

Accident and emergency care essay



**ASSIGN
BUSTER**

Teamwork is an integral part of Accident and Emergency care and if it is jeopardized problems tends to occur. Looking at communication, consent and teamwork I will explore and reflect the ways in which the patient I observed was treated and what could be done in the future care and practice of others in order to reach maximum potential with further clients.

First Part

An emergency call went out for a Chest pain in resuss one, Chest Pain Team required. As I was the student nurse in resuss for that particular shift. I was urged to join the medical team to see what was happening with this patient. As I stood and observed what I was witnessing was Myocardial Infarction.

As I was observing the situation, I was surprised to see how calm everybody was. The Resuss room is a room which consists of six bays which have specialist equipment in, if an emergency with a patient was to happen. The patient I was observing was put into the first bay, as this bay has much more space so the team of medics and nurses can work around the patient quite easily. As I was watching I noticed that the nursing staff used the ECG machine. As I was watching the patient's relative seemed concerned with what was happening to the patient. I took it upon myself to reassure the relative by explaining what was happening and why the medics where doing this procedure.

The ECG showed that the patient had ST elevation and was having a Heart Attack. I felt apprehension for the relatives and patient when this information was told to them. I observed that the patient remained calm and collected.

The patient seemed to accept the diagnosis quite well. I felt sad for the patient's relatives.

The Nursing staff then followed with the baseline observations of the patient. For example the blood pressure, respirations, pulse and oxygen saturations were measured every five minutes to monitor any changes. Everything seemed to becoming a bit clearer as I watched and I started to understand what was happening. The relative still appeared to be very apprehensive. I explained to the relatives with the knowledge that I had in order to help the situation and make them understand why the professionals were doing certain procedures. I felt almost helpless, although I did offer support to the family that needed it at the time.

It was determined that the patient needed to have a thrombolysis treatment. The patient was told by the doctor what was going to happen although I did not know what this treatment was. As this was my first experience of observing a Heart Attack as a professional. The relative asked what this treatment was and I felt helpless as I was unsure. So I took it upon myself to ask the professionals when they had time to talk.

This frustrated me; as if I would have known what the treatment was I could have helped. I feel as a Student Nurse I tended to get treated as a non entity by doctors and some nurses because you are unaware of the events unfolding in front of you. When I asked I got a comment back that was rude. This really quite shocked me to see that in a society which people are all trying to be equal and non judgmental that a Doctor could treat a fellow colleague in such a way. This really upset me, but I moved on. I explained to

the relatives what the ‘clot busting’ drug was. This made me feel good once I had done this, as I got the satisfaction that I helped the family.

My role in the critical event was observer; I did ring for a chest x ray and so that made me feel like I was contributing in a small way.

My whole perception of a heart attack is somebody gasping for breath and holding their chest. I suppose the media may have glamorized the whole episode of having a Myocardial Infarction. I was really surprised to see how controlled the situation was. Nobody was panicking everybody appeared to be calm and surprisingly the patient was calm and responding. I expected the patient to be in so much pain, and unable to communicate.

The patient did not appear to be in pain, but looks can be deceiving, as when I asked whether he was still in pain, he said that he was, but he was handling it very well. As people deal with pain in different ways. I was very interested to see post event the way the Doctors and Nurses reacted. When I asked how they felt whilst the event was occurring, the professionals were panicking inside, but they did not show it to the relatives or patient. I was panicking for the patient and the relatives. Also, the patient that I was witnessing having this episode of cardiac problems was still very young which made me feel sad, for the patient.

After speaking to the patient I felt sad for what had happened but good for what I had done to help, i. e. offering a cup of tea. I felt that I could have got more involved with the clinical aspect of the event, although I did not want to get in the way as I tend to feel like I am. I feel because it was at the beginning of my placement and I had not done much critical care I did not

know what to do. As I am further into the placement I feel I could have handled it better. I felt also that I should have spoken more to the patient, but again I may have been in the way of what needed to be done. I should have asked if the team needed any more assistance. If the situation happened now I would get more involved in the critical aspect of care.

