**Mrs Prescott WAGOLL Assignment 2: Learning Aim D**

**P5: Assess care needs of a selected service user with a physiological disorder.**

1. **Introduction**

A treatment or care plan is a written record of the stages of arranging treatment or care that is provided in order to help provide individualised care. A care plan may involve organising other health professionals to join in the care being provided for them, such as a local GP getting a counsellor involved if they feel that the service user needed it (RN central, 2017).

**Stakeholder consultation**:

This involves gathering all information about the service user and any other individuals and agencies involved. Can include:

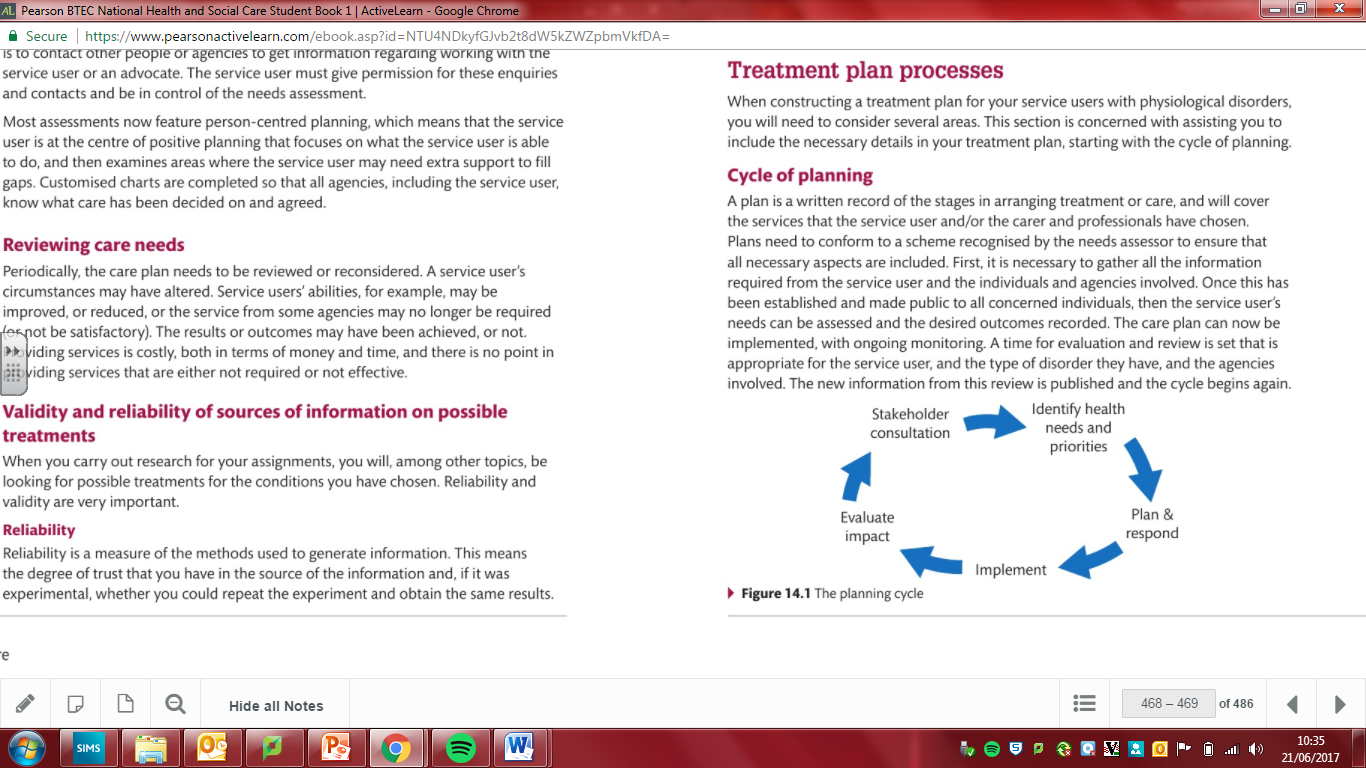
* Consultations (meetings)
* Medical history
* Diagnoses

**Identifying health needs and priorities**:

They can then consider the individual needs of the service user by assessing their PIES needs and holistically prioritising the desired outcomes of care and/or treatment.

