

# VoxPOPS: “SHARE AN EXAMPLE WHEN YOU HAVE HELPED A PATIENT WHO WAS NON-CONCORDANT”

We asked five experts in the field of wound care to describe a time in their healthcare career where they had to overcome the challenges of treating a non-concordant patient.

“T here are many instances where I have worked hard to reach patient concordance. One such occasion involves Gemma, who is a 45-year-old woman with lymphodema. She was overweight and had recurrent cellulitis and leg ulceration, which had been unsuccessfully treated in the past. After a holistic needs assessment, a treatment regimen of compression bandaging was recommended to be instigated by the practice nurse. However, Gemma failed to attend her appointments, claiming she was now housebound. I then sought help from the district nurses to see if they could instigate a bandage regimen to facilitate healing. But Gemma would often stay in bed for days and refuse their visits. The GP, district nurses and practice nurses were unable to offer any further intervention, so her left leg continued to be highly exuding, was malodourous and contributed to her being in significant pain. I went to see her to undertake a home assessment as she refused to come into clinic. After listening to her issues and a discussion with GP, some antidepressants were

prescribed as she had a low mood and was very depressed. Gemma decided that she wanted her partner to help her with the treatment, so she could have her bandages changed at a time convenient to her.

To ensure the correct compression was delivered, I taught her partner to apply a bandage system that had an application guide on the bandage. Amazingly, after 6 weeks of treatment she actually attended our leg ulcer clinic, she had started to lose weight and was taking and interest in her appearance and going out. Her leg ulcer had almost healed and we were able to put her into hosiery. The strategies of listening to the patient, working together and finding a compromise resulted in a good outcome for Gemma.”

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“We have all encountered patients who are reluctant to follow advice or treatment. This can be frustrating for clinicians who want to make a difference, and perhaps anxiety-provoking about the potential consequences if a patient suffers harm as a result of their non-concordance. In such situations, it is important to try to uncover the reasons behind non-concordance. It is rarely the case that patients just want to be ‘difficult’. Detailed questioning may reveal why they do not want to wear compression bandaging or accept pressure-redistributing equipment, for example. Is it the bulk, footwear issues, pain, or appearance? Is it a perceived disruption to their home environment? Is it because they will

be unable to sleep in a double bed any longer? Is it a previous bad experience, or experiences of friends/family?

I have frequently found the approach used by clinicians can make all the difference. When under time pressure, it is tempting to simply tell patients what they need and then become frustrated when the patient refuses. It takes time to explore with patients their reasons for non-concordance, and to realign any misperceptions they may have. Sometimes just taking an unhurried approach, sitting down and offering clear explanations, avoiding unhelpful jargon, can make the difference. This can be supplemented by written information if available. Previous poor experiences may prevent patients from engaging with treatment, and in this case there may be new products that should be

discussed and offered if appropriate. Working with patients who are non-concordant will usually involve negotiation and compromise.

The 2015 Nursing and Midwifery Council Code is very clear that people who have mental capacity are entitled to make their own decisions about their care and treatment and we have a duty to respect their right to refuse treatment. It is important not to be tempted to raise the issue at every visit, as this only serves to antagonise patients and may then damage any future encounters.

In all situations, it is essential to document the content of all discussions and decisions reached, and to review the situation at a planned future date.”

ELIZABETH NICHOLS



“Tissue viability in mental health can be challenging, as well as straightforward. We vary from the patient who’s really pleased to see us to the one who doesn’t believe any assistance is needed. This latter group are often actively psychotic when this happens, either with delusional thoughts or hallucinations. Sometimes, these thoughts can be really fixed and the trick is to identify how you can work with them to get what you want for your patient (possibly a case of who can out-manipulate who!).

One of the hardest situations to negotiate is where patients believe they are a doctor and a lot of time can be spent discussing treatment options to attempt concordance, and even then, dressings are frequently removed.

I think one of my favourite examples of working with someone’s delusional thoughts was a gentleman referred to me a couple of years ago from our Psychiatric Intensive Care Unit and local burns unit. He had partial-thickness burns to his lower limb after an incident of accidentally setting himself on fire; the wound bed was superficial slough with evidence of granulation tissue and re-

epithelialisation. On point of referral, the wound was clean, but the patient refusing to have a dressing on it; this increased the infection risk from contamination.

The patient was insistent that his spit would heal the wound and no dressing was needed; he was liberally applying his own saliva at various points in the day. While unwilling to have a dressing applied, he was prepared to allow staff to clean the wound twice a day. I decided the best way to minimise his infection risk (without resorting to antibiotics when we had no infection present) was to use a topical antimicrobial soak. Staff applied a PHMB irrigation fluid soak for 15 minutes, morning and evening, and the patient found this acceptable; at the point of discharge to an open ward, the wound was healing and not infected. The power of saliva!”

ANITA KILROY-FINDLEY



“Caring for someone with dementia who is always looking for their mum is a situation that many clinicians feel causes them distress. ‘What do you tell someone who has forgotten that their mum has died?’ is a question I am often asked.

It makes me reflect on my own practice as a young student nurse in mental health in the early 80s. We were taught that the technique of reality orientation was best and we were expected to apply it. It is reflecting on this in practice that can often pull at my heart strings. For the person looking for mum, it often resulted in them hearing that their mum was dead as if it had just happened. Everyone was then distressed. We, therefore, need to be

sure that we recognise the distress this can cause. James (2011) lets us deal with this in a much more person-centred way. Can we cue the person into their own memory of where mum is? If we can, then the distress is greatly reduced. We need to make sure we know enough about our patients to have this information to hand. Most importantly, we need to recognise that what the person is really telling us is that they are distressed.