I am glad I observed the Heart Attack it has helped me to grow and be a stronger person when dealing with critical illness. I did feel empathy for this family so I could not leave it at the Accident and Emergency stage. I rang the Coronary Care Unit to see how the patient was, which the patient was extremely pleased and grateful for. This patient made an impact on my life and I am glad I went through this with him and his family.

Second Part

A person has an acute myocardial infarction when the flow of blood through their coronary arteries is reduced to such an extent that part of the heart muscle dies. Approximately 300, 000 people in the United Kingdom suffer a heart attack each year and about 140, 000 die (Peterson et al, 1999). Many of these deaths are avoidable. Between two thirds of heart attack deaths take place outside hospital, many within the first few minutes of the onset of symptoms. Helping people avoid a heart[ss1] attack altogether is the prime aim. (National Service Framework for Coronary Heart Disease, 2000)

Whilst observing the MI I found that the patient described his pain in the chest as a stabbing pain. A recent study compared the verbal descriptions of patients with and without MI (Albarran et al, 2000). Although the preliminary findings were inconclusive, the study suggests that in addition to presenting <https://assignbuster.com/accident-and-emergency-care-essay/>

with feelings of tightness, heaviness and pressing sensations, patients with MI are likely to describe their chest pain in terms that convey a strong emotive component. In particular, women in the MI group chose words such as ‘frightening’ and ‘terrifying’ to describe their chest pain more often than men.

There are a number of studies that have discussed the difficulties in determining what a Heart Attack really is, how it is defined and the way the Heart Attack is assessed. Particularly in one recent study it was assessed that the way the questions are asked to the patient has a great bearing in which way the Chest Pain is going to be dealt with (Hofgren et al, 1994).. Over the past few years, analysis of verbal descriptions of MI has received increased attention. Research has shown that patients with subsequently confirmed MI tend to use emotive words when describing their chest pain (Hofgren et al, 1994). In reflection to the Heart Attacked observed I found that the patient could not quite understand what had happened to him. He was aware he had chest pain but could not pinpoint that it was a heart attack that he was having.

The nursing staff spoke to the patient at the initial meeting of the patient. The nurses asked specific questions to pinpoint the actual cause of chest pain. Communication is recognized as an important aspect of health care with far reaching effects (Jarman 1995). It has been frequently suggested that the use of communication skills by nurses is an integral and essential part of the care they provide (Mallett, & Dougherty, 2000).

As an accident and emergency department is a very busy environment I noticed that the nurses did stop to speak to the patient very briefly. In a study (Albarran, 2002) details that listening to a patient describe symptoms demanding a nurse's full attention and concentration, which can be difficult in a busy clinical environment. However, only by listening actively can nurses understand patients' interpretations of their experience. Through listening, nurses also communicate empathy.

Therapeutic listening takes conscious effort and involves interpreting both verbal and non-verbal cues. It can be emotionally challenging but rewarding (Albarran, 2002). Therapeutic listening enables nurses to recognise and connect various elements of the patient's presentation. In doing so they may begin to suspect that the patient has a particular condition, enabling them to pursue a specific line of questioning and carry out additional interventions to identify or eliminate life-threatening causes of acute chest pain (Mallett, J ; Dougherty, 2000).

Whilst the patient was in the resuscitation bay the doctors and nurses always spoke about what they were going to do to the patient. Asking for the patient's consent at all times. In cases of an emergency, consent will be implied by law even though there has been neither proof of actual willingness nor conduct indicating consent by the patient (Qualls, 1999). This type of situation occurs daily in a busy emergency department and includes situations where a "reasonable" patient would consent to treatment if able and delaying such treatment would endanger the health or life of the patient. Thus, patients who are incompetent, unconscious, or have an altered mental status and minors or those otherwise incapable of giving consent are

deemed by the “reasonable patient” argument to have given consent. It is prudent and expected that the physician seek consent if possible from a parent, spouse, or legal guardian once it is feasible to do so. This implied consent extends only as far as necessary to address the immediate threat to health or life (Qualls, 1999).

