‘Discuss the care of one patient from a participating placement area that demonstrates establishing a therapeutic relationship in the short term setting including advocacy, and the use of clinical science knowledge’.

Introduction.

This essay will discuss the care given to a patient whilst on placement at an NHS treatment centre. It will demonstrate the development towards establishing a therapeutic relationship within the short term setting, whilst including advocacy, and the use of clinical science knowledge, for the reason of the patient’s attendance. In accordance with The Nursing and Midwifery Council (NMC, 2008) Code of Professional Conduct Guidance on confidentiality permission has been given by all participants involved to discuss the case. In addition pseudonyms will be used to maintain anonymity and therefore the patient will be refer as Mrs Moore, the Consultant/endoscopist Mr Thomas and the student will be named Jill.

The event unfolded as follows. Mrs Moore had been experiencing chronic abdominal discomfort but had been too busy and fearful to take action. However, she eventually consulted her GP complaining various ailments including, stomach pains, fatigue, weakness, occasional vomiting of blood and unusually dark faeces. Following the consultation an appointment was made with Mr Thomas, at the treatment centre to discuss her concerns and thoroughly investigated her problems. The symptoms suggested peptic ulcers and so Mr Thomas initiated a pre-assessment process to confirm the diagnosis. To achieve this, the patient would undergo an upper gastrointestinal (GI) endoscopy, which was quickly explained to Mrs Moore. On the day of the examination, Mrs Moore was assisted and guided

through the entire process. She was led to the treatment centre where she was welcomed by Mr Thomas who greeted her with a smile and gentle handshake. According to Nolan and Ellis (2008) the establishment of any relationship begins at the initial greeting and is crucial in creating a good practitioner / patient relationship. A customary handshake is an effective way to establish a professional but friendly relationship Nolan and Ellis (2008). After briefly discussing Mrs Moore's ailments, Mr Thomas confirmed the likelihood of an ulcer. He then explained the endoscopy procedure and provided general facts about the illness. He took time to address any uncertainties and was realistic but reassuring, stating that whilst a biopsy result may take 7days, a diagnosis could be made immediately afterwards.

According to Ross and Wilson (2006) Peptic ulcer disease (PUD) is a common ailment, which involves the full thickness of the gastrointestinal mucosa. The stomach produces a very strong acid which helps digest and break down food before it enters the small intestine (duodenum). The lining of the stomach is covered by a thick protective mucous layer which prevents the acid from injuring the wall of the stomach Siegelbaum (2008) but when a part of the mucus lining in the stomach or duodenum is damaged, the sensitive tissue underneath is exposed. Without the mucus 'barrier' the stomach wall and duodenum is unprotected, from stomach acid, which damages these areas, eventually causing an ulcer. CKS (2008) reinforces that an ulcer is caused by an open sore in the lining of the stomach or intestine, much like mouth or skin ulcers. Walsh and Crumbie (2007) highlights that recent discoveries have indicated, that most peptic ulcers result from a stomach infection caused by Helicobacter pylori bacteria. This spiral shape bacterium has been identified as the basic cause of most peptic ulcers, along with aspirin and arthritis drugs. Its spiral shape is thought to strengthen the infection in the mucous layer lining of the stomach, creating inflammation of the stomach

wall, known as gastritis. Patients suffering from ulcers may experience discomfort, and a burning pain which radiates from the upper abdomen to the back. Such symptoms frequently occur several hours after a meal, generally because food leaves the stomach while acid production is still high. The burning sensation can be ongoing and many patients report painful sleepless nights. On the other hand some patients do not feel pain, but experience intense hunger or bloating which can be temporarily relieved by Antacids and milk. Other patients only experience black stools which indicate that the ulcer is bleeding. Bleeding is a very serious complication of ulcers (Siegelbaum 2008).

A patient's medical history records can be utilised to determine the likelihood of peptic ulcers. However, the most accurate diagnosis is achieved through an upper intestinal endoscopy, which is used to visually examine upper gastrointestinal tracts (Walsh and Crumbie 2007). It allows for the examination of ulcers or barium x-ray of the stomach. Whilst rare, an ulcer can be malignant and in such cases the consultant should inform a patient that a biopsy specimen may be taken for testing. Mr Thomas, the consultant informed Mrs Moore that she would be contacted directly with the examination results, and notified if further treatments or tests would be needed. Treatment for peptic ulcers involves reducing the amount of acid in the stomach, such a reduction would give time for the ulcer to heal, or treat the H pylori infection. According to CKS (2008) the treatment for a peptic ulcer will vary depending on its cause (whether caused by infection or through using non-steroidal anti-inflammatory drugs NSAIDs). If Mrs Moore was diagnosed with a peptic ulcer, but tested negative for the H pylori infection, her GP will prescribe proton pump inhibitors (PPIs), which are tablets designed to alter stomach acids. But unlike antacids, which neutralise the acid in your stomach, PPIs reduce the amount of acid that the stomach produces. It is advised that a patient must take PPI for 1-2 months to enable ulcers to heal properly. However, this time frame will vary depending on the severity of the ulcer.

