Title: Reflection on Taking Charge of a Bay of 4 Patients on a Stroke Rehabilitation Ward
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Introduction

Within this assignment, I will show my understanding of the skills that are required to enable me to make clinical judgements. Leadership qualities will be discussed along with an analysis of supervision and delegation skills needed to maintain safe nursing practice. I will show my knowledge of quality assurance and management strategies and an understanding of the requirements for clinical professional development and personal development. A specific day of practice has been chosen to show a clear and precise understanding of all criteria mentioned. During this day of practice I was required to fully manage a bay of four patients while under the supervision of my mentor. I worked with my mentor, one health care assistant and also a junior doctor. The nature of the care meant I had to look after four patients at all times. This gave me the perfect opportunity to undertake different tasks while delegating to others which helped towards my management and leadership skills.

I have looked at two models of reflection. Driscoll 2000 and Gibbs 1988.This assignment will be written following Gibbs reflective cycle. I have chosen to follow this particular reflective model because it encourages me to think carefully about an experience. It involveswith six headings description, feelings, evaluation, analysis, conclusion and an action plan (Gibbs 1988).While Discoll, has only three headings of What, So What and Now What. According to Jasper (2003), the Gibbs reflective model is a cycle of action you take in the final stage will feed back into the first stage, beginning the process. All names within the assignment have been changed to respect patient's confidentiality (The NMC, 2008).

Description

During my clinical placement within the Emergency assessment unit, I had the opportunity to manage a bay of four male patients. In bed 1 was james 63 years oldman who came in for a procedure known asParacentesis,. Paracentesis was the removal of fluid from the abdomen caused by Ascites and then was ready to be discharged once the fluid was cleared up from his abdomen. In bed two was Jeffrey, a 73 whohad fallen three days ago and had confusion and bruises around the face he also suffered from pain in the head. In bed three was Peter Wallis who came into hospital with confusion and Mathew who came in withuniary tract infection which had cleared up, and was being discharge once he was able to pass urine.

First thing in the morning I took the morning handover with my mentor from the night staff. After the handover had finished, my mentor and I went through the information to see what needed to be done for the four patients. James needed Albumin and then removal of the drain, Jeffery and Peter, skin bundles care every four hours, and Mathew was able to leave hospital once he passed urine. I looked at my handover notes and felt that James was my first priority because he needed Albumin for the next six hours to drain the fluids and then remove the drain

which I told my mentor that I was happy to remove the drain under the supervision. I went round and introduced myself to the patients along with my mentor, and also looked at their drug charts. Before we started the drug round, I ask the clinical support worker Karen, if she could get Mathew a urine bottle and explain to him that he needed pass urine in the bottle provide before he could be discharged and then, if she could monitor and recorded James's vital signs such as blood pressure, pulse, oxygen saturations and respirations, while I was looking on the patients drug chart and noticed that the doctor had not prescribed Albumin, which would be needed for James during the next six hours to drain the fluid from his abdomen. I went to look for the doctor who was looking after Jamesand I proceeded to ask the doctor to prescribe the Albumin and why he needed it. Once he had done this; Ithen asked my mentor if she would fetch the prescribed albumin from the blood bank. During the course of the six hours that the drain was in place, I stayed with James making sure he was comfortable at all time. For every three litres drained from James's abdomen, one bottle of albumin was to be given to him intravenously. My mentor was to carry out this part of James's care while I monitored and recorded his vital signs. During the procedure, the bag into which the fluid was draining was emptied and the contents weighed every time. While I carried out this task, I made sure that there was a trained member of staff with James at all times. Under supervision of my mentor, I removed the drain from James's abdomen when the procedure had finished James was to be discharged after this procedure, so I then went to get the information needed for after care, and what to do when he arrived home. After discussing and confirming James's discharge with my mentor. I contacted the unit porter to take James down to the hospitals main entrance in a wheelchair and explained all about the aftercare again to James before the porter arrived.

