

# [Refusal of treatment essay](https://assignbuster.com/refusal-of-treatment-essay/)

The purpose of this essay is to devise a plan of care for a patient. The plan must be in relation to an actual or potential problem as identified under the Activities of Living (ALs) using the Roper Logan and Tierney model of nursing. For this a patient has been selected after meeting with them in a ward setting in the geographical area.

Adequate verbal consent defined by Kozier et al (2008) as ‘ an informed decision making process’ has been obtained from the patient and in order to protect their identity and coincide with NMC guidelines of patient confidentiality the patients name has been changed and neither the ward nor the hospital shall be disclosed. The patient is Miss Webster who is a 46 year old female admitted to the ward with shortness of breath and an exacerbation of her chronic obstructive pulmonary disease (COPD).

Her past medical history includes asthma, COPD, chronic bronchitis, frequent chest infections, endometriosis, polycystic ovarian syndrome and a radical hysterectomy in 2007. As previously mentioned the Roper Logan and Tierney model shall be used in order to identify an actual or potential problem relating to any of the twelve activities of living and a care plan shall be devised and implemented based upon this. But what exactly is the Roper Logan and Tierney model of Nursing?

Holland (2008) summarise this model by stating that it is divided into two parts, namely the model for living and the model for nursing. For the purpose of this essay the model for nursing shall be used. In this model there are five components. The Activities for Living of which there are twelve namely- maintaining a safe environment, communicating, breathing, eating and drinking, eliminating, personal cleansing and dressing, controlling body temperature, mobilising, working and playing, expressing sexuality, sleeping and dying.

Within these twelve activities there are five influencing factors; biological, psychological, sociocultural, and environmental and politicoeconomic. The next component is lifespan which is again divided into five stages as a person’s ability to be independent in the AL are affected by where in the lifespan they lie at any particular time. These stages are infancy, childhood, adolescence, adulthood and old age. The dependence/independence continuum is the next component which is previously stated is strongly interlinked with that of lifespan. The fifth and last component is individuality in nursing care.

Roper et al (2000) consider that a person’s individuality can manifest itself in many different ways and that this is where individualised care and the nursing process comes into play. The nursing process can be broken down into four parts; Assessment, Planning, Implementing and Evaluating. Each of these parts shall be explained in depth throughout the body of the assignment. Before a plan of care can be devised a holistic assessment of the patient must be carried out as described in the model but what is assessment and why is it so important?

Heaven and Macguire (1996) and Kozier et al (2008) state that assessment is a systematic, continuous, interactive and deliberate process which involves collection, organisation and documentation of data which underpins every aspect of nursing care. Holt (1995) believe assessment to be ‘ the only way in which the uniqueness of the patient can be recognised and considered in the care process’ and Holland (2008) believe it to be through assessment that the Nurse-patient relationship is established and a bond made.

Although generally accepted as the first stage in the nursing process Roper et al (2000) point out that assessment should be ‘ cyclic’ rather than a one of event. Harris et al (1998), however, point out that too much emphasis is placed upon following such a model to the letter resulting in the prevention of the nurse realising the significance of information presented to them. This controversial statement is contrary to the beliefs of Fraser (1990) and McKenna (1990) who believe that such a model can articulate the nursing care and enhance the quality of assessment.

Timmins and O’Shea (2004) point out that as this particular model is arguably the most commonly used within Europe that it may be the most beneficial to use. This, however, means that it is of utmost importance for the nurse to use critical thinking skills and interpret information accurately which will rely on the nurse’s own knowledge base and so ‘ to accurately collect data both the nurse and the patient must actively participate’(Kozier et al 2008). There are many ways in which data can be obtained during an assessment.

Namely, from the patient themselves, from family members and significant other, from friends, from other healthcare rofessional and from previous nursing and medical notes. Data may be subjective- apparent only to the patient themselves or objective- easily seen and measurable (Kozier et al 2008). Carefully following Roper- Logan and Tierney’s model the following assessment was carried out. Firstly biographical and health data were obtained from the patient such as the patients name, important not only for patient identification but also to prevent potential harm to the patient such as medicine administration errors (Holland 2008). Age was confirmed to see where they were in correspondence with lifespan.

A Miss Webster is 46 she falls into the adulthood bracket. Address is confirmed to not only ensure the patient has a place of residence and does not require referral to additional services such as social services or homeless officers but also to gain an insight into the background of the patient and see whether social deprivation is evident (Kozier et al 2008). Employment status is gained to see how the patient may be economically affected by their particular illness and for legal reasons and to confirm a support system next of kin is appointed (Marsden 2003).

As the model progresses the twelve activities of living are individually assessed and the patient place on the dependence/ independence continuum established. The first Activity of Living to be assessed in this case, as with any other is breathing. As shortness of breath was Miss Webster’s chief complaint it is important to ensure that any physical breathing difficulties are dealt with first and that she is stable enough to answer any following questions. During the discussion which followed it was discovered that Miss Webster is a heavy smoker which is an actual problem in relation to her status as a COPD sufferer.

