

Reflective practice



**ASSIGN
BUSTER**

In this essay, I will reflect upon my practice placements and discuss my development in relation to professional/ethical practice, care delivery, care management and personal/professional development. These are the four domains related to the learning outcomes required by the Nursing and Midwifery Council (NMC, 2004) for entry in to the professional register. They are all concerned with promoting high standards of professional practice and good quality of patient's care. I will also reflect upon the Enquiry Based Learning (EBL) activities and discuss how these have contributed to my development in practice. I have changed all the names used in this essay for confidential reasons (NMC, 2004).

Nurses and other healthcare professionals are faced with challenging and unique situations in practice, by reflecting on these experiences it allows learning to take place and gain flexible ways in which to respond to these situations (Burns and Bulman, 2000). According to Whitehead and Mason (2003, reflection is the process of examining personal thoughts and actions while focusing on your-self interaction as an individual with colleagues and the environment to obtain a clearer picture of their own behaviour. They further describe it as a process within which a practitioner can think about and achieve a better knowledge of their practice. It is therefore a learning tool which provides a basis for changing practice through a systematic procedure that is logically constructed. Two different forms of reflection exist, reflection-on-action and reflection-in-action. Reflection-on-action means re-running and analysing events which have occurred in the past while reflection-in-action entails examining individual behaviour and that of others in situations which offer learning opportunities (Maslin-Prothero,

1997). Therefore, by writing and keeping a reflective journal, nurses can identify personal and professional growth to recognize their achievements (Ghaye and Lillyman, 2001).

EVIDENCE Professional/ethical practice Ethics is a code of principles governing correct behaviour and in the nursing profession; it includes behaviour towards clients, their families, visitors and colleagues (Fergusson et al, 1998). The professional and ethical obligations for nurses are set out in the new “ code of professional conduct: standards for conduct, performance and ethics” (NMC, 2004). NMC is the body that sets out regulations for registered Nurses and Midwives. The main purpose for these regulations is to inform the profession of the standard of conduct required of them, in terms of their professional accountability and practice (NMC, 2004). It is also to inform the public, other professions and employers, of the standard of conduct expected of a registered Nurse/Midwife (NMC, 2004). To achieve its aims and objectives, the NMC maintains a register of qualified Nurses and Midwives; sets out standard of Nursing and Midwifery education, practice and conduct. It also provides advice on a professional standard to Nurses/Midwives and considers allegation of misconducts or unfitness to practice due to ill health.

If a Nurse or Midwife acts against the code of conduct, he/she may have his/her names removed from the register (NMC, 2004). Care delivery Delivering care to various client groups across different care settings must be orientated towards practice which is responsive to their needs (Hinchcliff et al, 2003). It is reflected through the ability to assess needs, diagnose and plan, implement and evaluate care and empower clients and their carers to

participate actively. Care management This is the capacity to accept responsibilities for the efficient and effective management of care provided within a safe environment (Hinchliff et al, 2003). It involves being accountable in taking responsibilities to delegate aspects of care to other team members and to effectively facilitate/supervise their work. Both the nursing and other wider multidisciplinary team members should be involved in risk management which is the process of identifying risks that have adverse effects on the quality, safety and effectiveness of care delivered. They should also possess the ability to assess, evaluate and take positive actions to eliminate/reduce those risks (Hinchliff et al 2003).

I will follow Gibbs (1988) reflective cycle, which is an Iterative Model based upon the idea that awareness, increased knowledge and skilfulness arise from the clockwise 'movements around the reflective cycle' (Ghaye and Lillyman, 2001). Gibb's (1988) reflective model is a cyclical process with six stopping points from description of what happened, feelings of the individuals involved, valuation of the situation, analysis or making sense of what happened, conclusion to action plan and then back to description if needs be (Gibbs, 1988; Ghaye and Lillyman, 2001). I have maintained and developed a reflective journal during my clinical placement. The journal comprised of documented reflective accounts based on my own personal experiences which I have either learned from, feel I could have done better in, or times which I personally feel I have acted effectively in and improved on. To meet the requirement of this essay, the four areas of professional/ethical practice, care delivery, care management and personal/professional development will be discussed in a reflective format

and the learning experiences will be displayed using the example below.

REFLECTION ON LEARNING FROM PRACTICE EXPERIENCE. Description During my clinical placement, I joined Maureen, an Approved Social Worker (ASW) on a home visit to carry out an assessment of Jane, a 48year-old mother of four.