If a patient is suspected of having a MI the ambulance alerts the hospital either by alert phone or beeps and gives Accident and Emergency an expected time of arrival. Patients with chest pain are seen by medical staff extremely quickly. The time undertaking the first ECG is the time the medical team will arrive to examine the patient, almost instantly. Trusts are now consistently achieving a door to needle time of 30 minutes or less for their patients with an Acute Myocardial Infarction. Patients presenting with chest pain – whether self presenting or via ambulance – are ensured an ECG within five minutes of arrival (Improving Services for People with CHD, 2005).

When the patient was brought into Accident and Emergency there was senior and junior doctor. The nursing staff were there to assist with the care of the patient. A senior doctor should be on hand when a chest pain patient appears at Accident and emergency. This is to oversee the running of the incident. Relatively young and inexperienced medical staff are given the choice to make a critical decision on the degree of chest pain a patient is experiencing. (NSF, 2000) Arrangements for assessments and treatment of the patient’s acute chest pain are made; this includes the eligibility for the thrombolysis treatment or heparin. This is usually done by the junior doctor, assisted by the senior practitioner. The cardiologist will be contacted once the heart attack is over so the correct measures can be put into place for the

<https://assignbuster.com/accident-and-emergency-care-essay/>

patient to be taken to a cardiology ward (NSF, 2000). Here the patient will be put on close observations monitoring for signs of any further cardiac problems (NSF, 2000).

In some trusts across the United Kingdom nurses are beginning to administer thrombolysis treatment. This is so the patient can receive the treatment quickly, as the nurses can be the first on the scene when a patient is brought into the Accident and Emergency department (Improving Services for People with CHD, 2005).

Third Part

Having identified a number of areas, I will now look further into the consent of a patient and the ethical dilemma behind this. I will also address communication between patient – doctor and nurse.

Ethical decision making can perhaps best be described as an active, rational process by which we decide what we ought to do through application of moral and professional principles. Traditionally, medical decisions have involved the concepts of autonomy, beneficence, non maleficence, and justice (Brown, 1999).

The application of ethical decision making in the emergency setting does not allow for as complete an analysis as would otherwise be possible. A rapid approach to emergency ethical problems can be summarized in three tests.

Impartiality test: would you, as the practitioner, be willing to have this assessment or treatment performed if you were in the patient's place?

Universalizability test: would you be willing to perform this action in all

similar circumstances? Interpersonal justifiability: Are you able to justify your actions to other? (Brown, 1999[ss3]).

The decision making was done very quickly and precisely by the doctor in charge. Due to the Heart Attack that the patient was experiencing he provided the treatment quickly and efficiently. In a life threatening situation the doctor has to make good decisions in a small amount of time. So the correct treatment is administered (Beaver, 1999).

Adults that are of sound mind and ability can understand the consequences of their actions and can give legally informed consent or refuse treatment. The term competence refers to a legal definition of a patient's general mental ability to make decisions for one self (Qualls, 1999).

In an emergency setting, the physician must taken an immediate decision regarding a patients ability to understand and regarding a patients ability to understand[ss4] and make informed decisions regarding medical care (Qualls, 1999).

Consent must be granted freely and may be invalid when it is procured by coercion or under duress (Qualls, 1999).

Express consent, given by the patient either orally or in writing, grants permission to precede with a particular procedure or treatment plan. Most emergency departments use a general consent form that patients are asked to sign at the time of registration. This practice has been criticized because it fails to conform to the ideal concepts of informed consent and does not provide adequate legal protection against claims of insufficient disclosure. In

a survey by Biosaubin and Dresser, 16 emergency departments' patients, only 18% indicated that the purpose of the form was to give consent for treatment; 57% reported that they did not know the purpose of the form, and 26% believed that signing the form gave authorization for surgery (Qualls, 1999).

