

# Ensuring dignity and respect in patient care



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Explain and evaluate how you ensured dignity and respect during a service user/care interaction

The NMC code is a set of standards applicable to any nurse, nursing associate, midwife or student nurse entering or hoping to remain within the profession. It outlines what is expected of professionals not only by the nursing and midwifery council but from service users. Throughout the code occurrences of the words 'dignity' and 'respect' are frequent. These include maintaining people's dignity, treating people with respect and respecting people's right to privacy confidentiality which continues after death (NMC, 2018). However, there is some imprecision to the meanings on these words both words centring around seeing uniqueness and appreciating differences and in that treating people as such (Rizzo Parse, 2016). Much of the time when dignity in care is spoken about it focuses on maintenance within interactions and how patients are treated by staff however other definitions add that factors other such as environment and culture can influence someone's dignity. In spite of the broad range of interpretations of what dignity and respect mean, most definitions cannot easily be applied to patients with disorders of consciousness. Autonomy is not possible, consent is not possibly, and a question arises over the ability to experience environment. The Royal College of Nursing (2008) states that 'Everyone has equal value as a human being and should be treated as being able to feel, think and behave in relation to their own importance and values' and that this should continue until death. Dignity and respect in this essay are taken to mean the universal obligations of staff see the inherent value worth of individuals which should be given equally irrespective of patient's

characteristics (Adib-Hajbaghery and Aghajani, 2015). This essay will discuss first how dignity and respect of patients maintained in care first in a general sense, then relating specifically to the interaction in appendix one, going on to discuss wider themes of care of patients in similar situations.

Staff are told to and the majority of the time intend to treat patients with dignity and respect. However, this is as previously mentioned open to interpretation (Buchini et al 2014). In reality, within busy wards the terms dignity and respect are sometimes synonymous with the patient having their basic care needs met. In that they are appropriately nourished, cleaned or dressed but the idiosyncrasies of the individual are lost amongst biomedical focus and ward routines. Gowns are put on, pain relief is administered.

However, these actions alone do not ensure patient dignity; gowns cover a person's body, but they may still feel undressed. The absence of pain does not mean the patient is comfortable and it is patients feeling comfortable which is intrinsic to individual dignity (Kagan, 2017) Hope of clarification was provided when The Dignity in Care Campaign was launched by the government in 2006. This aimed to provide a framework for staff to adhere to. It sets out ten criteria health and social care services must meet, these include; treating everyone as an individual and offering services based on their requirements, listening to the opinions including being open to complaints, actively engaging and putting patients at the centre of their care (National Dignity Council, 2013) other guidelines give specific examples how dignity and respect can be maintained on an organisational level these include; protected meal times, universally accessible signs across all trusts, use of curtains to create privacy and side tying gowns. This guidance gives

staff tangible examples of what dignified and respectful care looks like (NHS, 2018)

In spite of the availability of this guidance, like discussions of what dignity or respect mean, it pertains mostly to patients who are conscious and able to communicate their wishes. Patients in persistent vegetative states are defined as a patient who maintains circadian rhythm, opening their eyes spontaneously (NHS, 2018). They also possess brainstem function such as breathing and digestion and have some basic reflexes. However, showing little or no signs of self-awareness or awareness of environment (Wu et al., 2017). This can make the application of principles of dignity and respect more difficult. During the interaction in appendix 1 the student spoke to the patient throughout. This is partially due to there being a question over whether the patient can hear or understand. Some studies show no evidence of language comprehension or ability to express. That only the most basic functions remain (Puggina, 2012). That the patient is 'dark inside'. However, repeated studies using magnetic resonance imaging on patients in minimally conscious states and vegetative states shows that some retain cognitive abilities and brain activity similar to someone who is fully conscious, in particular the ability to follow verbal commands (Bruni, 2016), though the study mostly found this to be true in patients with minimal consciousness rather than vegetative states, it is still not a certainty that it can't. In addition to this, some studies show that more patients who receive sensory stimulation regain consciousness than those without (Giesbrecht Puggina et al., 2011) As nurses and support staff are often too busy to spend significant time with patient, it is important that if there is a potential for interactions be

therapeutic, that any opportunity is take advantage of. Finally, and possibly most importantly from a wider care perspective when talking about the obligation of staff to maintain dignity and respect, not speaking to the patient, or speaking about the patient as if they are not there could be regarded as treating them as a shell, somehow less human. Guidance suggest patients with disorders of consciousness be communicated to in a similar manner to any other patient. This includes the member of staff introducing themselves, guiding the patient through the task they are carrying out, not speaking too loud rather moving closer to the patient, avoid talking between staff as this may be overstimulating, focusing on the task and using non verbal communication alongside simply speaking (Puggina, 2012). That the patient being afforded respect is inherent to being mortal rather than conscious or able to communicate. As mentioned at the start of this essay, irrespective of characteristics.

