

Health promotion and patient empowerment in the palliative setting

Sarah Simons

Faculty of Education, Health and Community
School of Nursing and Allied Health
Liverpool John Moores University

Abstract

This article discusses the concept of health promotion within a palliative care setting and the benefits of health promotion within this context. Promoting choice and autonomy benefits not only the patient but also impacts upon their family and friends. Three health promotion topics are considered: smoking, oral health and psychological wellbeing. Using case studies, it is elucidated how individualised care planning benefits and empowers the patient. Barriers to promoting health such as lack of skill and time management are considered, and how these were overcome. The legal, ethical and policy contexts governing best practice nursing care are considered alongside the chosen topics.

Keywords

Palliative care, Health promotion, Smoking, Oral hygiene

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Introduction

This article will discuss a four week placement at a local hospice. In accordance with the Nursing and Midwifery Council (NMC) Code of Conduct, the name of the hospice will not be revealed and the patients will be discussed using pseudonyms (NMC 2015).

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The hospice had 30 beds available for both male and female patients aged over 18 years. However during this placement patients were aged between 44 to 100 years were cared for. It specialised in cancer care, but patients often had co-morbidities such as diabetes and chronic obstructive pulmonary disease (COPD). As the number of patients was relatively low and the duration of their stay could be several weeks, the nursing staff got to know the patients well and student nurses worked closely with their mentors who supported them in practice.

‘There is tremendous potential for the idea of health-promoting palliative care...’ (Allen and Watts 2012, p.349). Not only does the nature of an individual’s death have an impact on the health of friends and relatives, but it is also an NMC requirement to ‘Prioritise People’ (NMC 2015). This involves listening to individual concerns and preferences, maintaining dignity, responding to both physical and psychological needs, and acting in the person’s best interests. All these elements are crucial to the holistic care provided in a hospice setting.

This article will focus on three health promotion topics: smoking, oral health, and psychological wellbeing. This will be followed by a conclusion summing up the main issues raised.

Background

The setting was a hospice in the North West of England, run by a registered charity. It had 30 beds, a day unit and an out-patient department. The patients could be at the end of life, but in some cases were attending for symptom control or ongoing support following discharge. Access to the hospice was free and patients were admitted based on doctor's referral.

Naidoo and Wills (2009) identify five main aspects of health promotion: medical, behaviour change, educational, empowerment and social change. The main aspect of health promotion at the hospice was centred on empowerment of the patients. Three aspects of health promotion will be discussed relevant to the patients cared for. Smoking was particularly relevant to one patient known as Julie, who had lung cancer. Oral health was significant to many of the patients, as the medications prescribed could lead to dry mouth and discomfort. Oral health will be discussed with a particular focus on a lady known as Rita. Psychological wellbeing was again very important for all patients. Discussion will focus on a patient known as Carole and how her health was promoted in terms of psychology.

Smoking

Tobacco smoking is '...responsible for nearly nine in ten lung cancers' (Foot and Harrison 2011, p.20). Lung cancer is the second most common cancer in the UK, with 44,488 new cases diagnosed a year (Cancer Research UK 2012). Research has shown that lung cancer survival rates in the UK are poor in comparison to other Western nations such as Norway, Sweden, Canada and Australia (Foot and Harrison 2011). Factors which

influence survival rates include co-morbidities, fitness, age, and health related behaviours. Continuing to smoke has been shown to reduce the effectiveness of cancer treatment, and increase the likelihood of secondary cancer (Foot and Harrison 2011). On a national level campaigns such as the National Health Service (NHS) 'Smokefree' and 'Stoptober' emphasise the impact on the smoker's health, their family's health and also the financial burden of smoking (NHS 2015).

Julie had smoked for twenty years, but found her diagnosis a shock as she 'did not think it would happen to her.' She suffered from co-morbidities of heart failure, arthritis, colitis and short term memory loss. Julie was attempting to reduce her smoking and was using nicotine replacement therapy in the form of patches. However she still requested for staff to hoist her from bed to wheelchair and take her to the courtyard for a cigarette.