Jane was referred to the community mental health team (CMHT) for social needs' assessment by her Consultant Psychiatrist who had known her for over 2 years. She was receiving treatment for Agoraphobia (a morbid/abnormal fear of open/public places) and depression. I telephoned Jane to remind her of our visit before setting off. On arrival, Jane answered the door and we introduced ourselves before she allowed us in. She was very tearful with increased respiratory rates and pale in colour. She appeared very restless pacing all over the room and had difficulties in speaking at first. Maureen tried to find out what the problem was and she said; " I have got to do this... I have been lying about it all, I never told anyone the truth.....I was brought up by a lady who taught me to say nothing to no one.

I cannot take it any more, you have got to help me... you have got to get me out of here..... " Maureen led the interview with minimal interruption while I listened attentively. Jane expressed her self and we found out that she had been using crack cocaine, cannabis and diazepam (approximately 24-30 tablets a week) for a very long time. Jane said that ' all hell broke loose and her body and mind fell apart' when she completely stopped using all the substances 3 days before our visit. Jane developed both physical and psychological symptoms of increased anxiety, panic attacks, insomnia, nightmares, fears of going mad, tight chest and breathless feeling, " flu-like"

symptoms, nausea, diarrhoea, distorted vision, dizziness, shaking and ringing in the ears. She had no suicidal feelings or aggression but she described creeping sensation on her skin and increased sensitivity to light, sound and touch.

She lived with her boy-friend who also used and supplied the substances. None of her four children lived at home but two of her sons were said to be frequently in trouble with the police. She continuously begged to be taken out of her flat to get help. She was prescribed Venlafaxine 75mg three times a day which she was not using as she was taking other substances. Maureen attempted to contact Jane's general practitioner (GP) but the surgery was closed. She also phoned the Home Treatment Team to ask for their services but this was not successful as Jane did not meet the criteria. Eventually, I suggested that we could take Jane to Accident and Emergency (A&E) department where she would be checked up by the medical team as well as Liaison psychiatric services.

However, Maureen contacted the duty psychiatrist who advised her to change Jane's prescription of Venlafaxine to 75mg once a day. I told Maureen that according to my training, it was against the guidelines for administration of medicine to give/take prescription over the phone and that in case of any error or adverse reaction; we would be personally accountable regardless of the doctor's advice (NMC, 2004). Considering Jane's physical condition, we explained to her the need to attend A&E department. She expressed her fear of being judged by other people in the department but following our reassurance, she agreed. We accompanied Jane to the department where she was assessed by both teams. She was commenced on

Zopiclone medication and allowed to go home the following morning. We made a follow up visit the following afternoon and Jane had marked improvement in her physical symptoms.

Maureen asked if I was able to organise a GP's appointment for Jane and make a referral to the Community drug team which I did. Jane was started on a gradual reduction dose of diazepam to limit the severity of withdrawal symptoms and her care was then transferred to the Community Drug Team who offered her immediate appointment. Feelings On reflection of the situation, I felt that we acted in the best interests of Jane, to promote and safeguard her well-being. I felt puzzled and speechless at the beginning as Jane had no known record of substance misuse on her file. She was very restless and tearful as she struggled to speak. She appeared very distressed and was breathing very fast. Maureen remained very calm while she encouraged Jane to express her feelings.

It felt easier for me to remain silent and listen to Jane attentively as I had very limited knowledge of her difficulties. I also felt that the advice given to Maureen by the duty psychiatrist on phone to change the prescription of Venlafaxine was contrary to the NMC (2004) guides for administration of medicine. Any alteration/cancellation of a patient's medication must be signed for by the prescribing doctor. Evaluation Section (1. 4) of the NMC code of professional conduct requires nurses to have a duty of care to their patients and clients, who are entitled to receive safe and competent care (NMC, 2004; DOH, 1999). On reflection, our decision to take Jane to A&E was beneficial as she needed a careful check to exclude any physical conditions which represent a contraindication to the usual benzodiazepine regime.

These include liver disease (cirrhosis) and chronic airway diseases which may develop into respiratory failure.