**Plan and respond:**

They can set aims and objectives to meet the overall desired outcomes. This involves setting specific timeframes, location and professional responsibilities in meeting the individual’s needs.



**Evaluate impact:**Overall evaluation of the impact the care or treatment plan had on the individual. Continuing the cycle if necessary but adapting to meet the individuals changing health and wellbeing needs.

**Implement:**

The care plan will start, taking action on:

* Treatment stages
* Monitoring (improvements or deterioration)

A care plan involves a cycle of planning which starts off with a stakeholder consultation in which involves gathering all information that the health professionals are going to need to know about the service users. This is going to involve meetings to get everyone involved together, discussions of medical history to see if the health professionals can see where the issue has started and also a diagnosis, so that the health professional knows where they can start on the care plan.

The second stage of the cycle of planning is going to be identifying health needs and priorities, which includes looking at the service user as a whole by seeing what the issues are and what they can do to make sure that they can minimise the risks or reduce them completely. This is going to involve looking at the physical, intellectual, emotional and social needs of the service users and if there is anything that the service providers can do to help the service users then they are going to do so, by looking into treatment and medication.

The third stage of the cycle of planning may be to plan and respond which is when the health professionals look into what treatment the service user can get from the services, the health professionals are going to set aims in which the health professionals are going to try to meet. This is also going to involve giving the health professionals roles and responsibilities in what they specialise in so that each need of the service user is going to be met.

The fourth stage is implement which is when all of the organising is taken into action and things are actually being done to make sure that treatment is being taken place. Another act that will be done whilst implementing the care is that the service users are going to be monitored so that if there is anything that could be improved, it will be improved to the best standard possible.

The fifth and final stage of the care cycle plan is going to be to evaluate the impacts to see what the overall outcome is, if it is good then the health professionals are going to carry on using it or others in which could be in the same situation. If the care plan wasn’t right then this may then mean that it will be altered to make sure that it can meet the needs of the individual, (Pearson’s 2016).

It is important to involve the patient in writing and agreeing the treatment plan in order to ensure they are empowered to take control of their own care. The treatment plan must also be regularly reviewed and updated, as the patient’s circumstances or condition change.

1. **Bowel Cancer case study**

**Name:** Margaret

**Age of diagnosis:** 61 years old

**Background:**

In this assignment I will be researching and investigating the physiological disorder bowel cancer and the service user Margaret, aged 73. Her name has been changed due to confidentiality reasons. She has given her full permission as a subject for this assignment and given her consent to sharing her medical information.

Margaret has very recently retired from Primary School teaching and lives with her husband, John, who is 74 and has a number of health problems including severe COPD and CHD. They have both always led an active life. She enjoys walking and aqua aerobics, as well as looking after her grandchildren 3 or 4 times a week. She has always led a healthy lifestyle; she very rarely drinks, does not smoke and eats a healthy, balanced diet. She is a volunteer at her local charity shop and at her local primary school she assists the teacher and listens to the children read. She has a very active social life including a Women’s Group, Book Club and regular theatre visits. She is also an active member of her local Church community. She attends Church weekly and sings in the choir on a Sunday at Mass. Margaret was very anxious when retiring from teaching as she had taught full-time for over 25 years and was determined to “stay busy and active”.

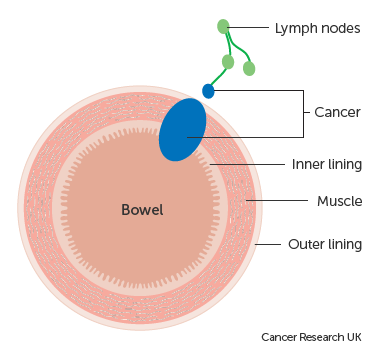
Margaret presented at the GP in July 2006 with pain in the lower abdomen and bleeding from the rectum. She had been treating herself for piles with over the counter medication but her symptoms were not responding.

