**REFLECCTIVE WRITING**

**MY FIRST-HAND EXPERIENCE AS A RECOVERY HEALTHCARE IN THEATRES**

**Introduction**

Throughout my high school education I have attempted to develop my interest in all my subjects but have constantly believed my biggest interest along with capability to lie in sciences. This is essentially pleasuring in the accuracy included in written and practical work. So, the potential of my future career, which is medicine, has been a unique chance for numerous decades; the large number of specialized subjects, which this medicine might bring about, thus the flexibility to move around in ones’ work, particularly being attractive to me.

**Description (My experience)**
In an internship all through my 2nd year, while I worked in a theatre/surgery room, I served under my mentor’s supervision, taking care of a 72 year old man, Mr Khane, who previously had gone through abdominal operation. I was requested to take out his sore bandage in order for the physician to assess the wound on ward round.

I took out the bandage under the supervision of my mentor, utilizing touch-free process, and cleaned the sore, as requested by the physician. The doctor got was called to tend to another patient during that time, thus as he needed I remained with Khane as we waited for the doctor to arrive to inspect Khane.

The physician was with another patient, investigating their sores, and then I noticed her come directly to Khane to inspect his sore. She did not clean her hands or utilize alcohol gel first. I as well saw him wearing long-sleeved top, and I became worried that cuffs might get contaminated. I thought in for a moment of what to do or say; however, after I summoned adequate courage to speak, I thought it was very late as the doctor was now checking Khane.

**Feelings**

I became shocked with this happening, since I expected the physician to clean her hands or utilize alcohol jelly before inspecting Khane’s wound. Nonetheless, I became intimidated since I thought that this physician was greatly professional more than my expertise as a nursing undergraduate in 2nd year.  Thus, I did not want to disgrace her. In addition, I did want to make Khane concerned by confronting the doctor in front of him.

Afterwards, I talked with my mentor about the event. She suggested we talk to that doctor jointly regarding the problem. My mentor called the physician privately, and questioned her whether or not she cleaned her hands before inspecting Mr. Khane. She became quite alarmed. She then answered that she was very busy and had not thought of washing her hands. My tutor then explained the significance of sanitation of hands to the doctor (Atanelov, 2016: Pankhurst & Wilson, 2009), and the doctor guaranteed that she will clean her hands before checking all patients in future.

**Evaluation (how I performed, what I gained, and my accomplishments)**

The occurrence was very difficult for me. I regret for noting taking action to challenge the physician’s practice prior to examining Khane, this was a poor performance for me. However, I’m happy the surgeon reacted very constructively to my mentor’s advice, and I’ve noticed that this doctor has already reformed her exercise after this happening. I as well have gained much from this occurrence, because it trained me significance of taking action boldly with equals, in an insightful way, so as to protect the wellbeing of patients. My accomplishment is that I was able to tell my mentor about the doctor’s act and he talked to the doctor about and, and the doctor agreed to change his unhygienic nature.

**Analysis (application to NMC Code)**

The Royal College of Nursing (2005) Code demands that hands sanitation is an essential action for minimizing crosswise-infection, furthermore states that numerous medical doctors don’t clean up their hand as frequently needed. Also, the Department of Health (2007) underscores the likelihood of doctors transmitting diseases through uniforms, as well as the requirement to assess standards on doctors’ attire. The NMC (2008) section 8, demands that nurses ' should take action to discover and eradicate the danger to clients and patients. As an understudy of nursing taking care of Mr Khane under my tutor's control, this too is applicable to my personal profession.

**Conclusion (my failures, areas of improvement)**

On reflection, I trust I could have taken action sooner, and I could have guaranteed that the physician cleaned her hands prior to checking Mr Khane. I now can perceive that this inaction of mine during this episode placed Mr Khane's healthy in danger. Following the discussion with my tutor, I realize I need to build up my courage to challenge the professionalism of my equals, and place the clients’ well-being a priority in my intellect. Also, I recognize I require being helpful to contemporaries, comprehending the strains, which they might be experiencing, but making sure their professionalism doesn’t put patients in danger.

**Action Plan (what I intent to do)**

In future, I’ll aim to build up my confident capabilities when doing work with contemporaries so as to make sure that the patients’ healthy is sustained. Likewise, during my placement, I will make this objective for my learning, and will talk about it in the midst of my tutor to find techniques to accomplish this.

