# Short reflection on the cpa exercise

During placement we were required to complete a CPA report. My problem was that the placement I was allocated – Older persons inpatients – did not compile CPA reports. This situation was compounded by the fact that this was a very short placement of 5 weeks and thus limited opportunities to seek an additional day or so elsewhere, and the fact that my mentor was reluctant for me to go elsewhere for learning opportunities and wanted me to meet all outcomes on the ward.

We had a patient on the ward who was going to be subject to a CPA review on discharge, and I negotiated with my mentor the opportunity to work with the patients CPN in order to complete this. Unfortunately this did not come to fruition as the CPN went on sick leave for 2 weeks, returning on my last week of placement. Due to the 40% with mentor rule (my mentor worked part time) and the bank holiday weekend, I was left with only two days where this would be possible. I decided to email my academic supervisor an anonymised discharge summary report that I had completed for a patient who was discharged into twenty four hour nursing home care.

This discharge summary had been checked by my mentor prior to sending to the nursing home and my mentor was satisfied with the content of this report and the feedback I received was that it was very comprehensive and of good quality. I was relieved when my academic supervisor emailed to say that the discharge summary report was sufficient to replace the CPA report required. I enjoyed compiling the discharge summary report. I downloaded the Trusts CPA policy in order to ensure that the required areas had been met sufficiently.

I then hunted around for a discharge summary report done on other patients so I could see how others had compiled the report and what information they had included, but unfortunately these are not kept in hard copy on the ward as the patients file is not kept on the ward after discharge. I could not access an electronic copy as my Trust password only gave me limited access to file drives. I asked a nurse to email me a copy of a report, however this was a blank template as the nurse had difficulty locating a completed report.

I compiled the report by following the blank template and searching through the patients file in order to find relevant information to inform the report. Prior to writing the report I completed risk assessments on the patient in order to report on relevant current risks. I feel that the report was very comprehensive and there was not anything omitted. I thought about the sort of things I would like to know about the patient if I was the manager of the home receiving the report and ensured that these things were covered.

As I had been acting as co-keyworker for the patient, I knew her well. However I am aware that compiling the report for a patient I did not know so well would have been more difficult. I sought some advice from the nurse on duty as I was compiling the report and he offered some feedback on expanding on certain areas. I emailed the completed report to my mentor in the first instance for approval as he was not on shift that day. My mentor was satisfied that the report was comprehensive enough to go with the patients notes on discharge without any additions or changes.

I later sought feedback from my mentor as to any additional comments that I could have included and the feedback I got was that the report was

comprehensive and nothing had been missed. However I did not have time to copy and anonymise the risk management plan and the final care plans that went with the patient as these are hand written and the file had gone off with the patient by the time I returned from my day off, so this is not included with the discharge summary. However, I did have time to anonymise the DICES risk assessments and the discharge plan that I compiled in the course of writing the discharge summary.

I did not have any difficulties compiling the report, and the process was more or less stress free. The only difficulty being time constraints, as the patients funding had come through suddenly and there was only a day to compile the report. The patient was due to be discharged the day after funding had been agreed and this day was my day off. Thus the report and the assessments needed to feed into the report had to be completed within one shift, as well as meeting the demands of nursing on a busy inpatient unit.

However, with support from the nurse on charge – allowing me minimal interruption as possible (however this was difficult due to the nature of nursing Older adults, the complexity of the care involved and an open office policy) – I managed to keep within the timescales. I found the whole experience to be a useful exercise in experiencing the real pressure faced by nurses on inpatient units and the demands of balancing direct patient care and essential paperwork. If faced with a similar situation as a registered nurse I don’t think I would do anything differently, apart from start the report earlier if workload and patient care allowed this.

We knew that the patients funding had been applied for, therefore some aspects of the report could have been done prior to the funding being confirmed, although it is always appropriate to ensure risk assessments reflect the most recent assessment of patient’s risk. If repeating a similar exercise as a student I would ensure that I had anonymised copies of all hand written paperwork before leaving shift, as these are difficult to obtain after the patients discharge.