This essay is a reflection which explores one’s own experience as an adult student the relevance of reflection in healthcare using the Driscoll’s (2007) Driscoll model of reflection approaches reflection from 3 angles asking What?, So What?, Now What questions. The what question describes the event which the reflector has experienced and end leads to the so what question which helps the reflector to purposefully reflect on selected aspects of his experience during the event, enabling the reflector to discover what learning arose from the experience leading to the Now what question, leading to proposed actions to implement the learning experience in clinical practice three stages of model of reflection “What? So What? Now What? Was selected to structure the student nurse reflection. This essay will demonstrates the student nurse understanding of reflective practice within the older adult area of nursing and focusing on Adult nursing field which is the student nurse area of placement)

Reflection is a mental process involving thinking, feeling, imagining and learning about the past experience and asking what might have happened differently and if this could affect present and future actions (Rolfe, 2011). Since reflection helps in shaping present and future thinking and action, its importance in healthcare cannot be overemphasised. Through reflection on own experience, a health care professional is able to identify key strengths in his/her actions as well as any weaknesses, enabling the professional to adopt the strengths as evidence of rendering effective care in future similar scenarios and improving on the areas of weakness in future by asking such questions as How can I do it better next time. Ultimately, reflection provides a window through which a practitioner can view his/ her performance within his own lived experience (John, 2000).

The reflection will focus on pressure ulcer risk management, Risk management can be defined as the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effect. (Standard Australia and New Zealand 2009). Deprivation of liberty safeguarding was introduced to provide a legal framework to prevent breaches of human rights (MCA 2005). Safeguarding those living a life free from harm and abuse is fundamental human rights of every person and an essential requirement for health and wellbeing (DoH 2011)

The evaluation will adopt a self-reflection approach to evaluate the effectiveness of the student nurse communication skills (Bramhall 2014) when in interacting with the patient. The Nursing and Midwifery Code (NMC) of professional practice: prioritising people; practicing effectively; preserving safety and promoting professionalism and trust. Mr Duffy is used in this assignment to protect the patient’s right of privacy as a requirement of the NMC (2015) code of professional practice. (Diamond 2005)

Mr Duffy was 85 year old gentleman admitted to the ward presenting with a history of a large deep smelly ulcerated grade 4 sacral pressure, (query neglect), reduced mobility and double incontinent. Mr Duffy lives on his own with no package of care, hence the neglect according to Northway and Jenkins (2013) detecting neglect is a problem and proving neglect is often not single event. Mr Duffy condition warranted risk management procedures.

Pressure ulcers are areas of localized tissue destruction caused by the compression of soft tissue over a bony prominence and an external surface for a prolonged period of time. (WOCN 2003, Alexander et al. 2006). Banks (1992) also suggested A pressure ulcer is an area of localised damage to the skin and may involve underlying structures. Blood cannot circulate causing a lack of oxygen and nutrients to the tissue cells. Likewise the lymphatic system cannot function properly to remove waste products. If the pressure continues, the cells die and the area of dead tissue that results is called pressuredamage. The amount of time this takes will vary, but may develop in as little as two hours in patients at greatest risk. Tissue damage can be restricted to superficial epidermal loss or extend to involve muscle and bone. An initial assessment was carried out by my mentor and I using an adapted Waterlow model. This risk assessment tool was first launched in 1988. It is a popular risk assessment tool in the UK as it has been well marketed by the author, Judy Waterlow. It is aimed at physically ill people in an acute care environment. The tool is a scoring system which covers 10 risk factors. It was revised in 2005 and includes a more comprehensive overview of the patients’ nutritional status. The higher the score the greater the risk, the tool makes useful recommendations for general nursing care and the use of pressure reducing aids. It also incorporates a wound classification for those who have already gone on to develop a pressure ulcer.

Negotiating involves asking for permission before proceeding to give care. During initial interaction with Mr Duffy, I introduced myself and my mentor to Mr Duffy if he was happy for I to proceed to assess his wound in which he agreed to. The student nurse under close supervision by her mentor assessed Mr Duffy by using the trusts Waterlow pressure ulcer risk assessment tool, assessment of the wound and other pressure area were carried out this includes measuring the size of the pressure ulcer, the depth, exudates, location and appearance. A wound swab and photograph of the ulcer was taken as a baseline reference and medical guide of the effect of treatment. An incident form was filled in line with the trust policy that stipulates the need for any patients admitted with pressure ulcers.

To meet the identified aspect of care which was management of Mr. Duffy’s wound preventative measures were taken to avoid further breakdown. These were pressure relief mattress (nimbus) ordered on arrival to the ward, referrals to the dietician and the tissue viability nurse. These duties were carried out by the student nurse under close supervision of her mentor. Mr. Duffy’s consented for referrals to be made to social services to assess and provide the necessary support and services she needed. Food chart and oral intake plan was put in place by the dietician and it was the duty of the student nurse to ensure that Mr. Duffy was encourage to eat and drink the recommended supplements so that his actual nutritional intake can be monitored. A nutrition assessment tool was used to assess Mr. Duffy, this is done because it has proven that nutrition intake is one of the factors influencing wound healing (Myles, 2006, Harding et al. 2000). According to Bridel (2003) the screening tool detects malnutrition by measuring the patient’s body mass which include weight, height and body mass index, which indicated that Mr Duffy was slightly underweight. Nutritional screening tool provide healthcare professional guidance on how to manage and treat malnutrition.

