

Ensuring effectiveness of critical reflection with reflection models



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The NMC (2008) requires nurses to maintain competence in all areas of practice (Meretoja et al, 2004). Nurses can contribute to the ongoing maintenance and development of clinical competence and ongoing professional development through reflection (Gustafson and Fagerberg, 2004). Reflection supports clinical reasoning, critical thinking and review of clinical actions and knowledge, contributing to ongoing evaluation of practice, for self and others (Bowden, 2003). However, reflection can be challenged as a pointless or limited process (Jones, 1995), and therefore, to ensure reflection is effective, and contributes to knowledge, understanding, learning and development (Rolfe, 2005), it is best to use one of the many models of critical reflection that have been developed within the theoretical domain.

As part of a process of critical reflection, I shall use Gibbs (1988) model of structured reflection, to structure and define the process of reflection and critical analysis involved in this scenario.

Description (What Happened)

I was involved in the care of a fifty two year old gentleman who has been under my care for some time in relation to monitoring of blood pressure. After initial tests were carried out, the gentleman was assessed according to standard definitions of hypertension. The gentleman, who shall be called Mr J for the purposes of this reflection, and to maintain confidentiality in accordance with the NMC Code of Conduct (NMC, 2008), had been complaining of some intermittent headaches, occasional dizziness, and blood tests were taken: full blood count, urea and electrolytes (to rule out any

renal involvement), and creatinine. Blood pressure measurements were one week apart, and his blood pressure was found to be 150/100 mmHg and 150/98 mmHg respectively. I carried out a further blood pressure measurements on three subsequent days and found the blood pressure to be within these two ranges on several occasions. There was no abnormality detected in the blood test results, and therefore, the decision was made to commence the patient on antihypertensive medication. I also carried out tests for diabetes and referred him to the GP for further assessment of cardiovascular risk.

In order to make this decision, I consulted not only reference books such as the British National Formulary, and the guidance on nurse prescribing, but the guidelines provided by the National Institute for Health and Clinical Excellence (NICE, 2006). In this guideline, NICE (2006, p 2) clearly state that:

“ Treatment and care should take into account patients’ individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient thinks it inappropriate”

Therefore, having explained the findings to the patient, I discussed with him the issues surrounding the diagnosis of hypertension, and what the consequence of this condition could be for his long term health. I also discussed the type of medication that was used, in order to make sure that he understood how this would affect him and how important it was to maintain a good treatment regimen and not to miss his medication. This

allowed me to assess his ability to self-medicate and also monitor his own condition and any effects of side effects of the medication. I also discussed with him the need to inform his family or next of kin of his condition and its treatment, as this would allow him to have support and help in adjusting to a chronic condition, and also other people who would assess symptoms and side effects during the treatment process. This is important as it can take time to adjust to the use of anti-hypertensive medication and sometimes the regimen needs to be altered in order to suit the individual patient (NICE, 2006).

Feelings (What were you thinking and feeling)

My thoughts during this process were focused on the need to properly diagnose this patient's condition, and to ensure that the prescribing process was correct, within the guidelines laid down for nurses by the NMC. I was concerned with getting the right dosage and frequency, choosing the right medication within the boundaries of my prescribing role, and also, ensuring that the patient was fully aware of the implications of his condition. However, more challenging to my current role was the realisation that my concern for the patient, and for his adjustment to being told he had a chronic illness that needed treatment, was overshadowed by my focus on the prescribing process, and therefore, on reflection, I realised that there was a degree of dissatisfaction, in that I could feel that I was finding it more difficult to focus on his psychological and emotional needs because of the prescribing role.

Evaluation (What was good and bad about the experience)

The positives of this experience relate to the ability to apply the principles of the NICE Guidance (NICE, 2006), whilst at the same time being able to provide continuity of care, quality of care, and holistic nursing care to an individual based on his own needs and reactions. While I became aware of the way in which the process of diagnosis and prescription started to eclipse the more holistic and humanistic elements of my nursing care for this patient, I did identify this and so was able to redress this during the consultations and to develop a more holistic approach. Thus, identifying my own feelings allowed me to take immediate action and to spend time with the patient discussing the impact of the diagnosis and his own feelings, particularly in relation to his social life and family life. As an active individual, he was concerned about the impact on his lifestyle, and the NICE guidance (NICE, 2006) does suggest that lifestyle advice should be provided at appropriate moments during care, so it was also good to be able to both meet the individual needs of the client and ensure I was taking the optimal approach to his monitoring, treatment, support and health education.