The GP referred Margaret for a colonoscopy at North Manchester General Hospital and a series of biopsies were taken. The results of these biopsies showed some abnormal tissue and Margaret was then referred for a barium enema and X-ray as well as a CT scan of the abdomen and pelvis on an urgent basis.

When the results came through, the Consultant Colorectal Surgeon diagnosed Margaret with recto-sigmoid adenocarcinoma (Dukes C).

**Dukes' C**

The cancer has spread to at least 1 lymph node close to the bowel.



1. **Individual Needs**

A treatment plan should be ‘holistic’ – treatment and care plans must consider the uniqueness of an individual taking into account their background and life experiences. This means that care planning revolves around the service user and treats them as an individual, rather than a task.

**Religion:**

* Some religious groups (e.g. Jehovah witnesses) have specific practices towards medication and treatment
* Some have restrictions on diet; e.g. kosher or halal meat, vegetarianism and abstaining from drinking alcohol.

**Culture:**

* Some peoples share certain traditions, values, beliefs, customs, dress, language and behaviours which need to be considered when providing care
* Simple examples include- preferred ways on dressing for modesty, females only being treated by a carer of the same sex, sitting at the table to eat or eating the main meal of the day at lunchtime.

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**Disability:**

* Some disorders may be in addition to other disabilities that cause other/similar symptoms E.g. a diabetic could also have arthritis which causes painful movement
* Learning difficulties could also impact on the rate that illness develops and the treatment options selected.

**Gender:**

* Female service users may prefer to be cared for by female carers and feel uncomfortable with male carers especially if undressing is necessary.
* Some males prefer the same sex doctor, especially if any intimate examinations are required

**Age:**

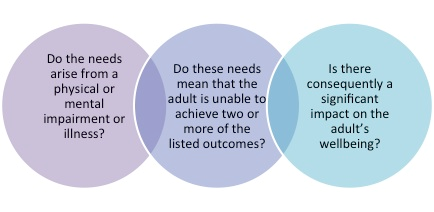
* Some needs are associated with age when treating people with physiological disorders
* Young children are reliant on parents to identify health issues and provide access to treatment.
* Those who are older also rely on others for support with taking medication and meet care needs
* A young mother would have different needs as she copes with the impact of the disorder on her family and day to day life

1. **Local Authority Care Needs Assessment**

A social worker or an occupational therapist would carry out the care needs assessment. This would look at her physical, emotional, social and intellectual health. It would also assess any medical needs, day-to-day living needs and any financial needs.

**Eligibility outcomes for adults with care and support needs under the Care Act 2014**

The eligibility decision-making process for adults with care and support needs involves the consideration of the following three criteria:



**Eligibility criteria for adults with care and support needs under the Care Act 2014**

When determining eligibility, local authorities must consider the following three conditions.

**Condition 1**

The adult’s needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.

This includes if the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

**Condition 2**

As a result of the adult’s needs, the adult is unable to achieve two or more of the outcomes specified in the regulations and outlined in the section ‘Eligibility outcomes for adults with care and support needs’.

Local authorities must also be aware that ‘being unable’ to achieve an outcome includes any circumstances where the adult is:

* unable to achieve the outcome without assistance. This includes where an adult would be unable to do so even when assistance is provided. It also includes where the adult may need prompting. For example, some adults may be physically able to wash but need reminding of the importance of personal hygiene.
* able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety. For example, an older individual with severe arthritis may be able to prepare a meal but doing so will leave them in severe pain and unable to eat the meal.
* able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others. This would include, for example, cases where the health or safety of another member of the family, including a child, could be endangered when an adult attempts to complete a task or an activity without relevant support;
* able to achieve the outcome without assistance but takes significantly longer than would normally be expected. For example, a physically disabled adult is able to dress themselves in the morning, but it takes them a long time to do this, leaves them exhausted and prevents them from achieving other outcomes.

Local authorities must consider whether the adult is unable to achieve the whole range of outcomes contained in the criteria when making the eligibility determination.

There is no hierarchy to the eligibility outcomes – all are equally important.

