

# Essay on developing autonomous practice in mental health nursing essay



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In this essay I will give a profile of a service user in whose care I participated in, during my clinical placement. The client's background and history to date will be described, a critical analysis of the individual's current psychological, physical and social needs will be provided by selecting and using published therapeutic/theoretical approaches. Furthermore a demonstration of how the therapeutic/theoretical approaches selected can provide a structure or guide the nursing care provided in assessment of needs, identification of aims/goals, therapeutic nursing interventions and clinical review. Finally the author will explore the therapeutic efficacy of the current clinical environment or service where care is being provided, consider possible alternative service provision options and discuss whether they may or may not be more beneficial for the individual.

The client chosen for the purpose of this assignment is a 60-year-old gentleman of British origin. I will refer to him as Peter to maintain confidentiality in accordance with clause 5 of the Nursing and Midwifery Council (NMC) Code of Professional Practice (2002). Peter has a history of depression and alcohol abuse. He lives alone in a three bedroom semi detached house, having separated from his wife 7 months ago after being married for 28yrs. She had been battling with his alcohol abuse for many years and her frustration had just worsened that she was beginning to be depressed herself.

The rationale for choosing Peter for this essay is not only because of my interest in Depression, but because I was involved in his care from initial assessment to his discharge to community care and we developed a very good working relationship built on trust and confidence.

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## **Personal and Family History**

According to Peter, he was born in Newcastle and is the eldest of his parent's 4 children (2 boys and 2 girls); he has lost contact with all his siblings. His parents are both deceased, mum died about 5 years ago (she had been battling with cancer for some years, he was her main carer) and Dad died when he was 15 years old (In a car accident, coming from work). There is no history of depression in his family but alcohol abuse is prevalent. Peter has been married twice, alleging that both his wives divorced him. He has twins with the first wife but after the divorce he lost contact with them, His second wife had a daughter from her own first marriage and they had another daughter together who now lives in Portugal.

He left school without any GCSE's to pursue a carrier in Truck driving at the age of 18 which he has been doing until April 2010 when he was dismissed after his licence was suspended for a year because of a drink and driving incident he was involved in . He made known to the services that he started drinking at the age of 17 but it became a problem at the age of 30, he blamed it on the divorce from the first wife which he reported left him with nothing.

## **Presenting Problem**

From his General Practitioner (GP) referral notes, Peter has a diagnosis of depression, he has been under the GP's care for months but his condition has deteriorated, he has been having thoughts of suicide and self harm. He was prescribed 30mg/ day of Mirtazapine at the time of referral. The GP thought that he hasn't been compliant with his medication; this with alcohol abuse was making his condition worse. He reports having a low opinion of <https://assignbuster.com/essay-on-developing-autonomous-practice-in-mental-health-nursing-essay/>

himself and worries a lot about his finances/debts. He presents with an overwhelming and extreme experience of sadness, hopelessness, despair and misery.

His ability to meet his daily needs has been deteriorating e. g. his self care had been noticed to be deteriorating for a person who is reportedly to be usually self conscious of his personal hygiene and also the GP noticed that he has been losing weight. This prompted the GP to refer him to our team. The responsibility of our team is to try and help him during his crisis to prevent suicide and also to prevent unnecessary hospital admission, in accordance with the Standard 7 of the National Service Framework (NSF) for Mental Health (DoH 2002a).

Hogston (1999) summarises that it is important to use a formalised framework of assessment as it enables the nurse to assess an individual holistically and form a sound theoretical base in the nursing process. He goes on to add that although individuals may present with the same characteristic of an illness, there is a considerable diversity in which individuals are affected by their illness. It is therefore important to adopt a framework that recognises the uniqueness of each individual and enable the totality of their situation to be understood (Alabaster 2000). According to Newell et al (2000) nursing models are well documented and have been widely used as an approach to assessing the needs of clients, identifying problems and formulating ways of helping them to improve their well being.