Thoughts and Feelings

When I was advised by my mentor that I would be taking charge of four patients care, my initial feelings were those of fear and anxiety, but also I felt happy as I felt the mentor recognised the hard work i had been doing. As this was the first time I had played this role within the team I felt slightly inadequate and inexperienced. As Ihad assisted in looking after the patients previously, I had already built up a therapeutic relationship with themand my mentor had helped me to put my anxieties into perspective. During the initial setting up of the trolley forthe procedure and the removel of the drain, I felt quite nervous as what If I had not got all the equipmentneeded I would look so unprofessional in front of the patient. I was also worried that I would pass the wrong piece of equipment. Although these nerves were there, I was careful not to show them and when the procedure was complete, I felt that I had performed the tasks in a confident manner. I felt that my biggest worry throughout came from the responsibility I had to James and I felt under a lot of pressure to get everything correct the first time but this was my own insecurities not what the mentor had communicated to me.

Evaluation

When evaluating the care, I feel that although I was apprehensive, I was fully aware of the skills I needed when making clinical decisions regarding all four patients care. I also looked on my past experiences from assisting in their care and appeared confident by showing that decisions I

made were appropriate in giving them the best care available. I did not find it difficult when delegating, but l did feel I needed to be more assertive in my approach in this stage of learning. Nagelkerk (2005) suggest that becoming assertive can lead to respect and recognition as a person and as a nurse. I was aware of asking for this task to be completed, but I would not have been prepared to ask anyone to do it, if I would not undertake it myself, however, when delegating the task of collecting and administering the albumin to James, I was aware that I did not have the skills to carry out this part of this task as a student nurse and it was beyond my limitations.
The NMC (2008) state that nurses should work within the limits of their competence and provide high standards of practice and care at all times. So as a student nurse this task would have been outside the boundary of my limitations which would have compromised the maintenance of safe nursing practice.

Analysis

Once the handover was completed I was able to lead and manage the team. Ely and Scot (2007 p56) suggests that handover from one team to another is an effective way
of communication. Whereas Yoder-Wise, 2011,p101 suggest that teamwork improves patient safety and patient safety depends on teamwork. Teamwork combines the knowledge, skills, and attitudes of each of its individual members which allows for the team to be pro-active in catching errors before they occur and focus on the patient. Ely and Scot (2007 p59) also suggests safety is all about relationships between the team members and their common goals, to reduce errors and provide quality patient care. According toSulivan and Decker (2005, p 140), suggest
that effective teams function through collaboration among patients,team members and other teams. Also, effective relationships and collaboration are built on trust, but without trust, team collaboration, along with patient safety, is compromised. For example, the conversation and dialogue between the nurse and the doctorestablishes a safe care plan based on the current status of the patient. Breakdowns in communication and teamwork are the leading contributors toward errors in the treatment of the patient. Sulivan and Decker (2005, p 140)
Jones, 1988 in Dowding and Thompson, (2002,p.49), suggests that high standard nursing care relies heavily on accurate judgements. During the care of the four patients, I had to undertake decision making throughout the shift. Jones (1988), also suggests that from a legal and ethical perspective, the patients should expect a good rational from nurses for the judgements they make that lead to decisions.
Jones, 1988 in Dowding and Thompson (2002,p.50), suggest that a study was carried out in an attempt to classify the different types of judgements made by nurses. This study identified four types of judgements that were made by nurses in practice. The first identified was ‘casual judgements’. This is a statement which expresses a condition based on attributes that are used to explain a problem.
The next identified was ‘descriptive judgements’, which is based on something that has been directly observed or obtained from another source. ‘Evaluative judgements’ are ones made when a difference in the patient’s condition has been observed directly and ‘Inference judgements’ are