**Condition 3**

As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult’s wellbeing, determining whether:

* the adult’s needs impact on at least one of the areas of wellbeing in a significant way or
* the cumulative effect of the impact on a number of the areas of wellbeing means that they have a significant impact on the adult’s overall wellbeing.

**P6: Plan treatment to meet the needs of a selected service user with a physiological disorder.**

**7. Overall aims for the treatment plan for Margaret**

Bowel cancer is the 4th most common cancer in the UK, accounting for 12% of all new cancer cases (2015).

The main aims of the treatment plan for Margaret are to cure the disorder (recto-sigmoid adenocarcinoma (Dukes C)) and remove all cancerous tissue. This will be achieved via surgery and Chemotherapy treatment. This will avoid spread to other body systems and gain remission from cancer long term. Support Margaret physically through treatment to minimise side effects and complications. Support Margaret emotionally to minimise the risk of mental health issues developing.

**8. Overall aims of the Treatment Plan**

These aims can be delivered and achieved in different settings within the NHS:

**Primary care** – This is usually an individual’s first point of contact with services in the community. For Margaret, the GP will assess and initially investigate her symptoms. The GP may then refer her to secondary and tertiary health care. The Pharmacist will also dispense any medication she is prescribed by the GP or hospitals. The GP will also support her once she is discharged.

**Secondary care** – This is care that service users receive in acute (that specialise in a certain area of medicine/treatment) or general hospitals that usually involves tests, diagnosis and treatment. Secondary care can be can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture. For Margaret, this would involve the planned surgery under the Colorectal department at North Manchester General Hospital

**Tertiary care** – This is the care a service user receives after transfer to units with special focus, such as palliative centre (end of life care), a spinal injury unit or an oncology centre (for those with cancer). For Margaret, this would involve Chemotherapy treatments by the Oncology department at The Christie Hospital.

**9. The Overall Aims of the Treatment Plan**

The service user is at the centre of the Treatment Plan. All aspects of the treatment plan will be discussed and agreed with the service user. We will ensure that the support is personalised for the service user; considering their likes, dislikes, religious preferences and beliefs. We will also ensure that treatment is tailored to meet their specific needs. We will empower the patient by educating them on all aspects of their disorder and treatment options and gaining their full agreement for the plan before it is put into place. It is also vital that a Multidisciplinary approach is taken, all carers and professionals communicate effectively and maintain confidentiality. Any actions or changes will be discussed and agreed across the multi-disciplinary team.

**13. Potential barriers that Margaret may face accessing treatment for her Bowel Cancer and how they can be overcome**

Margaret may find it difficult to access the GP when she needs to due to difficulty getting appointments. She may also be very unwell during her treatment and unable to walk down to the GP surgery on occasion. Her husband and daughter can offer lifts and also to accompany Margaret. The GP may make exceptions for cancer patients, and offer alternative ways to see him or her. Telephone consultations may be an option or a new phone app is available to talk to the GP over video link may be available. The local pharmacy may be able to assist without an appointment.

Margaret may experience fear of the surgery, and waiting lists to see the consultant may cause delays. (Although operations for cancer would usually be prioritised). If the GP and consultant give a full explanation of the disorder, the surgical procedure and follow-up, this will give her the knowledge she needs. Margaret will know what to expect, and so this will alleviate some of her fears. Staff can build relationships and trust with Margaret before the surgery. This would also alleviate some of the emotional stress and anxiety surrounding diagnosis and prognosis.

During Chemotherapy treatment, once a week the central Hickman line must be flushed out using a small amount of liquid and the wound cleaned. Margate may need to go to the Walk-In centre or be seen by District nurse for this. Over time, she will be taught how to do this herself but may have problems. To overcome this issue, Margaret may be given medication to help prevent a blood clot in the vein at the end of the line. She can be taught how to clean her own line and avoid further appointments. Enabling Margaret to be at home more would enable her to carry-on with as many of her previous activities as possible and maintain her sense of self – linked to work or volunteering or “keeping busy”.

