

Different aspects of patient care nursing essay



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To help me reflect upon my practice from my first placement to my second placement, I will use Driscoll's model of reflection (Driscoll's model 2000).

Driscoll's model uses three stages to help analyse practice; what happened; providing a description of the event, what have you learned; giving an account of how you felt at the time and what you have learned after revisiting the experience and finally your proposed actions for the future and how you are going to implement what you have learned from reviewing the experience (John Driscoll, 2011).

Throughout this assignment I will be discussing different aspects of patient care which have occurred during my time in my first and second placement.

To maintain patient confidentiality within my assignment I had to gain consent from patients, making them fully aware of why I needed their consent and how their information would be used, following the NMC code of conduct " You must respect people's right to confidentiality" (NMC, 2008).

During my assignment I will not be using the patient's real names due to confidentiality but, I will be addressing them using Patient A and Patient B.

Firstly, I am going to reflect on practice using Driscoll's reflective model. The first stage is to describe what happened during my experience. While on my second placement, myself and a nurse had to bed bath patient A in a side room. The patient was in the side room due to having Clostridium Difficile (C-Diff) which was found after sending a loose stool sample. I had already gained consent from patient A for myself and the nurse to give a bed bath in accordance with the NMC code of conduct (NMC, 2008) and following this I went to collect the correct equipment to perform the task. As patient A had Clostridium Difficile they needed to be isolation nursed. We isolate nurse to "

prevent the risk of spreading germs to other patients and staff” (NHS, 2010). Outside of the side room there were red aprons and gloves which needed to be put on before entering. Before entering the side room, it is essential to collect all equipment to avoid leaving the room unnecessarily. You need to put on a protective apron and gloves to prevent the risk of contamination to clothes and hands (Dougherty and Lister, 2011).

Once in the side room, I explained to patient A what would happen. I encouraged patient A to be as independent as possible; however, patient A could only do little due to reduced mobility. I made sure dignity was maintained at all times by exposing only the part of the body I was cleaning. As patient A was less mobile, patient A couldn't fully assist with rolling; however, with support from myself and the nurse, we could roll patient A enough to clean the back and buttocks. To enable this to happen; I put patient A's arms across their chest and gently rolled patient A onto their side, I provided support to patient A while the nurse cleaned and put clean sheets on the bed. During the task I communicated with patient A to ensure they felt comfortable, and to keep patient A informed of what myself and the nurse were doing.

Driscoll's model now asks me to analyse my feelings and what I have learned. Throughout the experience I felt confident in what I was doing as I had gained previous experience on my first placement; however, when I was on my first placement at a surgical ward I was asked to bed bath a patient with the assistance of a Health care assistant, I felt very anxious as I had never been in direct patient contact before and this was the first time I had been in a care environment. Although I had learned about the requirements <https://assignbuster.com/different-aspects-of-patient-care-nursing-essay/>

of personal qualities and how to promote dignity and autonomy which is needed to assist with personal care in lectures at University, I had never put them into practice until my first placement.

During this event I have learned what isolation nursing is and why we need to implement it if a patient has contracted certain infections. At first, I did not feel comfortable with the concept of isolation nursing as I had never come across this type of infection prevention and control procedure before; however, the nurse explained to me the importance of putting on a red apron and gloves before entering the room, and explained to me that I need to dispose of my apron and gloves in an orange clinical waste bag for incineration and to wash my hands thoroughly with soap and water before leaving the room to remove and spores, and explained that I should not use my alcohol gel in this situation as it is ineffective at eliminating spores. Infection Prevention and control is a term used to protect people from infections. It is used in healthcare to prevent patients acquiring those infections associated with health care and to prevent the transmission of micro-organisms from one patient to another (Dougherty and Lister, 2011).

In the future, if I were to isolate nurse a patient, I feel I would be more confident as I now understand the importance of infection prevention and control procedures such as wearing protective clothing to prevent spreading infections and the process of discarding contaminated waste.

On evaluation of this experience, I feel that my communication skills on my second placement have improved greatly from my first placement, as I am now feeling more comfortable with communicating with different people to

help establish a therapeutic relationship, as this is very important when delivering patient care. I believe I communicated effectively with the patient and a therapeutic relationship was recognised.