The interaction centred around an administration of medication. The patient had scheduled medications and other medications prescribed 'pro re nata' which included several analgesics. Though the absence of pain does not equal dignity or respect it is tantamount to it. Usually during medication round a patient is asked if they are in pain and the level of pain they are in. From this it is agreed with the nurse which level of the analgesia scale they wish to receive (RPC, 2019) However, in the instance of patients with disorders of consciousness, it is difficult if not impossible to establish if they are in pain or even if they are can experiencing pain. Following the Glasgow Coma Scale, when the patient's eyes were not open spontaneously they were open to pain suggesting some sort of pain perception. However, as the

patient did not exhibit any signs of pain for example changes in vital signs, facial expressions and body language, pain could not be identified in this manner. Conventional wisdom suggests that though information from nociceptors reach the primary somatosensory cortex, they do not reach higher order associative cortices meaning the individual does not experience pain as a negative stimulus and suffer as a result (RCP 2013). Studies utilising positron emission tomography scans have found patients in minimally conscious states showed similar brain activity patterns to that of healthy subjects while patients in vegetative states showed reduced activity alongside abnormal synapse activity which supports this (Miller, 2008). However, if it's possible for patients to hear instructions, a relatively complex structure, it may be possible to them to experience pain, something relatively primal. Other studies support this notion questioning diagnosis of disorders of consciousness (Puggina et al, 2012). Due to this uncertainty, some may approach the administration of pain killers in a manner of 'better safe than sorry', that is better to give unnecessary medication than it is to risk the patient experiencing pain which remains undetected. In addition to this, clinicians even when certain the patient is incapable of experiencing pain, feel pressurised to administer analgesics at the request of and to reassure the family (RCP, 2013). However, administration of pain relief which is too liberal in nature can cause ethical dilemmas in its own right; The primary aim of interventions is for the patient to recover, analgesics can act to sedate the patient, subsequently reducing signs of returning consciousness (Miller, 2008) Certain medications can also be life shortening in nature BLAH. This also doesn't meet the criteria of dignified care as its unnecessary treatment

Alongside this, a fundamental aspect of most definitions of dignity and respect in care is the right of the patient to be involved or to refuse treatment. Patients would ordinarily be consulted. However, again, in this instance, this is not possible (Buchini et al 2014). The patient, due to a lack of consciousness, was deemed incapable of have capacity to make medical decision under the Mental Capacity Act 2005. Unless a patient has made a 'living will' or have a power of attorney, 'best interests' decisions prevail. Though in this interaction it was at the nurse's discretion which PRN medications to administer, overall it is the responsibility of the senior physician to decide which treatment is utilised and which would be futile or cruel. There isn't a statutory definition of how 'best interest' decisions can be made, yet there is a checklist of factors. These incorporate the patient's past wishes, beliefs and values (Cardiff-York Research Centre, 2013). During this process family, defined as anyone significantly close to the patient, are spoken to as they are better equipped to know this information (RCP, 2013). This can be difficult for loved ones as many people, including staff, erroneously believe that it is that right of the 'next of kin' to make decisions on the behalf of a patient without capacity. In addition to this, for families of those following traumatic brain injury it is common for to perceive a greater degree of consciousness than medical staff, believing the chance of recovery is more likely (Span-Sluyter et al, 2018). Repeated studies have shown that families generally favour more active treatment, even when they would not to receive the treatment themselves. This was the case with the patient in appendix one whose family wished to continue repeated surgical interventions which would likely be futile. Situations like this can pose greater ethical dilemmas for physicians due to potential legal

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and emotional implications if families disagree with treatment plan. As with the administration of analgesics, in some cases it can become tempting to apply 'best interests' to the family which may be to the detriment of dignity and respect of the patient (RCP, 2013) However, though patients loved ones may not always agree with treatment plans which may cause tension, part of treating the patient with dignity and respect, is to treat the ones they love the most patient's family in the same way. It seems obvious but a friend or relative experiencing a disorder of consciousness can be extremely demanding and as a result additional time may be needed to ensure understanding and relevant support should be offered. It is imperative that staff build strong relationships where possible as these can act as a source of support, containing the inherent stress experienced (Buchini et al, 2014).

Unfortunately, patients who remain in vegetative states over a long period of time are not able to be considered for formal rehabilitation which is goal-orientated. As a result, the care given within hospitals often centres around the avoidance of further complications which may prolong recovery time, cause secondary infection and if the patient becomes conscious at a later date, reduce subsequent independence. Patients are subject to a 24 hour care. will receive nutrition and hydration, often through a percutaneous endoscopic gastrostomy feed (RCP, 2013) as oral intake is not clinically appropriate. PEG feeds are also preferable over nasogastric tubes as they significantly reduce incidence of pulmonary infection while also improving nutritional outcomes, overall increasing survival rates in those in vegetative states (Wu et al., 2017). The airway of the patient was managed, in the



