A case study evaluating the role and functions of the nurse

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A case study evaluating the role and functions of the nurse and the effectiveness of nursing care within a rehabilitation context ay crosspieces A case study evaluating the role and functions of the nurse and the effectiveness of nursing care within a rehabilitation context In recent years there have been an increasing number of people requiring rehabilitation in the I-J Ouster, 2007). Rehabilitation can be defined as " an active process which seeks to reduce the effects of disease (in its broadest sense) on daily life" (Greenwood et al, 1993. Cited by Davis & O'Connor, 2001, p. 4).

Rehabilitation nursing can be identified as a philosophy of care: an approach to any individual who needs assistance with their ability to function in life (Tracey, 2001). With assistance from a mentor, on a recent continuing and supportive care placement, a suitable patient was selected on which to base this case study. To ensure that ethical and legal responsibilities of confidentiality are maintained, any personal details have been altered to ensure anonymity, and consent obtained from the patient (Nursing & Midwifery Council, NC, 2008). A brief introduction to the patient and the care eating will follow.

The pathologically of pressure ulcer formation will first be considered, followed by a discussion on the discharge process from a hospital to a community setting. The roles and functions of the nurses involved in the rehabilitation of the patient will then be explored, before conclusions drawn as to the effectiveness of the care provided.

Mary was an eighty-nine year old lady encountered whilst on an extended practice placement, based in a community nursing team. She lived in a local

residential care home, which we visited regularly to provide nursing support to the careers.

Mary had been under the care of the district nursing team as she had developed a grade I pressure ulcer on her sacrum (European Pressure Ulcer Advisory Panel, APIECE, 2010). Rhea nurses offered advice about pressure area care and ordered pressure relieving equipment, to help prevent further deterioration of her skin integrity. Mary then developed a serious chest infection, requiring hospital admission.

She remained in hospital for eighteen days, undergoing two courses of intravenous (V) antibiotics, before being discharged to the care home.

The community nursing team was not informed of her discharge and received a telephone call from the careers, concerned about Marry pressure area. On inspection, the sacral wound had deteriorated from grade I to a grade Ill pressure ulcer (PAPUA, 2010) and was causing Mary a great deal of discomfort. It was also noted that her mobility had significantly reduced and she had very little strength to be able to maintain her independence in fulfilling her Activities of Daily Living (Roper et al, 2000). The discharge letter from the hospital made no reticence to Ma skin integrity and stated that seen was sell-caring.

Strict nurse discussed with the patient and careers the need for regular dressing changes to the wound and also recommended physiotherapy to help Mary regain strength and mobility. With their agreement, a referral was made to the intermediate care team (ACT) to assess Marry needs and take

over her care; an CIT nurse conducted a comprehensive, holistic assessment of Mary. With patient and career involvement, a series of goals were set to identify healthcare needs, address how these would be met and the expected time scale.

Mary underwent physiotherapy to strengthen her muscles and improve mobility; she also received input from the occupational therapist (TO) who supplied equipment to enable Mary to maintain as much independence as possible; the nurses visited twice weekly to assess her wound and change the dressing; Marry general practitioner (GAP) was also involved in her care and prescribed analgesia. Rhea skin is the largest organ in the body and performs essential homeostasis, sensory and protective roles (Peddle, 2006).

The ageing process causes changes to skin function and integrity; a reduction in elastic and collagen fibers cause deterioration in skin shape and strength, while poorer circulation reduces the amount of oxygen ND nutrients reaching the tissues and causes a build up of waste products (Hugh Grant, 2006).

Other factors also affecting skin integrity are poor nutritional status, sensory impairment, incontinence and co-morbidity’s (Lewis et al, 1998; Hugh & Grant, 2006); the elderly are therefore more vulnerable to skin damage (Peddle, 2006).

