

Care management flashcard



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The domain Care management will be addressed within this paper using a long term condition case study to highlight the development and learning of this student. The Long Term Medical Conditions Alliance (2002) defines the term long term condition as “ a condition of prolonged duration that may affect any aspect of the person’s life”.

A literature search was carried out using the terms care management and long term conditions and the results of which appeared to show that care management is an area of long term conditions that spans the Inter Professional Teams (IPT). From hospitals to primary care they all have input from the IPT and the focus appears to be increasing support for self care, strengthening primary care, responsive specialist care and management of vulnerable patients (DoH, 2004). The NSF for Long Term Conditions, as released by the DoH in March 2005, aims to bring about a structured and systematic approach to delivering treatment and care for people with long term conditions.

Personal/Professional Development

A literature search relating to personal and professional development gave rise to many results advocating reflection as the prime area for developing the nurse’s professional development. Gustafsson and Fagerberg (2004) suggest professional development starts when reflection begins. Williams (2001) suggests that reflection and the development of this ability should be inextricably linked to professional development.

Introduction to Case Study

The module four placement was based within a renal unit and was the first experience of a younger client group with needs that appeared to differ from the older adults whom I'd worked with on previous placements. The patients on the ward did not require help with their personal cleansing and feeding as those previously cared for. Consequently, I felt some confusion as to the skills required in the care of these apparently self caring patients.

Upon reflection I was still working and thinking in a task orientated way and to be exposed to an area where other nursing skills were required left me feeling a little unsettled. Douglas (1999) suggests that the task approach is often taken by student nurses as a “ haven” that offers security.

During the first week I was encouraged to work closely with my mentor. This gave me the opportunity to orientate myself to the ward and to get an overview of the needs and requirements of the patients. This also provided me with the chance to observe how the nursing team worked on the ward.

The majority of the patients admitted to the ward were diagnosed with End Stage Renal Failure (ESRF) and were there for observation and help with their condition which included education and health promotion from the IPT. ESRF is the most advanced stage of Chronic Renal Failure (CRF) where there is complete or almost complete failure of the kidneys to perform to excrete wastes, concentrate urine, and regulate electrolytes and where the CRF can no longer be controlled by diet and medication. Dialysis is required to replace loss of function and prevent death from uraemia (McDonald, 1997, MedlinePlus, 2003).

Dialysis is a method of filtering toxins from the body when the kidneys are unable to do so. This can be carried out by two methods, which are:

Peritoneal Dialysis (PD) and Haemodialysis.

In PD dialysis takes place within the peritoneal cavity. The peritoneal membrane is used as a filter to remove excess waste and water. A hypertonic dialysis solution is infused into the cavity. Excess waste and water pass from the blood into the dialysate and after a few hours the dialysate is drained and exchanged for fresh fluid. The catheter used to gain access to the cavity is inserted during an operation which is usually carried out under local anaesthetic (McDonald, 1997).

Haemodialysis is where blood is taken from the body to be cleaned in a filter known as a dialyser which acts like an artificial kidney. A dialyser works on the principle of blood flowing along one side of a semi-permeable membrane made of cellulose or a similar product, with the dialysate flowing along the other side. The dialysate contains a regulated amount of minerals normally present in the blood, but in renal failure they are present in excess. The membrane has microscopic sized holes which allow the excess fluid and substances in the blood pass through but prevent the larger protein and blood molecules from passing through.

Treatment is usually three times per week for approximately four hours each time. The blood is carried from the patient to the dialyser and returned through sterile PVC tubing which is connected to the patient in one of three ways: Arterio Venous Fistula (AVF), Synthetic Graft and Central Venous Catheter (CVC).

The AVF is where an artery is surgically joined to a vein under the skin. The vein enlarges and thickens eventually. Two needles are inserted to access it. One to remove blood and the other to return the blood after it has been pumped around the dialyser.

A Synthetic Graft is similar to the AVF but where the vein is attached to the artery an artificial tube is used instead. These are used when a suitable vein cannot be found, possibly due to vascular problems or old age. The AVF is preferable means of access as there are problems with the Synthetic Graft such as infection (McDonald, 1997).

A CVC is used to provide temporary access whilst the patient is waiting for an AVF to be created. A CVC is usually sited in the subclavian vein. The use of the subclavian vein for the CVC is not recommended for patients due to the risk of central vein stenosis which could impede the future success of the creation of an AVF (Thomas, 2002).