based on no information being gathered about the patient either directly or from another source Of the four identified, descriptive and evaluative judgements were the most common. Dowding and Thompson, (2002), also acknowledge that one aspect of nursing judgement that was not mentioned in the above study was 'prediction judgement'. This type of judgement is related to the risk of something happening to the patient. When leading in the patients care, the aspect of clinical judgements the author made fell into the category of 'descriptive judgement. This was achieved by drawing upon her past experiences of assisting with the patients care whilst under supervision. As James was a new patient, I not only received a handover for him which helped me with all the details regarding James's care, and therefore decisions was made were based on directly observing James after reading his file. When caring for James, Ifelt I lacked in knowledge, due to my past clinicalexperiences, which then gave me realisation, of a lack in confidence when making some of the clinical decisionsneeded. Sulivan and Decker (2005, p 111) suggests two of the main factors that affect decision making are experience and knowledge. According to Sulivan and Decker (2005, p 112) decisions making within nursing, consists of more than the application of theoretical knowledge. Sulivan and Decker (2005), goes on to a full understanding of the situation is needed if decisions regarding a patient's health are to be made. This understanding comes from knowledge and experience. Experience increases the cognitive resources available for interpretation of information which will result in more accurate decision making Sulivan and Decker (2005, p 111). During my three years of experience in different fields of nursing helped me to improve my decision making, for example, removing the drain from James

When caring for James and the other three patients, Itook on a leadership role. Bower (2000, p124), suggest that leaders are often described as having a vision, equipped with strategies and having a plan and desire to direct their team to achieve a goal. (Bowler, p124) suggest that effective leaders use problem-solving processes and skills and qualities needed to become an effective leader include things such as being active, enthusiastic, be able to motivate others and be solution-focused seeking to inspire others. According to Bowler 2000, Nurses must apply these characteristics to their work in order to win the respect and trust of team members and lead the development of clinical practice (Bowler, 2000). I struggled with this role as I felt inadequate to be able to lead a team as my experiences were not as advanced as other team members. Daley(2004) suggests that where there is no leader, a group will be unable to perform to the best of its ability. This could be detrimental to patient care in maintaining safe nursing practice. Sulivan and Decker (2005 p45-47) explains that two leadership styles that are common are democratic leadership and autocratic leadership. Sulivan and Decker (2005), states, that democratic leadership is a style where group members take a more 'hands on' role in decision making.

Sulivan and Decker (2005), also suggest that according to research on leadership, this style of leadership is very effective. When using the democratic leadership style, members of the team are asked to share ideas with the group leader having the final say over decisions that are made. This style helps team members to feel included in the process. Due to team members being

encouraged to share their ideas, democratic leadership can conclude to better ideas and solutions to problems. Team members feel more involved which leads to them being more committed and more likely to warrant positive end results. Leadership styles research shows higher productivity amongst team members. However, in situations where there are no clear defined roles or if the time scale is short, communication failure can occur. This can lead to goals and targets not being met. Sometimes, within the team, the knowledge base of team members may not be seen to enable quality contributions to the decision making process Sulivanand Decker (2005 p47). Daniels (2004, p481) explains that Autocratic Leadership is a style that is in contrast to Democratic Leadership. Autocratic leadership is leader focused. This is when the leader keeps strong control, makes all the decisions and solves all the problems solely. The leader will issue commands instead of making suggestions and gaining input from other team members (Daniels, 2004, p481). After considering both democratic leadership and autocratic leadership, I felt I took on the democratic leadership style when leading in the four patient's care. As I did this, I sought input from mymentor and all other team members when making certain decisions.

Benner (p13-35) suggests that student passes through five levels of proficiency: novice, advanced beginners, competent, proficient, and expert. Student entering a new clinical area as novices and have no experience with patient population. Advanced beginners are students who can demonstrate acceptable performance pointed to them by their mentors and much time is spent with their preceptors. Competence develops when nurse begins to see their action in long term goals. Profientlearns from experience and expert no longer relies onanalytical principle. With enormous background of experience, zeros in accurate region of problem without wasteful consideration of alternative diagnoses and solution. I did feel that if I had been asked to take on aleadership role earlier on in my training, I would not have had the confidence to have attempted it. As I progressed in my training, I had come across good role models and felt had directed me in good roles to attempt the leadership style I subconsciously chose. They have taught me to engage with team members and to earn respect. I felt that I had developed in this area during mytraining and have received positive feedback from mentors and staff alike but felt that I had to continue to develop in order to make my leadership effective. During the duration of my training, I had also come across trained staffs, that have chosen to use the autocratic leadership style, and I had found that these people can come across intimidating which could have prohibited me from fulfilling my full potential when acting as part oftheir team. This is not what I would want for my team members when I was acting as leader.