Impaired skin integrity may lead to severe nerve and tissue damage and an Increased risk of infection (Lewis et al, 1998). Pressure sores, also known as pressure ulcers or distributes ulcers, occur over pressure points, commonly

bony prominences, here areas of skin may be compressed for long periods of time against a hard surface, or caused by friction or shearing forces (PAPUA, 2009). When this occurs, tissues are damaged and blood flow to that area is compromised, resulting in Chemical (Lewis et al, 1998).

Initially the skin reddens, but as the pressure continues Chemical and necrosis occur, causing the skin to slough, leading to ulceration which may enlarge into a cavity as underlying tissues and structures are also damaged Royal College of Nursing, ARC, 2001). As an octogenarian, Mary was more prone to kin damage, as already identified; combined with reduced mobility and many hours sitting in one position, this contributed to her development of a grade I pressure ulcer.

When Mary developed the chest infection this would have further compromised her tissue oxygenation, as her lungs would have been less effective in gaseous exchange, resulting in reduced blood oxygen saturation (Hugh & Grant, 2006) and increased her risk of tissue necrosis. Numerous classification and staging systems exist to assess pressure ulcers and review the effectiveness of treatment (Peddle, 2006). In the I-J, the tool most molly used is the Stilling System (Reid & Morrison, 1994) (Appendix 1: NASH Quality Improvement Scotland, 2005).

APIECE have recently published new International guidelines tort boot pressure ulcer prevention and treatment, which include a grading scale; their aim is to share evidence-based practice and standardize the assessment and treatment of pressure ulcers across international boundaries (Black et al, 2007; APIECE, 2010). The district nurse identified Marry initial pressure ulcer

as grade l, non-blanched rather; the patients sacral skin was reddened and did not balance when gentle pressure was applied, but the skin reface remained intact.

However, on discharge from hospital the wound was determined grade lll as she had sustained full-thickness damage to the sacral tissue, Including subcutaneous layer, with some areas of necrosis.

According to Courtesan (2002), in the majority of cases pressure ulcers are preventable and their development can be an indication of poor quality nursing care; however, every member of the multi-disciplinary team has a role to play in the prevention and treatment of pressure ulcers (Lewis & Roberts, 1988).

In this instance, Marry initial pressure ulcer was preventable by educating both the patient and staff bout the importance of regular position change to prevent pressure damage occurring in the first place. Once in hospital, it should have been possible to prevent further deterioration of the wound with adequate interventions, such as pressure relieving devices and regular turning (Chambers, 2002); however, with Marry chest severe chest infection their primary concern, it would have been necessary to position Mary sitting in an upright position to maximize lung capacity, but would have applied additional pressure to the sacral region.

Also, some evidence suggests that once the initial damage has been caused, it is not uncommon for wounds to quickly break down, from a superficial wound to a large ulceration (Liposuction et al, 2008) and this may have been

inevitable in Marry case. As Mary returned home from hospital, her discharge was planned and implemented by the nurses and other members of the multidisciplinary team (MET). According to Birmingham (2004, cited by McLeod, 2006, p.

43), discharge planning is a process Nearby the patient's needs are identified before a plan is formed to facilitate a smooth transfer from one environment to another.

The aims of discharge planning are to co-ordinate resources and enhance the patient's involvement in their care and session-making (Affirmations et al, 2004; Billings & Kowalski, 2008). Smith (1996) argues that it should also aim to achieve continuity of care, whereby a well orchestrated discharge ensures that adequate and appropriate care continues after leaving an acute setting. One of the most important elements of successful discharge planning is communication (Esquires, 1991. Edited by Smith, 1996, p. 39).

The importance of effective communication and interpersonally collaboration has been recognized for many years (Meier & Pollard (2009), and forms an integral part of many national policies, such as The NASH Plan (Department of Health (DO), 2000). Indeed, there are many benefits to detective intergenerational collaboration, such as enabling capitalization of skills or expertise and streamlining care, with less duplication of efforts (Bella, 2007; Rued & Smith, 2002).