example; a tracheostomy with a humidified system. These are used for prolonged ventilation, to deliver oxygen to the lungs and remove secretions from the airway in patients who may have an obstructed airway (Balentine, n. d). However, Tracheostomy tubes can cause damage to the airway {NHS, 2017} and though not relevant in this instance, tracheostomies inhibit the patient's ability to speak and therefore express their wishes. Though these interventions may on the surface of it have the intention of making daily care of a patient more streamlined. The outcomes for the patient do help to maintain their dignity; PEGs they are far less visible than NGs meaning the patient can appear more ' normal' to love ones. They also need to be changed far less often, so as an intervention they are far less intrusive once the procedure is completed. Tracheostomies have the advantage over intubation as the patient does not need to be sedated to tolerate the tube, it also allows staff to carry out regular mouth care (Hutzel, 2019). If the patient was to regain consciousness, parts of the tube can be changed quickly allowing the patient to vocalise. In a day to day sense, prevention of pressure areas are a major component of care of patients in vegetative states. Patients are regularly turned and pressure relieving equipment is used to prevent pressure ulcers as these can become infected causing additional issues. The patient in appendix 1 also had a catheter in place. Though the primary purpose of this may be to maintain skin integrity, it also acts to maintain dignity. This is due to the patient being unable to detect or alert anyone when they have passed urine. The catheter ensure the patient is always kept dry (NHS, 2018). Pads were used manage the patient's bowel movements. These have the advantage over enclosed incontinence underwear as these hold fecal matter closer to the skin rather than wicking it

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away. Something about hand care. From a more medical perspective, visible signs of pain and clinical observations are closely scrutinised to see if there are any changes. Antiepileptic drugs are administered to prevent seizures which may cause further haemorrhage (RCP, 2013)

Day to day, maintaining the dignity of and respecting of all patients is more difficult than it initially sounds. While it may be useful for policy makers to provide examples and guidelines, these should in no way replace preference finding interactions. It may be workload and seemingly mundane tasks that are the greatest threats to this humanisation of treatment. However, being busy or complacent does not supersede the universal obligation staff have to treat all patients with dignity and respect. As the saying goes; 'one person's everyday may be another's once in a lifetime' and nurses should constantly bare this in mind. Though patients in vegetative states may not be as aware of this once in a lifetime. They are unable to express their uniqueness and preferences and are therefore more vulnerable to heterogeneity of care which is less dignified or respectful. It is essential that staff remember the patient is not the disorder, they are still the person and should be treated as such. The patient's life before was just as meaningful and significant as the life of themselves or any other patient, and it could be again. They are an individual and have inherent worth. As in appendix one; the student explained to the patient what was happening, ensured the patient was covered at all times and ensured the patient was as comfortable as possible. As with any patient, their human rights should be upheld and their known preferences should be met. They should be comfortable, free from pain, not

given unnecessary treatment, given the greatest chance of recovery, or if not possible the most dignified passage to death, all the time.

#### Appendix one

My placement was on a male neurosurgical ward. The patient was admitted following a fall whilst intoxicated in December. He suffered bilateral acute subdural hematomas. On admittance he had a craniotomy and evacuation of the left subdural hematoma and a tracheostomy inserted. A week later he had a shunt insertion. A month later a percutaneous endoscopic gastrostomy was inserted for him to receive any food, water and medication through. In April the patient had a cranioplasty. Throughout the patient's stay the patient maintained a score between 5 and 7 on the Glasgow coma scale and showed little sign of recovering.

The patient was all cares for the duration of his stay. The interaction the essay will be based on is an administration of medication through the patient's PEG. The patient was due baclofen, paracetamol, gabapentin and a tinzaparin injection. The patient was prescribed other medications PRN including diazepam and stronger analgesics. Due to the patient being in a persistent vegetative state it is understandably difficult for ward staff to know if the patient could perceive pain or what outward signs he would exhibit if he was in pain. Nurses are reliant on medical staff to establish this. It also because of the patient's low GCS, it was impossible for the patient to give consent as he is unable to communicate. Decisions on what medication to administer were based on the best interests of the patient. Alongside this, regular family meetings were held regarding care. Though doctors had

explained there was little if not no chance of the patient recovering, the family found this understandably difficult to accept and wished to continue intervention in the belief the patient would recover. This was particularly difficult as some days the patient would open their eyes spontaneously. The opted to continue surgical and all other interventions.

My mentor used her judgement based on the evidence available to decide what to administer at that time. Whilst my mentor supervised, I followed best practice such as the relevant checks, crushing medication into separate containers and preparing alternate flushes. Alongside my mentor, I approached the patient after drawing the curtain around to give the patient privacy. I introduced myself, checked the patient's wristbands and explained to the patient what I was administering, though it is unlikely the patient would have enough awareness to hear. I lifted the patients gown to reach the peg but was careful not to expose the patient. I spoke to the patient and my mentor while I was with the patient but ensured that I didn't speak around the patient as if he wasn't there and remained respectful. When I was finished, I informed the patient and double checked the peg was closed and wouldn't leak. I also checked the palm protectors he was wearing to prevent his nails from breaking his skin were still in place, ensured he was fully covered and in a comfortable position. I filled in the fluid balance chart and ensured other paperwork was up to date.

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