Rolfe, freshwater and jasper (2001) framework for diabetes

Reflective account, using framework from Rolfe, Freshwater and Jasper (2001) of a patient with regards to a long term condition and identification of a learning need to be achieved during the module.

This essay is reflective based on my experience while on a clinical placement. The aim is to demonstrate an understanding of my views encountered in practice using the Rolfe, Freshwater and Jasper (2001) framework with regards to diabetes mellitus which is a long term condition. According to Bennett and Morisson (2009), Diabetes mellitus is a lifelong condition marked by high level of sugar in the blood and a failure to transfer this to the organs that need it. The framework will show how it has been used to reflect on the condition, what has been learnt and the outcome on current and future practice. It also based on learning needs to be achieved during the module.

It was an eight week placement on an acute unit which consist of a male bay, one female bay and three side rooms. My mentor and I was assigned to the male bay. This was when I came into contact with Mr. A. Pseudonym will be used to conceal patient identity. Confidentiality will be maintained throughout in accordance with the Nursing and Midwifery Council (2008).

Mr. A was a 64 year old gentleman who was admitted to a critical unit from Accident and Emergency (A&E), in my third week of my first year as a nursing student but my second placement. He had several conditions inflicted on him. They were acute pulmonary oedema secondary to silent myocardial infarction (MI), acute kidney injury (AKI) and CKD. Past medical

history of Type 2 diabetes mellitus (T2DM), quadriplegic amputee and HONK. He was basically admitted for hyperglycaemic control

It became clear during hand over that this was a challenging and interesting case for effective learning to take place especially as a student nurse. Learning is a relatively permanent change in knowledge, skills or ability as a result of experience (Bennett & Morrison, 2009). However, I felt anxious as this was just my second placement for my first year as a student nurse and I did not feel experience enough to deal with all I was hearing about this patient.

My first impression when I saw Mr A. was a sad one because of his quadriplegic amputee. I realised that hearing or reading about a condition and actually giving hands on care is different. According to Bulman and Schultz (2008), thinking can be intellectual, thus emphasising the importance of practical as well as theoretical for learning.

My first encounter with Mr A. on the ward he appeared to be drowsy and somewhat confused from the conversation we had. For instance, his wife was sitting at his bedside and he told me he took his wife to a party last night. During the time he was mentioning he was hospitalise. Drowsiness can be a sign of hyperglycaemia as in Mr. A Case. As nurses and other health professionals, we are faced with challenging and unique situations in practice, therefore, by reflecting on these experiences it allows learning to take place and again flexible ways in which to respond to these situations (Burns & Bulman, 2000).

While caring and carrying out assessment of Mr A., it was noticed he had intravenous infusion (IV), urethral catheter, insulin pump, heparin infusion and central venous pressure line (CVP). I was assigned to monitor hourly observation because the patient was critical and this had to be done until they were stable, especially the blood sugar which was elevated. According to Dougherty and Lister (2008), maintenance of normal blood glucose should be within 4-7 mmol/l. I can remember at one point it was 27 mmol/l. Whenever I noticed any abnormalities in the observation I would inform my mentor. I noticed increase in insulin administration via pump when blood sugar level is elevated and decrease when lower readings.

Also, the patient was unable to carry out self-care or assist in his care because of his quadriplegic amputee. He was totally dependent on the nursing staff to take responsibility for all his basic needs and to promote high quality care (NMC, 2004). However he was given the care that he needed with consent. For example, wash in bed and assisted with nutritional needs such as feeding. When food was given he would refuse, but with much encouragement on my part in a good way he would. I can remember Mr A. asking me to scratch his head because he was unable to.

Strict fluid balance I maintained because the patient was reluctant to drink. I informed my mentor and I was advised to give at least 30 mls of fluids per hour. I asked Mr. A. what was his favourite drink, he told me tea. I remembered going to the kitchen after informing my mentor of my intention to make sure an eye was kept on him. The patient was also monitored using a water loo chart. This was used mainly because of his immobility and he was prone to pressure ulcer if proper care is not given.

During one of my encounters while nursing Mr. A, I remembered him saying to me diabetes is not good because it leave him without limbs. At that moment I felt compassion for him. At the same time he said that to me, I was pricking his earlobe to monitor his blood sugar. I felt sad for him thinking about the pain he was going through pricking his earlobe every hour.

At times I felt impotent because of my lack of experience and been unaware of how to deal with situations such as Mr. A condition. I was limited in my experience and it was my first hospital placement. I wanted to reassure patients, support my colleagues, and give sound advice but I did not have enough confidence and experience to do that.

I didn’t know how to ask Mr. A. about the pain he was experiencing when pricking his earlobe, but I gained the confidence to approach him and ask to tell be about when his earlobe is been pricked. My reason for asking is because I noticed every time his earlobe was pricked he would grimace on his face He said it hurts and is painful. Mc Caffery and Pasero (1999) states pain is what the patient says it is.

However, I have learnt something about myself. I have learnt basic communication skill especially listening just by sitting at Mr A. beside and listening to his conversations he would tell me about his country of birth Barbados and how he ended up living in Trinidad. I did not know that with just a few simple words of empathy and encouragement it would please and calm the patient. According to McCabe & Timmins (2006), communication is the process of conveying information between two or more people. Communication is essential in building relationships with patients and

gaining trust. To highlight how important communication is in the nursing profession, NMC identified it as being an essential skill and only if a student is competent in this skill they can go on and register as a nurse (NMC, 2007).

Communication has been describe as being both simple and complex process. For communication to be effective, the sender has to be very clear about the purpose of the message (McCabe & Timmins, 2006).

The care the patient receive has direct potential to improve through reflective practice it helped to make sense of complicated situations and staff can become motivated and empowered. This has given me a chance to link theory to practice. The way I communicated with Mr. A., had a positive outcome for both of us in that all his needs were met, and I learnt effective communication helps in building trusting bond between patient and nurses (Almond & Yardley, 2009).