

# All Wales NHS HCA Framework Induction

## Week 2 presentation 1



# Welcome

Training Etiquette

Microphones must be turned off at all times

No smoking policy

Questions can be ask at the end of each session .

At the end of the session time will be given to completed the activity book



## Week 2 Aims

8. Know the importance of diet, nutrition and hydration
9. Know how to support individuals to maintain continence while preserving their dignity
10. Understand how to support the wellbeing of individuals in a health and care setting
11. Know how to support oral care
12. Know how to support foot care
13. Understand the needs of individuals who have a cognitive impairment
14. Understand the needs of individuals who have a learning disability
15. Understand the needs of individuals with a mental condition
16. Know how to support individuals with sensory loss
23. Be able to use reflection in a health and care setting / Example
20. Understand how to support the hygiene needs of individuals (Nursing only)
21. Know about death and dying (nursing only)
22. Know how clinical specimens are taken (nursing only)



## 7. Nutrition & Hydration



# What is nutrition and Hydration?

- Nutrition and hydration is essential to keep your body healthy, functioning and alive.
- Without sufficient nutrition and hydration, the body cannot function effectively.
- All staff have a part to play in improving nutrition and hydration for the people we are caring for.

Malnutrition refers to deficiencies, excesses or imbalances in a person's intake of energy and/or nutrients. The term malnutrition covers 2 broad groups of conditions. One is 'undernutrition'—which includes stunting (low height for age), wasting (low weight for height), underweight (low weight for age) and micronutrient deficiencies or insufficiencies (a lack of important vitamins and minerals). The other is overweight, obesity and diet-related noncommunicable diseases (such as heart disease, stroke, diabetes, and cancer) (World Health Organisation (2020)).

World Health Organisation (WHO) Malnutrition. Malnutrition (who.int)



# Factors that can affect hydration and nutrition

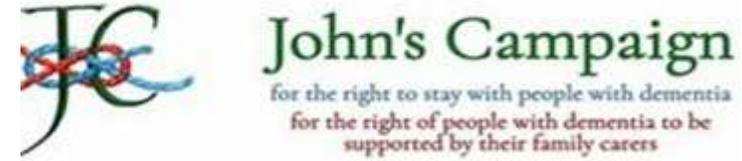
- **Illness -Appetite and Food appeal /Crohn's**
- **May be unable to swallow – Peg/Nasogastric tubes)**
- **Pain**
- **Lifestyle factors - vegetarian/diabetes/alcohol/social media pressure**
- **Poverty - embarrassment/dignity**
- **Fad diets - Grapefruit/Atkins/5:2/ketone**
- **Ageing - mobility/dexterity/ appetite/taste/loneliness**
- **Religious beliefs - Fasting/vegetarian**
- **Teeth/Mouth Care - Poor oral hygiene and pain**
- **Mental Health/Dementia - Low mood/confusion**
- **Difficulty Swallowing - should be assessed by SALT**



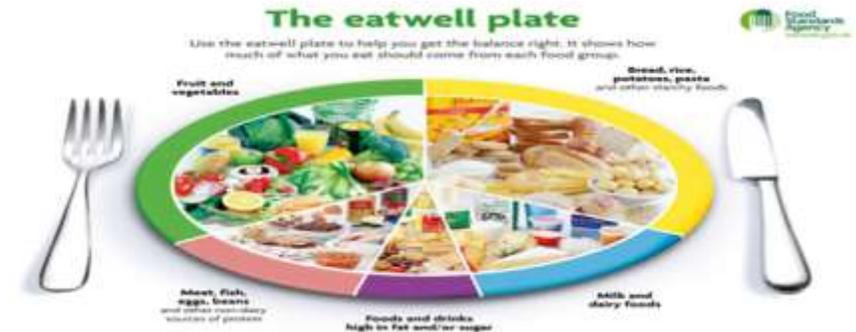
# Local and National initiatives



- Healthy eating in schools
- Tesco- free fruit for kids
- Change 4 Life
- Eat like a champ
- Think2drinkH2O



- **Healthy Food, Healthy Staff & Wellbeing Wednesdays**
- **Eatwell Plate**
- **John's Campaign**
- **Nutrition and hydration week**



# Allergies Definitions

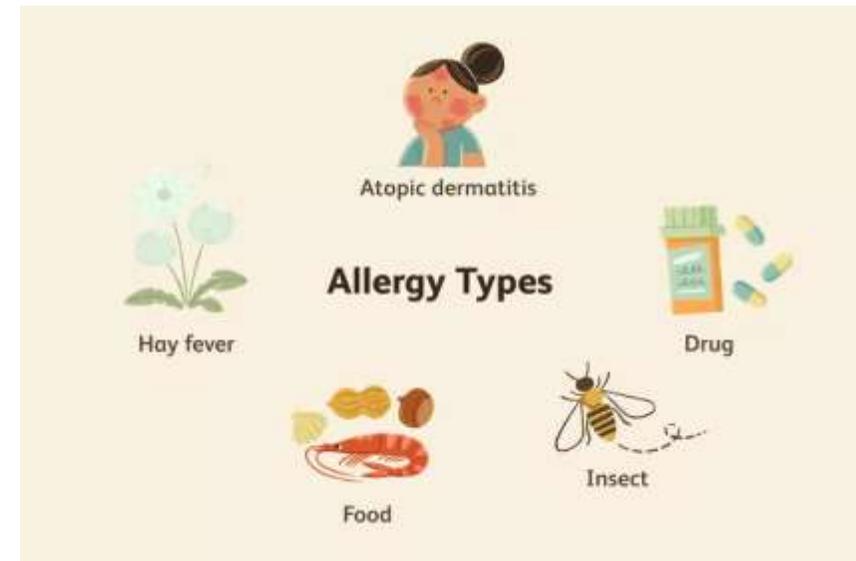
An Alergen is a substance that causes an allergic reaction

An Allergy occurs when a person reacts to substances in the environment that are harmless to most people. These substances are known as allergens and are found in dust mites, pets, pollen, insects, ticks moulds, foods and some medications

Anaphylaxis is a severe, life-threatening, generalised or systemic hypersensitivity reaction.

Policies relating to Allergens

- The Food Safety Act 1990
- Regulation (EC) No. 1169 /2011
- The Food Hygiene (England) Regulations 2006
- Natasha's Law 2021



# What are the main Allergens?

The 14 allergens are: celery, cereals containing gluten (such as wheat, barley and oats), crustaceans (such as prawns, crabs and lobsters), eggs, fish, lupin, milk, molluscs (such as mussels and oysters), mustard, peanuts, sesame, soybeans, sulphur dioxide and sulphites (if the sulphur dioxide and sulphites are at a concentration of more than ten parts per million) and tree nuts (such as almonds, hazelnuts, walnuts, brazil nuts, cashews, pecans, pistachios and macadamia nuts).

People may be allergic or have intolerance to other ingredients, but only the 14 allergens are required to be declared as allergens by food law. This also applies to additives, processing aids and any other substances which are present in the final product.

Atopy is the genetic tendency to develop allergic diseases. When atopic people are exposed to allergens they can develop an immune reaction that leads to allergic inflammation. This can cause symptoms in the:

Nose and/or eyes, resulting in allergic rhinitis (hay fever) and/or conjunctivitis.

Skin resulting in eczema, or hives (urticaria).

Lungs resulting in asthma



# What is Anaphylaxis?

Anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly.