During the consultation Mr. Thomas and Mrs. Moore discussed the problems she was experiencing. At the session Mr. Thomas listened carefully to his patient before offering advice. Burnard (1997) suggests that a good listener not only paying attention to what the patient generally says but responds appropriately to the actual words spoken, timing, volume, pitch, accent, facial expression, body language. Listening and appropriate responsiveness in the healthcare setting requires a deliberate commitment to fully engage with the patient. This coupled with the finding and observations derived from others can help healthcare staff determine whether a patient is emotionally fit for procedures. Appropriate reassurance, advice or information should be given and help to minimise repetition of questions and advice. Listening in the therapeutic relationship involves focusing on and being ever-conscious of the other person needs.

Mr. Thomas also advised Mrs. Moore that prior to the examination, she should to stop taking prescribed medicines and should not eat or drink for six hours. It is important for such tests to be conducted on an empty stomach to enhance visibility of the internal organs during the endoscopy, and if conducted under sedation, to help avoid the risk of food or fluid being aspirated into the lungs. Additionally Mrs. Moore was assured that all advice would also be confirmed to her in writing, and that she could contact the treatment centre with any queries. She was given the option to undergo sedation or to have the test conducted while awake, in which case a spray would be used to numb the back of her throat. NHS Choices (2009) points out that the latter procedure would make it easier for the patient to swallow the endoscopy tube; Mrs. Moore was uncertain and decided to wait until the day of surgery to decide. Due to the longevity of the drug effects, she was repeatedly reminded that if sedation was preferred, she would be accompanied to and from the hospital. Good communication is at the core of the any therapeutic relationship and one which nurses should always strive to attain and

maintain. However, there are specific barriers to communication, including the high turnover of day surgery patients, time limitations on nurses and the short duration of patient's stay. Helping the patient through the immediate experience alone would not demonstrate a satisfactory standard of care. Once discharged, patients need have a positive perception of their hospital experience, so that they feel willing and happy to return if necessary. They should leave feel healthier and must obtain adequate and relevant information to ensure self-care and recovery. Unfortunately with many day surgery patients reporting poor communication experiences from or between nurses, it is evident that improvements to staff communication are needed (Costa 2001, James 2000, Mitchell 1997, Otte 1996).

On the day of her examination and during her pre-assessment Mrs. Moore expressed slight anxiety and nerves about the ordeal. Walsh and Crumbie (2007) recognised that it is common for patients undergoing these investigations to feel anxious and fearful of a negative outcome, particularly first-time patients. It is essential, therefore, that, in addition to the obvious physical parameters assessed, anxiety should be monitored and knowledge deficits explored. Poor listening skills demonstrated by staff within the day surgery setting can elevate patient confusion and anxiety (Otte 1996). Phillips (1992) recognised wider benefits of good listening skills suggesting that they also help to prevent medical mistakes. A study conducted by Costa (2001) demonstrated the detrimental effects of poor listening skills, where a nurse had casually dismissed a patient who expressed a fear of dying during a procedure. The patient clearly displayed distress and anxiety, but these needs were ignored. This extreme form of emotional neglect, due to a lack of active listening can be emotionally damaging. Comparatively Jill was sincere and showed warmth and kindness to Mrs Moore listening to her qualms and reassuring her about the procedure and relaying that fact that the examination would be short, taking only a few minutes. The staff members were also very supportive and

reassuring, and Jill provided continuous support to Mrs. Moore by addressing ambiguities and encouraging her to ask questions in order to properly prepare for the procedure.

Whilst in the day surgery setting there is an opportunity for nurses to provide holistic, patient-focused care (Hodge 2000). Caring reflects an effective and informed response to patients' needs and is also the genuine display of warmth, compassion, consideration and interest (Arnold and Underman Boggs 1999). It is this informed response, rather than a routine mechanistic approach (a nurse priority) that patients often regard highly (Larsson *et al*'s (1998) study. A warm, trusting nurse-patient relationship does not require intimacy; but instead relies on the ability to create an environment, where the patient can feel safe and comfortable to have verbal discussions (Corbett 2001).

To ensure her suitability for surgery, Mrs Moore's medical history was thoroughly checked and baseline parameters (saturation level, pulse and blood pressure) examined. Mc Neil (2008) views physical examination may occasionally be necessary, however, such findings would confirm the patient's fitness to undergo surgery and anaesthesia, and also enables staff to determine their suitability for post surgical treatment within a day surgery unit. Mc Neil (2008) also believes the need for the patient to fully understand the proposed procedure. Mrs Moore was continuously given opportunities to ask questions, with the intent to relieve any anxiety and minimise fears, it also gave her the chance to confirm verbally and to sign the consent form that she desired to proceed with the examination. Phillips (1992) suggested that good listening skills also help to prevent mistakes such as those demonstrated in Costa's (2001) study. So it was important that on the day of investigation, the nurse listened, and acted in accordance with the patient's request. Howard-Harwood (1997) states 'effective discharge planning in day surgery is crucial to ensure an effective post-operative recovery at home', Edmondson (1996) stated that patients should only be discharged when they are

psychologically as well as physically recovered. Such good communication can also aid psychological recovery.

