

Using Two Chapelhow Enablers to Deliver Care

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Abstract

This article will demonstrate how two of the six Chapelhow et al. (2005) enablers were utilised throughout the care of one individual. The two enablers that will be considered in this article will be communication and professional decision making. This article will use both experience from placement and current research to inform practice to demonstrate how these enablers were used in practice. Communication and professional decision making enable healthcare professionals to deliver effective and efficient care. This article aims to enable healthcare students to develop their understanding of how these two enablers are used in practice and to raise awareness of their importance.

Keywords

Chapelhow, Assessment, Waterlow, Communication, NEWS, Decision Making, Clinical Judgement,

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Introduction

The enablers proposed by Chapelhow et al. (2005 cited in Lovell 2016) collectively comprised a Meaningful Assimilation of Skills for Care Model (MASC) that aims to identify the central elements for the effective and efficient delivery of skills in nursing. These 'enablers' are simplified and explained in the model and include: assessment, record keeping/documentation, communication, risk management, managing uncertainty and professional decision making (Lovell 2016). Within clinical practice, a nurse's work is shaped by the professional frameworks within which he/she must operate. This case study will explore the processes, issues and outcomes of nursing assessment and professional decision making over a period of 5 weeks as these are paramount to the chosen patient's needs. As recommended by the Nursing and Midwifery Council's (NMC) Code of Professional Conduct (2018), verbal consent was sought from the ward manager who oversaw the care of this patient as the patient was unable to give consent due to being deceased; patient confidentiality is maintained throughout via the use of a pseudonym.

Contextual Information

Mr. Douglas was an 82-year-old man from a working-class background; he fought in the war and was exposed to an extreme amount of stress. Den-Velde et al. (2011) found that the morbidity and mortality rates of war veterans was approximately 35.5% higher than a randomly selected population-based sample of similar aged males, suggesting that Mr. Douglas had a higher risk of developing illness due to his past. The only other significant factor that could have had an impact on Mr. Douglas' health was smoking which he was

addicted to for 30 years before stopping in 1995. Den-Velde et al. (2011) also proposed that smoking was the single, greatest contributor to mortality in people over the age of 60. Cox (2010 cited in Lovell 2016) states that collecting an accurate medical history is a critical diagnostic tool. Although Mr. Douglas had been generally well throughout his life, a fall in December 2017 resulted in a dislocated left hip and a fractured right elbow, which subsequently led to the identification of multiple health-related issues which had not been previously addressed.

Assessment

Nursing assessment is the systematic and continuous compilation and documentation of information (Berman, Kozier and Erb 2010) including a complete set of examinations that provide information about a patient's physiological, psychological, spiritual and sociological health (Weber and Kelley 2010). An assessment is usually carried out by a registered nurse or doctor at the beginning of a patient's care and the results are used to identify issues/treatments that a patient may have or need (Weber and Kelley 2010). Mr. Douglas was admitted to Accident and Emergency (A&E) before being moved to the orthopaedics ward where he waited for his x-ray. It was unclear how long Mr. Douglas would be waiting to get a diagnosis due to an increase in waiting times for x-ray results; a survey conducted by the Royal College of Radiologists found that 330,000 in/outpatients across a range of NHS trusts waited up to a month to receive x-ray results, including computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound scans (Mayor 2015).

The first assessment Mr. Douglas received on the orthopaedics ward was called the National Early Warning Score (NEWS) (Mitchell, McKay and Van Leuvan 2010). NEWS scores collect quantitative data that indicate any significant concerns regarding a patient's general health. NEWS scores have been refined to enhance early detection of patient deterioration. They are used to categorise the severity of illness and prompt nursing staff to alert medical staff if required (Mitchell, McKay and Van Leuvan 2010). NEWS scores are based on a scoring system which relates to the measurement of physiological factors: respiration rate, oxygen saturation, pulse rate, systolic blood pressure, temperature and level of consciousness or new confusion. A score is assigned to each parameter as it is measured; the higher the score the greater the deviation from the norm (Royal College of Physicians 2017). Mr. Douglas' observations were measured routinely, these measurements included: blood pressure, heart rate, oxygen saturation, respiration rate, temperature and AVPU (alert, voice, pain, unresponsive) (National Clinical Effectiveness Committee 2014).

Most staff within acute hospital trusts carry out NEWS measurements and take appropriate action if necessary; however, there are multiple barriers which may hinder the effectiveness of the NEWS assessment tool. For example, Spiers et al. (2015) conducted a study on 1,000 adults experiencing serious illness across several acute hospitals and estimated that an average of 1 in 20 deaths (5.2%) were preventable if the NEWS tool had been implemented accurately (if the results gained from patients were recorded precisely and responded to immediately). It was important that the roles and responsibilities of healthcare staff were clearly identified and the communication process following the identification of any problems was quick and efficient; any delay of vital

information, such as Mr Douglas' previous NEWS scores, could have had a profound effect on his health (National Clinical Effectiveness Committee 2014). Because NEWS scores don't always give an accurate indication of whether something is right or wrong, it was critical that the healthcare staff were able to identify changes in Mr. Douglas' behaviour and deviations from his normal observations. Buykx et al. (2011) suggests that a nurse can identify the deterioration of a patient using her own qualitative and subjective clinical judgement, for example, by recognising a change in how a patient looks and behaves. NEWS should be used as a tool and supplemented by professional knowledge to gain the most efficient care.