It is also known as anaphylactic shock.

## **Signs of anaphylaxis include:**

Itchy skin or a raised, red skin rash

Swollen eyes, lips, hands and feet

Feeling lightheaded or faint

Swelling of the mouth, throat or tongue, which can cause breathing and swallowing difficulties

Wheezing

Abdominal pain, nausea and vomiting

Collapse and unconsciousness

# What should I do?

**Anaphylaxis should always be treated as a medical emergency. If available, an injection of a medicine called adrenaline should be given as soon as possible.**

**Some people with a previous history of anaphylaxis will have an auto-injector of adrenaline.**

**This should be injected into their outer thigh muscle and held in place for 5 to 10 seconds. Instructions for how to use these auto-injectors can be found on the side of each device.**

**The person should lie flat, with their legs raised on a chair or a low table. If they are having difficulty breathing, they should sit up to make breathing easier.**

**If the person is unconscious, you should move them to the recovery position – on their side, supported by one leg and one arm, with the head tilted back and the chin lifted. If the person's breathing or heart stops, cardiopulmonary resuscitation (CPR) should be performed.**

**Pull the emergency Bell for rapid assistance**

**Act as a runner to assist the registered practitioners**

**Identify what has caused the allergic reaction**

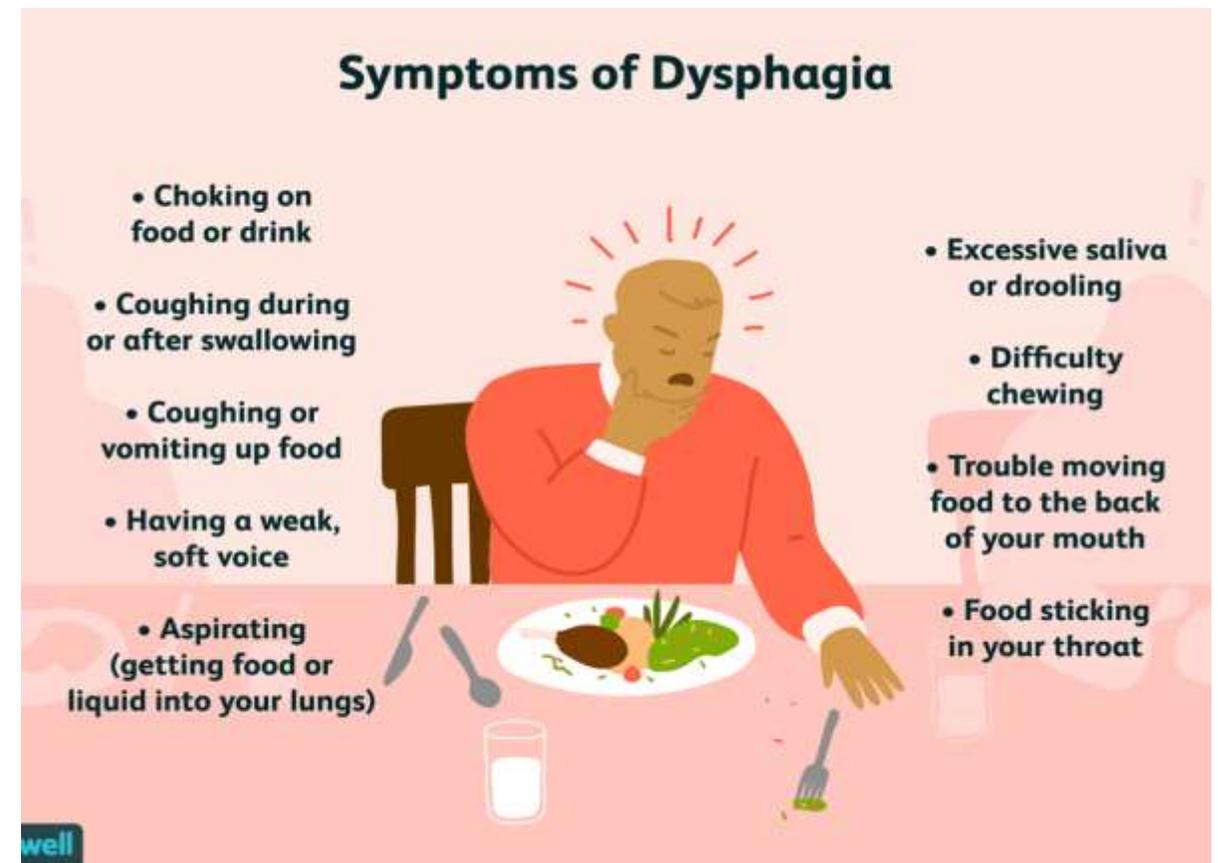
**Ensure other patients are safe**



# How to provide support for a person with swallowing difficulties

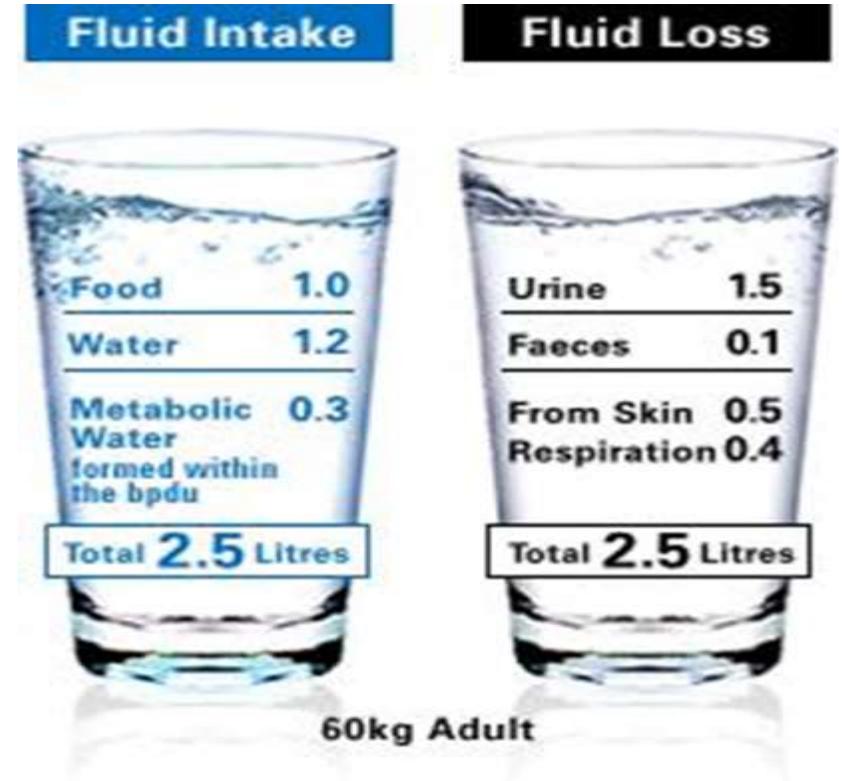
- Eat sitting up
- Modify texture of your diet
- Avoid foods that make you gag
- Chew your food well
- Time to eat and drink
- Watch for signs of pocketing food
- Regular review by dentist ( dentures fit correctly) if able to.

Report any signs of swallowing difficulties observed to Registered practitioner.