# RESEARCH ON DIFFICULT UPPER AIRWAY

# Introduction

I am making use of Gibbs reflection model (1988) in my thesis to allow me evaluate my experience in upper airway. For confidentiality purposes (Nursing and Midwifery Council 2008), I will rename my client, James. James is man of 70 years, admitted into pulmonary treatment programme. James has a disease called Chronic Obstructive Pulmonary and got prescribed for Short Rupture Oxygen Psychotherapy (SROP) to heal his symptoms.

The WHO (2013) describes chronic obstructive pulmonary disease (COPD) as lungs sickness, which prevents oxygen flow to lungs due to chronic obstruction. So, normal pattern of breathing isn’t sustained and COPD’s negative effects are fully not reversible.

# Description (my experience)

Throughout my internship, I closely worked with respiratory group after being offered the chance of going to PRP to get understanding into edification and reality for the sick people, who have COPD. A major focus of this training conference was about breathing methods, particularly tightened lip respiration (TLR).

In my practical work, I recorded the James’ score on ModifiedBorge Scale (Borge 1982). Immediately after beginning the walking work, James became so breathless, and agitated. From mornings’ teaching meeting, which I gained about motivation, I urged James to utilize the TLR method. After console of almost fifteen minutes, James recovered his gap and became calmer and comfortable. Conversely, James was incapable of continuing with the training programme such moment.

# Feelings

Since I worked in respiratory unit in a hospital during my internship, I felt calmer and courageous in helping James to assist in eradicating his nervousness and gasping. I became powerlessness because I couldn’t physically perform anything, which could alleviate the devastating symptoms James was facing. Contrary, I thought by utilizing the methods from our morning’s edification meeting plus my reassurance words could assist and comfort James.

**Evaluation (how I performed, what I gained, and my accomplishments)**

The activities of our morning class about breathing methods were important during this circumstance. Through such teachings, I was able to apply them in restoring James breathless state, and this was my accomplishment and good performance.

Through attending this course, I understood dyspnoea is a widespread problem for James and others who have COP Disease. This is an area I target to study more to get deep insight of the way it impacts ordinary life and the manner it adds to the anxiety linked to COP Disease. Additionally, I will study SROP’s effectiveness.

# Analysis (Application to NMC Code)

According to NMC code (2008), pulmonary treatment by nursing practitioners should include: first, e**xercise instruction**—which intends to increase patients’ confidence, improve inhalation methods, increase cardiovascular robustness, and hearten regular, current exercise. Second, it includes **education**—explain how the intervention works. By attending the morning class, it was fulfilling the NMC code of professional conduct I applied all that we learned to James after he became breathless. PRP utilized MBS (Borg 1982). This is a measurement instrument to gauge speed of potential dyspnoea. It is also supports clients to check their progress. Since James was incapable to talk this became a valuable device, because he became capable of recognizing his achievements devoid of becoming extremely breathless.

I helped James to his chair; after he got settled James sat upright to attempt to resume his inhalation. This was my accomplishment and my best performance. Kennedy (2008) consented that this is valuable for many patients. James was extremely short of breath and unable to talk. From our morning’s instruction meeting, I motivated James to utilize the TLR methods, which decelerated his respiration and minimized his stress.

# Conclusion (what I learned, areas of improvement)

To reflect, it’s clear that COP Diseases is an incapacitating sickness, which results in patients’ sentimental, social, emotional and bodily pain because of its effect on daily existence. Also, Dyspnoea is a key factor linked to all kinds of anxieties. Since that is an enduring issue, I will become a master in controlling such situations and recognize what strategies profit patients Nonetheless, programs like PRP may extremely be essential to me as the knowledge of training and bodily exercise may eradicate social seclusion and tendon deconditioning of patients. These are forces connected to the worsening of James’ situation (Bellamiy & Bookerr 2004).

# Action Plan (what I intend to do, areas of improvement)

In case a client has been ailing form COPD for many decades, they turn into experts in controlling their conditions. Communication and listening successfully will become fundamental in building treatments rapport. Because patients will now be anxious, it will be essential for me to remain unruffled and courageous so as to provide support and handle the condition lucratively.

When necessary I will attempt to utilize Zigmonnd and Snaithi (1983) HADS tool of assessment because being capable to evaluate a client holistically offers a superior assessment of the needs of such patient. I intent to use the latest knowledge I gained to all situations important since I have abundant insight about COPD as well as its underlying factors.