Also, more importantly, the patient benefits from effective collaboration through improved outcomes, continuity of care and cost- effective service

provision (Bella, 2007). Ukrainian et al (2007) believe that there substantial deficits in communication between acute and primary care settings; they feel that the traditional discharge summary does not provide the optimum method of immunization timely, accurate and important medical information to those responsible for follow-up care. Dynamic (2000. Edited by Ukrainian et al, 2007) states that inaccurate information about a patient's hospitalizing can lead to faulty decision-making or failure to monitor a patient's condition during their after care.

This is supported by Rothschild et al (2001), who believe that faulty transfer information can result in adverse incidents, such as drug errors and unplanned hospital readmission. When Mary was discharged from hospital there, unfortunately, appeared to be a significant breakdown in communication between he acute and primary care teams.

The district nursing team were not informed of her discharge, so were unable to take over her care when required. Also, the discharge letter given to Mary was lacking in information and failed to mention the deterioration of both her pressure ulcer and mobility. As has been suggested, these factors significantly affected the continuity in Marry care, delayed appropriate interventions from being implemented, and may have put her at risk of readmission to hospital. O enable appropriate and effective care to take place once in the community, it was accessory for the district nurses to undertake several roles within the MET.

The roles of the nurse in the rehabilitation context are numerous and varied (Whitlock, 2001; Long et al, 2002); however, Low (2003) believes that

although nurses have an integral role in patient rehabilitation, their boundaries are often blurred with other members of the healthcare team. Jester (2007) develops this theory by suggesting that the role of nurses in rehabilitation in the I-J generally remains underdeveloped.

She argues that nurses are struggling to find their identity as a specific role within obliteration, which can lead to confusion and uncertainty for other members of the MET, patients and careers Ouster, 2007). In contrast, Smith (1999) identified six main nursing roles in rehabilitation: technical expert and provider or care, psychological support, educator, coordinator, teamwork, and evaluator. Others have suggested additional roles such as counselor, advocate, researcher and goal-setter (Davis & O'Connor, 2001; Whitlock, 2001; Prior & Smith, 2002).

Due to word limitation, the roles and functions of the nurse being considered are those most pertinent to care of Mary; these have been identified as nursing expertise and care provision, education and coordination. Rhea provision of care is one of the most basic elements of nursing (ARC, 2003). Once described by Carper (1978) as the ' art of nursing, a nurses' knowledge and ability to care is temperamental to the procession, and essential tort nursing care to be detective : DO, 1999; ARC 2003).

The nurse's role is to provide holistic care in order to meet all the needs of the patient, such as psychosocial or spiritual and not merely the physical (McCarthy, 2006). Expertise is also of crucial importance; as the nursing role as developed and expanded, so too has to the need to acquire greater knowledge and clinical skills (Robinson & Vaughan, 1992). Indeed it is a legal

requirement of nurses to ensure that their knowledge and skills are kept up to date and the best available evidence is used to inform their practice (NC, 2008).

Hen the community nursing team first began caring for Mary, a comprehensive, holistic assessment was conducted to identify her healthcare needs and to help plan appropriate interventions (Bowie, 2001). The questions that were asked included how Mary felt within herself, her outlook on life, and her perception of body image, although the majority of the assessment did focus on her physical capabilities and healthcare problems. Mary may have benefited from greater opportunities to express her feelings about the things most important to her, rather than following the rigid structure of questions and answers.

However, from the assessment, the nurse was able to determine Marry primary needs as pressure area care and mobility, which were causing her a great deal of anxiety and frustration. The nurses used their knowledge and expertise in identifying the grading of the pressure ulcer and in determining the most suitable treatment to promote optimal healing. Hen it became apparent that Mary would require additional support from other healthcare professionals, the nurses discussed the possible options with Mary and her careers.