## Three routes of :

Fluid Intake	Fluid Loss
Orally	Diarrhoea and Vomiting
Sub-cut	Urine
Intravenous (I.V.)	Sweating



# Symptoms of Dehydration



## DEHYDRATION SYMPTOMS



Thirst



Dry Mouth



Rapid Heartbeat



Headache



Dry Skin



Decreased Urination



## Canllaw i Gyfeintiau Hylif Fluid Volume Guide



Llywodraeth Cymru  
Welsh Government

[www.cymru.gov.uk](http://www.cymru.gov.uk)

Diben yr wybodaeth hon yw eich helpu i roi gwybodaeth gywir am yr hylif a gymerir ar Siant Bwyd a Hylif Cymru Gyfan ar gyfer Lleoliadau Cymunedol. Cyfeirwch at y lluniau isod wrth lenwi'r Siant. Rhaid cofnodi pob hylif a gymerir yn gywir.

This information is designed to help you with accurate documentation of fluid intake on the All Wales Food and Fluid Chart for Community Settings. Please refer to the photographs below when completing the Chart. All fluid intake must be recorded accurately.



Cwpan Llawn /  
Full Cup = 150ml



Cwpan Plastig Llawn /  
Full Plastic Cup = 150ml



Bicer Llawn /  
Full Beaker = 200ml



Bicer Llawn /  
Full Beaker = 200ml



Bicer Llawn /  
Full Beaker = 200ml



Mwg Llawn /  
Full Mug = 200ml



Gwydraid Llawn /  
Full Glass = 200ml



Llond Jwg /  
Full Jug = 1000ml

Hylif o Ffynonellau Eraill / Other sources of fluid



Cawl / Soup

Ychwaneglon maethol /  
Nutritional Supplements

Hufen iâ / Ice Cream



Jeli / Jelly

© 2011



# Completing a Fluid Balance Chart (ACc 8.3, ACn 8.3)

Ms Louise Evans (not a real name GDPR) has been admitted to your clinical area having suffered diarrhoea and vomiting for the last 72 hours. She is looking pale and weak. Her past medical history includes:

- Type 2 Diabetes well controlled
- She has rheumatoid arthritis
- Mobilises with a Zimmer frame having previously fractured her hip 2 years ago

On Admittance to the ward the medical team has reviewed 22.00 hours and asked the ward to monitor her fluid input and output over the next 24 hours. She has not at present been prescribed any Intravenous fluids. The fluid chart commences at midnight (note different areas start fluid balance charts at different times, namely 00:00 or 06:00)

## This is her fluid intake/output for the next 24 hours:

02:00	3 sips of water (All-Wales guidance notes a sip as 5ml)	00:00 Vomit (250mls)
06:00	Went to the toilet (100ml urine)	15:00 120ml Urine Passed
06.30	300ml Diarrhoea	16:00 Reviewed by team-Continue monitoring
07:00	half cup of tea (100ml)	17:00 Vomit 100ml
08:00	75ml of urine passed	18:00 Half bowl of soup (170ml) and 100ml of tea
10:00	Went to toilet passed urine forgot to measure	20:00 Cup of tea
12:00	Cup of tea	22:00 Diarrohea 250ml



# Completing All Wales Food Chart (ACc 8.3, ACn 8.3)

Ms Louise Evans (89) has been transferred to your clinical area for rehabilitation having recently overcome a period of norovirus. She is still feeling unwell and appears weak. Her past medical history includes:

- Type 2 Diabetes well controlled
- She has rheumatoid arthritis and struggles to use cutlery

On admission to your ward, the dietetic team has reviewed her dietary intake. They are concerned by her nutritional score and therefore require her food intake until review. Please record the following onto the food chart.

Note: Cups/glasses = 200ml

	<b>Food</b>	<b>Portion served</b>	<b>Amount eaten</b>
<b>Breakfast 08:00</b>	Toast	2x 800g slices of white bread with butter	1 slice with butter
	Porridge	1 medium bowl	½ bowl
	Tea	1 cup	200ml
<b>Mid-morning 10:30</b>	Tea	1 cup	200ml
	Digestive Biscuits	2 biscuits	0 biscuits
	Fortisip compact	125ml	½ (60ml approx.)
<b>Lunch 12:30</b>	Cottage pie	1 large portion	¼ portion
	Mixed vegetables	1 portion (80g)	½ portion - 40g
	Ice cream	1 portion (80ml)	½ portion – 40ml
	Squash	1 cup (200ml)	½ - 100ml
<b>Mid-afternoon 14:30</b>	Tea	1 cup	200ml
	Digestive Biscuits	2 biscuits	½ of a biscuit
	Fortisip compact	125 ml	80ml
<b>Dinner 17:30</b>	Tea	1 cup	200ml
	Ham sandwich	1 (2x 800g slices of bread)	½ sandwich
	Ice cream	1 portion (80ml)	80ml
<b>Supper 21:00</b>	Horlicks	1 cup	½ - 100ml
	Digestive Biscuits	2 biscuits	½ of a biscuit

# 9. Continence Definition

## Factors which affect continence

- **Mobility** - footwear, distance to toilet, ability and speed of walking, balance, confidence, pain, joint movement, use of walking aids
- **Dexterity** - ability to dress, undress, wipe, wash and dry hands, flush toilet, open/close doors
- **Environmental** - steps and stairs, floor surface, cleanliness of toilet, smell, access, ability to reach light switch, toilet paper
- **Eyesight** – partial sight loss, level of lighting, toilet signage
- **Mental Function** – level of understanding, awareness of sensations, signage, communication skills
- **Emotions** – motivation, confidence, desire
- **Carers** – attitude, availability, willingness to assist, understanding, kindness, empathy, compassion

## Tools to support continence

- Bladder function
- Catheter (Urinary/supra pubic)
- Conveen (Uro Sheath)
- Pads
- Medication
- Commodes/bed pans
- Foam plugs/anal collectors
- Radar Key for public toilets
- Changes to diet
- Clothing which is easier to access



## 10. Health and Wellbeing



# Wellbeing of individuals in a health setting

Physical wellbeing is the ability to maintain a healthy quality of life that allows us to get the most out of our daily activities without undue fatigue or physical stress.

Factors that can affect the physical well being of an individual	
Hygiene	Enjoyable and fulfilling career
Spiritual or religious beliefs	Good night sleep
Poor diet – over or underweight	Eating well
Poor relationships	Good relationships
Regular exercise	Lack of mobility
Network of close friends	Happy intimate relationship with partner



# Factors that can affect mental well-being

Factors that can affect the mental well being of an individual	
Pain	Long tem injuries
Break down of relationship	Accident
Domestic violence	Bullying at work
Financial worries	A death
Job loss	Loneliness and isolation
Lack of sleep or sleep problems	Alcohol or dug misuse
Self identify	Body dysmorphia



# 11. Know how to support Oral Care

## Why oral care is important?

- Prevents Tooth decay
- Prevents gum disease, which can damage gum tissue and the bones that support teeth.
- Prevents bad breath
- Improves overall health



Oral Health Basics  
**Importance of Oral Care**

- **Teeth are part of the digestive system**  
Fewer teeth = Difficulty chewing  
Difficulty chewing = Poor digestion  
Poor digestion = Poor nutrition  
Poor nutrition = Poor health
- **Poor oral health = Poor health**