A further problem for Margaret would be travel to The Christie Hospital and time spent all day having the treatment. She will need a lift and the driver will have to wait around for a long time. Her husband and daughter can accompany Margaret, or she has a wide circle of friends who will also give her lifts on occasion. She could also take a taxi if no-one was available as she is financially secure.

Some weeks Margaret may not be able to have every treatment due to infection or fatigue – she will need a full assessment before every treatment is given. To help to minimise this, Margaret will need to stay away from others who are infectious e.g. common cold or flu virus. Every visitor will need to follow thorough handwashing techniques and be aware of passing on any illnesses.

A final barrier Margaret will face is the time and inconvenience of preparations for the colonoscopy investigations which she will have as a follow-up every 5 years. This involves a four-day preparation including a special liquid diet, laxative preparations and bowel cleansing. She will also need to allow time taken to travel to hospital and time away from other activities such as work or childcare. She will also experience stress and worry about the outcome of the procedure.

On the other hand, these will only be done once every 5 years and gives Margaret peace of mind that she is cancer-free. It is also an opportunity to get more information and counselling and to meet other sufferers and gain social and emotional support. This would alleviate some of the emotional stress and anxiety surrounding diagnosis and prognosis.

A huge part of coping with this very traumatic experience is for Margaret to accept the period of time in her life where treatment takes priority and she must find alternatives ways of maintaining social contact and support, e.g. Macmillan and The Christie support groups and meeting up with other cancer sufferers.

**11. Most beneficial treatment or care strategy for Margaret**

Margaret will need a range of treatments and care strategies to help her recover from Bowel Cancer. The two most important treatments are surgery and chemotherapy. After three years, 76.7% of patients who received chemotherapy treatment over three months were disease free (National Institute for Health Research). According to the National Bowel Cancer Audit Report 2015, during 2013-14 96.2 per cent of patients were alive 90 days after a major operation for bowel cancer. This is a significant improvement from 2009-10 when 94.2 per cent patients were alive on the same measure. This difference means hundreds more patients are now surviving bowel cancer following major surgery since more than 19,000 patients undergo surgery every year. Surgery is the main and most effective treatment for bowel cancer.

In addition to the effectiveness of these treatments for treating bowel cancer, they will resolve all the care needs identified in the Care Needs Assessment as seen in the template.

However, with a condition as complex as Bowel Cancer, many carers and care settings are required to deliver the support and care needed to support someone through this very traumatic process, including voluntary (Macmillan Cancer Support) and private organisations (Counselling, Wig makers).

**12. Professional responsibilities of staff involved in the Treatment Plan**

All carers involved will need to demonstrate professional responsibilities outlined in the Care Value Base when delivering the treatment plan:

**7. Using anti-discriminatory practice:**

* Even though a service user may be different to you (e.g. age, gender, sexual preference, appearance, ethnicity, religion, personal views / opinions) you must treat them fairly and with respect.
* Discrimination is saying or doing things wrongly/unfairly because someone is different to you.
* Anti-discriminatory practice is treating people fairly regardless of their differences.

**8. Respecting individual differences and identify**

* Closely linked to anti-discriminatory practice.
* Carers must respect beliefs associated with religion, sexual preference, views, opinions etc.

**1. Maintaining confidentiality of information and discussions on a need-to-know basis:**

* Information must not be verbally shared with other members of staff, other patients, friends, family.
* Only those involved in the treatment plan should know.
* Confidential documents – contain name, age, address, medical condition.
* Store on computer with password access or paper copies locked away.



**2. Considering the service user’s choices and preferences:**

* Service user should make own treatment decisions.
* Can’t insist/force treatment.
* Support them to make *‘informed decisions’* – explain the benefits/consequences of treatment options.
* Supporting choices shows respect.

**6. Being aware of the service user’s needs:**

* Carers need to be aware e.g. vegetarian diet, the need to pray, does not drive, fears/phobias
* All carers must read the treatment plan to discover their personal needs so they can be met.

