BDA The Association of UK Dietitians

Level 7 reflection based on

‘A day in the Life of a First Contact Dietitian’

Introduction

Are you considering a career in Primary Care as a First Contact Dietitian (FCD)? The BDA is here to support you to move into this exciting, emerging area of practice. To become a FCD, you will need to evidence capability at level 7 (Masters level) using the HEE dietetic roadmap. This creates a standard of practice that provides assurance for patient safety and governance of these roles within primary care.

Stage 1 of the roadmap requires an aspiring FCD to evidence, via a number of reflections written at level 7*, how they meet the 12 capabilities described within the Knowledge, Skills, and Attributes (12.15 of the roadmap). Ideally stage 1 is completed prior to moving into primary care however this is not always possible.

Stage 2 of the roadmap requires evidencing how the Knowledge, Skills and Attributes are transferred into the new environment to demonstrate capability within primary care. One part of this is using reflective log entries, at least one per week. Your reflections for Stage 2 should focus on what is different in Primary Care (for example managing undifferentiated, undiagnosed conditions; consultation models; personalised care; the general practice primary care team; medicines management).

The reflection below is written at level 7 as it critically analyses and evaluates practice and learning. It is based on 'A day in the life of a FCD', and shows examples of how your consultations can be reflected on, at level 7, and used as stage 2 evidence. As you can see, a thorough reflection can be used to evidence more than one capability. This reflection meets the required standard to be signed off by a roadmap supervisor.

*for further support in writing at level 7, there is a useful webinars here.

12.14 Reflection Template – First Contact Practitioner	FCP capability demonstrated (1-12)
What happened – brief description - presenting problem: This extract is taken from 'A day in the life…..' "Jessica is 24 years old and is booked in to see me as she has had abdominal cramps and bloating. I take a full history of her symptoms and explore Jessica's Ideas, Concerns and Expectations. Jessica worries about the bloating as on days when it is bad, she has had people ask if she is pregnant. Jessica and I agree that we will conduct some initial blood tests and when we have these results, we can agree next steps. I order the bloods on the clinical system and book a follow up appointment for 10 days' time. Jessica thanks me for my time and lets me know that she feels reassured".	FCP 1, 2, 3, 4, 5, 6, 8, 11, 12
Differential diagnoses & your clinical reasoning Given that Jessica is under 50 and presenting in Primary Care for the first time with these symptoms, my initial thoughts are that these symptoms could be irritable bowel syndrome (IBS). This is because it remains one of the most common gastrointestinal disorders seen in both Primary and Secondary Care (BSG, 2021). This cannot be assumed, however, so taking a full symptom history to include asking questions on duration of symptoms, unexplained weight loss, blood in stools, family history and assessing if the patient has iron deficiency anaemia will help to rule out more sinister causes as per NICE guidance on suspected cancer (NICE, 2021). As this presentation is in a female, the history taking also needs to differentiate from a gynaecological explanation for the symptoms. Age at presentation, menstrual cycle, frequency and duration of symptoms, urinary symptoms, whether the abdominal pain is fixed in one location and factors which alleviate the symptoms (such as opening the bowels) should all be included (NICE, 2021). Blood tests are also required prior to reaching any diagnosis and include full blood count (FBC), erythrocyte sedimentation rate (ESR), c-reactive protein (CRP), antibody testing for coeliac disease (tissue transglutaminase [TTG]) as advised by NICE guidance (NICE, 2017). These blood tests, alongside the history taking, will support a diagnosis by helping to rule out coeliac disease, inflammation, and iron deficiency. The history taking will help to determine if other tests such as faecal calprotectin should be ordered. In this instance as the patient was presenting with abdominal cramps and bloating, it was not indicated. I would have ordered this in patients <45 years of age with diarrhoea, to exclude inflammatory bowel disease (BSG, 2021).	FCP 5, 6, 7, 8

12.14 Reflection Template – First Contact Practitioner	FCP capability demonstrated (1-12)
Reflection – what did you learn? In managing undifferentiated and undiagnosed conditions, a range of consultation models may be needed to ensure a personalised care approach. Personalised care means considering individual needs, preferences, and circumstances. It leads to better outcomes, experiences and adherence to an agreed treatment plan (PCI, 2022). The importance of recognising patient's ideas and expectations during a consultation has been identified in early studies such as Barry et al (2000), who describes that when patients do not have the opportunity to express their thoughts this can result in patients not adhering to treatment. A more recent study conducted by Freilich et al (2019) found that out of GPs, district nurses and physiotherapists' patients felt that their thoughts and expectations were heard most by physiotherapists, emphasising allied health professional's (AHP's) skill sets when it comes to the ICE model. It is however, worth noting that this particular study was just one qualitative paper conducted in Sweden, and therefore comparatives to the NHS may be different. Evidence suggests that identifying and practicing ICE components are key competences related to shared decision making, especially when deciding whether to prescribe medication. Perhaps what is found is that this step of exploring ICE leads to more conservative decisions (Matthys et al, 2009). Prior to working in primary care, I had not considered the benefits of utilising different consultation models but after discussion and observations with my clinical supervisor, I regularly incorporate exploring the patients' ideas, concerns and expectations (ICE) which is part of the Pendleton Model (1984). Although this consultation did not involve prescribing medications, it is important to consider how utilising this model may impact on prescribing in other consultations. By exploring symptoms further in my history taking by using SOCRATES, (Site, Onset, Character, Radiation, Associated symptoms, Timing, Exacerbating and relieving factors), I was able to develop my most likely working diagnosis. Looking forward, if Jessica was diagnosed with IBS, I may consider using a psychometric scale such as Likert or Visual Analogue Scales (VAS) in assessing whether treatment had led to a reduction in severity rating of pain. Bengtsson et al., (2007) conclude that utilising VAS is a reliable tool for measuring the success of treatment response for IBS sufferers, however it should be noted that this study included only 71 participants.	FCP 1, 2, 3, 5, 6, 7, 9, 11

12.14 Reflection Template – First Contact Practitioner	FCP capability demonstrated (1-12)
Impact on your practice – what will you do the same or differently next time & why? I am aware that my background in a gastroenterology specialist role means that I feel more comfortable managing this type of presentation, however I have had to work on incorporating ICE into my consultation. This has taken a bit of time but I felt that this consultation flowed well and is potentially the first consultation where it felt most natural. I believe that this contributed to the patient reporting that she felt assured by our agreed management plan. IBS is unlikely to present for the first time in those aged 50 or above, and for this reason, I have excluded this age group from my FCD clinics. This is important whilst I develop my skills and confidence in Primary Care, particularly regarding clinical (physical) examination. Physical examination may not always be indicated when trying to establish an initial diagnosis. It is important, however, to be able to recognise when it is indicated and undertake or ask for support with this accordingly. I have identified this as an area to develop with my clinical supervisor and this is reflected in my personal development plan (PDP).	FCP 8, 10, 11, 12
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