The nature of informed consent is bound within legal and moral duties. An analysis of informed consent includes the elements of understanding, disclosure, competence, voluntariness and authorisation, all of which can be affected by a variety of factors. Nurses can make a unique contribution to informed consent situations either as advocates, interpreters, coordinators, witnesses or culture brokers[ss5]. In order to fulfill their obligations to the patient and manage potential conflicts, nurses need to have a substantial awareness to the diversity of issues and pitfalls. Communication skills and building a therapeutic alliance with the patient are at the heart of nursing care (Albarran, 1996).

Consent is a big issue in the health profession due to the legalities and the ethics (Qualls, 1999). Patients have the right to say no to any procedure they do not approve of. This is why physicians have to be careful when communicating with patients and this is why communication and consent stand side by side together[ss6]. If a physician was do a procedure without consent from the patient they could be in predicament with the law. This is why communication is a big part of nursing and doctor's profession (Quall, 1999).

Communication is complex and involves more than the spoken word. It is also about listening to patients and attempting to understand their knowledge, fears and expectations in relation to proposed investigations and treatments (Jarman 1995). Factors such as voice tone, volume and vocal content. However, the research into communication in nursing is often deductive, pre-categorized and pays little attention to the organization of naturally occurring verbal and, particularly, non-verbal communication (Albarran, 2002). This may result in a lack of consideration of the importance of factors such as gaze and gestures in nurse-patient interactions (Mallett 1997).

Body movements and touch are examples of non-verbal communication that may be crucial in assessing patient' needs (Porchet-Munro 1991). This article states that ' body language gives away our uncertainties' and ' unmasks words'. Thus, in a clinical situation it may be possible to give one verbal message whilst transmitting an incongruous non-verbal one. For example, a nurse may adopt an inappropriate, cheerful expression while conveying bad news to a relative. Touch is another important aspect pf non-verbal communication that can be directed and used in a meaningful manner.

However McCann ; McKenna (1993) indicate that most of nursing touch may be task orientated rather than expressive in nature, but some patients may not perceive any touch positively. Touch that is perceived as inappropriate to the patient is not therapeutic and with different cultures can cause offense and even harm to the patient. (Mallett ; Dougherty, 2000[ss7])

The most common problem in obtaining an accurate pain assessment is how the questions are asked. For example: ' Do you have chest pain?' is a closed

question. Rephrasing the question to incorporate the words used by the patient at presentation may result in a more meaningful interaction.

Interestingly, pain is a word often used by health professionals but rarely volunteered by patients, who may use a range of alternative words (Treasure, 1998[ss8]).

Patients may supplement or reinforce verbal descriptions of pain or other symptoms through body language. Non-verbal communication is often used to express physical or emotional sensations. In particular, manual gestures may depict or illustrate both the intensity and qualitative dimensions of pain symptoms (Treasure, 1998; Albarran et al, 2000). For example, clenching the fists over the sternum may denote a feeling of tightness in the chest.

The reasons for the problems with the heart attack and trying to determine what and where the pain was, is due to the way the questions are asked in emergency situations. The literature states that patients find it difficult to comprehend the language of chest pain and what is happening within the body. (Mallett ; Dougherty, 2000)

Communication can be seen to be a vital part of nursing care. (Mallett,; Dougherty, 2000) Patients are individuals with unique needs that should be addressed through careful assessment and with the use of therapeutic communication. (Mallett, J ; Dougherty, 2000)

The essence of nursing care is the relationship between the nurse, the patient and their loved ones, and the way in which they form a true partnership to negotiate care. (Mallett, J ; Dougherty, 2000)

Fourth Part

Teamwork in an Accident and Emergency situation is a must. Anything from a leadership role to a colleague making a cup of tea is valued in this environment. An awareness of the team allows you to adopt the correct role at the right time. The ability to work flexibly within a team is of great importance in an accident and emergency situation (Wardrope, 1998).