Case Study

Mrs Woods is a 28 year old lady who moved to London from France five years ago. Mrs Woods was diagnosed with ESRF six months prior to admission and was admitted to have an AVF created. As a result of her diagnosis Mrs Woods was commenced on dialysis. Initially she had been receiving dialysis via a CVC but did not feel happy with it as she felt it looked unattractive and felt very conscious about its appearance. In addition to ESRF Mrs Woods had been receiving treatment for hypertension which was diagnosed when she moved to London. According to Thomas (2002) ESRF is

the result of a number of pathological conditions which includes hypertension.

Hypertension is diagnosed when the systolic and diastolic blood pressure (BP) is greater than 140mmHg over 85mmHg (Riley, 2003). Long term hypertension is diagnosed when the average of three or more BP readings taken during rest, several days apart, exceed these measurements (Faithfull et al, 1996).

As we can see Mrs Woods suffers from two long term conditions which were being managed through medication. According to the NSF guidelines it is the role of the practitioners involved in the care of such patients to encourage them to develop skills to help manage their condition better on a day to day basis. In an attempt to help Mrs Woods achieve this on a small level I tried to participate in her care in such a way that she felt comfortable whilst on the ward and encouraged her to ask questions if she had any.

Whilst filling in her admissions documentation I asked her questions about her daily activities and general health. I noted whilst speaking with her that she appeared anxious as she had her bed covers pulled up closely to her face and her facial expression appeared tense. When I enquired if she was in pain she replied she was not. I then asked if she was feeling anxious and she replied that she was concerned about the surgical procedure. When asked to elaborate it transpired she was worried that she would not wake up from the anaesthetic and although she was happy that eventually the CVC would be removed she was concerned that the AVF would leave a scar on her arm.

When the anaesthetist arrived to speak with Mrs Woods he was informed of her anxieties regarding the anaesthetic. He explained, in what appeared to me to be clearly and understandable terms, what the surgical team were expecting to happen during the procedure. He asked Mrs Woods if she understood what he had told her and she confirmed that she had. When the anaesthetist left I enquired if she had understood the information given to her and she replied she understood a little. I offered to go through it again with her but she declined. Studies have shown that pre-operative preparation should involve matching the amount of information provided with the patient's coping style, whether this is vigilant or avoidant (Krohne et al, 1996, cited by Mitchell, 2000).

Vigilant

Should receive copious amount of information as too little makes them anxious

Avoidant

Should receive a small amount of information as too much makes them more anxious

As I did not feel comfortable with the level of knowledge I had and was unsure how effective my attempts in alleviating her concerns would be, I informed Mrs Woods that I would ask her nurse to speak with her and help to answer her questions. After communicating Mrs Wood's concerns her nurse came and sat with her to try and answer her questions. She asked if her AVF would make her arm look like the other patients arms. Many of the other

patients AVF had over time resulted in aneurysm formation which gave the patients arms a lumpy appearance. The nurse informed her of how the aneurysms were formed and ways of prevention. Mrs Wood appeared to be content with the answers she received.

When I reflect back on these incidents I am aware of the short falls in my knowledge and think that perhaps if I'd read a little more in preparation for the placement then I might have been a little more useful in helping Mrs Woods. But I also feel that although I did not have the information for her I was aware of how to facilitate her concerns by using the resources around me i. e. asking the nurse who did have the knowledge to answer her questions and help alleviate her anxieties.

I found myself reflecting upon the topic of sexuality as an aspect of care for patients. The area of living with a long term health condition and its impact upon the physical appearance was not an area that I had previously thought much about. Sexuality according to a study carried out by Gagliardi (2003) was viewed by participants as a form of self expression and was considered a large part of one's identity as a human being. The participants were asked to describe how they felt about their appearance. They suggested that their own opinion of their appearance was influenced by how others viewed them. If they were viewed in a positive or accepting way they felt sexually attractive and vice versa.

As nurses we spend a lot of time with our patients and this provides us with the opportunity to facilitate communications and to enable our patients to explore this area if they wish. Sexuality is a very sensitive area and not one

that many are comfortable with communicating about (Kralik et al, 2001). There also appeared to be some confusion regarding sexuality and what it meant amongst nursing staff. Reading through assessments carried out by staff had shown that many regarded this as an assessment of patient's marital status. Carter and Green (2002) suggest that the term sexuality refers to areas such as; gender, being a parent, body image, wardrobe, etc. Whilst Kralik et al (2001) suggest that sexuality spans the biological, psychological, social, emotional and spiritual aspects of people's lives.

As a young woman with a young family Mrs Woods perception of her appearance and how her condition would affect this and her relationships with others was I felt an important part of the care she was receiving whilst on the ward. In an attempt to familiarise myself with information on this area I found text written by Thomas (2002) who said that staff who had become familiar with caring for patients with AVF tended to forget the response received outside the clinical setting. The impact upon body image for many patients is quite high leaving many feeling uncomfortable and unattractive with their own self image.