Delegation defined by Chin *et al* (2010, p116) "as trusting and empowering another person with responsibility". It is a process that can be difficult to learn but is essential in the position of leader. I agreewith this observation as at this stage in my training, although feeling more confident with delegation than that in the beginning, and felt that I lacked assertiveness, and need to continue to be more assertive to be able to grow more confident. Daly andJackson (2004, p185) observes that when assertive behaviour is learned early in a nurses career, the chances of it developing over time increases.

The Nursing Midwifery Council (NMC, 2008) suggeststhat the delegator is accountable for the task and also for the responsibility resumed by the delegate. The NMC (2008) also states that it must be established by the delegator and that the delegate is capable of carrying out the task and confirmation should be sought that the outcome of the delegated task meets the required standard. Delegation is used to enhance effective management. With delegation, the manager can complete more tasks which increase productivity.

According to Chin *et al, (*2010, p117) delegation will involve careful assessment of the task and the capability of the delegate. When delegating tasks to the clinical support worker, I was aware that clinical support workerwas capable of carrying out the task. I was mindful that clinical support worker may have felt degraded by following instructions from a student, but she was aware that the delegated task was not one that the I would not have completed myself if I had, had the opportunity.According to Benner p10, experts pass on instruction that make sense only if the person already has a deep understanding of the situation.

Graham (1999,p536) suggests delegation is a very positive skill but unfortunately has some disadvantages and also putting trust in team members can be risky as the responsibility lies with the manager. Graham (1999) also suggests due to this, some managers may be reluctant to delegate as it means they have to relinquish their control. When looking at these disadvantages, it would been easy not to delegate and I would haveundertaken all tasks myself, but that would put me under immense pressure as a staff nurse which would in turn felt compromised the care I gave to the patients.According to Cherry and Jacob (2005, p424), in reality, registered nurses have an increasing responsibility delegation and supervision. It is essential that registered nurses have the confidence when delegating and are mindful of the legal responsibility that they have when delegating to and supervising other members of the team. . Cherry and Jacob (2005), also suggest that registered nurses should be aware of what aspects of health care can be delegated and the level of supervision required to ensure safe nursing practice is maintained. As a nursing student on my first year clinical placement I had buddy up with one of the friendlyhealthcare assistants, and my duties were to takepatient observations, blood pressure, temperature, saturated oxygen level and also the respiration intake. I would also observe my mentor how she would delegate.Learning these basic skills I progressed onto second year. Once I gained enough confidence I would ask to undertake new challenges such as record keeping, learning to work in a multidisciplinary team and surgical skills such as removing of drains under the supervion of my mentors and also drug rounds. In the third year, I am able to use my nursing skills with confidence. Now that I am in my third year with most of these skills I am able to delegate tasks to the appropriate members of staff andalso learning different communication skills, dealing with people, and developing a relationship with people, andworking in a team.

