Literature review of ritualistic care in practice

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The purpose of this essay is to validate the use of evidence based practice via constructing a literature review of ritualistic care in practice. Literature may be obtained from many various for example books, Internet, articles, and research. The most up to date literature is found in the form of relevant and valid nursing research. Research is important source of information for the nursing profession because it is critical and valid to the development and refinement knowledge in order to enhance practice.

Nursing research can be defined as the systematic objective process of analysing phenomena of importance to nursing (Earlene 2001). Many articles indicate that a gap exists between research/theory and practice. This is due to a number of different factors such as lack of research, lack of access to research, barriers placed by staff etc. To reduce this gap the approach of evidence-based practice has been introduced. (Rolfe 1998, Upton 1999).

Evidence based practice can be defined " as an approach to problem-solving in clinical practice" (Roseburg and Donald 1995) or the" systematic interconnecting of scientifically generated evidence with the tacit knowledge of the expert practitioner to achieve a change in a particular practice for the benefit of a well defined client/patient group" (French 1999). Within literature multiple definitions of the term evidence based practise exist as they do for many other nursing terms (Upton 1999)

Evidence based practice originated from evidence based medicine whach was defined by Sackett (1996) as the " conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" which was developed to teach medical students. Evidence based

medicine then developed in to evidence based heath care broadens the term evidence based medicine which can be defined as the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services.

Evidence based practice is even more general taking in to account health economics, practice management, education etc. 2 The approach of evidence-based practice takes into account patient centred care and aims to improve patient care. 3 Strategies to enhance evidence-based practice include research-based articles, the internet, lectures, meetings, courses, study days, articles, more good quality research in all areas of practice, as well as additional understanding of evidence based practice. Obstacles which may hinder the utilization of research / change / utilization within practice may includes time, peoples attitudes, the unwillingness to change, peoples beliefs that the best way is the old way.

People may also not understand the research, how to use the research for change. Research could possibly be unavailable via search engines or inadequate resources. Also it maybe unobtainable because insufficient computer skills, or due lack of research in certain areas. book L may) 5 Ritualistic action can be defined as carrying out a task without thinking it through in a problem-solving logical way, therefore ritualistic practice could be interpreted as carrying out a care/practice without thinking it through in a problem-solving logical way. Ritual practice has been described as irrational unscientific, unsafe, repetitive and repetitive (Philipin 2002, Geffrey 1997, Biley 1997).

However the discussion of ritualistic care brings areas in to light, which needs additional valid up to date research. Views regarding ritualised practice are usually negative as in Wash and Ford (1989) classic text in which they called for a 'drive for the replacement of ritualised practice'. However even though articles reproving of ritual pracice are seen repeatedly ritualistic practice still persists (Strange 2001). Ritualistic care/practice can be seen throughout clinical practice.

Several examples of care that have been termed ritualistic include pre-operative fasting, wound/pressure sore care, observation and drug rounds. Excessive pre-operative fasting has long been recognised a ritualistic practice even as early as 1883 when Joseph Baron Lister said 'while it is desirable the there should be no mater in the stomach when chloroform is administered, it will be very salutary to give a cup of beef tea about two hours previously' (Jester, 1999).

However preoperative fasting was not always carried out as it was only made mandatory in practice after Mendelson's lamark study in 1946 before which a drink was often recommended before the procedure (Greenfield, 1997) Pre-operative fasting is believed to eliminate the risk of vomiting/gastric aspiration during induction which may lead to complications which could be fatal (O'Callagham, 2002). O'Callagham (2002) states that it is a 'medical and legal requirement that a patient must not be anathetised without a period of fasting from food and fluids, except in emergency surgery'.

The length of time, which a patient should be fasted from fluids and food, is still controversial as it takes variable amounts of time for the stomach to

empty depending on what is what is eaten and what is drank. Walsh and ford (1989) found that patients were ritualistically starved from anything from 8 to 20 hours and deemed it as unthinking and irrational as research shows that fasting time would cause no harm be 4-8 hours for food and 2 hours for clear fluid (Philps 1993, Morris 2002).

In the case of solid food Nimmo et al cited in Walsh and Ford (1989) found that a light meal of toast had 2-3 hours before surgery had no effect. Also Chapman 1996 Hung 1992 Maltby 1993 cited in Jester 1999 demonstrated that it was safe for patients to have food 6-8 hours before surgery. In the case of clear fluids Argarwal et al (1986) cited in O'Callagham (2002) demonstrated that patient who drank 150ml of water prior to surgery had lowered gastric volumes that patients who had fasted since midnight. Also the amount of saliva swallowed would be more that a small drink of water.

Starvation for vast periods of time can be uncomfortable and source of increase stress (Walsh and Ford 1989). Apart from being uncomfortable it could also put the elderly at risk of dehydration and confusion, which may in turn lead to the operation being cancelled (Jester, 1999). In addition vomiting after surgery is usually due to drinking to soon following surgery, patients who have drunk within a few hours of induction of anathesia should be less thirsty post-operatively and try not to drink to soon (Smith, 1997).

There sufficient knowledge that preoperative fasting is a classic example of ritualistic practice that the days of nil by mouth at midnight should be drawing to a end (Morris, 2002) and patients fasting times should be calculated individually. Fabricius Hildanus first described for the clinical

characteristics of pressure sores in 1593 (Defloor, 1999). Pressure sores be defined as " lesions on any skin surface that occur from unrelieved pressure and result in damage to underlying tissue" (Schultz 1999 pg 434). Pressures sore care/treatment has come along way in the last 20 years.

There is a great deal of research, which has been done on the prevention of pressure sores. However the majority of this research is funded by company's, which sell mattresses or creams therefore is probable that the research maybe bias. Over the last 20 years numerous methods, which have been deemed ritualistic (unthinking) have been utilized to treat pressure sores. The methods have included using meths, oils with according to Anthony (1987) cited in Walsh and Ford (1989) promotes breakdown of the skin by destroying normal flora therefore helping infection and skin necrosis.

Other preventative measures that have been used in the past also include talcum powder, creams and rubbing/massaging the skin for better circulation. These methods have not shown to reduce incidence of pressure sores and may have caused harm. The simplest way to prevent pressure sores is to remove the pressure. Exton-Smith (1987) conducted a study in a 100 at risk which patients were turned every 2 hours; the result was a reduction from a19% incidence to a 4 % incidence of pressure sores.

This is study show's a more evidence based/rational method than ritualistic method used in the past. However ritualistic practice is still seen in practice relating to pressure sore prevention as friction is a cause of pressure sores and even though it is not allowed draglifts that create friction are still being done with patients. As mentioned before the special mattresses usually

rippled rippled are believed to relieve the incidence of pressure sore, however there are numerous company's with different beds.

Exton-Smith (1987) indicates that these beds are affective, if lying. When a patient has been lying flat I have seen in practice 2 turning sheets with a blanket over the special mattress left under the patient this must reduce the preventative affect of the mattress. Observation Ritualistic practice in drugs and drug rounds. My experience with this topic on placement was with ritualistic care of the elderly. Ritualistic care that occurred was with incontinence pads, which were put on patients even though many patients did not need them.

Other ritualistic aspect of care that I noticed was regarding meal times, which were very rushed and very chore like. Bed times were also ritualualised as everybody was woken up and dressed and washed before breakfast and around 6. 00pm patients were started to put to bed. The general consensus on ritualistic care in practice is that in usually not evidence based and therefore irrational. However there are some social studies, which say that routine is needed and is a part of everyday life. Therefore to make ritualistic care research based I think that research should be made the new ritual.