It has been found that smokers suffering from COPD are at a significantly higher risk of developing lung cancer than their smoking counter parts that do not have this Long Term Condition (Bellamy and Booker 2004). Breathlessness was also assessed here, although a subjective term it is one of the most important ways of establishing a baseline and will help to identify whether any future interventions and subsequent treatment is effective. As breathlessness is also an actual problem for Miss Webster perhaps methods such as pulmonary rehabilitation and pharmacotherapy should be explored in the future (Bellamy and Booker 2004).

The next Activity of Living to be assessed was maintaining a safe environment. In order to assess this physical observation such as pulse, temperature, blood pressure and respiration rate were obtained. This not only established that Miss Webster respiration rate was high at 26 breaths per minute but also that her breaths were rapid and shallow. These observations are important to establish a baseline so any physical deterioration can be detected and to detect any early warning signs. These also help to plan any care or treatment Miss Webster may receive.

One issue raised as a potential problem for this AL was again smoking. This is due to the fact that a high number of COPD sufferers require at home oxygen therapy in the final stages of the disease process and as a smoker Miss Webster would not be suitable for this treatment in the future due to the potential for explosion (Marsden 2004). Communication was assessed to ensure that Miss Webster could not only understand any verbal but also written information provided to her. Miss Webster had no literacy or hearing problems, however, her ability to talk was compromised by her shortness of breath.

Robinson (2002) state that ‘ effective communication is an essential prerequisite to an effective nurse patient relationship’ which meant that this was a potential problem for Miss Webster communicational needs. Eating and drinking, which are not normally a problem for Miss Webster were also assessed. It was found that due to her increased shortness of breath Miss Webster was not able to eat or drink and so interventions such as artificial nutrition and hydration may need to be explored in order to prevent complications for Miss Webster such as dehydration and malnutrition.

Miss Webster BMI was high at 36 which was also noted as a potential problem here as her being overweight can also affect her ability to exercise and breathe properly in the future (Lippincott et al 2008). Normally Miss Webster is independent with elimination and personal cleansing/ dressing, however, since her exacerbation she has found these tasks increasingly difficult and has been relying on help from her sister in order to get washed and dressed in the mornings. She has also been incontinent on more than one occasion as she has simply been too out of breath to make it to the bathroom in time.

This has a knock on effect to her mobility also. Miss Webster has no physical problems with mobility other than being overweight but her breathing means she has a limited mobility as she cannot walk far without becoming short of breath. This may mean that an assessment such as waterlow should be carried out to maintain Miss Webster skin integrity. When it comes to working and playing one potential problem here is Miss Webster’s job. As a foster carer Miss Webster is required to be fit and healthy enough to look after children of any age placed in her care along with her own two boys.

Miss Webster’s current health condition means that she is unable to do so and does not have a reliable income at the moment meaning her and her two boys are in economical crisis. As Miss Webster is not currently in or looking for a sexual relationship this issue does not require to be discussed in depth. However, it is important to remember from Miss Webster past medical history that she has had a hysterectomy and may require emotional support with her sexuality as a woman without these sexual organs.

From a health promotion point of view Miss Webster may not realise the importance of continually practicing safe sex now that the element of unwanted pregnancy is no longer an issue and so may require advice on the best safe sex practice to avoid sexually transmitted diseases and infections which are so prominent in her age range (Kozier et al 2008). Another area where Miss Webster may require emotional support is when it comes to death and dying. Although it is not expected that Miss Webster will die at this time she may feel that is not the case due to her severe breathlessness and may require reassurance from staff.

Immediately following this assessment a plan of care for Miss Webster should be initiated (Kozier et al 2008). Although mainly the nurse’s responsibility in order for this to be as effective as possible the patient and any significant support person should be involved in this process (Parsley and Corrigan 1999). According to Roper et al (2000) the objective of a care plan is to ‘ prevent identified potential problems from becoming actual problems, solve actual problems, alleviate those which cannot be solved and prevent recurrence of treated problems’.

This process requires the identification of nurse/patient outcomes and appropriate interventions to allow the patient to reach these desired outcomes or goals (Marsden 2004). Priorities should be set and referrals made where appropriate (Shaw 1998). Measurable goals should be set (Alfaro-Leferve 2002) and a realistic timeframe should be applied. These goals should be both short and long term (Kozier et al 2008). Kemp and Richardson (1994) believe that ‘ one advantage of goal setting is that it gives the patient something to work towards- something to strive for’.

White (2003) believes that suitable nursing interventions should be put in place in order for these goals to be achieved. When this has been carried out it is important to ensure all planned care is accurately documented not only to ensure continuity of patient care but also as a legal requirement (Walsh 2002). Walsh then goes on to say that these care plans can either be handwritten or a more modernised computer version. For the purpose of this essay only one actual problem has been chosen to formulate such a plan of care.

Smoking was chosen by the patient as her top priority perhaps due to the fact that she realises that smoking is, as described by MacNee and Rennard (2004) ‘ the single most important factor in the development of COPD’. As she is a mother Miss Webster wishes to slow down the progression of this illness which not only affects her breathing but every single aspect of her activities of living. Bellamy and Booker (2004) suggest that stopping smoking is the only intervention to significantly affect the natural history of COPD and the sooner Miss Webster stops the more benefit she will gain from it.