As a student nurse this was a difficult situation, feeling reluctant to enable Julie to smoke. However, the hospice was near to a main road and due to Julie's memory issues it was important a member of staff stayed with her to maintain her personal safety. Julie was informed about the impact which continuing to smoke could have on her treatment and prognosis. However, she had smoked for a long time, was addicted to nicotine and enjoyed smoking.

The Code of Conduct states that nurses must 'encourage and empower' people (NMC 2015, p.5). However, nurses must respect the decisions an individual makes about their own health. Dowling et al. 2011 (cited in Baillie and Black 2015, pp.174-175) identify that

patients must be willing to ‘...participate in change and to engage actively...’ in the management of chronic illness. Discussing this with the mentor led to reflections on the ethical issues arising from the scenario. Whilst it was important to encourage Julie to quit smoking, it was also necessary to promote her safety and respect her choice as an individual.

Psychological Wellbeing

Carole was a 69 year old patient with ovarian cancer and peritoneal metastases. She was at the hospice for palliative care. During the placement Carole’s condition was deteriorating. In addition to cancer, Carole had vascular disease and the blood supply to her feet was beginning to shut down. Due to this, she was nursed in bed.

Carole suffered from anxiety regarding her condition and would comment about the state of her diminishing health. Owens (2012) explains that in palliative care, anxiety can have many aetiologies such as deriving from physical pain, or psychological, social or spiritual issues. Regular analgesia was given to Carole in a syringe driver and also benzodiazepines to help with the anxiety.

The Code of Conduct (NMC 2015) states it is a duty of nurses to ensure that ‘people’s physical, social and psychological needs are assessed and responded to’ (NMC 2015, p.5). Therefore it was important to consider what measures could be taken to improve Carole’s psychological health. During the placement time was spent in the ‘day unit’ which was a centre where both inpatients and outpatients could spend time involved in activities; such as craft, gentle exercise and quizzes. As a student nurse it was very

inspiring to see the benefits this gave to those involved. Carter and Mackereth (2008) explain how 'complementary therapies' such as this and also massage, for example, are rapidly increasing in use in the UK in addition to traditional medical treatments. However, such initiatives are often funded by charities and rely on volunteers, meaning availability is scarce.

'Nonpharmacological interventions should always be considered first' when dealing with patient anxiety (Owens 2012, p.208). It was indicated in Carole's care plan that she was interested in the day centre and staff should encourage this. However, Carole had become used to staying in bed and watching television, and with the deteriorating condition of her legs she was frightened to use the hoist. Naidoo and Wills (2009) raise the ethical principle of beneficence, meaning that actions taken must be of benefit to the patient. It was discussed with Carole that she could be hoisted into a wheelchair by the physiotherapists so that she could attend the day unit. Although nervous, Carole gave consent for this. She was reassured that someone would stay with her and that she would receive pain relief prior to being moved.

Together we went to the day unit and Carole's spirits were really lifted. She enjoyed looking around the hospice and stated she felt more settled, having seen the entirety of the surroundings where she was staying. Time was spent in the courtyard discussing the different flowers there. Boog and Tester (2008, p.69) states that '...great relaxation can be found for a person by visiting a place of meaning and recalling 'contentment they had at that time'. Although the courtyard itself was new to Carole, smelling the flowers there

reminded her of her own garden and her love of nature.

Reflecting with the mentor was an important part of this experience. One factor in Carole's care plan was for staff to provide ongoing spiritual support. The care plan was updated and it was documented that she had been able to mobilise out of bed with assistance, and that staff could repeat this experience if Carole desired.

