Reflective essay: stroke patient

ASSIGNMENT FROM MOTHER NA’

A Reflective Essay on significant patient care event within a multidisciplinary setting.

This will be a reflective analysis on a significant event that I have observed and experienced in clinical placements. A reflective model was not used, as it was too restrictive for the event being analysed, critiqued and discussed. My focus on this assignment is on assessment on a stroke patient and prevention of pressure ulcers. This was my first experience to nurse a stroke patient and therefore was very interested to know about the disease and how to make an assessment on patients in this situation. All details that could identify any person, clinical placement or trust have been changed to protect confidentiality, in line with The Nursing and Midwifery Council (NMC) Code of Professional Conduct, Performance and Ethics (2008).

Reflection is an active process of witnessing one’s own experience so that we can make an evaluation in order to make a decision. Reflection has its foundations in the discipline off learning and experience in a student (Jasper 2003). Jasper (2003) believes that we learn by doing, and realising what came of what we did. There are so many models of reflection however, these are not meant to use for an inflexible set of questions to be answered but to give a construction on how to go about a problem.

While on placement I worked with one of the qualified staff on the ward and looked after a lady aged 84 years. Doris had suffered a stroke which developed to impaired swallowing and speech. She was admitted to the ward due to having an ischemic stroke. A stroke is a disease that affects the

arteries leading to and within the brain and categorised as ischemic or haemorrhagic stroke. This occurs when the blood vessel that carries oxygen and nutrients to the brain is either blocked or burst. This results in the brain not getting the oxygen and nutrients that it needs and eventually starts to die (Feigin et al 2003). Because of this patients have a propensity to develop swallowing impairment or speech impairment. Ischemic stroke take place as a result of an impediment within a blood vessel supplying blood to the brain. The original circumstances for this type of obstruction are the development of fatty deposits lining the vessel walls. This condition is called atherosclerosis (Lopez et al 2006). These fatty deposits can cause two types of obstruction that is cerebral thrombosis or cerebral embolism. In the case of an embolism, a clot breaks loose and enters the blood stream and eventually fails to pass when it reaches smaller brain capillaries. Irregular heartbeats known as atrial fibrillation is another cause for embolism which is likely to form a clot in the heart and later dislodge and travel to the brain (Feigin et al 2003). The National Audit office (2005) report shows that 130, 000 of United Kingdom population suffer a Transient ischemic attack (TIA) every year, of which half of the figure the stroke occurs in the people aged above 75yrs, however stroke do happen in all ages (Kwan 2001). Saka et al (2009) explains that the UK economy has to account for £9 billion per year to cover the costs of stroke related diseases including its management and therefore causing a burden on the economy. Because of the muscle weakness due to a stroke, there’s loose of control on the bladder sphincter causing incontinence. In addition statistics show that 63% of the population who are hospitalised develop pressure sores over the last 10 years. The figure includes the elderly and patients who have suffered a stroke.

Communication was another issue; Doris could not communicate well due to the dysphasia which developed after the stroke and sadly no one in the family or friend had escorted Doris to hospital for health care staff to obtain her past history on admission. Taking a medical history is good practice as it allows health care staff to apply effective assessment which will meet the patient's needs. It is through effective communication that effective assessment will be implemented. There are other approaches in communication, for example The " VERA" framework (validation,

Emotion, reassure and activity) suggested in a study that it enabled student nurses to counter to elderly patients whose communication and behaviour proved to be difficult. These frameworks give choices to healthcare staff a set of principles to guide them with communication while providing any medical intervention. Childs, Coles and Marjoram (2009) state that the inability to communicate to others cause anxiety and fear. While Happ (2000 cited in Childs et al 2009) think that people who are unable to talk or communicate are " voiceless" and therefore it increase powerless and isolation in patients. Buckman (2000) emphasised that ' effective symptom management is imporsible without effective communication'.

. Assessment is a process that involves collecting and organising information and acknowledged as an on-going process associated with the other nursing stages of the nursing process (Thomson and Mathias 2000). Brooker and Waugh (2007) state that decision making and judgement is usually based on information collected. The data is then used to identify the patients nursing problems on the base of need, which hopefully is brought out or recognised assessment (Thompson and Mathias 2000). Timby (2001) identifies two

types of assessment a data base assessment and a focus assessment. The data assessment is the initial information about the patients physical, emotional, social and spiritual health, is lengthily and comprehensive. Database information is obtained during the admission interview and on carrying out physical examination. Field and Smith (2008) demonstrate the importance of person-centred assessment and also the need of multi-agency involvement. An observation was made that all these areas were met. Although each discipline had achieved assessment in a different way, they are valued for the assessment they will contribute to patient care. Brooker and Waugh (2007) feel that including integrated care pathways in patients care plan is good. This is a single document of which all the multidisciplinary team are able to record their care.

