

The Issue Of Consultation Abilities In Connection To Nurses Endorsing

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Case Study One

For effective healthcare practices, it is important for the nurse practitioner to be aware of Independent Prescribing. The Independent Prescribing process is defined as the prescription by a practitioner who is responsible and accountable for the evaluation and assessment of the conditions of patients and makes an appropriate decision regarding their clinical management and prescription (Aronson, 2006). This process, however, must involve the patient as a partner as well during the consultation process (RPS, 2016). Strengthening and instruction of patients are presently all around perceived as a vital objective; however, most human services experts. Furthermore, it takes after that if patients are to be included then their specific needs should be found out and tended to, ordinarily in the system of the consultation. A continuous finding in a significant number of examinations regarding the matter is the way that patients have a tendency to incline toward prescribers who tune in and furthermore enable them to talk about their issues in an unhurried manner. Therefore, this case is specially coordinated with the issue of consultation abilities in connection to nursing endorsement. Even though we have quickly analyzed the general issues of nurse endorsing, the consultation is clearly the center expertise required to build up the conclusion and, accordingly, the fitting treatment and solution. Numerous investigations have taken a gander at the impact of relational abilities on recommending and different variables identified with the consultation.

The consultation took place at the ABC (pseudo name) facility, a healthcare delivery facility staffed by physicians of different specialties and other non-physician healthcare providers who specialize in the diagnosis and management of patients with chronic pain. The primary goal of a pain treatment facility is to provide effective and humane care for those who suffer from chronic pain. The complexities of the chronic pain patient must be recognised to accomplish these goals. As a member of the team, I am strongly committed to the idea that a multidisciplinary approach to diagnosis and treatment is the preferred method of delivering health care to patients with chronic pain of any etiology.

During the consultation, I rigorously applied the standards of the prescribing competency framework set by the RPS (Royal Pharmaceutical Society, 2016), which consists of ten competencies split into two domains: consultations and prescribing governance. In this case study, I integrated the competency framework into my practice using competencies 1 to 9. I then used the Gibbs method to reflect on my practice (Gibbs, 1988).

A 78-year-old lady – Mrs Stark, was referred to the facility by her GP as she complained of acute asthma and also had a history of arthritis and knee pain. Mrs Stark is a widow living with her dog and

has always claimed to be quite independent in daily activities until five months ago when her pain started to become unmanageable. She now has to call her son daily to walk the dog and to help her with food shopping as needed because this, as well as other simple tasks, have become increasingly difficult to accomplish because of the recurring pain.

The medication prescribed only provided minimal benefit to the patient's condition, and the use of over-the-counter medications such as Paracetamol seems to have not made any difference. Also, the use of NSAIDs has exacerbated symptoms of mild asthma she was diagnosed with fifteen years ago (RPS framework competence 2: Consider the options). The rest of Mrs. Stark's medical history was unremarkable; she has no major medical problems and no known allergies. She lives on her own; her 46-year-old son visits her daily to ensure that she has everything she needs in order to be reasonably comfortable at home.

The latest X-ray reports show a severe degeneration in her knees due to bilateral joint space narrowing with medial femur shift and valgus deformity, moderate popliteal and superficial femoral artery calcification.

Mrs Stark was prescribed one capsule of Tramadol HCl (50 mg) capsule twice daily. Furthermore, she was also prescribed one tablet of Amitriptyline HCl (25mg) tablet to be taken at night. She was also taking two tablets of Paracetamol 500mg tablet according to her needs for pain relief. Finally, Mrs Stark was also prescribed 1 to 2 puffs of Salbutamol (Ventolin) 100mcg inhaler based on the frequency of her asthma complaints.

I utilized the PQRST (Krohn, 2002) pain assessment tool to obtain a holistic description of the pain during the examination. Although this tool was used, the consultation was essentially based on the Calgary-Cambridge model of communication (Greenhill et al. 2011), which consists of six distinct areas (REF)

The first step in this model is about 'Initiating the session.' This step involves planning for the session and formally initiating the consultation session with the patient. This also involves specifications of all consultation protocols. The second step involves 'Gathering information'. In this step, information about the patient and their medical history is gathered so that the foundation of the session can be developed. Once the information is gathered, the next step is to 'Provide structure to the consultation' so that all the formal protocols and specifications can be met appropriately. As the consultation process begins, it is important to 'Build the relationship.' This helps in ensuring that the right consultation is being provided to the patient sufficiently. Once these specifications and requirements have been met, the fifth step involved 'Explanation and planning'. In this step, the physician or the consultant explains the scenarios, possible treatments and their implications for the patient. Once the patient and the consultant have been satisfied the session is formally closed.