<b>Examples of how you would support an individual with their oral care needs</b>	<b>Examples of when an individual may require additional support to meet their oral care needs</b>
Undertake a Patient assessment	Cognitive impaired patients
Brush at least twice a day	Diabetic patients
Encourage plenty of fluids/if Nil by Mouth (NBM) wetting lips or use lip gloss (Do not use lip gloss or balm if on oxygen as this can make the lips worse)	Mobility Problems
Regular mouth care- Mild toothpaste and soft brush/ mouth wash	Poor eyesight
Denture care	Paralysed
Brushing the tongue	Long term dental problems

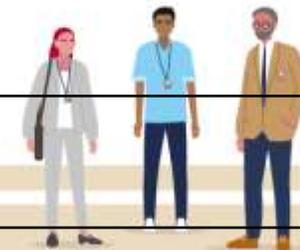


## 12. Know how to support foot care



Looking after your feet (foot care) and treating common foot problems – such as corns, calluses, bunions and ingrown toenails – can help to prevent problems that make you unsteady on your feet and at risk of a fall. Wearing footwear that's safe, appropriate and in good repair can also help to prevent fall

<b>Examples of how you would support an individual with their foot care needs</b>	<b>Examples of when an individual may require additional support to meet their foot care needs</b>
Checking feet in good order	Cognitive impaired patients
Keeping the feet clean	Diabetic patients
Keeping your skin in good condition	Mobility Problems
Keeping your toe nails at a good length	Poor eyesight
Wearing the correct shoe size	Paralysed



# All Wales NHS Health Care Assistant Induction Programme Week 2



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## Week 2 Aims

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22. Know how clinical specimens are taken (nursing only)



### 13. Understanding the needs of an individual who have a cognitive impairment



**An individual's mental abilities (cognition) are not as good as they used to be.**

This usually refers to problems affecting memory, but could involve a change in problem solving, thinking, attention, concentration, language or visual ability.



# Types of cognitive impairment you may come across

- **Alzheimer's disease**
- **Attention deficit disorder**
- **Dementia**
- **Early onset dementia**
- **Epilepsy-related cognitive dysfunction**
- **Normal pressure Hydrocephalus – with related cognitive impairment**
- **Parkinson disease- related cognitive dysfunction**
- **Posterior cortical atrophy**
- **Primary progressive aphasia**
- **Stroke - related cognitive dysfunction**
- **Traumatic brain injury**
- **Other neurologic disorder-related cognitive impairments (e.g. Multiple sclerosis)**
- **Chemotherapy-related cognitive impairment (chemo-brain)**



**Signs and symptoms that may indicate an individual has a cognitive impairment**

**Ways you could support an individual in your work area who has a cognitive impairment**

Difficulty concentrating

Regular physical activity

Struggling to follow a conversation or find the right word

Healthy diet

Finding it hard to carry out familiar daily tasks, such as getting confused over correct change when shopping

Social activity/ Hobbies

Being confused about time and place

Keep a positive, upbeat tone. ...

Mood changes

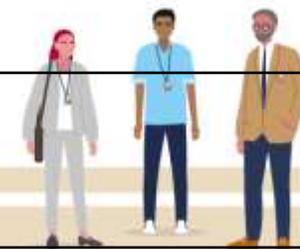
Stick to easy-to-understand words and short sentences. ...

Poor motor coordination/ Impaired judgment.

Be patient. ...  
Distract and redirect. ...  
Smile and reassure

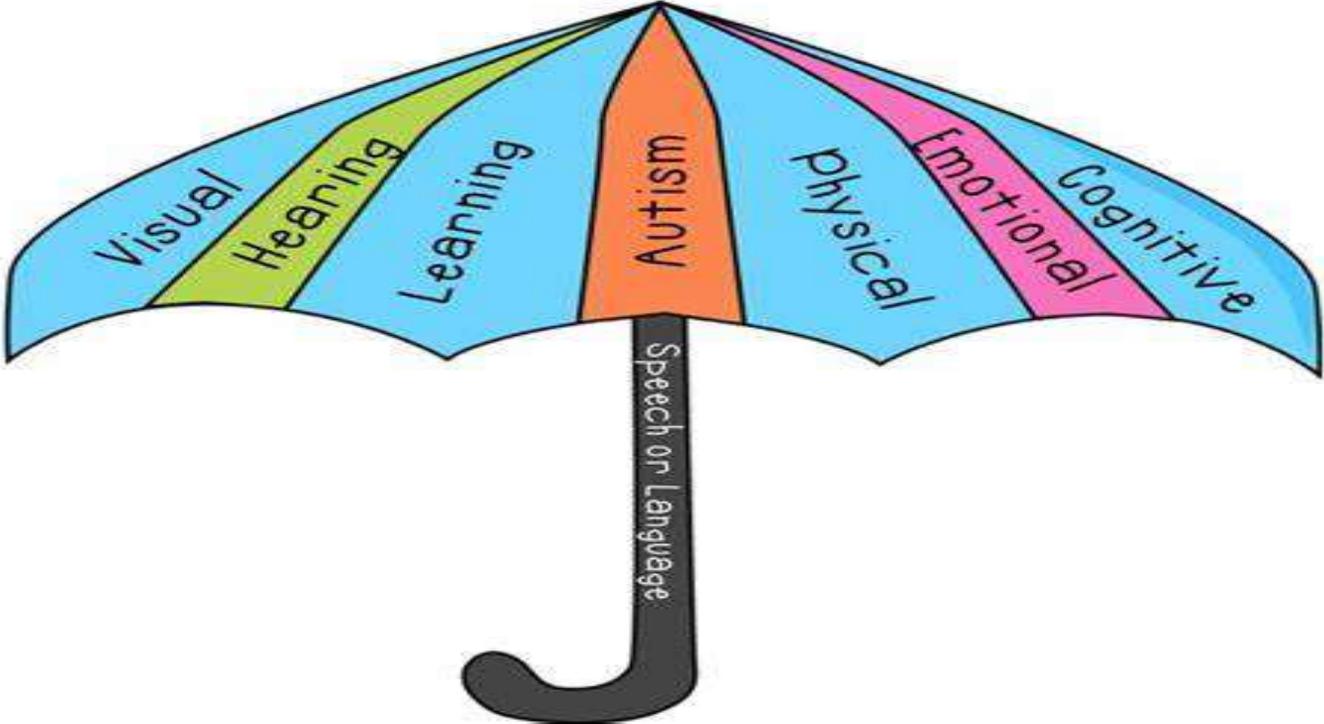
Loss of short-term or long-term memory.

Intellectual stimulation



# 14. Understanding the needs of an individual with learning disability

## Disabilities



# What is a learning disability?

**A learning disability affects the way a person learns new things throughout their life.**

A learning disability is different for everyone. No two people are the same.

A person with a learning disability might have some difficulty:

- understanding complicated information
  - learning some skills
- looking after themselves or living alone



# Underling health conditions that individual's with learning disability may have

- Heart Condition
- **Mobility problems**
- **Speech impairment**
- **Sight problems**
- **Hearing problems**
- **Gastrointestinal.**
- **Diabetes**
- **Epilepsy**
- **Anxiety disorders**
- **Depression**
- **Schizophrenia**
- **Obesity**
- **Respiratory disease**
- **Swallowing and eating problems**



# Barriers to communication

Barrier	Ways to address them
Sensory impairment- sight and hearing	Makaton's / BSL, glasses, hearing aid
Comprehension	Use accessible language – easy words
Lack of attention	Use different communication tools / try using objects to keep attention
Differences in perception and viewpoint	Follow the lead of the person you're communicating with
Emotional barriers and taboos – personal relationships	Go at the pace of the person you're communicating with, check you have been understood and be creative.
The use of jargon	Avoid jargon or long words that might be hard to understand.