Tomey (2009 p150) suggest that Quality assurance is a programme where internal reviews are conducted to identify problems and find solutions to improve situations. Each trust has a quality assurance committee who periodically meet to evaluate care that is provided in different departments within the trust. These reviews evaluate areas such as infection control and pressure

ulcers. The committee will perform audits in departments and make recommendations for improving care (Acello 2005, p457). Quality assurance is also known as clinical governance. The Royal College of Nursing (2009) state that Clinical governance is a system through which National HealthService organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. To implement clinical governance into the placement area, RCN 2009, states that new responsibilities are placed on staff in order to demonstrate consistent high quality clinical practice. The responsibility of training and education is shared between the director of human resources and nursing and medical directors. Patient involvement issues are led by the nursing director and research and development has a nominated director.RCN (2009)

Campbell et al (2007, p114), suggests that Clinical governance has seven standards. They are clinical effectiveness, clinical audit, clinical risk management, clinical staff performance management, clinical staff education clinical staff training and patient involvement and research & development. During training the aspect of clinical governance I have been involved with, is that of clinical risk management. Clinical risk management is responsible for co-ordinating clinical risk assessment and the monitoring of clinical incidents. During the care of Peter, I had to complete written risk assessments for him as part of his admission documentation. This involved giving him rating of his likeliness to fall whilst present on the unit. Campbell et al (2007), also suggest that this type of documentation is essential as it provides the opportunity for measures to be put in place to prevent incidents from happening. During training I had to complete documentation such as this on all of myplacements. When reflecting on my development in this area, I had grown in confidence and knowledge as mytraining has progressed. In the beginning of my training, she would ask my mentor to check over the risk assessments I had completed at regular intervals as I did not had much faith in myself. When completing them as a third year, I have found that I no longer do this as often and trust my own judgements.

I believe that all care given to the four patients was given to the highest possible standard, and therefore place full confidence in the quality assurance process. Iwas aware, as highlighted with the trust policy, that training will be available to me as a qualified member of staff and will embrace this to enhance my skills within this area of nursing.

As a nurse it is essential that skills continue to be developed, whether this is as a student or qualified. The Department Of Health (1999) state that “continued professional development as lifelong learning for individuals and teams”. Learning should meet patients’ needs and deliver health outcomes and priorities of the NHS and should enable professionals to meet their fullpotential.

Daniels (2004, p55) also acknowledge that continued professional development can be defined as someone taking control of their own learning and development. This can be by means of reflection and action. It is a process that can stimulate someone to achieve their goals. Continued professional development opens doors to career progression from a wider perspective. As a

student nurse I have found reflection a very positive anda helpful tool. It has helped to highlight areas for continued professional development in areas that were not apparent when actually completing an episode of care. In the instance of caring for all four patients, reflection has identified a number of areas that needs to be improved on, through continued professional development as I progresses to staff nurse.

Siviter (2008,p121) states that "student nurses are expected to write reflections to prove to the university tutors and mentors that you are learning and showing insight into becoming a staff nurse". As a student nurse you focus on reflection changes. Instead of proving to someone else that you are learning and gaining knowledge, as a staff nurse, you are improving yourself because you choose to. Reflection allows me, the reasons to think about why I choose the decisions, and how I can improve on the decisions I made.

The NMC set standards for continued professional development. These are known as 'The Prep CPD Standard'. The NMC (2010) state that in order for nurses to maintain their registration, they must undertake no less than thirty five hours of learning linked to their area of practice every three years. This learning could include private study or simply observing a new skill or technique, as well as mandatory study days. Continued professional development is essential to the development of all aspects of health care. It is the driving force through which high quality patient care is identified, maintained and developed (RCN, 2007). Nurses must maintain a personal portfolio containing evidence of their learning and they should conform to any requests to check on how they have met these requirements. Any study should be reflected upon and formally recorded in the personal portfolio. This will then become evidence of the thirty five hours learning requirement.

Action Plan

As Continuing professional development is essential in the development of all aspects of health care. Once I am qualified, I will set myself several goals and go onto staff development courses. Some of the goals will be to develop further skills and knowledge on phlebotomy, canulation training and obtaining blood products from the blood bank, in order to update my skills so that if these experiences were to arise again I would follow it through with confidence as a qualified nurse. Benner (p;181) suggests that staff development programs need to promote clinical knowledge development so that each nurse learns from clinical experience. Also I will further my development on delegation, leadership role and decision making, as it will progress me further as I develop into my career of nursing.