**4. Respecting the service user and their personal worth and dignity:**

* Dignity involves showing respect so the service user is not embarrassed or is denied their privacy.
* The carer should ensure the body is not exposed, close the door when they are in the toilet/shower, pull the curtain around the bed for privacy.
* Personal worth = Treat them as an adult, an autonomous person, don’t patronise like a child.

**5. Maintaining a positive relationship and showing a sensitive manner:**

* Always be there for the service user so they don’t feel alone.
* Must be enthusiastic, don’t make them feel like a burden.
* Show empathy, be sensitive to their feelings.
* Develop a supporting ‘professional’ relationship with them.

**3. Giving praise, and encouraging independence and support:**

* Giving praise/encouragement is essential during treatment, but carers must not be patronising.
* Without support the service user may give up hope or determination to fight.
* If mobility is reduced, don’t do tasks for them, encourage them to be independent and do things alone – boost self-esteem.

**18. Justification of the Treatment Plan – how the Treatment Plan will impact the patient’s health and wellbeing**

This treatment plan has been written with Margaret and her individual needs and wishes have been considered at every step of the way.

**Physical:**

She will get clear confirmation of the diagnosis at North Manchester General and the outcome we are all aiming for is full remission from cancer.

“During 2013-14 some 96.2 per cent of patients were alive 90 days after a major operation for bowel cancer. This is a significant improvement from 2009-10 when 94.2 per cent patients were alive on the same measure. The difference means hundreds more patients are now surviving bowel cancer following major surgery since more than 19,000 patients undergo surgery every year. Surgery is the main and most effective treatment for bowel cancer.”

31% of patients diagnosed with colon cancer and 42% of patients diagnosed with rectal cancer have chemotherapy as part of their primary cancer treatment.

The SCOT study, led by the Cancer Research UK Clinical Trials Unit in Glasgow, recruited 6,088 patients with high-risk stage II or stage III colorectal cancer from 244 centres across Europe, Australia and New Zealand. They received either a three or six month course of chemotherapy and were followed up for a minimum of three years.

After three years, 76.7% of patients who received treatment over three months were disease free compared to 77.1% of patients treated over six months. Patients treated over three months had fewer side effects and reported a better quality of life as well as reduced peripheral neuropathy.

Although the treatments can have a negative impact on her physical health, this is short term and there are a number of ways the side effects can be minimised. Taking pain relief and ant-nausea medication will help, as well as gentle exercise. Relaxation techniques such as meditation and yoga will also help Margaret to sleep and enable her to recover from each treatment more quickly.

**Intellectual:**

The charities and specialist staff will explain how the disorder and its treatments will affect her body. She can also do a lot of research online on the Macmillan website or use the helplines. This will ensure Margaret is clear on all treatment options, and that she understands the plan for her treatment in detail. This will empower her to get more involved in the decision-making process and boost her confidence as an expert patient. She will be able to express her thoughts and concerns more clearly with professionals.

**Emotional:**

She will receive emotional support from all specialist staff, as well as the support groups, helplines and her friends and family. She has a lot of support around her during this difficult time. If Margaret is struggling with her mood and feeling depressed, she can ask to be referred to a Counsellor or choose to pay for a private counsellor. They will give her the opportunity to voice her fears and talk through her emotions with someone who is not emotionally involved in the situation. This will improve her relationships with her family and friends.

**Social:**

Margaret’s social health will be maintained as much as possible in new ways such as making new friends who are also going through a similar process. She can do this through the support groups and social events offered by Macmillan and The Christie. Her self-confidence can be maintained by getting a well-fitting wig so she can go out and not feel self-conscious when she feels up to it. Her level of independence will be fully supported as much or as little as she requires at different stages of her treatment. Margaret’s family and friends will adapt and cover for her responsibilities until she is well enough to resume them. As soon as she has completed Chemotherapy and feels better, she will need to regain her strength; friends and family can do this by cooking her nutritious meals and taking her out for dinner.

**Achievement of Outcomes**

The plan also gets agreement form all relevant members of the Multi-Disciplinary Team and they are committed to full communication and maintaining confidentiality. This treatment plan will give Margaret the best possible chance to recover from Bowel Cancer and enjoy her retirement, and see her grandchildren grow up.

