) stimulates erythropoiesis which is the production of red blood cells from the red bone marrow. The function of renin is to control blood pressure. Calcitriol helps to maintain a normal chemical balance and promotes calcium reuptake to enrich the supply for bones. Renal failure can happen in either acute or chronic ways. In both cases damage will be done to the nephrons making them lose their filtering capacity. In the majority cases both kidneys are affected concurrently. The acute renal failure or acute kidney injury is most often a result of an acute blood loss, like an accident, or poisoning episode, which could be even a side effect of some drugs. This type of renal failure can be reversed if no serious damage is suffered from the kidney. On the other hand, chronic renal insufficiency or chronic kidney disease is brought about gradually from underlying conditions like diabetes, hypertension or other inherited diseases. Hyperglycaemia, which is a consequence of

Diabetes Miletus, damages the small blood vessels in the nephrons by becoming narrower or even clogged with the high blood-glucose level, therefore reducing ultrafiltration of blood through the kidney. Similarly, hypertension will damage these same blood vessels due to the excessive flow of blood. The result of these conditions will only be evident after years, when an irreversible nephropathy is developed and kidney function is then ceased, leading to ESRD. If untreated this condition leads to uraemia, which is the retention of extra water and waste products in the bloodstream, which in turn if severely untreated can lead to seizures, coma and eventually death. These individuals can only recur to Peritoneal Dialysis, Haemodialysis or Kidney transplantation. These chronically ill persons and their families are evidently psychologically and socially affected due to their actual condition and its treatment; therefore care must not only focus on primary physical interventions, but also on the psychosocial impact of the on daily life. These may include a mixture of emotion, self-esteem, lifestyle, personal values, socio-cultural beliefs, and sexual function. Generally one of these implications would lead to the other. BODYThe above listed psychosocial implications will be looked in further detail using Howard Leventhal's Common Sense Model, where the patient is an active participant in the health care process (Leventhal et al, 1984). Illness perceptions are created by the patient, thus when a symptom is felt, the patient will try to give this threat a label. This identity is given through the patient's own belief, using the symmetry rule that for every symptom there is a name. As the name of the model suggests, the patient will try using common sense to think about and interpret a symptom, triggered through emotional and cognitive

processing. Then conclusions are made upon these interpretations and more complex emotions will be summoned. These illness perceptions are affected by the patient's socio-cultural background and media influence, thus making these dimensions unique. An ESRD patient will often be emotionally challenged, not only by the illness itself but also by its treatment. This is mainly characterized by the fear of the unknown, concerning any complications or progression of the illness. However, this emotion theme besides fear also deals with the altered body image, leading to anger, grief and subsequently depression. These are all issues that will challenge the patient in accepting the reality of his life with a chronic illness, the adherence to the necessary treatment and changes in lifestyle like diet and fluid intake restrictions. Dialysis treatment is a tough fragment of this disease; it requires the patient to have a catheter implanted in the abdominal region for peritoneal dialysis (PD), or otherwise, a tunnelled central venous line, AV fistula or AV graft for haemodialysis (HD). PD gives the benefit that the patient can have his treatment done at home, thus avoiding those extensive four hour hospital visits, usually three to four times a week which is necessary for HD. Obviously this comes at a price being the increased risk of the 'infamous' peritonitis which a substantial number of patients experience at some point in time during their treatment. This infection usually occurs due to the lack of asepsis during treatment at home. Apart from this fear of infection, patients on PD have to live with altered body image leading to lowered self-esteem, diminishing of personal values and sexuality function issues. These are brought about by the hanging catheter from the patient's flank and the enlarged abdominal girth due to

the dialysate in the peritoneal cavity, which is usually an extra one and half to two litres of extra fluid, replacing the kidney function. On the other hand, HD diminishes some of these issues, since an AV fistula or graft would definitely do less impact especially during any intimate moments. An additional advantage is the risk reduction of acquiring an infection, as the handling is all done by nurses at the Renal Unit who make sure to be always aseptic as possible. Moreover, blood samples are taken regularly to monitor any abnormalities. The worst part of this type of treatment is usually the extensive changes in the patient's regular pattern of daily life. During my experience on the Renal Unit, a patient shared his experience about what he went through since the onset of his illness. As a young, courageous man he attempted all the possible managements for renal failure. He exclaimed that PD made his life horrendous, because although it gives you the ability to do your treatment at home, it requires a continuous treatment with restrictive timings that require comprehensive adherence. The patient still managed to do a year and a half in this lifestyle although going through a series of infection episodes. Later on he had to opt for HD, and while he defines it as a burden, it does not affect him anymore since it became part of his routine which has been going on for seven years. He only had a short interrupting period, where he had a kidney transplantation, which unfortunately only survived for six months, as the same autoimmune disease that destroyed his original kidneys managed to damage the transplanted one as well.