I sat with Mrs Woods and listened to her speak about her views on her illness and its impact upon her life. She said that her husband was very supportive of her and she considered him to be her closest friend. She did not have any other family in the UK other than her husband and two children. Her children were, as she said, too young to understand what was happening. Her husband did not speak English and as a result she felt the responsibility for communications outside the home was hers. Because of this she felt anxious to return home as soon as possible. When asked if she received any help or

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support at home from Social Services (SS) or if she had communications with the Renal Clinical Specialist Nurse (CNS) she replied that she had not. She then mentioned that she would be interested in hearing a little more about the services that were available. I tried to inform her as best I could of the social support that she may receive from SS with regards to housing and help with attending her dialysis appointments. She said that she was interested in having a Renal Social Worker visit her to discuss the matter further. I informed her nurse of this decision and proceeded, under supervision, to fill in the SS referral form for Mrs Woods.

Conclusion

The work I carried out with Mrs Woods gave me an important insight into holistic nursing. I had been assigned the job of completing the admissions documentation with Mrs Woods and by the end of which we had completed the admissions but I had also helped make her comfortable by helping provide information on the procedure and her AVF. I also became involved in helping her transition from the clinical setting to her home by making the referral to SS who would be able to provide her and her family with support when she was at home.

These experiences as well as leaving me with an enormous sense of achievement provided me with an insight into the side of nursing I had not participated in previously. I feel upon reflection on previous placements that there are aspects of the care of the patient that are in general overlooked, such as sexuality, patient education and ensuring that the patient has the necessary support network in place when discharged. I realise that I was

lucky in that I had more time on my hands and was able to spend it with Mrs Woods but the documentation involved in admitting and discharging patients covers all of these areas.

Professional/Ethical Practice

Defining professional practice is different for each of us with definitions including; individual knowledge, professional qualifications, skills and conduct (Jasper, 2001). Jasper (2001) states there are guides and criteria that arise from professional bodies which govern professionals groups and outline how they should practice. An example of such is The Code of Professional Conduct (2004) (CoPC) from the Nursing and Midwifery Council (NMC), which outlines how registered nurses act as professional practitioners.

Ethical practice within nursing is drawn from many sources. We arrive into nursing equipped with our own ethics which include honesty, respect for others, privacy and self-esteem. When we train as nurses we are then introduced to other areas of ethics such as moral concepts, ethical principles and moral theories (Hunt, 1994). According to a study carried out by Varcoe et al (2003) participants suggested that ethical practice suggested a way of being and a process of enactment. Levine (1977), cited by Varcoe et al (2003), suggests that ethical practice or behaviour is the daily commitment to others and our interaction with one another.

Care Delivery

Since the advent of the National Health Service (NHS) in 1948, there has been pressure upon those working within the health service to provide quality and efficient care. With regards to care delivery the Department of Health (DoH) produced *The Essence of Care* (2001). This document outlines benchmarks which focus on meeting patients needs and provides examples of government legislation and guidelines. Since then the DoH has, in response to the growing demands of the health needs of the population, released policies and guides to achieve the care to meet those needs. Examples of the policies are the National Service Frameworks (NSFs). The NSFs are long term schemes for improving specific areas of care. The goals of the NSFs include: setting national standards; establishing strategies in order to facilitate the standards; generate procedures to track progress within agreed timescales and to improve quality and delivery of care (DoH, 2005).

The following case study will follow the role of ethics and the delivery of care within the community setting. I will attempt to show how sometimes when we as care professionals attempt to deliver the best possible care and treatment the final decision and choice belongs to the patient (NMC, 2004).

Case Study

Mrs Tong is a 56 year old lady living in a house she shares with her daughter and grandson. Although married for thirty years, during the last ten she has been living separately from her husband. Five years ago Mrs Tong was diagnosed with breast cancer. When diagnosed the tumour had already developed into a fungating or malignant wound.

A malignant wound is where the wound has a cauliflower or fungus appearance. This term is also used to describe wounds where there is an ulcerating growth pattern (Naylor, 2002). The malignant wound that was present on Mrs Tong's left breast was a result of the tumour breaking through the skin surface.

According to Naylor (2002) the malignant wound is often seen in cases of cancers that have been left untreated for some time. The charity Cancer Research UK (2005) suggest that clients are often too frightened to visit their doctor when a lump is discovered and that it may be left untreated many months or years.