**REFLECTION ON (HANDLE OVER) FROM THEATRE TO RECOVERY STAFF**

**Introduction**

This is my reflection of my experience on how untimely loss of pregnancy influenced the sentimental and emotional health of a patient with her folks. The client, who is key for this reflection underwent unplanned abortion (miscarriage). She became disturbed and shocked by this loss and ensuing operation to remove the remaining pregnancy remnants. This client’s major aspect of treatment was selected firstly since the occurrence left a big effect to the writer. Secondly, it was because miscarriage act involves the common complications faced by females during expectancy. This reflection essay will be composed in 1st person, according to NMC Code (2008) Code, which states that, Privacy must be adhered to and thus every name has been altered to safeguard privacy.

**Description (my experience)**

I was in internship inside the recuperation room in a hospital’s surgery department. I worked under the control of an expert clinician from orthopaediatric recuperation, who was specialized and professionally trained. Though she wasn’t my tutor, she acted as such and will get alluded to all through this reflective narration.

I acknowledged the client; I call him Kim, in my consideration from anesthetist. Kim was aged 30 and wedded to Dickson for four decades. This was her foremost pregnancy. Kim was admitted into the daylight surgery room by the Pregnancy Division (PD) when she felt agony plus internal bleeding at week eight. Foreseeable miscarriage Diagnosis got made via ultra sound examination. Kim and Dickson were offered the alternative of having their miscarriage managed conventionally using pregnancy management process, medically through oral medicines, which drive out the embryo or have surgery treatment in ERPC form through suction removal under normal anesthetic.

Kin and Dickson chose the surgery because they didn’t want prolonging the expectancy anymore and Kim was taken into the daylight operation unit next day. Inside the recuperation room the anesthetist said Kim had gone through ERPC without difficulties. On recovering I informed Kim that her surgery was complete, and she now was recovering. Her achievements were documented per 10 minutes according to department requirement and Kim stayed in static state during her recuperation.

When Kim came from the anesthetic she was psychologically upset. She started weeping and requesting to be given her baby. I consoled her. My tutor did her checking to Kim but offered no mental aid. I escorted Kim into ward section wherein she got nursed. She still was extremely distressed and explained her feeling of emptiness of stomach but the doctor remained unconcerned.

**Feelings**

I felt extremely immobilized at Kim's pain and mourning during this happening since I could not do anything to make her child back. I placed myself in Kim’s shoes and imagined what I could feel during such as a circumstance.

**Evaluation (how I performed, what I gained, and my accomplishments)**

I managed to try and console Kim by giving him courage and making myself available to help her. I also assured her that in whichever time of miscarriage, in case he didn’t comprehend the cause; I will present myself to guide and explain to her. This was my best accomplishment since my consolation managed to calm Kim. Normally, a suffering patient should be brought to sense and accommodate them in the hospital setting (Zigmond & Snaith 1983). The location of our surgical operation was fundamental as Kim wasn’t proverbial with clinical theatre-oriented setting. Available throughout the operation were Kim, myself, and my mentor. The selected location was unexploited theatre; it got selected because it’s a calm location, and reduced disruption. This location also guaranteed that Kim had total attention to me during the recovery time.

**Analysis (Application to NMC Code)**

According to NMC (2008) Code, doctors and midwifes must be compassionate and courteous, placing care along with safety foremost. They must assist and hearten the patient in his suffering state. Thus, the doctor violated this code by not counseling the patient during her painful moment. However, my accomplishment is that I managed to observe the NMC code by giving confidence and emotional support to Kim and he was consoled. Therefore, nursing encompasses holistic advance towards health, incorporating every aspect that impact the health of patients (Antón & Elizabeth 2015; Lee 2009; Cohan 201; Johns & Christopher 2010). Though my tutor provided good care Kim, she did not attend to her mental, social, and spiritual requirements.

**Conclusion (my gains, areas of improvement)**

All in all, I have learned that that nurses’ role is difficult. The role rotates around 2 key attributes, explicitly being an excellent example and a dynamic therapy facilitator. It’s highly difficult and entails much accountability and responsibility. Actually, guidance incorporates the current era of medical experts and thus bad guidance may lead to a deficiency of committed, well-informed and capable future physicians. I also learned that successfully guiding and caring skill will be fundamental to me. So, learning guiding will assist me in keeping my professionalism state of the art and permit me in networking with more teachers and students.