# How to support a patient with learning disabilities

- Talk directly to the patient and make eye contact.
- Avoid sitting a long way from the patient and their carer.
- Work out how much understanding someone has at your first meeting. ...
- Tell the patient (and carer, if present) what is going to happen in the consultation.
- Allow carers or family members to be present as much as reasonably possible
- Don't talk down to the individual
- Effective communication skills





Mental Health Condition	Signs	Symptoms	Support
Anxiety Disorder	<ul style="list-style-type: none"> <li>• Feeling Nervous, restless or tense</li> <li>• Having a sense of impending danger, panic and doom</li> <li>• Increased heart rate,</li> <li>• breathing rapidly</li> </ul>	<ul style="list-style-type: none"> <li>• Sweating</li> <li>• Rapid or increase heart rate</li> <li>• Difficulty sleeping</li> <li>• Dizziness</li> <li>• Dry Mouth</li> <li>• Muscle tightness</li> </ul>	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Relaxation techniques</li> <li>• Psychotherapy</li> <li>• Self Care- Yoga/avoid alcohol. Get a proper nights sleep</li> </ul>
Depression	<ul style="list-style-type: none"> <li>• Continuous low mood</li> <li>• Feeling Hopeless</li> <li>• Low self esteem</li> <li>• Difficult making decisions</li> <li>• Having suicidal thoughts or harming yourself</li> </ul>	<ul style="list-style-type: none"> <li>• Tearful</li> <li>• Guilt ridden</li> <li>• Irritable and intolerant of others</li> <li>• No motivation or interest in anything</li> <li>• Not getting any enjoyment out of life</li> <li>• Avoiding contact with friends or social activities</li> </ul>	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Counselling</li> <li>• Exercise</li> <li>• Cognitive behavioural therapy</li> </ul>



Mental Health Condition	Signs	Symptoms	Support
Schizophrenia	<ul style="list-style-type: none"> <li>• Delusion</li> <li>• Hallucinations and illusions</li> <li>• Disordered thinking</li> <li>• Disordered Behaviour</li> <li>• Agitation</li> </ul>	<ul style="list-style-type: none"> <li>• Losing interest and motivation in life and activities</li> <li>• Hallucinations</li> <li>• Delusions</li> <li>• Confused thoughts</li> </ul>	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Psychotherapy</li> <li>• Counselling</li> <li>• Mental health teams input</li> </ul>
Bi-Polar Disorder	<ul style="list-style-type: none"> <li>• Extreme happiness, hopefulness and excitement</li> <li>• Restlessness</li> <li>• Agitation</li> <li>• Rapid Speech</li> <li>• Poor concentration and judgement</li> </ul>	<ul style="list-style-type: none"> <li>• Increased energy</li> <li>• Less need for sleep</li> <li>• Unusually high sex drive</li> <li>• Setting unrealistic goals</li> <li>• Paranoia</li> </ul>	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Psychotherapy</li> <li>• Counselling</li> <li>• Mental health input</li> </ul>



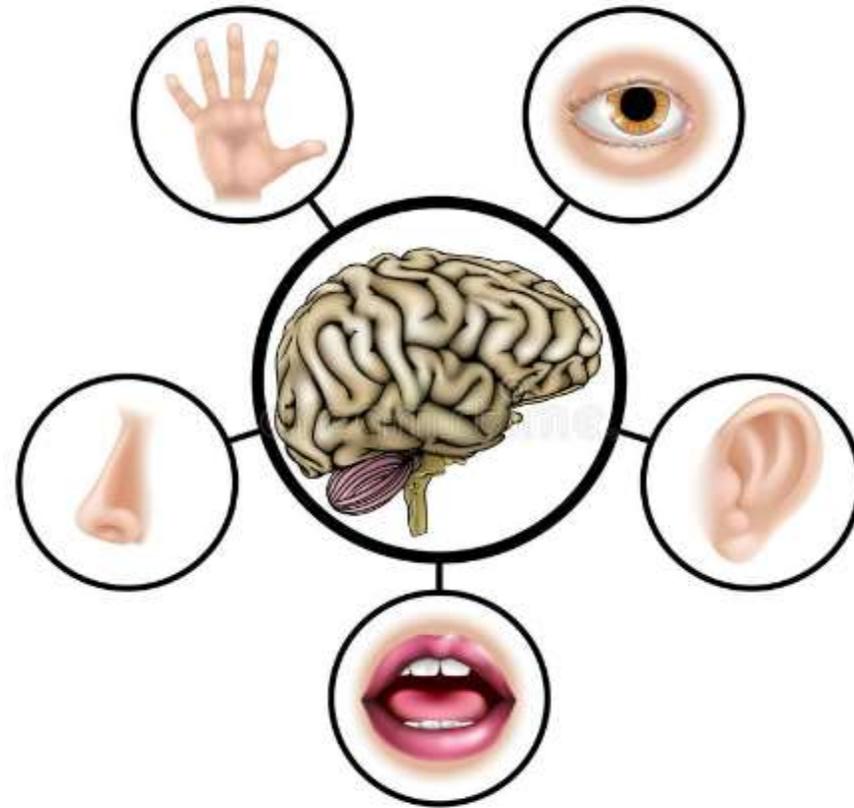
# How to support an individual with a mental health disorder

There are some general strategies that you can use to help:

- Listen without making judgements and concentrate on their needs in that moment.
- Ask them what would help them.
- Reassure and signpost to practical information or resources.
- Avoid confrontation.
- Ask if there is someone they would like you to contact.



# 16. Know how to support individual with sensory loss



# Know how to support individual with sensory loss

Sense	Contributing factor to loss		Methods to support	Tools to support
	Congenital – from birth	Acquired		
<b>Hearing</b>	Genetic disorders herpes simplex virus premature birth low birth weight birth injuries Difficulties during birth	Hearing loss due to measles, rubella during childhood Infections Injury to inner ear Head injuries Loud noises	Effective communication Slow and clear speaking Face patient so they can see lips Be patient Don't finish sentences Translator BSL or <b>If deaf and blind</b> Hand-under- hand/ tactile sign language.	Ensure hearing aid is working Interpreter sign language pen and paper photo charts, Hand-under- hand/ tactile sign language. Tactile Fingerspelling.
<b>Sight</b>	Vitamin A deficiency Genetic disorders herpes simplex virus premature birth low birth weight birth injuries	cataract. age-related macular degeneration. glaucoma. diabetic retinopathy. Injuries Infection	Effective communication – when giving written instruction Explain what is around Easy access to bell / water Describing what's on a plate of food <b>Translator</b> Hand-under- hand/ tactile sign language.	Braille Guild dogs white stick Specialised equipment that will translated letters to braille Supporting them around new areas and explain what is around them explaining food on plated relating it to a clock Ensure glass clean