Oral Health

Oral health is often overlooked; however, it is very important particularly in palliative care. Good oral health in cancer care is '...essential for nutrition, recovery and wellbeing...' (Wårdh, Paulsson and Fridlund 2009, p.799). Cancer patients suffer oral problems such as dysphagia, excessive dryness (often medication induced) and pain. Nursing staff may experience barriers to prioritising oral health, such as time constraints or lack of training/understanding. Wårdh, Paulsson and Fridlund (2009, p.800) also state that documentation of oral care given can be 'unsatisfactory'.

Rita was a 69 year old female with T cell lymphoma and multiple metastases, including on her tongue and the roof of her mouth. This was very uncomfortable for her, and in addition medication was causing xerostomia. It was challenging initially using the oral gels and mouthwashes but over time it became easier. Consent was always gained prior to the delivery of oral care.

Rita's symptoms were alleviated greatly by receiving oral health assistance. Encouragement was given to use the call bell whenever she wished for further care, which

she did. It was also discovered that Rita preferred children's toothpaste, as the flavour was less strong and therefore less likely to cause nausea. Rita also enjoyed foods such as ice cream, which are easy to eat and numbed the sensation in her mouth. Rita found pleasure in eating certain foods, and it was important to encourage this. Corner (2008, p.242) explains that eating is not just '...a means of obtaining sustenance' but also a '...deeply felt human experience.' This reflects the Code of Conduct (NMC 2015) responding compassionately to those in the last few days of life. Care provided for Rita was documented in her daily care plan.

Legal, Ethical and Policy Context

The hospice is a charity registered with the UK Charity Commission. It is also subject to Care Quality Commission (CQC) regulation (CQC 2015). They check that the hospice respects patients, provides safe, high quality care, has appropriate staffing levels and is well managed. CQC also gather comments from patients and relatives regarding the service. All CQC reports are publicly available online. In addition, the National Institute for Health and Care Excellence (NICE) provide guidelines on hospice best practice (NICE 2015).

Legally, nurses are required to register with the regulatory body for nurses, midwives and health visitors, the NMC. As Cribb (2007, p.30) discusses, the ethical onus on nurses is for 'individual accountability'. Nurses must take responsibility to keep their own knowledge and practice up-to-date, along with maintaining values of respect, consent, confidentiality, teamwork, minimising risk to patients, and being honest and trustworthy.

If a nurse fails to do this they can be subject to fitness to practise proceedings, which can lead to being 'struck off' the nursing register (Cribb 2007).

Nursing ethics are based on 'value judgments' (Evans, Coutsaftiki and Fathers 2011, p. 20). This can be simplified to the consideration of what is 'acceptable' or 'unacceptable' in health care. Nursing ethics are informed by Beauchamp and Childress's concepts of autonomy, non-maleficence, beneficence and justice (UK Clinical Ethics Network 2015). This involves respecting the individual's decision-making process, doing good and not harm, and distributing benefits equally.

The CQC have recently rated more than 90% of the UK's hospices as 'good' or 'outstanding' (BBC 2015) and the UK ranks first in the world in terms of palliative care quality (Line 2015). However advocacy groups such as Hospice UK highlight concerns that only 32% of funding for hospices is received from the government (Hospice UK 2015). The ageing population of the UK is expected to increase over the next twenty years (Hospice UK 2015), raising fears that hospice provision will be insufficient in years to come.

Conclusion

Initially it was difficult to understand how the principles of health promotion could be applied to a hospice setting. However, it has now become clear that it is the nurse's responsibility to promote health and best practice for all patients, at all stages of life.

It is also crucial that nurses document all care given to patients and maintain accurate records. This is vital so that other staff can follow developments in the care plan, and also because care plans are legal documents which CQC inspect.

Whilst writing this article, there has been an opportunity to reflect on practice in terms of how small gestures, such as assisting with oral hygiene or taking a patient out in a wheelchair, which can make huge differences to that patient's wellbeing. It was possible to recognise the ethical dilemmas involved when a patient may not accept the advice offered, for example to stop smoking. However it is a legal and ethical requirement that nurses respect the autonomy of those under their care.

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