The theoretical approach used to analyse Peter's current psychological, physical and social needs is the Stress Vulnerability model. The rationale for

using this model is that it can assist in the engagement process with the client as a method of understanding why levels of stress should be monitored (Zubin and Spring 1977). Used also as an assessment tool is the twelve activities of daily living based on the Roper, Logan and Tierney model of care, the rationale being that it provides a structure for doing physical health assessments, which is the examination or inspection of first, the person as a whole, their general appearance then their mechanistic function of body parts as explained by Jarvis (2000) and the model also provides a holistic assessment of a patient. Aggleton and Chalmers (2000) state that it is simple to understand and devoid of confusing terminologies. To determine the extent to which our client was depressed we used the Geriatric Depression Scale (GDS) which is a basic screening measure for depression (Brink et al, 1982).

According to Zubin and Spring (1977) they suggested that a vulnerability to psychosis is acquired through a genetic predisposition or as a result of environmental factors. This vulnerability, however, is not considered to be sufficient to manifest the disorder and must be 'triggered' by environmental processes. The environmental component can be biological (an infection, even drugs and alcohol) or psychological (e. g. stressful living situation). The 'stress' component of the model may take many forms, including: Traumatic life events, use of drugs and alcohol and stressful living conditions.

Zubin and Spring (1977) postulated that individuals vary in the amount of vulnerability that they have for psychosis and also in their ability to withstand stressful events. It is an individual's own perception of the stressfulness of an event that ultimately defines the severity of the load.  
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## **Psychological needs**

According to Peter and the GP's referral notes, he was diagnosed with depression a year ago though he was treated before for depression, 5 years ago. Isolation and loss of status i. e. being unemployed and a bachelor after so many years of being a hard working husband has been a big source of his psychological stress, also the bereavement (death of mum ) and loss of support networks on which he had relied on in the past.

Personality style and the way Peter has learned to deal with his problems (by drinking alcohol and isolating himself) may have contributed to the worsening of his condition. Having financial difficulties combined with mounting debts including Mortgage repayments has been stressful , he reports that after years of paying his mortgage he can't stand the thought of his house being repossessed with only 5 years left to complete the repayment. Peter reports that he has been drinking a lot of alcohol which has caused most of his problems i. e. he lost his job, driving licence and his wife left him because of drinking .

## **Physical needs**

Poor physical health can lead to poor mental health, according to Harris and Barraclough (1998) people with mental health problems have a higher risk of premature death. The stress caused by loss of employment, isolation and loss of support has been making him abuse alcohol, he reports using alcohol as a coping mechanism to stop negative thoughts and being depressed. The reported loss of weight and possible malnutrition has been as a result of poor diet and eating habits according to him. However because of his

deteriorating mental health and physical health, combined with the alcohol  
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abuse leaves him very vulnerable to other more severe physical health problems like Anorexia, liver problems or even becoming an alcoholic. Furthermore because of his low self esteem and lack of routine he is not motivated to get out of bed, do anything, has no structure to his day and lacks the skills needed to do activities of daily living.

## **Social needs**

Socially, from the information gathered from his history, he has a very poor level of social functioning. He is always very withdrawn, isolates himself in his house and his level of activity is very low. His life revolves around his house, he hardly has any friends, the person he used to confide in left him (his wife) and his biological daughter moved to Portugal (she has been his main support after the divorce). All this leaves him very vulnerable to self neglect, having low self esteem and social isolation.

This social isolation is a relapse risk factor and can form a key point in the nursing intervention (Barker 2004). He reports being overly dependent on his wife for all household chores including cleaning , cooking , paying and organising the house hold bills, this shows his lack of household skills. He is currently unemployed since he lost his job due to the drinking & driving incident, this resulted in a change in his social role from being the bread winner for the family to relying on welfare benefits. The ongoing stress and social isolation associated with these family circumstances can lead to depressive symptoms (Bartha et al, 1999).

As reported by Burns et al (1999) the GDS is essentially a self-reported inventory with a simple yes/no format which lends itself to ease of

administration by the older person or by an interviewer, supported by a validation study by Yesavage et al (1993) cited by Norman et al (1997) the GDS adequately detects depression in medically in-patients in the acute setting, or their own homes and also in the continuing care setting.

According to the GDS scoring system 0-9 is considered normal, 10-19 indicates mild depression and 20-30 indicates severe depression, he scored 22 which indicated his depression was severe.

