Level 2 End-point Assessment for ST0215/AP01 Healthcare Assistant Practitioner (9576-12)

You must use this section to record you reflective statement.

Level 5 Healthcare Assistant Practitioner Reflective Statement
Working as part of the ITU team my first task today was supporting a RN with a patient on a ventilator. I asked questions regarding blood gasses and if she needs anything else or additional support. I am looking after one gentleman; he is having his medication administered by the RN. Whilst waiting, I knock enter the side room door spoke and say hello to the patient. I discussed the moving and handling requirements with the nurses and offer to be the third person as the RN's risk assessment dictates. Throughout the manoeuvre, I listened carefully to instructions of the RN and suggest we attend to personal care whilst the patient is moving. I communicated in a clear and audible voice ensuring the patient could also hear and provide consent. I involved the patient and asked him to do small supporting actions to help. I was asked to input complex data and information into the computer system, I double checked this against my paper handover copy of notes. During the ward round, I communicated with the unit coordinator, registrar and consultant. I actively participated in the discussion and asked questions appropriately. I agreed to the instructions given and challenged with questions re: arterial lines, diet introductions and mobility. I have taken and tested blood for blood gases on completion I report the complex results directly back to the consultant. The patient was asleep during the ward round and was disappointed he had missed the consultant and asked me what had been said. I gave very clear explanations re: bloods, procedures and plans to the patient and answered his questions within my role. I repeated some information to check he had heard and understood and show compassion when discussing sensitive information regarding bowel habits. I pulled the computer trolley over to the patient and went through his blood results with him. I discussed how he felt about starting to eat and accessed a soft diet menu for him to select his own choice. I contacted the kitchen staff to order a meal for my patient, ensuring I communicated the relevant information fully and clearly. I had previously taken handover and made my own notes to help in planning for caring for my patient for the shift. I kept this on the single patient use computer next to his bed for quick reference and so I can add to it if required eg. during the ward round discussions. I gain secure access to the computer system and makes all the necessary entries on the Flowsheet. I input specific data re: input and output to maintain accuracy, checking this against my paper handover. I entered fluid balance readings and patient position. When working in the test lab, I ensured a sample was labelled and scanned into the system. I gained secure access to the machine, proceeded with the test and retrieved the results. I closed the scan book prior to leaving the room. I took this information straight to the consultant and shared my findings.

Level 5 Healthcare Assistant Practitioner
Reflective Statement

I wash my hands according to the Trust policy, regularly, before and after patient contact, after handling bodily fluids, waste and linen and before an aseptic procedure. I also do this when moving between patients. I select the correct PPE for the task for example supporting the RNs to reposition a patient, I suggested the use of a barrier agent and offer the sterile single use ones. I wear full scrub uniform according to uniform policy, hair tied up and appropriate footwear. When taking blood for blood gasses, I use a no-touch technique and wear PPE to protect the patient and myself. All waste is disposed of appropriately ie. sharps in the clinical yellow sharps bin, used PPE and clinical waste but in the yellow clinical waste bag and soiled linen placed in the laundry trolley bag.

I ensure I use an effective and safe ANTT, ensuring my sterile field is always maintained. Blades are used with caution when removing sutures and disposed of in the yellow sharps bin. When opening the sterile pack, I used a no touch technique and dispense other sterile equipment onto the field with the same caution. I changed my gloves for sterile ones and clean around the line. I removed the sutures and then removed the arterial line ensuring I apply firm pressure for several minutes. Once bleeding has ceased, I applied a sterile dressing over the wound. I then removed all the lines and disposed these in the clinical waste bin. Throughout the procedure I ensured I communicated with the patient, giving reassurance and answering any questions they had.

I saw an unfamiliar doctor entering the unit and challenged him asking, 'can I help you.' I was happy with his response and reason for being on the unit.

As the morning progressed, I removed any unused or redundant equipment including, Bear hugger, syringe drivers, IV fluids and pumps. Due to the volume of pumps and electronic equipment, there are many wires, so I stored these away to prevent trips.

I prepared to remove an arterial line, I prepared the environment by positioning the bed, preparing the patient with information, gained consent and removed obstacles to ensure I could gain close access. As the patient had bled previously, I ensured I applied firm pressure to the arterial line site for several minutes to ensure coagulation.

Following use of a urine bottle, a patient asked me to remove this. I put on PPE, took the bottle to the sluice, measured the output and placed the bottle in the macerator. I then removed my PPE and washed my hands. I follow the same process for bedpans after use and then clean the commode with Clinell wipes according to hospital policy.