Although I felt this was not completely true in my particular incident. The nurses involved in treating the patient was very biased and only interested in doing the job they was there to do, and forgot about the relative. This is why I took it upon myself to take the relative into my care and see that she was alright. It is important to recognize that partners or families may also have communication needs (Blauglass, 1991). They are often the people that tend to look after the patient once they have come out of hospital, so they should not be left in the ‘ dark’ with the patients situation (Blauglass, 1991; Northhouse et al. 1991[ss9]).

As an observer looking in on the situation I found that many people did adopt their role and they did this to the best of their ability. The problem I experienced was that the physicians forget about people around them. Unless it was something to do with the patient. This in retrospect is a very good thing as you know that the patient is getting the best quality care available. As the professionals will be focused towards that particular patient. Patients are individuals with unique needs that should be addressed through careful assessment and with the use of therapeutic communication (Mallett, J ; Dougherty, 2000). Good communication can prevent crises in the

workplace and can remove many irritations that lead to stress, especially where these are due to misunderstanding (Skinner, 1998).

The break down in communication in team work can be due to the stress of the situation. Many people react in different ways to stress and this can make the situation more intense or make it flow. A stressed doctor is not necessarily a bad doctor, but difficulties may occur when the stress gets out of control. The signs of stress are subtle and progressive. Colleagues must be aware of those signs in others and be prepared to act (Stress in Accident and Emergency Medicine, 1998).

The stress reaction is a basic physiological response to real or perceived danger, which enables the individual to stand and fight or flee (Skinner, 1998). Modern threats, while great, are largely intellectual and the fight or flight response is therefore inappropriate. The psychological response to stress in the 20th century appears to arise not only from the original physical reaction but also from its suppression. There is a delicate balance between the positive effects of stress helping one to rise to a specific challenge and the eventual inability to cope with constant, unremitting stressful situations (Skinner, 1998).

When the doctor spoke to me in a very abrupt tone I saw that he was stressed and this is why he responded in such a manner. To lash out at people when you are stressed is a normal reaction and many people do this. Depending on the way that an individual person can cope with stress (Mallett, J ; Dougherty, 2000). Looking back at the situation I should have not have asked the doctor at that particular time, so I was wrong. I should have

waited until he had finished his duties with the patient, although I was doing this in the best interests of the relative.

Conclusion

In conclusion to this essay I feel that I have learnt that in order to get on with the people working around you, you need to listen to people. I have learnt that communication is the key to a smooth running of an Accident and Emergency Department. Everybody has their role and they should stay within their role and this will make the area a lot easier to work in. I have learnt that to ask questions after a procedure has been performed. I know that an Accident and Emergency department is a very busy environment but nurses need to focus more on the relative and to help with the communication with this. Although that this is one of the biggest complaints at accident and emergency departments ((Improving Services for People with CHD, 2005).

I have learnt that this particular Accident and Emergency Department did not have particular set roles so in order to produce a better service. The department needs to adopt structured nursing roles in order to help the smooth running of the department. This will include the nurses each having an individual nursing role. This is so the relatives will be dealt with and all the caring needs for the patient.

If a nurse is given a set role and all the nurses know what they need to do this will help the patient and the relatives. Due to the break down in communication with what was happening with the relative this is why I the Student Nurse was dictating to the relative why certain procedures were

<https://assignbuster.com/accident-and-emergency-care-essay/>

happening. If a nurse would have acknowledged the relative then she might have felt less apprehensive. This is why I helped her. I know when I have another relative come to Accident and Emergency with a patient I will make sure I speak to them and try to help them. Accident and Emergency departments are stressful enough.

Better communication skills between the doctors and nurses need to be adopted for a smoother running of the Accident and Emergency Department.