The consultation process was established in accordance with the RPS Framework competencies. The consultation was initiated by developing an initial rapport with Mrs Stark, who was asked to describe the problem she was experiencing. Here, the RPS framework competence 1, i.e., Assessing the

patient, was ensured. She described the pain in her knees as a constant ache that gets unmanageable, especially in the morning, only partially relieved by the Tramadol that she takes twice a day as prescribed by her GP.

The PQRST (Provoking, Quality, Radiation, Severity, Timing) Pain Assessment Tool has been used during the consultation to formulate specific questions to adequately understand Mrs Stark's pain:

According to Mrs Stark, her pain improves in the afternoon but does get worse after prolonged periods of rest as well as following stressful activities. The quality of the pain can be described as an achy, cramping and numb sensation on both hips and knees that can suddenly radiate down from her knees to her feet. The patient's pain score is a seven on a scale of 0 out of 10.

Osteoarthritis is a type of degenerative joint disease (Loeser et al. 2012) that results from the breakdown of the joint cartilage and the underlying bone, with the most common symptoms being joint pain and stiffness.

In the early stages of the disease, symptoms might occur following exercise or activity, but over time, they can manifest without any aggravating factor at all. There is no cure for osteoarthritis, and the condition can get worse over the years, so the best goal is to find the appropriate combination of pharmacological and non-pharmacological treatment to ensure that the condition doesn't evolve to become a significant limitation for the patient.

After careful consideration of the patient's pre-existing diagnosis of osteoarthritis, the symptoms reported, the drugs she is currently taking, as well as the patient's preference, I decided to prescribe Morphine Sulphate (Zomorph) modified-release 30mg capsules twice daily to start immediately as a substitute for the Tramadol 50mg oral capsules. According to the WHO Ladder of Pain (Burton & Hamid, 2007), if the pain persists or is increased after treatment with an opiate for mild/moderate pain, such as Tramadol, the next option is to consider an opioid for moderate/severe pain like Morphine sulfate.

I opted for the modified release form considering Mrs. Stark's social history and age to facilitate ease of administration, maintain constant drug concentration during the day and minimize side effects. Since the patient has to be informed about the prescription process and plan, I explained to Mrs. Stark the reason I suggested starting with a relatively high dosage of 30mg twice daily is that she used to take Tramadol, and over time, her body has developed a tolerance to small doses of opioids. Also, the BNF (2017) suggests a Morphine dose of 40mg to 60mg daily in divided doses when switching from a regular weak opiate regime. An increase of the dosage at a later point in time may be considered to compensate for any gradual reduction of the analgesic effect associated with oral administration. Here, the RPS framework competencies 3,4 and five, i.e., to Reach a shared decision, prescribe and provide information, were ensured.

Morphine Sulphate is an opioid analgesic, and it acts mainly on the central nervous system and smooth muscle (Hanks et al. 2001). It comes in a sustained-release form, which makes the twice-daily

oral administration possible. Morphine is immediately absorbed from the digestive tract, and the percentage of the drug binding to plasma proteins was considerably low, i.e., about 34%; the liver metabolizes a considerable quantity of the drug to glucuronides, which undergo enterohepatic recirculation. In the end, the product is eliminated essentially in the urine and a small amount in the feces. Here, it is important to understand the metabolism and excretion process of morphine and the way it impacts the physical dynamics of the patients to ensure that no side effects are being exposed to the patient. The individual health concerns of the patients must also be ensured during the prescription of opioids such as morphine.

The patient has also been informed of common side effects of the drug, such as nausea, constipation, confusion and some occasional vomiting. I have the professional responsibility to review and evaluate the treatment outcome; therefore, I arranged a follow-up visit with Mrs Stark in a week's time to establish if there have been any improvements in her symptoms.