When supporting a patient to sit out on the commode and transfer to the chair, I ensure I had enough room around the bed area, asked questions to ascertain number of assisting staff she required and offered blankets to keep warm when out. I offered him wipes to clean his own hands after using the commode.

Prior to being called away by the patient, I listened to the instructions from the RN about a potential infection that had been identified by microbiology and she gave advice and instruction on how to deal with this.

Prior to supporting a patient to reposition, I checked that all the lines and tubes are free and will not be pulled during the manoeuvre. I discussed the moving and handling risk assessment with the RN who agreed to support me, identifying that 3 staff members would be advisable.

I knocked on the door prior to entering and await a response, I then gained consent to enter. I checked the height of the bed and gain consent from the other staff to raise. When rolling, I

observed the patient in case of any discomfort and to maintain safety of tubes and lines. I anticipated the needs of the patient and had prepared personal care equipment to use, if required. Slide sheets were used correctly and I managed to remove the slide sheet and insert pillows to maintain comfort and position and to prevent pressure damage.

When my patient wanted to use the commode, I asked questions to assess mobility and number of people required to safely move. I ensured a clear area was made and obstacles removed, the commode was place close to the bed and the patient was able to transfer with minimal support. I allowed privacy and left him behind the curtains, ensuring he knew to call me when finished. I waited within earshot at the nurse's station and quickly assisted him when he called. I encouraged the patient's independence and gave reassurance when he requested support. The patient voiced his embarrassment, and I was able to offer reassurance and comfort. I used distraction techniques and asked questions about his work.

When a syringe driver alarmed, I assessed the equipment and noted the battery was running low. I asked my colleague if I could use a redundant lead to prevent it running out and the medication not being administered.

I recognise when others need support and help with moving and handling. I check on the progress of the RN when giving medication to my patient and ask if she needs anything. I access the equipment requested. I adhere to Trust policy and guidance and perform all procedures and activities to best practice standards. I asked the RN if I could help by accessing a suture kit for her while the RN was preparing to show me how to flush an arterial line.

The unit is consistently busy, but I try not to appear or show signs of stress or rushing my patient. I need to plan well which gives me time to deliver the care that is required. I am aware of my limitations both practically and regarding knowledge base. I am aware when I need to seek support or clarify information.

During discussions with the Consultant I agreed to the instructions given and asked questions re: arterial lines, diet introductions and mobility. This was received well, considered by the consultant and plans made, I informed the consultant about the blood gas results and the progress with oxygen saturation and respiratory rate. I listened to the consultant who would like the readings to be above 94%- and agreed.

I asked for guidance from the clerk re: soft diet menus. I then contacted the kitchen staff to order a special meal for my patient, transferring all the required information as necessary.

The consultant asked me if he could sit at my computer and access the patient's notes and used the entries I had made to inform the discussion. I offer to perform further checks within my remit and he agreed.

The patient I am caring for asked about the transfer process and I explains the disciplines involved in this. I explain the process and that bed manager and operational managers oversee this and ICU will be contacted when a bed is available. When discussing mobility plans, I advised the patient that I would speak to the physiotherapist.

I was asked by the RN to remove a patients dressing, when removing the adhesive dressing, I observed the patient wince and offered an apology confirming I would take care.

Level 5 Healthcare Assistant Practitioner Reflective Statement
A student nurse I was working with made me aware that a patient has thick mucus at the back of his throat. I checked and tell the student I will inform the RN so she can use suction. If necessary I gave the information to the RN, who then checked on the patient. A colleague is supporting a patient in a side room, I checked that she was okay and tell her where I would be if she needed support. I am deemed competent by my senior team to care for level 1 or level 2 patients independently. I lead and coordinate all the care for the patient apart from administering medication, with this I ensured it was given and if the nurse required any assistance with this. I ensure that all patient's privacy and dignity is always maintained through closing of curtains and communication. I use questioning to identify the needs and preferences of the patient and allow choice in activity and the level of support required. Patients can be distressed at times on the unit, I take time to sit with them and give reassurance. The RN regularly delegates me to co-ordinate the work of healthcare assistants and student nurses (on their placements), making sure they understand how the unit works, what their role is and so they have the opportunity to learn and practice techniques, some of which I am responsible for supervising. I help them to plan their work, ensure records are completed as required, support them to develop their skills and help interpret physiological measurements so that they understand when to report significant changes to me or the RN. I contribute to their performance reviews and appraisals.

Word count:	2000