# Know how to support individuals with sensory loss

Sense	Contributing factor to loss		Things to consider	Tools to support or ways to support
	Congenital – from birth	Acquired		
<b>Smell</b>	Congenital anosmia – loss of smell birth defects Kallmann syndrome lose of tasted and smell	Covid 19 Brain injuries common cold. Sinus infections	May have a poor appetite or does not enjoy food and fluid and at risk of poor nutrition and hydration	Explain how it smell, sweet, bad Be respectful
<b>Taste</b>	Kallmann syndrome birth defects	Covid 19 Brain injuries Medication Poor diet	May have a poor appetite or does not enjoy food and fluid and at risk of poor nutrition and hydration	explain the taste sweet bitter
<b>Touch / feeling</b>	Birth injuries, birth defects , before or caused during pregnancy Brain injury Paraplegic	Stroke Head injury Spinal cord injury	Patient may be high risk of pressure injuries , At risk of not knowing when they injured them self May get heat injuries such as getting into hot baths	Equipment that will recorded temperatures – and speak temperatures in case  All the above may also need support with wellbeing and mental health

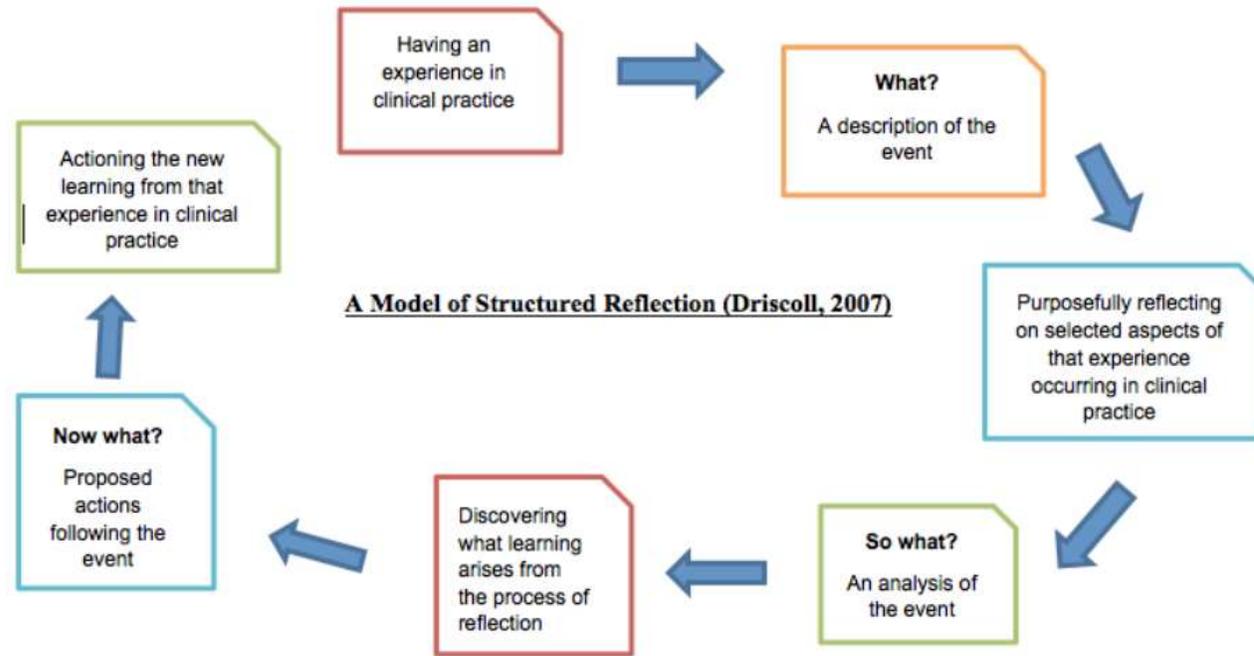


# Reflection

Reflective practice is a cognitive skill that demands conscious effort to look at a situation with an awareness of own beliefs, values, and practice enabling nurses to learn from experiences, incorporate that learning in improving patient care outcomes. It also leads to knowledge development in nursing.



# Reflection



*A Model of Structured Reflection (Driscoll, 2007, p.44)<sup>[2]</sup>*



# Reflective Cycles

## How do you introduce a Gibbs reflective cycle?

Image result for simple explanation of Gibbs reflective cycle

Using the Model

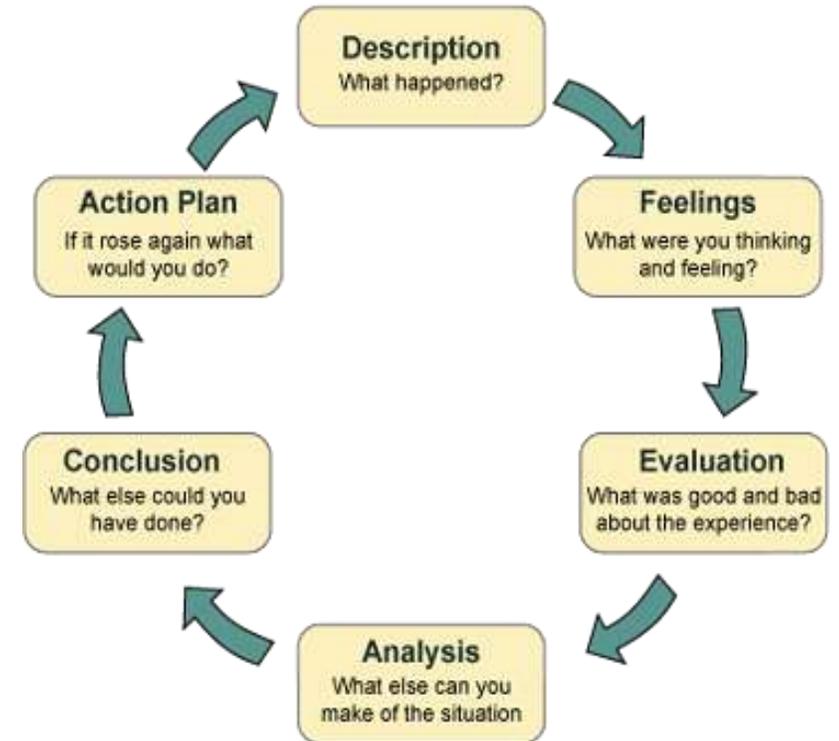
Step 1: Description. First, ask the person you're coaching to describe the situation in detail. ...

Step 2: Feelings. Next, encourage him to talk about what he thought and felt during the experience. ...

Step 3: Evaluation. ...

Step 4: Conclusions.