To achieve good patient assessment, there is need to collect information from the past medical history and this will allow care to flow with one another.

During the ward round a consultant had suggested that an indwelling catheter was to be inserted for easy flow of urine and to prevent the development of pressure sores. It was when the nurse advised that the catheterisation was to be done after all other works has been done on the ward because she had to carry out an aseptic procedure. Whilst on other placement this observation was not done instead catheterisation was carried out as a clean procedure. This prompted me to question, should all health care settings observe catheterisation as an aseptic technique procedure and when do health care staff identify the need of inserting a catheter. This issue has been brought to light by numerous guidelines and theories that have

been published relating to and concerning infection control by the Department of Health. Although it is clear that Doris was vulnerable and likely to develop pressure ulcers, was it really necessary to insert a catheter? All parts of the multidisciplinary team caring for the patients need to have an understanding of each other's role, to achieve effective care through collaboration and decision making, but some nurses feel disempowered by more senior staff, for example; doctors; consultants, due to intimidation and hierarchy of roles and so can affect the influence nurses have on the decision making process (Coombs 2003). Nurses may come into conflict when collaboratively making decisions with the multidisciplinary team and patients as their personal and professional values may vary.

A study suggests that catheter insertion has a potential off introducing micro-organisms into the bladder (Barford and Coates, 2009). In another study, Pratt et al, (2007) mentions that catheterization should be treated as a skilled aseptic procedure to be carried out by trained and qualified staff in order to reduce infection. Health associated infections are acquired while patients are receiving treatment in a care setting and can prolong hospital stay. These infections include any infection obtained as a result of healthcare whilst in hospital or other healthcare settings and can have an effect on both patients and all aspects of the multidisciplinary team, in addition teamwork means everyone has to be involved in the patient care (Nicholson et al 2010). . The Department of health (2006c) released a broad document which includes the generated acute hospital waste and the community practitioners. What is not known is whether the patient acquired the infection in hospital or not. The patients' age matters as infection risk increase in the

elderly and young people. Patients whose nutritional status as in the case of Doris affects the ability of the body to fight infection and therefore a broad risk assessment is required (Horton and Parker 2002).

Grandies et al., (2003 cited in Field and Smith2008) clarifies that in any assessment, the age, nutrition status, circulatory status, mobility, dependence level and mental awareness are to be taken into account. Patients need to be critically assessed for possibilities of developing pressure sores as the cost is huge to both the organisation looking after the patient and the patient herself. Health care staff needs to identify the existing risk factors already presenting on the patient which may lead to developing pressure sores. Iggulden et al (2009) describes pressure sores as damage to the skin and the underlying tissues caused by shearing, friction and moisture while Bick and Stephen in another study say that physical, and psychological well being including the environment is a factor causing pressure

Sores. Mallet and Dougherty (2004) add on to mention that the extent of these ulcers if not properly treated may lead to damage of the involving muscles, tendons and the bone. Skin integrity is important in this situation. Due to illness arterial blood pressure may drop causing obstruction of circulation to the skin and therefore an ulcer will develop.

It is clear that Doris was vulnerable and likely to develop pressure ulcers. Pressure ulcers are developed when patients sit or lie in one position for a long time. “ The essence of care toolkit for clinical practice benchmarking has pressure ulcer prevention (department of health 2003). The water low score and Braden (cited in Bergstrom et al 1987) are good toolkits for

assessing patients at the risk of pressure sores. However the NICE (2005) guide line instructs nurses not to rely on them alone. Doris' water low score indicated she was at a risk of developing pressure sores. This was because her mobility and nutrition status were affected after the stroke. There is evidence in study that females are more vulnerable to pressure sores that male. This is because anatomically males are more muscular than females. It is the nurse's responsibility to ensure patients receive optimal nutrition and good hydration while in hospital. In another study statistics show that 63% of elderly patients with stroke develop pressure sores due to poor mobility and nutrition in the last 10 years. Doris was at higher risk to develop as she typically lost muscle and subcutaneous tissue due to poor nutrition following her difficulties to swallow, poor nutritional status also makes her more vulnerable. Ongoing assessment at this time is crucial as it will trigger on all the possible barriers of poor nutrition and hydration on patients who require help in feeding and drinking (NHS Choices2010). Nutrition and hydration are important in health but in illness there are certain considerations that have to look into because the body needs nutrients in order to recover mostly in wound healing including preventing infections (Royal collage of Nursing (RCN) 2009). The RCN (2009) clarifies that poor nutrition and hydration is a threat to patients who have suffered stroke as this may cause delayed discharge and other complications like low blood pressure and electrolyte imbalance which are likely to cause poor circulation and allow a patient to develop pressure sores.