**Action plan**

So as to become a victorious nurse and I believe that I should be probing and committed towards the nursing field, and additionally be well-formed, and kind. I trust such are a few of the things I will aim at doing through my career. I aspire to contribute positively to mu community I stay in.

**MY FIRST-HAND EXPERIENCE IN (LEADERSHIP AND MANAGEMENT ROLE) IN RECOVERY AREA THEATRES**

**Introduction**

This is my reflective account about my encounter during surgery placement that took five years inside our nearby clinic. The goal of this paper is to explore communication plus relational skills used in medical profession. I chose this specific occasion because I exhausted a great deal of time communicating orally and expressively with this client. To secure the privacy and uphold secrecy of my client I chose to alter his name and call him ‘Jones', according to NMC (2008) professional code. To help me amid this reflection procedure I will use Gibbs model of (1988) reflection.

**Description**

Jones is aged 70 and was admitted in ward room from crisis unit 2 days before I started my foremost placement. He was ailing from Diabetes, and feeling great agony. I and my tutor got told we will be caring for Jones during this day. Later Jones knee got amputated. My tutor said we have to change Jones bandage by first washing the wounds. We were ready for the task. I introduced myself to Jones an understudy clinician.  I acted under my mentor’s supervision. We told Jones what we had come to do and asked him if he was ready for the undressing of his wound.  After getting his consent, I began the task and later on, the doctor joined us to inspect the wound for further action. The doctor observed and concluded that Jones was okay and should be bandaged and be ordered us to discharge him to go back home.   We bandaged him, though Jones had not recovered fully and could not walk well, the doctor gave order that he should be discharged. I was shocked because Jones needed rest and full recovery but the doctor denied him confirmed that he should be discharged. Though I capable as a leader, I couldn’t intervene for Jones at that time since the doctor’s decision was final.

**Feelings**

I pitied Jones because he could feel pain while going home since he had not gained full recovery. The doctor showed no compassion to Jones and disallowing him full recovery in hospital before discharge was in an inhumane act. I felt worried of the doctor’s decision, though I could not confront him to stop that at that time because it would have brought chaos and bad impression. I felt annoyed, and regretted why I failed to be more courageous as a leader and question the doctor why he discharged Jones yet he had no attained full recovery.

**Evaluation (how I performed, what I gained, and my accomplishments)**

The occurrence was very difficult for me. I regret for noting taking action to challenge the physician’s practice of forcefully discharging Jones, I therefore, performed poorly. I have gained much from this happening, because it trained me significance of challenging boldly the malpractices of my equals in an insightful way, so as to protect the wellbeing of patients. I did accomplish anything during this placement.

**Analysis (Application to NMC Code)**

According to NMC Code (2008), patients should not be discharged when they have not fully recovered, and that they should be discharged when they have consented. The doctor acted unprofessionally by violating NMC professional code of practice. As per Ghaye and Lillyman 2001), ‘Consent is important in making well informed decisions for patients. Also (American Psychological Association 2010; Association of Collegiate Schools of Nursing (U.S.) & National League for Nursing 2016; American Psychiatric Nurses Association 2013; American Association of Neuroscience Nurses 2014) highlights the importance of getting patient consent before discharging him/her. Therefore, the doctor violated the NMC code of conducts by ordering to discharge the patient before his full recovery.

### Conclusion (my gains, areas of improvement)

Eventually, I have learned that patient consent is very important in every hospital setting. When a patient gets admitted in hospital, assessments must be done and proper decisions created. Jones’ doctor needed to identify the degree of needed care and establish what period he could stay in hospital. Overall, throughout this reflective I have learned that that consent is a fundamental requirement in nursing practice which will make me perform well in my future career as a nurse.

**Action plan**

By mean of Gibb's reflection model, I have known how to assess issues in clinical background and I will apply it during my upcoming practice in nursing career. I will learn to be more courageous and question my colleagues’ profession to ensure that patients’ rights are not violated. In future, I’ll seek to build up my confident capabilities when doing work with contemporaries, so as to make sure that the wellbeing of patients is sustained. During my practise, I’ll make this objective be my priority in my education, and will debate it with my tutor to find out techniques I use to will accomplish this.

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