Patient involvement in the planning and decision-making of their care is pivotal in providing person-centered care (McCormick & Enhance, 2006); a concept Inch fundamental to many government initiatives and policies such as The Essence of Care (DO, 2001 a) and The National Service Framework for

Older People (DO, 2001 b). Rhea nurses sought at every opportunity to involve both Mary and her careers in all the sections about her care; this involved providing them with adequate information so that they were able to make informed choices. He nurses' role as educator is also essential within the rehabilitation context Earnest, 1999; Wiles et al, 2001). Penitent & Grove (2007) believe that rehabilitation is an education-based discipline; an integral part of the nurses' role is to provide education and information, whilst modeling evidence-based practice (Penitent & Grove, 2007). It not only helps the individual to make informed choices about care, as already discussed, but also promotes mental wellbeing, as the patient is able to feel included and in control of their care (Bastard & Sleeve, 2003).

The nurses were able to offer advice and education about pressure area care, so that both Mary and her careers were aware of how best to prevent further tissue damage and promote healing, such as the need for regular position change and the use of pressure- relieving devices. They were also able to otter advice regarding Ma lilt, such as the optimal way to aid transfer between bed and chair, and by encouraging deep breathing exercises to prevent a recurrent chest infection. However, the nurses also realized the need for referral to other services, to ensure hat Mary received the complete and holistic care that she required.

According to Linked & Cricketers (2005. Cited by Hall et al, 2007, p.

69), no profession can stand alone, but is dependent on the knowledge and skills of other health care professionals, in order to practice successfully and provide a complete service. Gasper (2003) states that is it important for the

individual to be aware of their own competencies, so that when one's own skills or knowledge are lacking an appropriate referral is made, to ensure patient safety is maintained and that the best possible care is delivered.

This is also another requirement of the NC (2008); a nurse must Nor cooperatively within teams, respecting the skills, expertise and contributions of colleagues, make referrals to other practitioners when it is in the best interests of an Individual under their care, and must be able to delegate effectively (NC, 2008). Rhea nurses identified that the expertise of physiotherapists and Tot's were required to provide Mary with a comprehensive care service.

By coordinating Marry care, a prompt referral to the intermediate care team ensured that her additional needs Nerve swiftly addressed and treatment could be commenced at the earliest opportunity. The nurses also liaised with the GAP to ensure Mary received the appropriate medication and analgesia she required.

Coordinating her care in this Nay ensured that all the healthcare professionals who needed to be involved were, and that each professional was aware of the others' input; this helped to ensure continuity of care whilst preventing a duplication of services and waste of resources. He purpose of this essay was to consider the roles of the nurse in a rehabilitation context, by way of examining a patient case study, to determine the effectiveness of these roles in the delivery of patient care. The pathologically of pressure ulcer development identified the potential risk factors for this elderly patient and helped to explain how her wound developed from a grade I to a grade Ill

pressure ulcer; however, the fact that the majority of pressure ulcers are as a result of poor nursing care, this entire scenario may have been prevented.

The discharge planning process Nas seriously flawed; what should have resulted in a clear, prompt referral from acute to primary care was lacking. This had a detrimental affect on the patient’s Ineligible and recovery as this caused a delay in the district nursing assessment, retirement and subsequent referrals to other members of the MET. Good communication is key to effective interpersonally collaboration and in ensuring the safety or patients under our care; when this is lacking patient care suffers.

This essay has identified that nurses play an integral role in the rehabilitative care of their patients.

Their role may be vast and complex, but the boundaries between other health professionals is often blurred and there may be difficulty in clearly defining the exact nurses’ roles. Due to word limitation, the nurses’ roles in this scenario could only be briefly explored The three main roles were identified in the care to Mary were nursing expertise and care provision, education and coordination. From the literature discussed and the interventions of the nurses involved, these three main roles were undertaken effectively and were of benefit to the patient. However, many other roles, such as those advocacy and teamwork were also apparent.