They go on to say that perhaps an exacerbation of COPD is just the trigger needed by a patient to decide to stop smoking where as slowly progressive breathlessness is not enough to spur such a decision. They also believe that targeting a patient when they are most susceptible helps to increase success rates when it comes to stopping smoking. All of this in mind a SMART goal was set by Miss Webster with the assistance of health care professionals. This means the goal was Specific, Measurable, Attainable, Realistic and Time-bound (Nursing Avenue 2011).

The goal set by Miss Webster was to quit smoking on the 9th of December 2011. As can be seen this goal fits into all of the aforementioned categories. Kozier et al (2008) suggest that the goal should be written in response to the patient rather than to a nursing intervention in order to guarantee success. In order to help Miss Webster achieve her Goal nursing interventions were devised. These were firstly to ensure that Miss Webster had access to smoking cessation services in order to achieve her goal as set out by NICE (2006) guidelines in relation to smoking.

This is useful as it has been found by studies carried out by MacNee and Rennard (2004) that although 70% of adult smokers wish to quit and 45% of them carry out a serious attempt each year only 2% are successful without the intervention of appropriate services. Further studies by Silagy et al (2001) and Rice and Stead (2001) discovered that when advice, counselling and behavioural support is offered by health care professionals this number is significantly increased.

MacNee and Rennard found that simple advice given conversationally by physicians helped to boost this number by up to 6%. The second intervention applied was to ensure Miss Webster received pharmacological support in order to quit smoking. MacNee and Rennard (2004) have again carried out studies which have shown that pharmacological support increases a person’s chances of successfully quitting smoking by up to 50%. They believe smoking is not a lifestyle choice but a disease entity in its own right and should be treated as such.

In 2001 Nicotine replacement therapy became available on the National Health Service (Holland 2008) due to the fact that it had been found to be economically more viable than treating conditions brought on by smoking. Bellamy and Booker (2004) suggest that by matching the patient to the correct product success rates are further increased. As Miss Webster is heavy smoker it may be most suitable for her to use a product such as gum, sublingual lozenges or inhalers as they allow the nicotine to enter the bloodstream quicker and provide a ‘ hit’ much the same as smoking would (MacNee and Rennard 2004).

These interventions are described by McClosky and Bulechek (2000) as being dependant interventions as they cannot be carried out independently by the patient without the support of a health care professional. Implementing is the third stage in the nursing process (Holland2008) and consists of ‘ doing and documenting’ the activities that are specific nursing actions needed to carry out the interventions (Kozier et al 2008). In this case this involved referring Miss Webster to smoking cessation services who were able to take over her care.

Her GP was also involved in this process as he was required to prescribe any pharmacological interventions required. Family members and support people were also required to help Miss Webster through the nicotine withdrawal symptoms which Kozier et al (2008) explain should have been described to her beforehand in order for her to prepare for them. It is said in Holland (2008) that although tasks may have been delegated within the implementing process it is important that the nurse maintains the responsibility of ensuring these are carried out effectively.

Evaluation is the final stage in the nursing process (Kozier et al 2008) which involves judging or appraising the patient’s progress towards the goal and the effectiveness of the nursing interventions (Holland 2008). Roper et al (2000) believe that the evaluating phase provides a basis for ongoing assessment and if the goals have been met then the interventions were successful. Due to the fact that this essay is based upon a real patient and a real time frame an evaluation has not yet been carried out.

This is due to the fact the MacNee and Rennard (2004) believe that the optimum period for an evaluation to be carried out is one to two weeks after the set quit date. They do however, point out that the follow up evaluations are strongly linked to a higher success rate. Has Miss Webster been successful in her attempt to quit smoking her NRT may have to be altered in order to ensure her continued success (Bellamy and Booker 2004). However, if this is not the case then it is important to encourage her to try again (Holland 2008).

Failure may be due to something as simple as the patient having the wrong pharmacological product for her needs. Tashkin et al (2001) suggest that many COPD sufferers require intensive interventions when quitting smoking and so further referrals may have to be made for Miss Webster. When reviewing this process it can be said that smoking has a great link to decreased independence and ability to perform many of the activities of living. While assessing the patient an appropriate nurse patient relationship was built.

Although the patient had trouble breathing she appreciated the fact that she was listened to and heard. A non judgemental attitude was used which also helped with the nurse patient relationship and helped Miss Webster come to the conclusion that stopping smoking was not something she was being bullied into but something which she decided upon herself. Although an evaluation has not yet been carried out it s the hope that Miss Webster has been successful in her attempts to ensure she stays well for as long as possible and enjoys her time with her family.

In conclusion it has to be said that when an appropriate model is used for guidance it can actually help to enhance the nurse patient relationship as the nurse has more time to spend focussed on her patient than to wander what she should do next. By following this framework an effective care plan was drawn up and implemented meaning that the patients care was as effective and quality driven as possible.