9043-22 Level 3 End-point Assessment for ST0217/AP02 Senior Healthcare Support Worker

You must use this section to record you reflective statement.

Level 3 Senior Healthcare Support Worker Reflective Statement
Following handover, I ensured I had my notes informing me of changes that had occurred since my previous shift. I gave specific advice to a patient whose care plan had changed and adapted my plans to meet the new guidance provided by the physiotherapists. I then gained consent to provide support for a bed bath and explained the reasons for the change in plans. I explained to the patient that, although I knew he wanted a shower and that was what he had requested, due to review by the physio, this was now not advised. I explained the reasons why. I described the activity and my expectations of the patient that this would maintain his independence. I drew the curtains ensuring these remained closed throughout, reminding one member of staff to adjust them during the activity. I preserved privacy and dignity and ensured spoken discussion with other staff and the patient were always done in a lowered voice and that he remained covered. I reminded my colleague to keep the curtain completely closed at all times and advised her a routine ward test would need completing. I accessed the computer to identify additional information about the patient's need, then explained these to the patient ensuring he was actively involved in his own care. I then gave preparatory instructions to another patient who was having a scan and repeated these to ensure she had understood. I listened to what she was saying answering her questions within the scope of my role and considered her feelings in my responses. Following my break, I informed the other staff I had returned then ensured all other staff had their break or had planned it. I discussed my workload with the RN and asked if I could support her later in a moving and handling activity. I attended to my patient as planned but the physios had arrived and were in the process of assessing him. I joined them and listened to their judgments. I suggested the use of the hoist, which was agreed, I asked the physio additional questions to ensure the safety of the patient and best practice was adhered to. I then relayed this information back to the RN and indicated a specialist referral was to be made. I clarified the amended plan for the patient and the level of support required. When supporting a patient with personal care, I turn away from the patient to allow privacy and advise them to dispose of wipes safely. I was discrete when discussing bowel movements and cleaned this up with limited fuss. I accidently disposed of the urine sample but needed it to be sent to microbiology. I admitted this to the RN and then asked my colleague to obtain another specimen during catheterization. I approached another patient and realised the physios were assessing him, so I offered to assist them with his transfer and moving and handling needs. I accessed the care plans and checked off the tasks had been completed and needs met.

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I completed all the personal care needs and the MUST assessment. I used the hoist ensuring I used the correct sling having first checked the moving and positioning risk assessment. I obtained the weight to supplement recording of the MUST assessment and calculation of the BMI. I completed a bladder scan to assess the level of urine retained and confirmed this with the staff and the patient. I also risk assessed the patient's pressure areas and completed the body map accordingly.

I completed a routine ward test on the urine, recorded the result and fed this back to the RN. I accessed the computer and printed off a microbiology request. When testing the urine, I did this in the sluice, used PPE, ensured the workspace was covered and tested it against the bottle guide. I disposed of the urine in the macerator and recorded this on my handover sheet. I weighed this prior to disposal and calculated volume.

I ensured I was close by the patient when talking with him and maintained good eye contact to show I was listening. I gave clear explanations to the patient and invited questions from him. I monitored and recorded the patient's verbal response regarding pain and observed his pained facial expressions. I asked questions re: analgesia and asked the RN if he had had some. I recognised his pain and gave him a choice to complete certain tasks after lunch when his pain may have settled, the patient agreed.

When accessing the computer, I did so at the nurse's station and used my personal protected password, checking information against my hand-held paper handover which I kept in my pocket securely.

A new patient was admitted and I was asked by the RN to complete a risk assessment according to the complex needs of the patient I included the patient and her carer in this, I needed to risk assess the moving and positioning of the patient, I obtained all the necessary equipment, cleared the area, ensured privacy, coordinated with my colleague and took the lead, transferring the patient safely to and from the bed. I ensured the comfort of the patient at all times through observation and questioning. I moved the wheelchair and hoist safely and stored these when not in use to prevent cluttering and obstacles. I took physiological measures as requested by the RN including weight, blood pressure, temperature, ensuring I recorded them all correctly. I used clear and articulate verbal communication and paid attention to non-verbal cues. I completed and signed various documents including Skin risk assessment, Skin integrity ward check sticker, fluid balance chart, stool chart as well as weight and height to calculate BMI.