According to Roper et al (1996) the twelve activities of daily living model states that 'human activities' exist between two extremes, the dependence and independence continuum, with factors such as age, childhood and illness playing a major role in determining the exact location of each of the twelve activities of living. The focus of this model is on prevention of potential problems from becoming actual problems, resolving actual problems and effective management of problems that cannot be solved. The use of a holistic approach was supported by Ewles & Simnett (2000) who stated that all aspects of health are interrelated and interdependent. Furthermore according to standard 3 of the National Services Framework (DoH 2002) this model helps empower the client by empowering his ability to take steps to gain control and the will to a healthier lifestyle.

## **Assessment of Needs**

### **Physical Health needs Assessment:**

This assessment was done using the activities of daily living as identified by Roper, Logan and Tierney, as follows:



**Breathing:**

Baseline respiration count was 16 breaths per minute, which lies within the normal range. He does not smoke and did not have any breathing problems.

**Controlling body temperature:**

His body temperature and blood pressure were taken so as to have a 'baseline', for the nursing team to be able to compare any rise or fall based on his normal range in the future.

**Maintaining safe environment:**

Peter is unable to maintain his own safety because he is drinking too much, according to him, his house is in a total mess (the floor is full of rubbish); this poses a high risk to him.

**Eating and drinking:**

His dietary consumption is inadequate; he hardly eats cooked meals at all citing that he is finding it difficult to cook (lack of skills). He just makes sandwiches, toast and drinks alcohol most of the time.

**Communication:**

He can communicate very well though lately has been isolating himself from people including neighbours since the onset of his illness.

**Personal hygiene:**

His personal hygiene has been very poor, according to his notes from the GP he used to be a very smart gentleman.

## **Eliminating**

His bowel movement is good though not as regular, this could be attributed to his lack of eating and drinking. No problems were identified with urination.

## **Sleeping**

He is having sleeping problems, he sleeps around 4 hours during the day and 3 hours at night, while staying up the rest of the night.

## **Expressing sexuality;**

Recently divorced, has not expressed interest by way of opposite sex, he has no female friends.

## **Working and playing:**

He was sacked from his job as a driver, spends his time drinking alcohol, watching TV and hardly does any activities.

## **Mobilising:**

He walks with no aid and can travel on public transport.

## **Dying:**

He reports that he can't take the hurt any more and is unhappy with his life, he feels dying is the only solution to his problems. He reported having suicide thoughts, but does not have the will power to do it. Cited his children and grandchildren as his protective factors, they mean a lot to him (he did not want them to go through any pain).

**Other areas assessed include:**

The stress Vulnerability model provided a structure for the assessment of needs by looking at all the factors causing him stress and the possible vulnerabilities.

**Relationships and sexual functioning**

Recently divorced, can't see himself with any other person except his ex wife. He reports that he has lost all interest in sex. The person who was supporting him has relocated to Portugal (his daughter); this leaves him vulnerable to further isolation and low self esteem.

**Interests and activities**

He reports being interested in going to the cinema, watching football on TV or at the pub. He is not participating in any activities at the moment but would like to try and do as much as he can to occupy his time and reduce stress.

**Education, training and employment**

He left school without any GCSE's and has a problem of writing though he can read well; finds it difficult to write letters. He would like to do a DVLA course about dangers of drink & driving which will reduce the suspension he was given to half the term. He was promised by his former boss that he can get his job back when his suspension is over. There is also need for him to learn about medication management and the importance of being concordant with medication.

## **Benefits and finances**

Currently unemployed and having financial difficulties. Receives unemployment benefit but it is not enough to cover all his debts. He requires help to apply for other benefits.

## **Accommodation**

Lives in a 3 bedroom house, due to non-payment of mortgage repayments, could lose his house; this has been a major source of stress which leaves him vulnerable to self harm, homelessness and more depressed.

## **Risk:**

Risk to self is currently medium/high due to frequent suicidal thoughts but no plans, intent or prior attempts owing to identifiable protective factors (Daughters and grandchildren).