Following the initial assessment of Mr. Douglas, his nurse had to complete his admission paperwork which included a range of assessments, such as a bed rail assessment, a Waterlow chart and a pain chart. Some of the questions asked in this process were of a private/intimate nature, which could have made Mr. Douglas hesitant to answer honestly. As proposed by *The Data Protection Act* (1998), it was important for the nurse to emphasise confidentiality and inform Mr. Douglas that his information would only be shared with the necessary people to guarantee effective care could be maintained. Establishing a therapeutic relationship was essential for the maintenance of trust between the nursing staff and Mr. Douglas (Doherty and Thompson 2014) and this is found to be a key factor when gathering relevant and accurate information (Silverman, Kurtz and Draper 2013).

A Waterlow chart was used to measure Mr. Douglas' risk of developing a pressure ulcer

and this suggested that his risk was increased. Because of this, Mr. Douglas was provided with an air mattress and was repositioned as often as possible (NICE, 2018). As recommended by NICE (2018), Mr. Douglas was encouraged to change his position frequently but due to his lack of mobility, he was offered help to make sure this was done every 4 hours. However, because of the increasing pain he was experiencing, Mr. Douglas often refused to be rolled and therefore, other methods of pressure ulcer prevention, such as barrier creams, were used to prevent moisture lesions and sores due to incontinence and dry skin (Burch 2015).

From day 1 to 6, Mr. Douglas had a maximum NEWS score of 3; Mr. Douglas was scoring 1 for low blood pressure, 1 for low heart rate and 1 for a high respiration rate. Although this score would be concerning for most people, the healthcare staff felt that this wasn't a major cause for concern as Mr. Douglas presented himself as alert and generally well. On day 7, nurses were concerned as Mr. Douglas had a severely low blood pressure (systolic number was below 80, possibly due to an internal bleed or dehydration) and he was vomiting, light-headed, breathless and tired very easily, resulting in a score of 5 on his NEWS chart. It was Trust policy that a score of 5 should be followed up immediately with a call to the Medical Emergency Team (MET). The MET would assess the deteriorating patient closely and take the appropriate medical pathways. In a study of 370 patients, 18.9% of them had an incorrectly calculated NEWS score, which could have been due to inaccurate assessment of patients or no assessment at all; furthermore, an appropriate clinical response was only seen in 74.1% of cases that required medical attention (Kolic et al. 2015). Normal saline (sodium chloride and water) is normally used

intravenously for dehydrated patients who are struggling to consume any food or liquids. It was used to rehydrate Mr. Douglas and stabilise hypotension until the medical staff could determine its cause.

After a series of blood tests and physical examinations, doctors concluded that although they could put Mr. Douglas' arm in a sling, they were unable to put his hip back in place due to his current poor health. After 4 weeks of managing his pain with oral and intravenous (IV) analgesia, Mr. Douglas began to excrete blood from his rectum. Rectal bleeding has a positive correlation with colorectal malignancy and 8% of patients aged 50 years and over who present with rectal bleeding are diagnosed with colorectal cancer (Royal College of Surgeons 2013). Mr. Douglas underwent an examination of his abdomen to exclude abdominal mass and had a colonoscopy. He was then referred to a specialist consultant based on initial presentation and the results of his tests. This was followed by more baseline blood tests, such as a full blood count.

After a few days under investigation, the consultant found that Mr. Douglas had an upper gastro-intestinal (UGI) bleed that had been caused by a malignant stomach tumour, which was also the cause of his hypotension. Because of this, the staff on the orthopaedic ward felt a move to a gastrointestinal ward was appropriate. This caused a barrier to effective treatment as moving Mr. Douglas meant he became uncomfortable and confused. Furthermore, it had taken a week before healthcare professionals recognised that he had multiple underlying health issues that required reviewing; this delay may have influenced the effectiveness of any future treatment. On transfer to another ward it is crucial all the

documentation is present to ensure continuity of care (Kripalani, Yao and Haynes 2007). Failure to communicate effectively at the transfer stage could have adversely affected the treatment that Mr. Douglas received.