## Gibbs Reflective Cycle

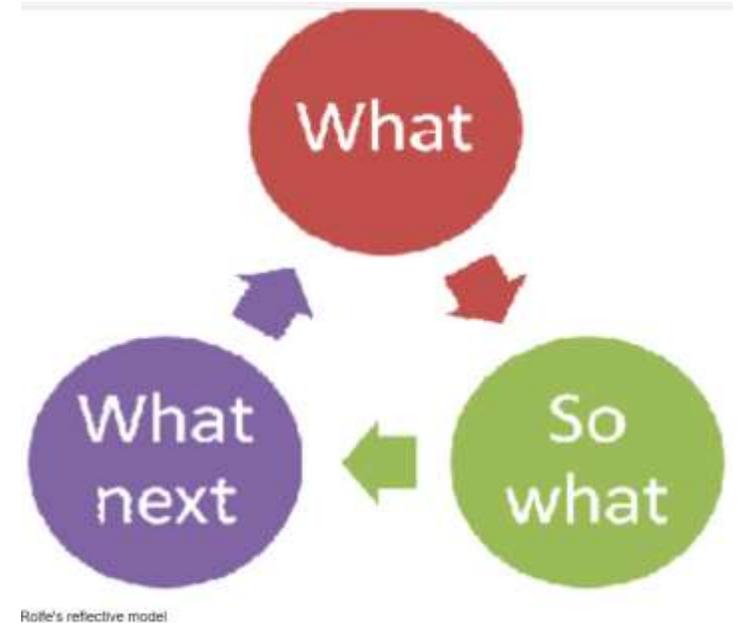


# Rolfe reflective cycle

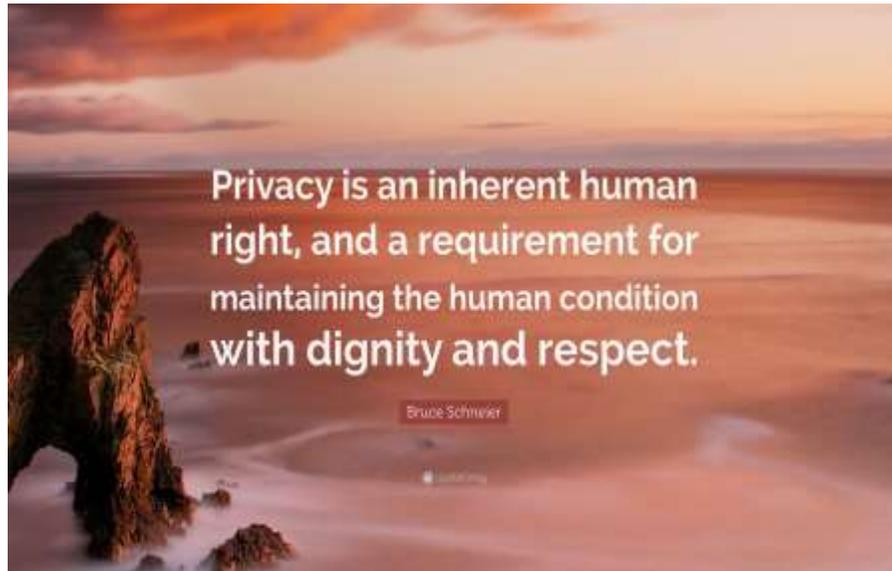
What is the Rolfe reflective cycle?

Image result for simple explanation of Rolfe reflective cycle

The three stages of the model ask you to consider, in turn, what happened, the implications of the occurrence, and the consequences for future conduct



## 20. Understand how to support hygiene needs of individuals



## 20. Understand how to support hygiene needs of individuals

<b>Examples of how you can protect the privacy and dignity of individuals while providing support with hygiene needs</b>	<b>How you would support an individual with their hygiene?</b>
When talking about an individual's personal information- make sure that you speak quietly and away from people who could overhear if possible	Ensure curtains, doors are closed to ensure privacy and dignity maintained
Always arrange clothing such as hospital gowns in a dignified way	Obtain consent prior to procedure- could be verbal or non verbal
Make sure you don't keep an individual waiting if they need support to go to the toilet	Offer choice of clothing, cleaning products to ensure patient centred care
Always ask individuals consent before touching them in any way ( e.g.) assistance with toileting, hygiene needs etc	Avoid accidental exposure- ensure intimate parts are covered



## 21. Know about dying, death and bereavement



Useful link <https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/final-days/caring-last-days>



# Know about dying, death and bereavement

Cultural or religion	Differences
Hispanic	Celebrate death with humour and joy ( Día de los Muertos)
Jamaican	Funerals can be held up to a month later, to allow the spirit to leave the body and relatives who leave abroad to come over Wake – ninth night is a celebration of song and dance
Polish	The body lies at state in the house of the deceased or their relatives. Family, neighbours and friends gather and pray during the day and night for around three days. Then the coffin is carried in a procession (usually by foot) to the church, where a remembrance service takes place.
Islam	<p>Muslim's every prayer during life; and of their final resting hours before death. A dying Muslim will normally want to lie on their right-hand side facing Mecca as they reach end-of-life. It's viewed as an important religious duty to visit the sick and dying, so a person may receive a lot of visitors.</p> <p>After death, the body is prepared for burial, happen as soon as possible after death. First, family members of the same gender as the person who has died will wash the body, at least three times. body is wrapped in sheets, secured with rope, and taken to the mosque. Afterwards, the family will usually be brought food by the local community for three days. An Islamic mourning period officially lasts for 40 days.</p>



# Ways in which you would care for an individual in their last days of life

- Ensure they have time to talk about concerns they have
- Provide physical contact. Try holding hands or a gentle massage.
- Set a comforting mood. Some people prefer quiet moments with less people. Use soft lighting in the room.
- Play music at a low volume. This can help with relaxation and lessen pain.
- Be present. Visit with the person.
- Consider hospice and palliative care services, spiritual practices, and memorial traditions

**Ensure that the individual is at the centre of any decision. Involve the dying person. If the person can still communicate, ask them what they need.**



# Identify how to care for an individual after death

## Personal Care of the Deceased Patient,

- Lay the deceased person on their back, adhering to manual handling policy.
- Keep the patients face in alignment with the chest making sure their head does not lean to the right or left
- Clean the mouth to remove debris and secretions, clean and replace dentures as soon as possible after death.
- Close the eyes of the deceased person, applying light pressure for 30 seconds
- Cover exuding wounds or unhealed surgical incisions with a clean absorbent dressing and secure with an occlusive dressing. Leave stitches and clips intact. (Avoid waterproof, strongly adhesive tape as this can be difficult to remove and can leave a permanent mark).
- Contain leakages from the oral cavity by suctioning and positioning.
- Intravenous cannulae, drains, indwelling catheters should be capped and left in situ. This helps prevent leakage of bodily fluids. Mortuary staff will remove these at a later stage.
- Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum

- Wash and dress the deceased patient appropriately, a shroud is usually used. N.B. The UK is a multicultural and multi-faith society and therefore the care that is given at this time should demonstrate not only our respect for the dead but also should be focused on fulfilling the religious, spiritual and cultural beliefs of patients as well as fulfilling health and safety, and legal requirements. The patient's previous wishes should be established where possible and should always take precedence. If not previously documented, an attempt should be made to determine patients' previous wishes from family or carers. Further guidance and information around religious/spiritual practices can be found within the 'Religion or belief equalities resources, see link Religion or belief - Equalities resources (sharepoint.com) or the Chaplaincy Service, where advice can be sought 24-hours per day, access via main switchboard

## Identification-

- Two new identification bracelets- One on patient's wrist and one on the ankle. If the patient is wrapped in a sheet a further label is attached to the outside of the sheet. Second independent checker is required and **MUST** be a Registered Nurse
- Complete the record of deceased form, including counter signing of a registered nurse

Information taken from the IPC32 IPC  
32 Infection Prevention Management  
of the Deceased Patient Procedure



# Handling patient property after death

Describe how these items of jewellery would be handled and stored in line with workplace policy (ACn 21.4):



Yellow metal ring with green and white stones



White metal chain with white stone teardrop pendant

When handling patients property there needs to be

- Two witnesses to check any property
- Personal property list need to be completed
- Valuable checklist needs to be completed
- Some areas also leave the jewellery on the person and this dealt with by the undertaker, if this is the case, this will need to be documented on a label that is part of the Last Offices Pack.
- If the patient passes away during the night then valuables will be locked away until the morning and then taken to general office
- The patients family may take the property if this is the wish of the patient



# Support that is available to you whilst you are supporting individuals through death, dying and bereavement

- Occupational Health Support
- BCUHB staff wellbeing share point
- Bereavement support in the workplace- (Cruse)
- Compassionate bereavement Support (CIPD)
- How to support bereaved employee- Marie Curie
- Specialist Palliative Care teams



**Most importantly Colleagues can help support each other**

Please see [Bereavement Resources for Staff and Patients \(sharepoint.com\)](#) on Betsinet



# Specimens Collection



A specimen may be defined as a small quantity of a substance or object which shows the kind and quality of the whole (sample).

