

Palliative care - clinical experience



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Introduction

The purpose of this assignment is to reflect on a clinical experience in palliative care and demonstrate the knowledge and skills associated with this. The symptoms, symptom management and government guidelines and standards will also be discussed in relation to how this will impact the care of the patients who are experiencing life threatening illnesses. This will be achieved through using Gibbs (1988) model of reflection. I chose this model of reflection because it is clear and cyclical model which allows the reflector to revisit the same problem and also to examine my practice which will help me to develop and improve in the future.

Description

As an adult nursing student, I will be reflecting on an experience with a patient who was receiving palliative care that I encountered during my community placement. The patient received palliative care and required management of symptoms to help maintain their quality of life for the patient and their family. This involved a patient, who will be named Mr. Jones for confidentiality reasons. Mr. Jones was an elderly patient who had been diagnosed with bowel cancer along with liver metastases, the cancer was in the advanced stages. Mr. Jones was being cared for at home by his wife and carers who visited him at home twice a day to help with getting him up, washing and dressing and helping him back to bed. The district nursing team also visited him on a regular basis. When meeting with the patient his main concern was his pain control and available options which he would be able to receive to manage this.

Feelings

Initially when I heard about the diagnosis I was intrigued and wanted to find out more about the patient and their condition. When I met the patient I felt sympathetic towards him and the family and upon discussion he revealed that he felt like 'giving up' and 'ending it all'. A mixture of thoughts entered my mind, although I could understand why he would want to give up, the only reason was because he was worried about the pain he was starting to experience. When the nurse and I discussed the pain control options he appeared to be more positive about the situation and apologized for what he had said. On reflection it was a positive experience as it allowed me to see how people cope differently with terminal conditions, and the impact it has on the family and carers

Evaluation

During this experience I thought that the nursing team had built a good professional relationship with the patient and their family. The patient had plenty of time to discuss any concerns or issues that he had. The issues discussed such as symptom management were all assessed and prioritized well; how the patient is feeling is important and needs to be taken into consideration. This would also need to be discussed with his wife alone, to find out how she is feeling and to offer her support. When discussed further, the feelings of 'giving up' related to his pain management. This is why the Visual Analogue Scale was used for a couple of weeks to monitor the progression of his pain (Crichton 2001). I found the tool to be beneficial for effective management of pain because it was a good indicator as to when we would need to adjust his analgesia using the World Health Organization (WHO) analgesic ladder (WHO, 2004). This aims to give the correct drug, <https://assignbuster.com/palliative-care-clinical-experience-essay-samples/>

correct dose, given at the correct time and proves to be inexpensive and 80-90% effective (WHO, 2004). This ensured the patient was in the least amount of pain which enabled them to carry on with activities of daily living.

Analysis

The World Health Organization (2009) has defined palliative care as: “ an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems such as physical, psychosocial and spiritual.” Caring for those receiving palliative care in the community during the end stages of life requires an extraordinary commitment from the nursing team, not only human resource but also competence, compassion and focus in anticipating the needs of the patient and family. It is a complex activity involving a holistic approach, building relationships together with expert professional skills and decision making processes (Melvin 2003). As well as pain, other common symptoms during advanced cancer are nausea and vomiting, with rates ranging from 50-60% (Kearney and Richardson, 2006). It is important to treat the reversible causes of nausea and vomiting before resorting to antiemetics. This can be achieved by appropriate assessment and documentation of symptoms which evaluate the effect of treatment given and can be completed and reviewed quickly to utilize less patient energy and nursing time (Kearney and Richardson, 2006). Cancer patients also experience psychological or affective symptoms of fatigue which include lack of energy and motivation, depression, sadness and anxiety, the sense of willpower and ‘ fighting spirit’ is often lacking and

personal resources that have usually kept a person going in the past are ineffective (Juenger, 2002). Fatigue can take away the ability to do things that the patient and family want to do or need to do. The control over life events reduces, further affecting the person's quality of life. An essential part of nursing care for fatigue includes returning some of that control (Porock 2003). Giving information can be a positive way to do this. Nurses can explain that the person is not alone in the experience as fatigue is an expected occurrence in advanced cancer and discuss the causes of fatigue, effects and side effects of treatment and the impact of stress and depression, this will help the patient to manage the fatigue more effectively (Porock 2003). Mr. Jones was prescribed oral slow-release Morphine Sulphate for his pain, however he was beginning to experience break through pain, nausea and vomiting which was making it difficult for him to take his morphine. We suggested he kept a record of his pain over a couple of weeks using a visual analogue scale (VAS). When we visited him again we were able to use the VAS to assess his pain and make changes to analgesia as appropriate using the analgesic ladder (see appendix). From the assessment it was appropriate to increase his analgesia to step 3 of the analgesic ladder (WHO, 2004). A syringe driver was prescribed to administer morphine and an antiemetic over a 24 hour period which could be increased or decreased as required. Providing drug compatibilities have been checked, a combination of three drugs can usually be administered safely with the advantage that vomiting will not affect absorption, as it is given subcutaneously and the gut is not involved (Thompson, 2004). Although using a syringe driver improves symptom management with minimal inconvenience, complications can arise and nurses should be able to recognize these quickly and solve the problems

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efficiently (Lugton, 2002). The disadvantages of using this equipment is the painful injection site, infection risks and infusion rate problems (Thompson, 2004).