I will now reflect upon Organisational Aspects of Care. During my first placement on a surgical ward, I had to take many observations including; Respiratory Rate, Oxygen Saturation, Temperature, Blood Pressure and Heart Rate. On the surgical ward, immediately after surgery the above observations needed to be taken every hour. During my second placement, which was on a medical ward, observations are taken every 4 or 8 hours depending on the needs of the patient; however, if the Doctor or Nurse deems the patient to be at risk, the observations are increased.

When carrying out all observations, it is vital the patients Early Warning Score chart is available, as this is where all observations are recorded. This assessment tool is divided into sections relating to the types of observation you are taking. Within the sections is a colour code to indicate if the recording is of no, low, mild or high concern. All observations need to be recorded, as anything that is not written down did not happen. When recording in official documents all information needs to be eligible and correct and needs to have the date and time it commenced (NMC, 2008).

The first time I had to assist with taking observations, I was very nervous as I had never taken them before and was unsure of how to approach the patient as I had not yet formed a therapeutic relationship with them. I found it difficult to take patients temperature as I was not sure how far into the ear canal I should put the tympanic probe; however, I asked my mentor for

advise and she said that what I was doing was correct which gave me more confidence the next time.

With regards to the patients Early Warning Score, I always record each result as soon as it has been measured to make sure I do not forget, or mistake it for something else. When recording any result, it is vital to check if the patient has any parameters set, most patients on my second placement had parameters set. Patients would have parameters set if the EWS parameters are not specific enough to the patient. Once all observations have been taken it is essential to note whether the patient has an early warning score or not. If the patient does have an early warning score, it is imperative to tell a staff nurse immediately as this could be a sign of something severe. “ Measures and documents vital signs and responds appropriately to findings outside the normal range” (NMC, 2010)

Another observation which I found difficult was respiration rate. I learned at University to be discreet when looking at a patient’s respiratory rate, as, if the patient knows what you are observing, they are more likely to alter their breathing rate, which gives you a false reading. On my second placement, I feel more confident with taking observations; however, I still struggle with respiration rate. I now know that I can observe the patient’s breathing while checking their pulse; however, if they start to talk or their chest does not make significant movement I find it takes me a while.

When taking observations now, I feel much more confident with the layout of the Early Warning Score Chart and knowing when it is necessary to inform my mentor or staff nurse. Over a period of time, my skills will develop

sufficiently, and I will gain more experience helping me to understand what is appropriate for the patient; nevertheless, I feel as a first year student nurse, my skill level when taking observations, recording them and my knowledge of an Early Warning Score assessment tool is what it should be.

I will now discuss Nutritional and Fluid Management in accordance to Driscoll's reflective model. While on my second placement, a medical ward, I had to care for patients who needed assistance with eating and drinking. During meal times, some patients required assistance with eating and drinking, such as; cutting up their food into reasonable sized pieces which they could independently manage. On one occasion I was asked if I could feed a patient, to which I agreed. I already had my apron on, so I approached patient B to ask if it was OK for me to assist them with their dietary needs, to which they answered it was, I then proceeded to wash my hands to prevent contamination of infections (NMC, 2008), (NICE, 2012). I brought patient B's dinner straight from serving to ensure it was hot and manoeuvred patient B's table to a comfortable position for myself to avoid over stretching, and prevent spillage of food, then sat patient B upright in their bed to prevent choking and, made sure they were comfortable and presentable before starting to feed to maintain patient dignity and autonomy (NMC, 2012) . Throughout the meal time, I was careful not to rush patient B with their eating, and I encouraged them to drink plenty. I acknowledged when patient B wanted a rest, and when they were full, trying to encourage patient B to eat as much as possible before indicating the need to stop. Patient B had a food and fluid chart as they were at risk of malnutrition. A food chart provides suitable evidence of a person's nutritional intake which acts as a

valuable resource for all members of a multi-disciplinary team; dieticians and nurses to assess whether a dietary treatment plan is necessary for the particular patient (Freeman, 2002). It was my role, once patient B had finished their lunch to complete the charts accurately.