Specimen collection defined as the collection of the specimen for the purposes of diagnosis, treatment and recovery.



# Types of specimen collection

## Mid-Stream Specimen of urine (MSU)

Fig 2. The procedure



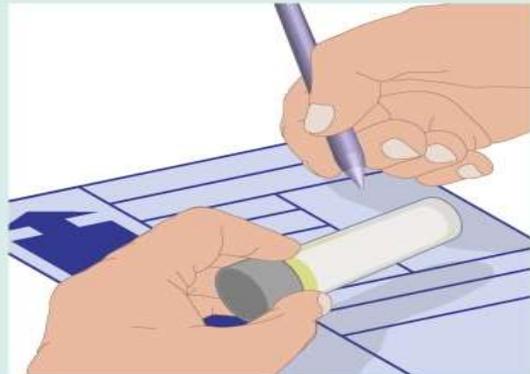
**Fig 2a.** Ask the patient to clean around the urethra meatus to reduce the risk of contamination. Uncircumcised men should retract the foreskin and women should part the labia and clean from front to back



**Fig 2b.** Ask the patient to pass 15-30ml of urine into the toilet to wash away any bacteria colonising the distal urethra



**Fig 2c.** Ask the patient to collect the middle part of the stream in a wide-neck sterile container and void the remaining urine in the toilet



**Fig 2d.** Complete the specimen request form and label on the specimen pot, and document in the patient's notes that the sample was taken

### current procedure of urine sample collection

1.



get a sample container

2.



pass the initial urine out

3.



collect mid stream into the container

4.



clean the area soiled

5.

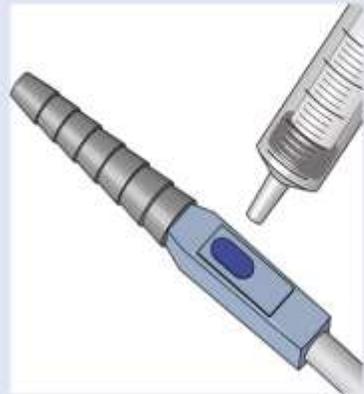


hand over the sample to the incharge

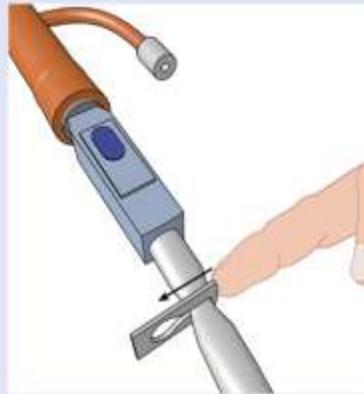


# Catheter specimen of urine (CSU)

Fig 1. Collecting a catheter specimen of urine



1a. A sampling port can be found on the tubing of the catheter drainage bag - urine should only be obtained from this point.



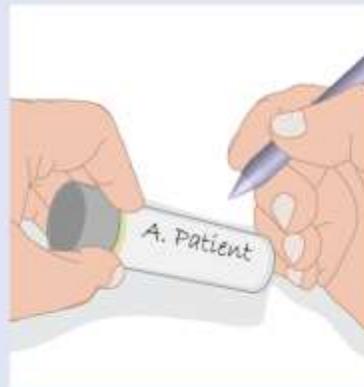
1b. Clamp the catheter below the port so that urine can collect above it in the tubing. Some catheter bags have an integral clamp.



1c. Swab the sampling port with an alcohol-impregnated swab following local policy to reduce the risk of cross infection and contamination of the specimen.



1d. Insert the syringe tip into the sampling port and withdraw the urine following manufacturer's instructions.



1e. Place sample in the specimen pot, avoiding contact with the syringe. Secure top to prevent leakage and contamination, then label, place in a specimen bag and seal.



1f. If the sample is taken from a catheter valve, the valve must be cleaned with an alcohol-impregnated swab first to reduce the risk of cross infection.

# Stool Sample

## Stool Specimen

Analysis of fecal material can detect pathological conditions i.e: **Infection, hemorrhage, tumors.**

### Tests

- Occult Blood
- Bacteria
- Ova & Parasites

Medical aseptic technique

To lab on time

Labelling /Documentation



### Note the:

#### 1-Color

- Melena (black stools)

#### 2-Odor

#### 3-Consistency



Collect on plastic wrap and transfer to vial until liquid reaches fill line.



Remove spoon from lid and discard.

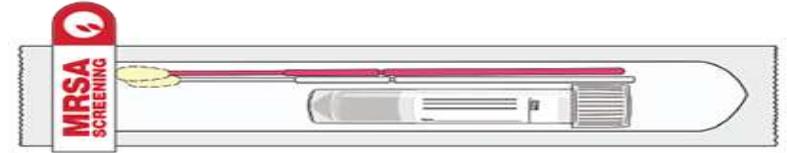


Replace cap on vial tightly and shake for a minute. Place vial in refrigerator until ready to ship.



# Sputum collection

# MRSA screening



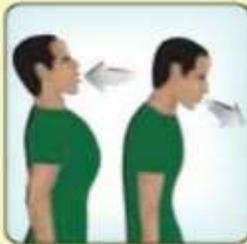
## 1 CLEAR YOUR MOUTH



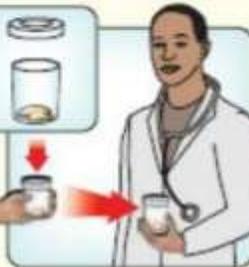
Rinse with water

Empty your mouth

## 2 BREATH IN AND OUT 3 TIMES



## 3 GIVE A SPUTUM SAMPLE



No saliva

## COLLECTION KIT

**1** Open the MRSA eSwab sample collection pouch and remove the tube and PINK swab.

**2** Use PINK swab to collect specimen from the axilla and groin.

**3** Unscrew and remove the cap from eSwab tube making sure not to spill the medium. Insert the swab into the tube. Dip and gently stir the swab for 5 seconds.

**4** Lift the swab from the liquid medium and squeeze the eSwab against the container 5 times to allow release of the sample from the flocked fibre holding the tube away from your face.

**5** Use white swab to collect specimen from the anterior nares.

**6** Insert the swab into the tube and break the swab at the molded breaking point.

**7** Recap the tube with the white swab in-situ. Label the tube with CPOE label. Put the tube in a specimen bag and send to the lab.

Remove swab and discard into general waste.

# Labelling of Specimen samples

**Samples must never be pre labelled and must always be labelled in the presence of the patient.**

## Sample labelling criteria:

- Last name/surname
- First name
- Date of Birth and/or NHS/Hospital number
- Date and time of sample
- Signature or initials of the person taking the sample
- Source/location of the patient



## Rejection criteria

- If Three out of four of the following identifiers: patient's first name, surname, DOB and NHS/ hospital number are not present on the sample.
- Samples labelled with addressograph labels
- If there is evidence of relabelling, e.g. details crossed out on the sample or different Electronic test request (ETR) labels
- Sample with needle still attached – dispose of immediately in sharps bin, report to laboratory staff, raise a Datix against the referring department.