Whilst completing observations in my bay I notice a patients diastolic reading is low, I check how much she has had to drink this morning and encourage her to increase her fluid, record the reading and inform the RN.

I go to a patient in a side room. Before entering I check the patients notes and the required PPE to enter the sideroom as the patient is immuno suppressed. The patient expresses she feels nauseaus I empathise with her and explain the effects of the chemotherapy and radiation.

A further patient expresses she feels nauseous, and tells me that she has to take 26 pills at at time which she feels contributes to this. I empathise and reassure the patient if it gets any worse to call a nurse and they will give her something for it.I then check the patient is passing urine. During this the patient becomes tearful and feels everything is becoming too much. I quietly speak with her and establishe the patient feels overwhelmed by the number of appointments she has got this week and doesn't feel she can cope with them all. I offer to see if some of the appointments could be changed. The patient is also interested in complimentary therapies but feels the doctor will be

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cross. I reassure her that the doctors will not be cross. I ask the patient if she would like her to talk to the nurses about re-arranging some of her treatments. I quietly explain to the RN that the patient is very low and tell her the issue with the appointments. The RN goes straight to the patient to discuss the issues with her.

A patient's pulse is raised, and her temperature is at 35 degrees after I have recorded it, I inform the RN. A student nurse tells me that she has completed the next patient's obs but she still requires her blood pressure taking. I ask the patient for her consent to take their blood pressure.

Another patients oxygen sats are low, I have already advised her to take deep breathes and to sit up more, following guidance from the physiotherapy team, but they remain low. I check if she has COPD, the patient says a little. On completion of taking the obs I report to the RN re the low sats and update the patients records.

I clearly record each patients obs having taken them and check if each patient is experiencing pain and record their pain score and calculate the Early Warning Scores.

After taking each patients observations I wash my hands using the handwashing procedure. I then put on gloves and using hard surface wipes clean off the cuff and leads of the sphyg and oximeter. I use a probe on the tempanic thermometer and remove and correctly disposes of this after each use. I remove and dispose of gloves in the clinical waste and paper hand towels to the household waste. I noticed one of the cuffs for the sphyg is soiled, remove this, dispose in the clinical waste and locate replacement.

The RN requests that I support him in log rolling a patient so we can check her pressure areas and skin integrity. Working together we clearly check the pressure areas and I make the RN aware that there is some redness and areas of dry skin. The RN asks me to record these areas on the patients bodymap.

RN asks me to do another patient's obs. On taking the obs I find temperature is very low and other measures are not within normal boundaries. Immediately I inform the RN who comes and checks the obs with me. I complete the NEWS score and asks the RN that I have calculated it correctly as it is at 6. The RN confirms that this is correct. I support the RN to cover him with extra blankets.

Another patient requests a cup of tea, having checked his care-plan I use thickener as per his eating and drinking protocol.

One of the RN's has to get a MAR sheet for the pharmacist and asks me to show a new student nurse how to use a dyna-map and to record the results electronically. I log onto the system and show her how to complete the ward rounding sheet also.

A patient rings their call bell so I respond, it is a lady with dementia who is asking when her son will visit, she asks repeatedly, I reassure her that he will be visiting later in the day and I would ensure she knew when he was here, she asked why she was in hospital so I took time to explain the reasons behind her admission in a way I felt she could understand, I then assisted her to complete her menu for her teatime meal, she was relaxed when we had finished and I arranged for the student nurse to make her a cup of tea.

A patient complains to me about pain in her cannula sites I checked with a colleague when these are going to be removed. The colleague has come to remove the cannulas, so I collect a sharps bin for her. I also collect PPE for myself and my colleague. Once the cannula has been safely

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removed, I then support this lady with personal care, encouraging her to wash her own face, using lots of encouragement as this lady would prefer myself and my colleague to do it all. As I support the lady, I chat generally with her about the fall she has had and her family. The lady is now more relaxed and communicative. I empty the lady's catheter having measured the output. Immediately after disposal/hand wash I record everything on the patient's electronic record. I need to update my electronic notes with information that a patient has refused personal care. However, all of the computers are occupied by Dr's. I go to the other end of the ward and politely asks a colleague if she could quickly jump on to a computer to update the notes. I am asked to join a colleague to support a lady with personal care. I co-ordinate with my colleague in supporting this lady who has a fractured leg. We work together to co-ordinate moving and handling tasks following the risk assessment within the care-plan.

Word count:	2000

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