REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user or colleague. Please refer to our guidance on preserving anonymity in Guidance sheet 1 in *How to revalidate with the NMC*.

Reflective account: 9th April 2018

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

Reflection on a resident's clinical care as part of an multidisciplinary team (MDT) review.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

This reflection represents the themes which emerged from a period of respite care for a lady with complex needs in a residential home. The focus is on MDT working and includes discussions with the resident, staff and relatives, observation of practice and analysis of metrics. The lady is referred to as the "resident" to preserve confidentiality

The key areas which emerged were;

- Communication with resident and family including assessment and goal setting
- Inter professional collaboration and learning
- The delivery of person centred care
- Nursing leadership

Communication with resident and family

During the time spent at Red Cedars I was able to interact with the resident and her family with respect and compassion. Examples included,

> Assisting to maintain her spiritual needs by ensuring her religious observance was facilitated this involved educating the staff about the residents religious personal needs Teaching a support member of staff to assist the lady to go to the toilet using a piece of equipment which had been supplied by the occupational therapist working in the intermediate care team.
>
> I was able to initiate the conversation about setting person centred goals specific for our resident during her stay, initially she "just wanted to well be enough to go home". I explained if we broke that goal down into smaller sections we would have something to work on each day which meant we could demonstrate progress toward going home. The resident explained wanted to improve her mobility and wanted her

wound to heal. The resident's family wanted her to have more interaction with friends and family as they felt she had become lonely and this had precipitated her mental health problems. We explained from a nursing perspective we wanted to ensure that the resident's new medication was working and not causing inappropriate side effects. These goals were broken down into a dynamic care plan and I involved all the MDT to ensure the goals were well rounded and met the needs of the resident , the other professionals and the family. Both the resident and her family (with the resident's permission) had copies of the care plan and this was reviewed on a daily basis to reflect the changing nature of the goals and the close scrutiny that was required particularly in relation to the new medication.

Inter professional Collaboration and Learning

It is recognised that inter professional working promotes effective clinical decision making the resident journey more streamlined and person centred. It affords opportunities for teaching and learning between professionals and sharing learning.

My observations demonstrated many opportunities for inter professional collaboration and learning. Examples included, learning about the use of new equipment, understanding the presentation of mental health needs, particularly those underpinned by loneliness. Our resident lived with a large family but had become personally isolated and this had exacerbated her mental health problems such that a crisis had occurred. I was prompted to do some further work on understanding loneliness particularly as the resident was a member of an ethnic minority in the local area. . I was able to share this new learning with the MDT at a weekly case review.

Social isolation is a real or perceived inability to interact with other individuals and the wider community it can be chronic or episodic It is thought of as an objective measure The terms loneliness and isolation are often used interchangeably but loneliness is a subjective experience and may relate to physical isolation and lack of companionship or the lack of a useful role in society. Although both isolation and loneliness impair quality of life and well-being, efforts to reduce isolation are likely to be more relevant to mortality. (Steptoe 2013) Rates of social isolation are difficult to quantify and depend upon the definition used. Defining social isolation as lack of frequency of contact with family, friends and neighbours suggests that 6%-17% of older adults are socially isolated to some degree. Over 50% of adults in England are not engaged in a group, club or organisation. About one in nine older adults (11-12%) could be described as excluded in terms of cultural and civic participation using the above data. Social isolation is more often experienced by those aged over 80 years, those of lower socioeconomic status, and those who are separated, divorced or have never been married. (Roberts 2014). Having established how common the experience of loneliness is and the effects on mortality. I investigated what as healthcare professionals we are doing about it, particularly as those who experience it most.

Relevance to the code (3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages)

The Department of Health's Public Health Outcomes Framework provides indictors for measuring social isolation and self-reported well-being and I tried to establish how useful the tools would be particularly in the care home sector.
De Jong Gierveld Scale

The scale consists of 11 items - six formulated negatively and five formulated positively around people's situation of being alone.

The de Jong Gierveld Loneliness Scale

1 There is always someone I can talk to about my day-to-day problems
2 I miss having a really close friend
3 I experience a general sense of emptiness
4 There are plenty of people I can lean on when I have problems
5 I miss the pleasure of the company of others
6 I find my circle of friends and acquaintances too limited
7 There are many people I can trust completely
8 There are enough people I feel close to
9 I miss having people around me
10 I often feel rejected
11 I can call on my friends whenever I need them

This tool appeared very appropriate as it was sensitive enough to pick up loneliness when the resident was amongst her family and with the care home.

How did you change or improve your practice as a result?

I realised that even when surrounded by people it is possible to be lonely. I have led a piece of work to assist safe to improve the quality of care in our care home which has included assessment of loneliness and the development of meaningful interactive events, that have been led by the residents wishes. This has included such as setting up a choir which families can also participate in. I am speaking at a local event with NHS and community colleagues to highlight the issues of loneliness and look at prevention on a personal and societal level. I plan to submit this as a resolution at the RCN Congress next year

This work meets part 22.3 of our code of conduct keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance)

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

The relevance is in prioritising people and practise effectively