Public health reflection on care

Title: Reflect upon an incident which occurred during your clinical placement as a student Public Health Nurse. The chosen incident is one where you met an elderly client with a leg ulcer who was not complying with the treatment prescribed from hospital.

This essay is a reflective consideration of a case that had been encountered in clinical practice. For the purposes of illustrative discussion, I shall use the Gibbs model of reflection as a guide. (Gibbs, G 1988)

Description: describe in c. 400 words the experience. Client fell at home and fractured lower ankle. He neglected this and developed ulcer. He attended GP and completed 2 courses of antibiotics: referred to leg ulcer clinic in local hospital; diagnosis was ulcer with mixed arterial / venous disease.

The client concerned will be anonymised and referred to as Mr. S in accordance with the NMC guidelines (NMC 2004). Mr. S is a 68 yr old man who lives alone having been widowed for 12 years. He is normally self caring but has been getting progressively more frail as time goes by. He fell at home and fractured his lower tibia. There was a suspicion that he has been drinking rather more than might be considered good for him and it is possible that this fall was after a bout of drinking. (Nicol M et al. 2004).

Being generally very stoical, he initially ignored this but was forced to seek medical advice when the pain got too great. The fracture was treated with a plaster cylinder after reduction of the fracture but he subsequently developed a leg ulcer from direct pressure and friction from the cylinder which eventually attained a size of about 10 – 15 cms across and, despite being referred to the leg ulcer clinic and having regular visits from the

community nurse who applied Aquacell AG , it refused to heal. (Harding K G et al. 2002)

It was subsequently discovered that after the nurses had been to clean and dress the leg, Mr. S would take the dressings off and put iodine onto the wound which produced a marked allergic reaction. When challenged about this he said that he “ didn’t hold with these newfangled ideas” and that he wanted to use a remedy that his grandmother had used with great success when she had developed a leg ulcer. Initially there was an impasse with the nurses wanting to use the dressings that had been prescribed by the hospital and Mr. S, although allowing them to be out on, would promptly disturb them and put the iodine directly onto the wound. The community nurses were asked to persist with the dressing regime and after a few weeks it became clear that the leg ulcer was making no progress at all. It was not healing, it was permanently infected and persistently sore with inflamed and macerated wound edges. (Donnelly A et al. 2000).

There was considerable discussion in the primary healthcare team relating to Mr. S’s right to autonomy (Seedhouse D 1998) and whether it was right or not to continue to commit large amounts of resources to a clinical situation that was not only not healing but was actually being actively undermined and made worse by the patient. (Thomas J E et al. 1990). To an extent, it is not ethical to insist on, or to impose a treatment which the patient is (by word or action) objecting to. It is difficult to justify a course of therapeutic action, which may have the strongest of evidence bases, if the patient does not want it. (Hunt T 1994)

The situation was compounded by the fact that Mr. S was not an easy patient to deal with as, since his wife died, he had become progressively more reclusive and he was clearly uneasy with other people coming into his house. The current course of treatment was clearly not successful and therefore a completely different approach needed to be tried.

Feelings: how did client/you/others feel in this situation? How did you know this? The student was annoyed that the client was not complying with treatment and she knew the treatment he was applying was outdated and potentially harmful. Student is accountable to An Bord Altranais for their practice and must refer to evidence based practice. Student observed how the treatment applied by client had its place in the past and PHN made family aware that new dressings have silver content which has greatly improved results. Empowerment and advocacy were adopted.

I found my feelings ran through an evolution of emotions and that the initial set of feelings were of annoyance, frustration and irritation that Mr. S could not see that the healthcare professionals were trying to help him. I initially saw him as a rude and aggressive gentleman who clearly did not want “ interference” from the nurses and was content to live in comparative squalor. His persistence of the use of the iodine seemed to me to be mainly due to sheer perversity rather than any rational reasoning. (Osterberg L et al. 2005)

I know that my original exchanges with him were very terse and aggressive, as I could not understand why he was persisting in using something which had no substantive evidence base and was clearly making the situation

worse. My feelings changed to being less overtly annoyed as I came to realise that Mr. S was actually trying to use something that he had seen his grandmother use to heal her own leg ulcer and that there was a degree of reason beneath his obstinacy.

My mentor took a different view and explained that empowerment and education (Howe J et al. 2003) was the way to achieve success with Mr. S and I watched as she firstly gained his confidence and then explained the reasoning behind the new Aquacell AG, she also explained that the iodine, far from helping healing was, in his particular case, preventing the leg ulcer from healing and that his situation was quite different from the situation of his grandmother‘ s ulcer. (Miller, A. 1995). After about three sessions, it was noted that Mr. S had stopped interfering with the dressings and that the iodine was no longer being applied. As a result, the wound started to heal. As soon as he saw this, Mr. S became much more content to allow the nurses to continue with their work and actually became almost welcoming. (Faden, R R et al. 1986). At this stage, I found that my feelings changed to actually liking Mr. S and looking forward to each meeting. I also developed a great deal of respect for my mentor and the other important realisation was a feeling of annoyance towards myself at my own initial inability to realise the motivation behind Mr. S’s actions. (Schon, D. 1997)

Evaluation: what was good and bad about the situation? Mentor was able to develop relationship of trust with client.