Depression is naturally occurring in these examples of life situations. In this patient's opinion when you are trying to do anything possible to treat the condition and live with it, you always hope for the best, but when you seem

to be rowing against currents you can't beat, there's a good chance that unless you find good support from relatives, workmates and medical/nursing staff, you will go down as well. It is a bio-psychosocial adaptation that a patient does. Grief is usually more present before this adaptation where in those weak moments, patients will start remembering themselves prior to their current health situation, leading to depressive states, which can result in the lack of adherence to treatment. Accepting the illness and adhering to treatment is recognition that the uninvited is here to stay, additionally bringing about a self-esteem challenge. The patient's ideals of worth may be reduced due to more dependency on others. A patient who prior to the illness considered himself as the family leader or was the major breadwinner in the family, now has to face economic problems due to substantial reduction of working hours or even quitting his job. Therefore roles in the family have to be inverted as the patient is now more dependent on his family members, affecting also his self-esteem. Different illness perceptions based on the patient's socio-cultural beliefs challenge the acceptance and adherence to treatment. For instance, a patient who believes that any treatment regarding his health should be done by a professional won't adhere to home-based self-care of PD, or a patient may believe that any changes in his diet won't be beneficial for his condition. These all will vary depending from ethnic groups, countries or even families. In the light of these issues, a nurse should consider avoiding these sensitivities and plan care keeping in mind the patient's background while still focusing on optimal treatment. Therefore the nurse should analyse the patient's needs and through establishment of a high quality nurse-patient relationship, provides

advice and reaches a compromise for care plan. During the course of the illness and treatment, numerous changes will happen in and out of the patient's body. These changes will definitely make the patient going through a rough sexual devaluation time as sexual performance will be affected, namely by organic, psychosocial and physical responses. Hormones levels will be affected, as well as self-esteem from altered body image and role changes. A complex of these responses will lead to sexual dysfunction. A patient should be made aware that help is available by the nurse, preferably prior to the onset of severe sexual issues and referral to sex therapist should be considered when needed. This should aim to improve sexual strategies and sexual function, reducing the frustrations of both partner and patient, leading to reduction of negativity brought about by the illness and helping the sufferers maintain a decent quality of life.

CONCLUSION In the discussion it was observed that chronic illnesses, like ESRD, bring about a radical change to anyone's life including the sufferer's relatives. There is a whole rollercoaster ride of emotion challenges leading to several self-esteem and personal values implications that can easily devastate an unsupported patient's life. Lifestyle changes necessary for a renal failure patient may seem to be a one-way trip to losing one's quality of life, but eventually through a strong network of support both from the healthcare professionals and family, these negative effects may be drastically reduced, and help the patient retain a decent level of integrity. Nurses are responsible in developing an intense nurse-patient relationship to understand any challenges the patient is going through and identify what changes can be done to improve quality of life during treatment. A patient may seek

education himself, as some may find refuge in being knowledgeable about their condition, therefore a nurse needs to help the patient get the valid information needed and discuss any eventual problems to build a better unique care plan around the patient's beliefs. A nurse should explain the importance of the patient's role in promoting or deteriorating his/her well-being to avoid any unnecessary complications. Access to different treatment regimens and any further professionals that the patient throughout his life with a chronic illness may need should be offered by the nurse to help promote the patient's quality of life, reducing the ill effects of chronicity. The inclusion of relatives in the chronic patient's care plan is undeniably important, as they need to become more understanding of what the patient is going through and will see and monitor a series of changes in a patient and may feel lost and helpless if uninvolved. To conclude, only with a good communication between the nurse and the patient, a lot of negative consequences can be avoided or at least prepared for to reduce the negative impact. A nurse should make the patient feel comfortable to bring about his concerns and encourage seeking advice to adapt and adhere to the necessary changes. Only with repetitive input and guidance a patient will manage to feel in control over his illness, improving his coping mechanisms and quality of life.