I would always start by investigating what is concerning or worrying the person who is looking for their mum. We now know that behaviour is always a form of communication. What is it that may be being communicated by asking for mum? A good place to start is looking for anything that may be causing

discomfort. Pain can be debilitating, while being able to find the toilet is also very important, for instance. Often the person is not sleeping well overnight. Being hungry or thirsty can also cause distress. Don't exclude that it may be the first sign of infection, particularly if it is a new behaviour. Making sure our practices make us recognise and prevent delirium in people with dementia will ensure our care meets our patient's most basic needs, and create the optimum conditions for preventing distressed behaviour.”

James I (2011) *Understanding Behaviour in Dementia that Challenges*. Jessica Kingsley Publishers, London

SANDRA SHIELDS

“The day began as usual. Referrals were picked up from the wards via telephone message and online incident reporting. The patient had a grade II pressure ulcer to the right hip. A pressure-relieving mattress was *in situ*, risk and skin assessments were completed, and slide sheets used. Everything suggested that nursing staff had assessed the patient and implemented all necessary measures to prevent a pressure ulcer. Despite this, the patient had gone on to develop a pressure ulcer due to being non-compliant with his repositioning regimen.

A review of documentation on the ward confirmed that all appropriate actions had been taken. On entering the bay, the patient was found to be lying on the affected side. I approached the patient, with refusal of treatment form in hand, introduced myself and asked if I could assess the sore skin he had on his hip. Expecting a little resistance, I was surprised when the patient rolled,

with a little assistance, onto his left side to enable me to inspect the pressure ulcer.

He told me that he had been in hospital for 5 days after developing a chest infection that the antibiotics his GP had given him hadn't helped to clear. He lived alone, had help from his family with shopping and cleaning, but was able to look after himself at home. Having imparted so much information so readily, I decided to broach the subject of his reluctance to change position in bed. I explained the cause of pressure ulcers and why the nurses helped him to change position every 2 hours. ‘I wish they'd told me,’ he said. ‘I had my hip done last year and it's a bit uncomfortable to lie on my other side, but I would put up with it if I would get rid of this sore. If only they'd told me that's why they keep rolling me over every 2 hours when I'm comfy!’

It still seems to be the little things that can make a big difference to our patients' care!”

RACHEL REECE



“With the addition of the title ‘dementia champion’ to my role, I am now very often asked to support people with dementia who cannot be convinced by staff to keep their dressing intact. Often the referral will use language like ‘patient refuses’, ‘patient non-compliant’, or occasionally ‘non concordant’. My first thought, therefore, is that I am going to be offering support to someone who has no understanding of dementia. Why is that? How can you expect to care for a person with no understanding of the effects of the organic disease process? If a patient was diagnosed with cardiac or kidney disease, registered nurses understand this disease process and, if they don’t, then they read up on and learn about it, except with dementia, as it almost seems, to some at least, that this disease doesn’t count.

Before I became a dementia champion, if I was asked how I support the nurse who was not following the plan of care I prescribed, I’d expect one of the following things to be true: perhaps the nurse was not aware of the advice; did not have or know how to use the correct dressings; or felt the dressing was not working for the wound. Since becoming a dementia champion, however, I now would add that the patient didn’t understand or remember that they needed the dressing or was unaware what the dressing was for.

People without dementia can decide not to comply with treatment recommendations and, in most cases, when you discuss the reasons why he/she are not complying, the issue can usually be resolved. This is not always the case with patients who are cognitively impaired. In my experience dealing with those patients, I tend to find some staff are exasperated with the situation and the patient, and they just continue with the plan of care without trying to find a solution specific to the problem.

I once received a referral to review a leg wound on a patient with cognitive impairment and, when I arrived, I found the nurse distressed. I was told the patient had purposely removed his dressings on three separate occasions that morning.

I went to see the patient who once again had removed the dressing, but who seemed calm and happy to see

me. After introductions, I mentioned the leg wound. As I had to review the dressing, I spoke to the patient about the previous dressing regimen. While the patient could not remember specifics about the dressing, he was able to explain that his leg and foot were really warm and itchy, and that was what was causing discomfort.

I explained to the patient that due to the wound on the leg, a dressing was required and this caused some distress, however, I took some time to go over the plan of care with the patient.

From a holistic wound assessment, it was decided the dressings the patient kept removing were not comfortable and it would be unlikely that the behaviour of removing them would change. I suggested the use of a hydrocolloid — a thinner dressing, which was skin coloured.

The rationale behind this was the patient should not find the dressing too bulky and it would be less likely that the leg would become warm and itchy due to dry skin. The skin tone colour means that the patient may be less likely to notice it. To treat the dry skin, a simple moisturiser was chosen and a further review by the medical staff was undertaken to confirm that the warm, itchy sensation was just due to dry, flaky skin.

Once I finished applying the moisturiser and dressing, I remained in the room to clean up and to keep the patient occupied with other things while they got use to the sensation of the dressing. The patient seemed at ease and happy. On review, I was advised that the dressing regimen was working.”

EILIDH HENDERSON