When Mrs Tong was diagnosed she was informed of the treatment options available to her. Mrs Tong chose not to accept any of the treatments offered as she preferred to use complementary medicine.

Mrs Tong's ability to understand the choice she had made and if she had fully understood all the information given to her was not questioned as she was deemed legally competent by her doctor. As set out within the CoPC (2004) the nurse's duty is to presume that all patients and clients are legally competent unless proven otherwise by a suitably qualified practitioner.

When I visited Mrs Tong with the district nurse I did not feel comfortable with asking her why she choose not to receive treatment. I felt that I would upset her unnecessarily and did not wish to do so. I therefore asked the district nurse prior to visiting Mrs Tong and was informed that she had believed there were no obvious benefits from receiving treatment i. e. a cure or prolonging her life.

In an attempt to provide a more holistic approach to Mrs Tong's care I carried out a literature search on attitudes towards death and dying. The results of my search showed that my feelings of discomfort with death and dying are not uncommon. According to a paper by O'Gorman (1997) we have become so enmeshed with the ideas of promoting health and well-being that we avoid referring directly to the concept of death. Instead we use such euphemisms as "passed away" or "departed this life". Sheldon (1997) suggests that contemporary society treats death as a taboo subject.

Sheldon (1997) writes the important aspect of providing care is to understand the variety of approaches and beliefs towards death and dying and not to seek to impose their own ideas of the proper way to die or grieve. She further suggests that we should be ready and able to communicate with patients and families who wish it.

Equipped with the knowledge I had found I decided that my role was to attempt to help Mrs Tong feel as comfortable as possible. There were many opportunities to visit her during my placement and I found myself becoming more at ease and was able to communicate with her in a less formal manner. Frequently during the dressing change Mrs Tong spoke of her concerns and shared information about her life. Although I was not able to provide answers for her concerns I believe that by providing her with the opportunity to talk may have helped her.

Whilst searching for information with regards to the care for Mrs Tong, I also searched on the topic of the patient's right to autonomy and consent. To consent to treatment there is a requirement by law for the health

professional to provide an explanation of the treatment, any substantial risks involved, side-effects and the consequences on the life of the patient, to be given in a way that is understood by the patient (Taplin, 1994).

As I was not aware of the full history of Mrs Tongs diagnosis and consequential choice to refuse treatment I am making the assumption that she made a fully informed decision. Since the advent of the patient's charter in 1991 the need for patients to exercise their rights and to make decisions about their care was highlighted. Since then we have had various guides outlining what patients have a right to expect and what are the duties of health professionals. One such document is the CoPC which highlights our role as nurses to respect the autonomy of the patient; the patient's right to decide whether or not to undergo treatment and all have a right to receive information about their condition.

Henderson (2002) argues that she does not believe this always happens. In her study she looked at the roles of the nurse and patient and whether there is a true partnership between them. She identified factors where nurses withheld information from the patient because of beliefs that the nurse "knows best", the patient held little or no medical knowledge and the need for the nurse to hold onto their power i. e. knowledge is power.

Such personal values and beliefs, if the CoPC were followed explicitly, would be superseded. But as highlighted earlier, we come into nursing with our own personal ethics and beliefs which occasionally contradict those ethics that we learn about when train as nurses. Botes (2000) refers to these ethics as the ethics of care, which are the personal ethics that we hold with regards to

involvement with others, and the ethics of justice, the ethics that are based upon universal rules and principles.

When I first learned of Mrs Tong's refusal to treatment my immediate feelings were of shock. This was prior to getting to know Mrs Tong a little better and my literature searches. The feelings that I had were based upon the values that I had come into nursing with, the belief that to refuse treatment would be the wrong choice to make and the trained health professional knew what was best for the patient. Through communication and slowly building a relationship with Mrs Tong I learned that she was fully aware of the implications of her decision. She enjoyed our daily visits to change her dressings and it was obvious that she and the district nurse had built a close working relationship in the time that they had known each other. I learned a little of the complementary therapies that she used and saw that she felt very positive about them and how they improved the quality of her life.

Conclusion

Whilst reflecting on the development from the beginning of my second year to the present I am able to witness the changes made from a student who when uncertain and confused slid back into a task centred role to one more competent and confident with a client centred approach. The experiences gained throughout placements and the role of using literature found in journals and books to improve my practice has facilitated my growth and development. Robinson (1996) writes that the importance of evidence based

care enables professionals to assess, implement and evaluate everyday situations and should be seen as a means of enhancing our role.

In conclusion I have found the experiences and learning I have had throughout my second year of training have enabled me to see the greater role played by the nurse. I look with anticipation to what the experiences of the third year have to offer.