All through the experience I was very nervous as I had never assisted someone with food and drink, and I had not yet developed a therapeutic relationship with patient B. On my previous placement, a surgical ward, most patients were independent with food and drink so did not require support, or monitoring on a food chart due to the majority of patients having healthy diets, therefore I did not have a great opportunity to learn what they are, or how to fill them in correctly. However, on my second placement I had witnessed a health care assistant filling in a food chart, so I used my initiative to ask what they were and how you fill them in, so I knew what to do if a situation arose where I needed to complete it. As I had never assisted anyone with feeding before, I felt inadequate and uncomfortable in case I put too much or too little onto the cutlery or fed the patient slower or faster than they would usually eat.

On reflection of this experience, I feel I communicated well with patient B to ensure I was appropriate with my actions and that I met their nutritional and fluid needs. I believe I completed the food and fluid charts accurately, leaving me feeling confident if a similar situation occurred. If this situation arose again, I now feel confident I know how to approach it, after gaining experience on my second placement with helping patients with food and drink. I now consider myself to have acquired the correct knowledge and skills to not feel inadequate as I previously had, and I now know what to do

when assisting with feeds and completing the required charts, giving me more self-assurance when I approach patients.

I will now reflect upon the skills cluster; medicines management comparing my first placement and my second placement as a first year student nurse. Throughout my two placements subcutaneous injections were commonly used. The injection I will be talking about is Tinzaparin because it was used on both the surgical and medical ward. Tinzaparin is a low molecular weight heparin and is used for the treatment and prevention of blood clots (British National Formulary, 2011).

During my first placement; a surgical ward, Tinzaparin was frequently used and I had previously observed my mentor administering the injection. After observing my mentor, she asked if I would like to administer the injection, to which I agreed. I had never given an injection; only to a model when learning the technique in University, so I felt very apprehensive. Before giving the injection I would gain consent from the patient, explaining what I would be doing and where on their body I would be administering the injection as there are various places subcutaneous injections can be given. I would ensure I would not be giving the injection into the same sight as the previous day as this can affect absorption rate (Dougherty and Lister, 2011). The patient gave me full consent to give the injection into their abdomen so I would continue to prepare. Prior to giving the subcutaneous injection, I checked it was the correct; drug, dose, patient, route, date and time and if it was signed by a doctor. If this was all correct, I would proceed to cleanse my hands to prevent contamination of medication. To administer the injection I would gently pinch the skin to lift the adipose tissue away from the muscle,

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removing the needle sheath and inserting the needle into the skin on a 45° angle then releasing the skin. I would withdraw the needle quickly and apply pressure with a cotton wool ball (Dougherty and Lister, 2011). After giving the injection I would make sure all sharps were disposed of correctly and all documentation was completed and countersigned by my mentor.

When on my second placement administration of subcutaneous injections was common on the evening medication rounds. I now feel less apprehensive about giving a subcutaneous injection as I have had practice and my professional skills have developed; however, I feel I need to increase my confidence, which will happen after I have given more injections. This is my first time in a health care environment; I had never observed anyone giving injections before my first placement. I found giving an injection daunting, especially if the patient was underweight; however, my mentor on my first placement said my technique was OK which calmed me down and gave me more self-esteem. I am definitely happier with the technique of administering a subcutaneous injection and I no longer feel as hesitant as I did on my first placement.

On evaluation of medicines management, if I were to give a subcutaneous injection again I would feel less anxious as I now have practice and all relevant paper work completed to say I am competent. Even though the practice in placement has developed my skills greatly, I do not feel confident giving a subcutaneous injection to an underweight patient. I would communicate more with the patient, putting them at ease with my ability to administer the injection and I will continue to use the correct technique shown to me in University.

After reflecting on my practice from placement one and two of my first year as a student nurse, I now know what I need to do to develop my skills throughout my second year as a student nurse. To show my development I will keep an up to date portfolio of my achievements to provide evidence of meeting the required competencies.

To develop my skills as a second year nurse, I will continue to work closely with my practice mentors and academic mentors, seeking help and advice when needed to ensure I am professional and knowledgeable in my career. I will gain more experience as a second year, participating in different aspects of a nurse's role to help further my development as a nurse. At all times I will work within my limitations as a student nurse and I will abide by University and work protocols to maintain a safe environment for myself, colleagues and patients.

I aspire to nurse patients in a holistic manner, having a greater input into decisions about patient care, putting into practice all what I have learned by implementing the essential skills clusters. I will continue to treat all patients as individuals, maintaining their confidentiality and building therapeutic relationships to ensure I am promoting their health needs.