Mr. Jones commented on 'giving up' and after further discussion, we found this related to his pain. Evidence shows that there is a link between chronic pain and depression as they share similar physiological pathways, whilst social and psychological factors appear to affect the severity of it and when they co-exist the severity of both conditions appears to worsen (Gray, 2001). Ineffective management of psychiatric disorders can be caused by failure to recognize, diagnose and treat appropriately in palliative care settings with 50% of psychiatric disorders being undetected (Payne et al, 2007). Patients with cancer should have access to appropriate psychological support and should be assessed regularly by trained professionals as recommended by National Institute for Clinical Excellence (NICE, 2004). Many people may wish to try complementary and alternative medicines to improve symptoms of their cancer, the reason being many feel dissatisfied with conventional medicine and feel the desire to experience holistic health care for symptomatic relief with a sense of well being (Nayak et al 2003). Auricular acupuncture (acupuncture to the ear), therapeutic touch, and hypnosis may help to manage cancer pain, whilst music therapy, massage, and hypnosis may have an effect on anxiety, and both acupuncture and massage may have a therapeutic role in cancer fatigue (Mansky and Wallerstedt 2006). However there is a lack of evidence to support that complementary and alternative medicine treatments are effective, the risks associated with them are unknown and can potentially be harmful. There has been increasing

concern with the use of botanicals and dietary supplements by cancer patients because of the potential interaction between them and prescription drugs (Mansky and Wallerstedt 2006). During this experience, I realised just how important communication is, not only in this situation, but any situation that includes the patient, relatives, carers and multi-disciplinary team.

Communication is an essential part of good nursing practice and forms the basis for building a trusting relationship that will greatly improve care and help to reduce anxiety and stress for patients, their relatives and carers (NMC 2008). Groogan (1999) acknowledges that communication is not something that people do one another, but it is a process in which they can create a relationship by interacting with each other. From Mr. Jones' perspective, patient-focused communication can be the most important aspect of treatment, due to its capacity to exacerbate or relieve the fear that often accompanies cancer, with evidence of effective communication resulting in decreased anxiety, greater coping ability and adherence to treatment (Dickson 1999). Communication can be divided into three types; cognitive, emotional and spiritual. Cognitive communication involves the giving and receiving of information, emotional communication involves the feeling and expression of psychological responses and spiritual communication involves the expression and feeling of thoughts relating to existing issues beyond the person (Fallowfield & Jenkins 1999). When speaking with Mr. Jones and his family the language used was clear and easy to understand. Stress, emotions and fatigue that accompany a terminal illness make it necessary for the information to be repeated to ensure the patient and family have absorbed it and feel reassured (Latimer 2000). Mr. Jones was given enough time to discuss his concerns and issues without

feeling like he had a limited period or that the nurses had many other patients to see, however, what often matters is the quality of interaction rather than the length of time. Giving a few moments of time which are totally focused on the patient's communication needs can often limit the amount of time spent communicating later when further explanation or clarification is needed (Faull et al, 2005). Mallet and Dougherty (2000) suggested that patients tend to be more dissatisfied with poor communication than with any other aspect of their care and concluded ineffective communication continues to be a major issue in health care. The Department of Health has produced the End of Life Care Strategy (DoH 2008) which promotes high quality care for all adults at the end of life which is the first for the United Kingdom and covers adults in England. Its aim is to provide people approaching the end of life with more choice about where they would like to live and die. In addition, the Macmillan Gold Standards Framework (2003) is another way of combining many different practices. The framework includes 7 Gold Standards which relate to key aspects of care, and guidelines for best practice on teamwork and continuity of care, advanced planning, symptom control and support for patients and their carers. Primary Health Care Teams who join the programme are guided and supported through a combination of workshops, resource materials and networking (Macmillan Cancer Relief 2003). In place is also the NICE clinical guidance on supportive and palliative care (NICE 2004) which advises those who develop and deliver cancer services for adults with cancer about what is needed to make sure that patients, their families and carers, are well informed, cared for and supported. These initiatives had a positive impact on Mr. Jones as the nurses were able to use these guidelines to offer Mr. Jones

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the best care suited for him and he was then able to make informed decisions regarding the care he would like to receive. These initiatives also have a positive impact on health care professionals as they are supported and encouraged to improve their knowledge through workshops and resource materials.

Action Plan/Conclusion

My reflection of this experience has taught me how complex it is caring for someone receiving palliative care. It requires a holistic approach to ensure the patient and the family receive the best possible care in accordance with the guidelines and standards, in which they must remain empowered and make informed choices regarding their care and treatment with the help of health care professionals. I now understand how complicated symptom management can be; cancer patients experience many symptoms from their condition and also side effects from their medication. Assessments are vital to ensure the appropriate treatment and management of symptoms. The importance of communication has been brought to my attention once again, in my future nursing practice I will focus on my communication skills as this is an essential part of good nursing practice and plays a vital role in palliative care. Although this was an upsetting experience it has also been a positive one as this will affect my future nursing practice a great deal as I have gained vital skills to look after those receiving palliative care and I am now aware of the various strategies and frameworks in place to ensure patients and families receive a high standard of care.