The bad elements of the situation was that the concept of empowerment and education (Howe J et al. 2003), was not embraced earlier in the treatment

programme and that each treatment application was simply met by the acceptance that Mr. S was interfering with the dressings. There was the additional possibility that Mr. S was drinking more than was good for him and this element of the situation was overlooked with the prime focus being on the leg ulcer rather than making a holistic assessment of the whole situation. Equally bad was my inexperience-based lack of insight into the situation.

On the good side, the fact that the mentor was able to " stand back" from the situation and make a dispassionate and empathetic assessment of the situation, construct an appropriate managements plan and then persuade Mr. S to comply with it to achieve a good clinical outcome, was a very positive step and a testament to the clinical experience of the mentor.

Analysis: what sense can you make of the situation? what knowledge did or should have informed you? how does this connect with previous experiences? Reflection is necessary to enlighten a clinical situation. Element of compromise needed. Client centred approach required. Student PHN had experience of working as Community General Nurse. She found observing how the mentor dealt with the situation very enlightening. Discussion with client's family was beneficial.

Analysis of the situation shows the potential gulf between the pursuit of evidence based medicine and the practical difficulties in actually applying it. It is all very well knowing that Aquacell AG releases ionic silver into the wound in a delayed and controlled release manner as the wound exudate is absorbed, thereby releasing more silver in the most contaminated wounds. (Bowler P G, 2003).

The fact that the dressing formulation itself is thought to protect the periwound skin and thereby aid in granulation formation is of theoretical importance. In cases of leg ulceration, the fact that the dressing conforms easily to the surface of the wound helps with occlusion and thereby maintains a moist healing environment (Jude E B et al. 2007) is clearly a substantial contribution to the evidence base in this area. The fact that dressing exerts a demonstrable antimicrobial activity for up to 7 days reduces the need for frequent dressing changes and therefore frequent wound disturbance (Jude E B et al. 2007) is of practical and clinical importance, but none of these factors are of any use at all if the patient does not understand or is willing to comply with the clinical therapeutic regime.

In essence, this case illustrates the gulf between the knowledge that is assimilated in an isolated academic situation and the knowledge that is derived from experience in clinical situations. (Van Manen, M. 2007). It was my reflection on the situation that allowed me to appreciate the true value of my mentor’s experience and handling of the situation which was the critical factor in persuading Mr. S to understand both his predicament and the rationale behind the treatment that was being offered and this was the key to his eventual understanding and compliance. (Marinker M. 1997). It was clear that simply persisting with the situation was not going to achieve the desired effect and that a degree of compromise was needed. That compromise was achieved by viewing the situation from the patient’s viewpoint and then tailoring the clinical approach to an empathetic understanding of that perspective. In other words a client centred approach. (Platt, F W et al. 1999).

The point about Mr. S's drinking was no longer overlooked and discussions with his extended family confirmed the clinical suspicion. Pressure was exerted by the family to reduce the opportunities for his drinking and they increased the degree of social interaction (reduced his social isolation) which also had a beneficial effect (Wilkerson, S. A et al. 1996)

Conclusion: how do you now feel about this experience? what else could you have done? has this changed my ways of knowing?

I can say with confidence that reflection on this whole episode was a major learning experience for me. Not only did I witness and important lesson in patient management, but I was able to reflect on the evolution of my emotional approach to the situation. It showed me how my initial aggression and annoyance was not only completely misplaced, but that it was also completely counterproductive. As a conclusion, I have seen just how important it is to stand back from a difficult or deteriorating situation and make a completely dispassionate and holistic assessment of the patient and his clinical situation before trying to construct an appropriate management plan. A further conclusion must be that there is very little merit in simply knowing the evidence base surrounding a particular course of treatment if one lacks the experience or humanity to actually effectively put it into action. (Fawcett J 2005)

Action Plan: if this arose again, what would you do differently?

As I have already mentioned in the conclusion, it is because this episode was a major learning experience for me that I can say with confidence that, if a similar situation arose again, I would deal with it in a completely different

way to the way which I handled this episode. I would not initially approach Mr. S with a feeling of aggression and annoyance as it proved not only to be counterproductive but it was also a barrier to my standing back and reviewing the situation. If Mr. S was clearly not complying with the treatment I would ask myself (and the patient) what were the reasons why compliance was a problem. Having ascertained the reasons, I would then construct an appropriate treatment or management plan which directly addressed this reason and contained a mechanism for directly confronting it. Empowerment and education have been demonstrated to me as very powerful tools in the quest for patient compliance and concordance. I would actively use these concepts to try to maximise the effectiveness of the treatment and also to enhance the overall patient experience. (Hewison, A. 2004)

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