The following problems were identified:

- 1). Disturbed sleeping pattern and lack of sleep.
- 2). Peter is unable to maintain his own safety.
- 3). He has low level of interaction with other people (isolation and low self esteem).
- 4). Low in mood and expressing suicidal ideation.
- 5). Loss of weight and failure to meet dietary needs.
- 6). Self neglect and lack of good personal hygiene

7). Not attending to his dietary requirements and abusing alcohol.

## **Aims/Goals**

According to Zubin and Spring the Stress-Vulnerability model helps to guide nursing care is by identifying stressors and problems which will be helpful in the formulation of aims/goals. The three main goals of treatment according to this model are:

### **1). Reducing biological vulnerability**

To control alcohol consumption

To manage his medication effectively

### **2). Reducing stress**

To maintain good self-hygiene and healthy sleeping pattern

To encourage eating, drinking and maintenance of a balanced diet.

To be able to maintain his own safety by demonstrating awareness of his surroundings, whenever possible

To engage with welfare for help with finances/debts

To attend a DVLA course so that his suspension will be reduced

### **3). Coping with stress more effectively**

To elevate the patient's mood and self esteem

To encourage social inclusion and attend Occupation Therapy

To seek supportive relationships with nurses and therapists.

To encourage positive self- talk

## **Therapeutic Nursing Interventions**

(a) Develop a therapeutic relationship with client based on trust, empathy and understanding.

Staff to arrange with client, once daily home visits to help him ventilate his feelings.

Encourage interaction with other service users through referral to day centres for group activities.

(b) Encourage good sleeping routines without need for medication by making client keep his own sleeping chart.

(c) Client to be encouraged to eat and drink all meals, and be placed on a food-monitoring chart.

(d) Client to be encouraged to have a wash every day and to meet all hygienic needs.

(e) Client to be educated on the need to manage medication effectively by providing specific information about the medication he is taking and how to get the best results from them.

(f) Client to be encouraged to avoid / reduce alcohol abuse by referring him to Alcoholics anonymous groups.

(g) Risk assessment to be done on a regular basis in agreement with client.

Review frequently,

Client to seek immediate assistance if fleeting thoughts become more serious or depression deepens.

(h) Care plan to be reviewed weekly.

A nursing intervention is more likely to be successful in an atmosphere of trust and cooperation. According to Thomas et al (1997) the interpersonal relationship between the patient and their helper is considered the primary instrument for change. The relationship is necessary, but not the only condition for successful therapeutic outcome. If the patient distrusts their nurse they are less likely to accept help, neither will they listen or experience any hope of success. Having learnt to trust the nurse the client is able to open up and share his problems with the nurse, who can then help the patient to deal with his worries.

Meeting and talking to the client everyday (one to one) not only helps the service user ventilate his feelings but it is also a form of counselling which helps the client feel worthy as a human being, provides a hand that conveys friendship and confidence, can also result in strengthening the therapeutic relationship. During the home visits, the nurse can continually assess how the client is doing on a daily basis thereby providing an accurate account of the patient's progress. Being involved in-group activities can help the service user to make friends, share experiences and ideas about how to cope with depression and will also help distract him from negative thoughts, boredom and lack of social stimulation which tend to reinforce a sense of isolation and depression.

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To help the client reduce biological vulnerability the use of medications can help correct the chemical imbalances which lead to symptoms. According to Healy D (2002) medications are one of the most powerful tools we have for reducing or eliminating symptoms and preventing relapses. The client is to be educated on effective management of medication by providing specific information about the medication he is taking and how to get the best results from medication by not mixing with alcohol (interferes with the beneficial effects of medication).

Sleep is a necessary part of life, to overcome his sleeping problems without using medication, Peter is to be encourage to stick to a particular sleeping routine, that is going to bed and waking up at a regular time and avoid napping for long hours during the day as it upsets the ' body clock'. Peter would be encouraged to avoid drinking too much coffee or alcohol as these will disrupt his sleeping pattern. A sleep-monitoring chart is to be introduced to him to see if Peter is getting enough sleep and be able to evaluate how effectively the interventions are.