Analysis (What sense can you make of the situation)

The literature suggests that decision making in nursing is focused on optimal treatment and management for the best possible outcomes, and the first stage of this is assessing and observing all features of the patient, ie their condition, clinical signs and symptoms, and their holistic state of being (Hedberg and Satterlund, 2003). In this case, the decision making process began with the assessment of the blood pressure measurements, and these were the first indication that there was a need to intervene, as the readings were above the diagnostic 'line' on more than two separate occasions (NICE, <https://assignbuster.com/ensuring-effectiveness-of-critical-reflection-with-reflection-models/>)

2006). Thus, I knew that I would need to intervene, and that there was a need to prescribe medication appropriate to the client's needs, within the guidelines set out locally (Latter and Courtenay, 2004). My competence in the diagnostic and prescribing processes was confirmed by my recognition of patient need and the ability to also carry out further tests, or refer the patient for further tests relating to their condition (Meretoja et al, 2004; Ashworth and Saxton, 1990). The NICE (2006) guidelines clearly state that in the absence of established cardiovascular disease, when raised blood pressure persists, they need further testing to identify cardiovascular risk, and further tests specifically in relation to diabetes and renal disease, due to the connections between these two chronic conditions and hypertension.

A key feature of this diagnostic process however was the intersection of advanced nursing competence in relation to diagnostic and prescribing practice, and general holistic nursing care principles, including person-centred care (Price, 2006). The management of the complex clinical knowledge required in a situation like this, and the more interpersonal and humanistic side of nursing practice, is almost second nature to many nurses, but I became conscious of it during this encounter, and it was an important learning point for me. Older clients have complex personal and social lives, and complex histories, and therefore it is important to see and understand them as individuals in the light of that complexity, rather than falling into the bad habit of reducing them to their signs, symptoms, and disease (Redfern and Ross, 2001). Thus it was possible to view the clinical decision making process from multiple angles: from the clinical and objective angle and from the holistic viewpoint (Harbison, 1991). Critical thinking processes were

involved, in assessing the need to take action, in assessing the patient as a person, and in assessing their self care ability and their ability to cope with this new medication regime and its likely effects, all part of ensuring that they are being monitored appropriately after the introduction of the anti-hypertensive medication (Department of Health, 2004).

It was also apparent that this was an appropriate time to discuss health promotion and lifestyle changes to improve patient health and wellbeing (Croghan, 2005), and taking a positive and patient centred approach, focusing on patient empowerment during the transition to acceptance of their condition (Funnell, 2004). Thus it is possible to see how the process of diagnosis and prescribing fits into the overall assessment and decision making processes of clinical nursing practice, in the context of an effectively developed nurse-patient relationship (Luker et al, 1998).

Conclusion (What else could you have done?)

On reflection, I could argue that there is always scope for improvement within nursing practice. Therefore, I could have perhaps considered earlier on in the process what the full implications of this diagnosis were. I did consult the NICE guidelines, the local guidelines, and worked within the rules laid down by the NMC, but perhaps I should have been considering the patient holistically first, and considered lifestyle factors and changes earlier on in the process (NICE, 2006). I could have also perhaps asked if he would like to bring his wife/primary carer with him to an appointment so I could have involved her, with his permission, in discussions of his condition, and in the explanation about his medication and its potential effects.

Action Plan (If it arose again, what would you do?)

If this occurred in the future, I would focus on the nurse patient relationship immediately, and would consider the holistic view more consciously earlier on in the diagnosis, assessment, and prescribing process. This might allow the patient to come to terms more effectively with their condition, and would also allow them to get carers involved if necessary. However, the adherence to the NICE guidelines is also something I would repeat in future, as this has provided a useful source for supporting practice, decision making, and prescribing.