**19. Why is it important to do a Care Plan review?**

The Treatment Plan considers the patient when they are first diagnosed. As the patient continues on this plan over months, or even years, circumstances may change that will influence the disorder and how effective the treatments or care strategies may be. For example, the patient may experience lifestyle changes such as redundancy or divorce which could affect the Treatment plan. In addition their disorder may deteriorate and they may need a different range of treatments and support.

**20. Justification of the Care Plan Review: Palliative Care**

Due to the changes to Margaret’s condition, she will need palliative care. She will no longer require surgery or Chemotherapy. This is because her cancer has spread to the liver and is now inoperable and cannot be treated. Margaret will be referred for Palliative care as her family can no longer support and care for her at home. She also needs specialist care for her condition and to be settled and happy as she approaches the end of life.

Palliative care can’t cure cancer, but it aims to improve a patient’s quality of life. Palliative care also offers emotional, social and spiritual support to you and your family. It helps you to stay independent for as long as possible and helps you make decisions about your care.

**Physical**

Margaret will be kept as comfortable as possible with pain relief that is reviewed and adjusted regularly. She will be supported to manage her symptoms as effectively as possible and the care home GP will visit regularly to assess her condition. This will also enable her to build a trusting relationship with her GP. Margaret will be encouraged to do gentle exercise and various activities are offered at the Care home including walks, yoga and the fitness suite. This will enable Margaret to stay active as long as possible and also boost her mood.

**Intellectual**

Margaret will be offered practical and financial advice and information about her condition and its impact. This will empower her to discuss issues with clarity and make the right, informed decisions for her and her family. She will also be offered the opportunity to get involved with a variety of activities to stimulate the mind at the Care home including arts and crafts, games and puzzles and memory games. Reminiscence therapy can also improve memory.

**Emotional**

The Care home will offer a range of Complementary Therapies which can boost emotional health including relaxation techniques, mindfulness and meditation. There are also regular massage and beauty treatments available to boost confidence and wellbeing.

**Social support**

Living in a Care home means making new friends and spending more time in contact with others in a similar position. This gives Margaret the regular social contact she needs and the emotional support of others. The Care home also organises trips to a local Spa, meals out, as well as other events. The local Primary School regularly come to the home in order to sing in the choir and spend time with the residents and cheer them up!

**Spiritual support**

The Care home will fully support Margaret’s spiritual wellbeing by offering weekly Mass, regular visits form the local Priest and other parish members, as well as supporting and the Sacraments.

The care home will also advise and support Margaret’s family through this difficult time, including bereavement counselling.

Patients and their families like and appreciate the support offered by hospice care. A report commissioned by the Real Time Reporting pilot project developed by the National End of life Care Programme (now part of NHS Improving Quality), Marie Curie Cancer Care and Help the Hospices working in partnership. The ‘Friends and Family’ test gave an aggregate score of 75% of individuals who would recommend the service to their family and friends. Of the total number of participants, 96% of those receiving care responded to this question and 92% of the family/friend/carer of the person receiving care.

This evidence supports the effectiveness and need for hospice care delivered through a range of settings in the UK for terminal patients.

**Original aims of the Treatment Plan**

Margaret’s treatment initially achieved the first two outcomes she had set:

* Removal of all cancer from the body and peace of mind that it is all gone.
* Avoid spread to other body systems.

Unfortunately, due to the terminal nature of her condition, Margaret will not achieve the third aim of the treatment plan in the longer term:

* Remission from cancer long term.

The aims of the Health Care Professionals:

* Full input and agreement from Margaret and rest of Multi-Disciplinary Team for the Treatment and Care strategies. This was achieved.
* We will empower the patient by educating them on all aspects of their disorder and treatment options and gaining their full agreement for the plan before it is put into place. This was also achieved.
* It is also vital that a Multidisciplinary approach is taken, all carers and professionals communicate effectively and maintain confidentiality. Any actions or changes will be discussed and agreed across the multi-disciplinary team. This was also achieved.

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