Follow up assessment should take place once a week for the first two months. Further appointments will then be carried out every six months by a member of the team as well as annually by the pain consultant. Any undesired pharmacological effect should be reported to the Hospital facility during working hours, from Monday to Friday, to 111 or A&E during nights and weekends. Here, the RPS framework competence 6,7,8, i.e., Monitor and review, prescribe safely, and prescribe professionally, were ensured.

I concluded the consultation with Mrs Stark, advising her to avoid any stressful activities or sudden strenuous movement, to have a little rest in the afternoon when possible and to consult a chiropractor of her choice if the pharmacological treatment results in pain improvement. Mrs. Stark needs to make sure her pain due to arthritis is well managed and controlled while she is undergoing treatment for asthma as well. Medications for asthma tend to induce joint pains that need to be reported immediately (Smyth et al. 1999).

The case study represents a common type of patient who visits the facility regularly. When I encounter people like Mrs Stark, I can appreciate a better understanding of their chronic condition, feeling empathetic for patients who have to learn how to coexist with pain. I am now aware that the same pathologic condition between individuals does not mean that the treatment should also be the same because every individual has different pharmacological responses to medications; here, the RPS framework competence nine, i.e., to Improve prescribing practice, was ensured.

The challenge is to find a way to improve a patient's life, allowing preservation of the individual physical needs and self-esteem. Chronic pain, like other degenerative conditions, can seriously debilitate the individual; when constantly subjected to it, patients can experience a gradual withdrawal of their autonomy. My tools are the knowledge gathered along the path of this course and the experience that the facility has offered me. I consider the skills that I have acquired to be a completion of my holistic approach to pain management. I have always felt 100% responsible for the well-being of my patients, whether they are on a theatre table, on a bed in a ward or attending the

facility. Therefore, I believe that every single healthcare professional is accountable for patients' safety; it is our duty to make sure that any treatment, assistance or care for which we are responsible is delivered effectively. I'm aware that I'm accountable for my actions to practice competently. I also understand the limitations of my professional competence, and I will only accept responsibilities for those activities in which I am competent (NMC 2004).

It is important to include the patient in the prescribing decision to ensure that they can adhere to the proposed drug regime without any problem or reluctance.

I was dissuaded from proposing an alternative treatment that would involve physical activity at the moment because of the patient's reduced mobility due to severe pain. I would consider it an option for future consultation if Mrs Stark's symptoms improve. Overall, the consultation was a positive experience for the patient and me, as she seemed to be grateful and positive about the new treatment regimen.

The entire consultation and prescription process helped me understand the importance of positive consultation as well as ensuring that the prescription of medication is done in such a way that it may not trigger secondary pains and discomforts in the patient. The experience and exposure to such cases will enable me to improve my competencies and enhance my self-confidence (Jones et al. 2004). This is important because a good prescription routine is not only a theoretical practice. Instead, it requires analytical and critical thinking skills to ensure that the prescription is appropriate for the individual needs of the patients (Jones et al. 2004). Therefore, the inclusion of the patient in the process is very important. In order to ensure this competency, as suggested by RPS, I explained the rationale of my choices of prescription to the patient and waited for her feedback or queries so that she could be satisfied with the prescription process. Furthermore, the background health analysis and history check also ensured that the individual needs of the patients were being considered throughout the consultation process.

Therefore, it is important to understand that success is only possible when the nursing prescription process is ensured in accordance with RPS competencies. The dynamic acknowledgment of the worldview of concordance offers all social insurance experts an instrument to move towards ever more secure and more effective recommendations. Exact recognizable proof of the patient's points of view, needs, and convictions and, after that, the tending to any noteworthy contrasts between these and the prescriber's prerequisites are believed to be dynamically more vital in the fruitful conveyance of nurse-endorsed social insurance. The appearance of the nurse recommending conveys added obligation to the more conventional part of the nurse. It is essential not to disregard the significance of the part of intelligent practice here. It isn't only the demonstration of working out the solution that is imperative, however it is the comprehension of the procedures and progression of the cooperation that are occurring amongst prescriber and patient that are the basic key to great endorsing practice.

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