Professional Decision Making

Each day we make judgements based on what we observe and what we know; when these perceptions are implemented in practice, they become 'clinical judgements' (Thompson and Dowding 2009). The process of making a judgement includes: observation of a patient's vital signs (such as Mr. Douglas' NEWS score), medical history, test results and behavioural changes (Lovell, 2016). It was only after observing Mr. Douglas and informing him of their findings that the team could validate their perceptions and make appropriate clinical judgements and decisions (Dougherty, Lister and West-Oram 2018). Based on clinical judgement, the medical professionals who were caring for Mr. Douglas decided that his condition was deteriorating quickly. The Royal College of Nursing (2008) propose that the aim of professional decision making is to improve, maintain or recover health and to ensure the affected patient leads the best quality of life until their death, and therefore, it was paramount for the healthcare staff to consider what would benefit Mr. Douglas most.

Within the *Mental Capacity Act*, the Department of Health (DoH) (2005) states that a person must be assumed to have capacity, unless proven otherwise. *The Mental Capacity Act* also suggests that a patient has the right to decide even if the decision is seen to be unwise and these decisions should be respected unless it could cause harm to their health (DoH 2005). Mrs. Douglas stated that she believed her husband lacked capacity due to

recent memory loss and confusion. To overcome this barrier, he completed a 'mini-mental' test, along with several other assessments (Mitchell et al. 2014). His results suggested that he did not have dementia and was able to make his own decisions regarding his health. Mr. Douglas' family were encouraged to aid him when making decisions but advised to refrain from influencing them. It is found that when relatives take part in the decision-making process, it helps the nursing staff individualise, and therefore improve, patient care (Mitchell and Chaboyer 2010).

By week 4, and after numerous episodes of rectal bleeding, the palliative care team were advised to speak to Mr. Douglas and his family about developing an 'Advanced Care Plan'. The concept of palliative care was introduced by Dame Cicely Saunders in 1967 and has now developed to provide high quality care and services for patients who are at the end-of-life (Faull et al. 2012). Mr. Douglas required primary care and the team were advised to follow *The End-of-Life Care Strategy* which is a pathway used in England and Wales to optimise continuous high-quality care during a patient's last days, weeks or months of life (Faull et al. 2012).

Advanced care planning is a process which involves the patient, their relatives and the healthcare team. It is predominantly associated with preparation for future incapacity and supports the holistic practice of multidirectional communication between those involved in the patient's care, to ensure their needs and requests are met (Faull et al. 2012). It was crucial for Mr. Douglas to make his own decisions regarding his care with support from the team. As medical professionals, the staff involved in Mr. Douglas' care evaluated his

condition using questions such as: 'Is the patient dying?', 'Are they comfortable?', 'What do we need to decide?', 'What do we need to anticipate?' and 'Have we spoken to the patient and their relatives?' (Faull et al. 2012). OMEGA (2009) found that only 27% of patients who died had been identified as needing an advanced care plan. Out of these, only 58% were involved in their end-of-life care and only 42% had their preferences recorded.

During the advanced care planning process, the issues surrounding cardiopulmonary resuscitation (CPR) naturally became the focus of many conversations. As advised by the medical staff, a 'Do Not Attempt Resuscitation' (DNAR) order was put in place for Mr. Douglas and a sensitive discussion between him, his family and the consultant in charge of his care took place. After coming to terms with his terminal illness, Mr. Douglas decided that he would like to spend his last days at home. In a retrospective study of two practices in Leicestershire (Exley, Field and McKinley 2003) 95% of patients had requested to die at home and 77% of their carers felt that this was the right decision, suggesting that many patients feel most comfortable in a more familiar environment, but possibly indicating that some carers believe that the patient would benefit more from being in hospital.

After the palliative care team had spoken with Mr. Douglas and his family, Mrs. Douglas followed the nurse out of the room and confided that she felt that Mr. Douglas should stay in hospital, as she would be unable to care for him at home having recently suffered a heart attack herself. McAndrew, Leske and Schroeter (2016) suggested that nursing staff engender a moral obligation to reduce the suffering of patients during end-of-life; conflict

and uncertainty around this professional decision making is the cause of such moral distress. Due to increasing confusion and disorientation of Mr. Douglas over the next few days, the healthcare team felt it would be most appropriate to hold a 'best-interest' meeting regarding his advanced care plan. A best interest meeting is carried out when a person lacks capacity (Griffith 2018). The people involved were his doctor, nurse, family members and other people who cared for and had knowledge about him. The decisions made during this meeting were based on existing knowledge of his wishes and values and allowed all parties involved to voice their opinions and come to the agreement that a hospice would be the most suitable place for him to receive end-of-life care.

Conclusion

In conclusion, all six of the Chapelhow et al. (2005 cited in Lovell 2016) enablers are vital when providing effective nursing care. This case study proposes that without efficient assessment, it is impossible to make beneficial, professional decisions. Furthermore, nursing staff should be educated on how assessment tools work and consult with other medical professionals if they feel that something is wrong; it is made apparent in this case study that not all clinical judgements and assessments should be based on outcomes from tools such as Waterlow; therefore, a nurse's judgement of the patient should be recognised as being equally important. However, nurses should always follow the legal and ethical guidelines when making professional decisions such as data protection and confidentiality, and should not allow their own moral conscience to affect their clinical judgements.

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