Nutrition and good hydration is fundamental in nursing to promote quick recovery and wound healing. However there are patient's factor which may

affect their nutrition and hydration such as stroke which possibly will reduce their independence to eat freely. According to (Green 2011) by improving patients nutrition and dehydration the patients skin and well being will be promoted and this can be achieved through delegation to healthcare assistants to help with feeding at meal times with nurses ensuring proper meals have been given to patients' e. g. soft meal, puree, low fat or residue meal which are required for patients with dysphasia or digestive problems in line to prevent pressure sores.

All patients are prone to develop pressure sores but the emphasis is on the elderly because basic factors are related to immobility, age and illness . Pressure ulcers are preventable if proper nursing measures are carried out. NICE (2001) guidelines state that all patients likely to develop pressure sores are to be on a pressure relive mattress while in hospital. Therefore a decision was made that Doris needed a pressure relief airflow mattress as her score was high. Evidence based practice is essential in nursing, it has the potential to develop and increase patient care outcomes as it will enable nurses to evaluate and deliver care according to patients needs. The Nursing and Midwifery Council (2008) advocate that nurses should make care of people their first concern. Therefore a broad medical history taking form the patient becomes essential so that an accurate diagnosis can be made for the patient to receive optimal care and treatment (Kale 2001). Nurses have a propensity of communicating with patients during intimate intervention and it's during this time that individuals are likely to speak freely which is why Doris's mode of communication has to be identified through the speech and language team in order to support her. The need for nurses to know their patients

better and understand their problems and specific needs becomes fundamental. Nurses may come into conflict when collaboratively making decisions with the multidisciplinary team and patients as their personal and professional values may vary if proper history was not taken.

Lloyd and Craig (2007) suggest that although history taking is the cornerstone of assessment in patients, nurses are sometimes not at ease with taking patients history. History taking is not focused on identifying patients' signs and symptoms of the illness but to involve the whole person in a holistic way which will help the health care staff to plan and evaluate patients' care (Department of Health 2001). There is need for nurses to develop their history taking skills as this will allow them to acknowledge social, medical psychological and biographical domains of the patient. Fischer (1995) feels that doctors " make a history " instead of " take history" this process becomes complete when both patient and doctor are both satisfied on the causative problem. However Gask and Usher wood (2002) in the article emphasises that successful history taking is based on skilled and patient -centred communication that a therapeutic relationship will begin between nurse and patient. It is through this therapeutic relationship between the patient and the nurse that they will work together to make a collaborative decision and address the problem. Therefore health care staff must act as a patient advocate to protect and respect their dignity.

Palliative care is in any illness which is progressive and incurable, therefore there is need for the multidisciplinary team to work together and provide a high- quality end of life stroke care. Although there is evidence that Doris is likely to develop pressure sores catheterisation could not be a solution at

this point. The department of health (2003) aim to reduce the risks of health associated infection and indwelling catheters are among the common cause of invasive medical devices used in health care settings and, consequently, are a frequent cause of Health Care Associated Infections. Other than affecting patients, HCAI is also having negative burden on the National Health Service (NHS). Patients like Doris are more prone to infection due to that the body mechanism to fight infection is already compromised. Catheter acquire infection can be very distressful to patients and prolong hospital stay. The possibility of Doris going into palliative care is obvious and therefore there is need to plan for it in her care plan or discharge plan. In this reflection it is noticed on admission that Doris is alone. Loneliness has an impact on elderly people. In a campaign to end loneliness research shows that many people have no peers or friends. It is through the general practitioners and district nurses that support to these people can be offered, all decisions made in the multidisciplinary context have to involve the patients' family (NHSQIS and the University of Glasgow 2010). All parts of the multidisciplinary team caring for the patients need to have an understanding of each other's role, in order to make a collaborative decision.

In conclusion, while reflecting and making recommendations for different ways of approach on situation in practice, holistic assessment followed by full history taking to allow care to flow should be a priority followed by improving nutrition and hydration in very ill patients. Cauterisation could be a last option in order to prevent pressure sores as there other options to do this. The risks that patients who are immune compromise may be exposed to other infections and how it can be avoided needs to be addressed and it is a

constant effort, but is fundamental by all areas of the multidisciplinary team, organisations to reduce rates of infection more and to continue at a lower rate. To improve patient safety and continuum care it is necessary for health care professionals to reflect on nutrition and hydration status of the patient to promote good skin integrity and prevent pressure sores. For reflection to occur, health care professionals need to be aware of the implications that pressure sores can have on patients and the importance of education from policies and to comply with relevant procedures.