According to Barker H (1996) for the problem of eating and drinking, it is important that immediate treatment should include monitoring food and fluid intake to prevent dehydration and further weight loss. By putting Peter on a food monitoring chart the nursing team will be able to see how much food he is eating so that if necessary supplements might have to be provided e. g. Fortisip or Complian. Peter should be encouraged to eat three meals per day. He should also be weighed on a regular basis, suggest weekly to help evaluating his progress. Since he reported having household skills problems,



staff to refer him for Occupational Therapy (OT) to be taught and develop life skills e. g. cooking.

According to Roper et al (1996) apart from taking pride in their appearance, people have a social responsibility to ensure cleanliness of body and clothing. It is important to explain the importance of good personal hygiene to Peter. He will be reminded and encouraged to attend to his personal hygiene i. e. have a wash, care for his hair, nails, teeth and mouth.

A risk assessment needs to be done on a regular basis; this is in accordance with standard 7 of the National Service Framework (NSF) for mental health (DOH 2002), which is aimed at preventing suicide. When visiting the client there is need to ask him if he feels or has thoughts about harming himself so as to try and find ways to minimise the risk or prevent client from committing suicide.

## **Clinical Review**

The clinical review of Peter's care was done by evaluating of all the interventions used to facilitate recovery. Evaluation is making judgements as to whether the care actions that you implemented have successfully resolved the patient's problems or met his needs. A review meeting was held by the multidisciplinary team (MDT) once every week and the care plan reviewed. Over the few weeks during my placement there were only minor changes to his care plan but a lot of changes to Peter's presentation were noted.

Initially we visited him once daily but as he became better at coping with stress we changed the visits to once every other day, with a phone call to <https://assignbuster.com/essay-on-developing-autonomous-practice-in-mental-health-nursing-essay/>

him on alternate days. Peter had many social difficulties, but after a few weeks he had made friends and developed other interests like going to the Gym, cooking, bowling and playing golf. His medication was changed to Fluoxetine which helped him sleep better, elevated his mood, also a marked improvement in personal hygiene was observed and his biological vulnerability was reduced. There was also an improvement in his weight due to better eating habits.

Attending Alcoholics anonymous helped him change his coping style; he saw the effects of alcohol and what it had done to others which were even worse than his situation. By completing other benefits forms and the completion of the DVLA course (which helped reduce the term for his suspension from driving), helped ease his financial worries and resulted in reduced stress. The Citizen Advice bureau helped him with his mortgage issue; he was able to arrange payments using his pension contributions.

### **Therapeutic Efficacy of current clinical environment**

Treating Peter at his own home offered a more personalised approach by including him into his own community rather than fitting him into the service system. It also impacted on the stigma associated with hospitalisation through emphasis on community integration, including life satisfaction, social networks and it also provided care in the least restrictive environment, without disrupting his life and providing flexibility in his daily routines. There was also an element of comfort, security, relaxation, confidence all which is associated with being treated at home according to Reynolds & Hault (1984).

On the other hand Reynolds & Hault (1984) agreed that hospitalisation is a negative, upsetting and unhelpful experience because of the rules, restrictions, patient mix and lack of communication which applied. Other themes are well known such as deprivation of liberty, lack of autonomy, lack of status and recognition, an emphasis on behavioural conformity, oppression, medicalisation of social disharmony and removal from family. However if treatment at home does not produce good results, (e. g. the risk to client increases) hospitalisation may be considered, it has some known benefits which include 24 hour professional care i. e. having qualified carers within arm's length all the times and being observed regularly helps to minimise risk of self harm.

## **Conclusion**

By examining the client's background and history to date, the use of the Stress Vulnerability model and Activities of daily living model helped in making a holistic and individualised assessment as supported by Pearson et al (1996) of Peter's psychological, physical and social needs. Furthermore a demonstration of how the therapeutic approaches used guided the nursing care provided when the assessment of needs, identification of aims/ goals, therapeutic nursing interventions and clinical review was done.

Though the stress-vulnerability model helped to identify stressors and problems, care was made more effective by incorporating the activities of daily living model which viewed the individual as having the ability to function dependently or independently. However the activities of daily living model was criticised by Salvage and Kershaw (1986) as being excellent for physical aspects of care, but social or educational aspects do not seem to be

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very important. On the other hand, Pearson et al (1996) appreciated the model for its clarity and being evidence based.