It is also imperative that the Mr Duffy nutritional status is assessed objectively and regularly and recorded in the patient’s care plan. It has been cited that protein calories malnutrition is a major factor in the development of pressure ulcers because it reduces the body’s ability to heal and repair itself (Breslow et al 1991). Ribu and Whal (2004) state ulceration causes psychological distress, fear and anxiety. They therefore urge nurses not to ignore the psychological needs of patients suffering from ulcers. By involving these specialities, it enabled the nurse to comply with the philosophy of care which states that nursing care should be promoted by good communication and relationships between staff and all members of the multi-disciplinary team.

Reduced mobility, the body owns defence mechanism against pressure injury to shift frequently throughout the day and night, which reduces individual’s ability to move the physiotherapist also has a key role to play in assisting Mr Duffy to mobilize.

Roper et al (2003) also suggests that a systematic assessment process in the holistic manner can give clear configuration for nurses to work around which reflects a problem solving approach and also incorporates the nursing process. It is important that evidence- based practice is maintained when implementing care to prevent and treat pressure ulcer development. It is fair to suggest that this was evident throughout Mr Duffy’s care delivery. DiCenso et al (1998) argue that in practising evidence-based nursing a nurse has to decide whether the evidence is relevant for that particular patient.

Under supervision of my mentor I dressed the wound on a daily basis according to the tissue viability nurse’s recommendation that is irrigating with saline then applying aquacell Ag as a primary dressing and biatain adhesive as a secondary dressing, carefully assessing the tissue within the wound boundary, colour and condition of the surrounding skin as well as the size, depth, shape and width of the wound to assess for signs of infection (Roper et al, 1996). Aseptic technique was used as it was imperative to minimise the risk of introducing infection. Wound swab was taken and sent to the laboratory for microscopic test to ascertain to what extent Mr Duffy’s wound was infected. Following the dressing procedure the findings were accurately documented on a wound chart initiated on admission. A grid to record the shape and size of the wound was also used which allowed changes to the wound shape to be noted (Benbow and Dealey, 1995).

Reflecting on the scenario and the actions taken by me, the student nurse believes that I have demonstrated competency in preserving safety as a health professional by utilising communication skills effectively. Given the effectiveness of the skills exhibited by the student nurse in preserving safety, I will continue to utilise these skills should any similar case of this nature present in the future. Pressure ulcers range from being little more than areas of discoloured skin, to superficial ulcers, to deep purulent cavities extending to muscle and bone. (DoH,1993) These guidelines provide a framework to support decision making with the purpose of promoting best practice in the prevention of pressure ulcers based on current research. The NMC Code of Professional Conduct (2015) states that nurses have a responsibility to identify patients at risk.

The National Institute for Clinical Excellence published a guideline for “Pressure ulcer risk assessment and prevention” in April 2001, which further endorses this notion. All members of the multi-disciplinary team had a responsibility to assess Mr Duffy, risk of developing a pressure ulcer and to report and document the risk assessment as appropriate. Assessment should be ongoing and the frequency of re-assessment should be dependent on change in the patient’s condition. Skin inspection should be based on an assessment of the most vulnerable areas of risk for each patient, these are carried out by the student nurse during assisting Mr Duffy with his personal hygiene and on each position change. Mr Duffy was on two hourly turning chart that was ongoing to prevent him from developing further pressure ulcers.

High-risk sites should be assessed each time a patient’s position is changed. Any skin changes should be documented immediately and acted upon. This approach was good because it was another way of involving Mr Duffy in his own care. His care plan was reviewed on a weekly basis, and as progress was made with the treatment, his dressing was then done two to three day a week for a month, and then twice a week for another month, and then weekly until the wound healed completely. This was pivotal since care should be evaluated as an on-going process throughout each shift and pressure areas re-assessed as part of this process. All care given and evaluated should be documented in the patient’s notes for each episode of care, incorporating progress in the condition of any pressure ulcer(s) present (NMC, 2015). I would also maintain computerised records and liaise with the multi/inter disciplinary team through telephone conversions (Brant et al. 2009, Lizarondo et al. 2010). Furthermore if the risk assessment score differs from the previous assessment, the plan of care must be amended accordingly.

In conclusion having carrying out an extensive research that enabled me to put theory into practice and reflect on practice during compiling this essay has helped me to understand the importance of risks assessment, that when caring for patients with pressure ulcer holistic and patient centred approach should be adopted with referrals to members of the multidisciplinary team as required by standard practice. In addition it has highlighted the importance of the risk assessment tools in assessing, planning and implementing care. This enabled the student nurse to determine the underlying aetiology for successful management, and also the importance of involving the patient in his treatment as well as the importance of close collaboration between the members of the MDT to achieve the goals for Mr Duffy’s care delivery.