Mrs. Moore was then taken into theatre where she signed a consent form; she was then assisted onto the bed positioned on her left side to ease the insertion of endoscopist into the stomach. A plastic mouth guard was used to prevent the endoscope causing damage to her teeth as it passed down and to also stop her biting on it. A sedative was also injected through a plastic canula in her arm which caused relaxation and drowsiness. Prior to the procedure she was made aware that she would be weak but alert enough to follow any instructions. The back of her throat was also sprayed to numb it, NHS Choices (2009) mentions once the sedative or throat spray has worked, the consultant will put the endoscope into the patient's mouth and they would be asked to swallow the first part of the tube. Whilst uncomfortable to swallow, there was plenty of room around the scope for Mrs Moore to breath through her mouth and nose. Jill held Mrs. Moore's hand continuously reassuring her with comforting words and to squeeze her hand should she wish for the procedure to stop. Jill acted as an advocate for Mrs Moore during the procedure, Nolan and Ellis (2008) points out that an advocate will act only when the individual patient feels unable or unwilling to represent themselves. Peate (2005) went further to referring to an advocate as one who acts for a patient who expresses concerns in relation to his or her medical condition, treatment or ongoing care, but feel unable to express his or her concerns directly to the appropriate member of the multidisciplinary team.

Once she had swallowed the endoscope Mr Thomas pushed it gently and carefully down to her stomach and a short way into the intestine beyond the stomach Mrs. Moore was asked to breathe through her nose. Once the endoscope was in her stomach, air blown into the stomach was used to enhance visibility and reveal any patches of redness, holes, lumps, blockages or

other abnormalities on a TV monitor screen. The detection of any abnormality would be followed by a biopsy- this investigation would involve intricate, microscopic laboratory research on a specific area NHS Choices (2009). After the examination, Mrs Moore was allowed to rest and all food and fluids were withheld until the effects of the local anaesthetic had worn off and the gag reflex returns (usually 1-2 hours). The reflex would need to be tested (prior to the initial fluid intake) by gently touching the back of the throat with an applicator or spoon and it is common for the patient to complain of soreness in the throat and mid-chest. A carer should tend to the patients needs by providing warm fluids which can soothe and offer temporary relief. Any expectoration or vomiting of blood or severe pain should be reported promptly.

Nurse patient communication often manifests as a one-way information-giving paradigm. Rather than patients passively receiving information, it is suggested that good communication skills are used to identify and harness patients' needs and enhance what they already know. This respects the information and knowledge that patients already have, thus empowering them to take responsibility for their care. In day surgery settings, it is accepted that patients will take responsibility for their wellbeing and welfare (Markanday 1997). This empowers patients to question professionals'

Aftercare was a huge priority to ensure an efficient and rapid recovery. To assist in the return to normal function, Mrs Moore was closely observed and monitored for vital signs of problems, anaesthetic agent and drugs administered to reduce any pain or discomfort. Howatson-Jones (2008) draws upon the need to offer snacks and a drink after such procedures and most patients will have fasted, or had a modified diet, prior to the surgery. When Mrs Moore had fully recovered from the sedative, Mr Thomas explained the findings

from the examination, provided instructions for Self care and any follow up appointments. Her husband who had accompanied her was now able to take her back home.

Conclusion

The establishment of a therapeutic relationship is clearly an important aspect of all stages of procedures in the short term settings. And it can be argued that it is especially important for first time day-surgery patients. For instance Mrs Moores expressed anxieties demonstrated how such patients can feel reluctant and uncooperative if staff fail to establish a good therapeutic relationship. A patient may even opt out of future medical procedures jeopardising their health. Sustained good communication is essential in maintaining a good therapeutic relationship, Whilst poor communication such as failing to address ambiguities or ignoring complaints- can lead to both direct and indirect neglect and can have dire consequences on mental and physical recover. A peptic ulcer can be treated by preventing acid injuring the wall of the stomach, but poorly conducted upper intestinal endoscopy, may result in misdiagnosis, lesions or surgical instruments being left in the body. This can have harmful physical and psychological effects on the patient, and they may lose confidence in medical care altogether. Surgeons should conduct a thorough visual examination of upper gastrointestinal tracts, following strict procedures to avoid misdiagnosis. Whilst verbal communication is vital prior to surgery, subtle forms of physical and verbal communication are important during a surgical procedure. Sedation can be an uncomfortable and scary ordeal, but small physical gestures from both nurse and surgeon can reassure a patient throughout the process. Whilst general rules may apply, medical staff should adapt their communication technique to suit the individual needs of a patient. A good therapeutic relationship continues onto the final stages of a pre-surgical examination. Proper care and advice should be given to ensure the patient's

knowledge, cooperation and confidence is maintained, to also ensure they are willing to proceed in the event that a medical illness is confirmed.

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