Daily use of even therapeutic doses of benzodiazepines (such as diazepam) for longer than 4 weeks has been reported to result in physical dependence (Clayton and Stock, 2004). Jane reported to have been using diazepam including other substances like cocaine and cannabis for several years. Withdrawal syndrome occurred after she suddenly stopped the regular use. Healthcare professionals including qualified nurses, students and managers should be proactive to ensure that risk and quality management is their priority (DOH, 1999). This means that, we should be able to identify actual and potential risks to clients, their carers, others and ourselves to promote and maintain health and safety at all times (NMC, 2004). Jane was at risk of developing withdrawal seizure or fit as a result of “cold turkey”. Stopping all at once overwhelmed Jane with severe withdrawal symptoms and as the pain and distress was unbearable; Jane would have started taking diazepam again, which can result in a sense of failure, or a fear of going through withdrawal again.

Analysis Jane was very brave to seek help after so many failed attempts in the past. She thought that the information she had given us would be used to put her and her boyfriend in trouble. It is acknowledged that to trust another person with private and personal information about your-self is a significant matter. However according to the NMC (2004), if the person to whom the information is given to is a nurse, midwife, or a specialist community public health nurse, the patient or client has a right to believe that this information, given in confidence, will only be used for the purposes

for which it was given and not be released to others without his/her permission. In contrast, I explained to Jane that the information she gave us would only be used for the purpose of her treatment and would not be released to others without her permission (NMC, 2004). As part of the shared values for all health care professionals caring for patients and clients in the United Kingdom, all nurses must: “ respectthe patient or client as an individual obtain consent before giving any treatment or care,..... to maintain confidentiality of patient’s record... co-operate with others in the team,act to identify and minimise risk to patients and clients” (NMC, 2004). This requires nurses to work co-operatively within teams and to respect the skills, expertise and contributions of their colleagues.

My suggestion that Jane should be taken to A&E was valued by Maureen and this increased my confidence in inter-professional practice. Conclusion Risk factors in any situation, habit, environment or physiological conditions such as those experienced by Jane, increase the vulnerability of an individual to other illnesses. If Jane’s habit of substance use was uncovered earlier during assessment, she would have received some help before stopping the diazepam use abruptly. Rather, a gradual reduction of the dose would have been carried out to limit the severity of the withdrawal (Clayton and Stock, 2004). Action plan In future if I come across a similar situation, I would probably make the same decision to refer the patient to hospital where he/she would be clinically assessed by qualified professionals and an appropriate plan of care drawn. To maximise compliance, it is important that the rate of dose reduction is negotiated with the patient. The patient will

need to see a specialist at least once a week for supervision of the withdrawal.

This provides them with an opportunity to monitor the dose to the severity of any symptoms. Most of the patients will require observation as their withdrawal symptoms do not follow a linear reduction but tend to exhibit occasional peaks. I will also remember that where an aspect of care is beyond my competency, I will seek supervision to ensure safe and effective practice. I will try to work according to the guidelines laid down for any procedure. PROFESSIONAL/PERSONAL DEVELOPMENT, According to the NMC (2004), one must identify his/her own professional development needs through reflection. Since starting the Diploma in nursing, the key areas I feel I have developed greatly in include self awareness, assertiveness and communication. Communication is an important aspect of nursing, effective communication is central to providing sensitive and individualised care.

Patient centred care involves respect for and responsiveness to patient preferences, needs and values. Achieving patient centred care requires complete and effective communication between healthcare workers and patients (Riley, 2000). When I first begun my nurse training, I was a quiet person who did not communicate much with others. I found it difficult to mix with people I did not know and I was quite happy to sit on the side lines and allow everyone else to do the talking for me. However I feel that the lectures and experiences I have had through out the course of my training regarding communication were extremely helpful. This allowed me to see how I could improve within myself and strengthen my communication skills and the

important non-verbal communication. By reflecting on these lectures and paying more attention to how I portrayed myself, I discovered that I rarely made eye contact when speaking to people I did not know and I frequently stood with my arms folded.

According to Riley (2000) we disclose ourselves in many ways, through what we say and do. This includes facial expressions, gestures and other forms of non-verbal communication. Non-verbal communication does not involve words and is used unconsciously as we interact with other people (Riley, 2000). I learnt that my posture and standing with my arms folded could actually portray lack of interest in the other people (including clients) and to others; I may come across as hostile. Riley (2000) believes that if a non-verbal message contradicts a friendly verbal one most people will believe the non-verbal message. Eye contact is a powerful non-verbal cue used as a method of regulating the flow of conversations for example, looking at someone normally means we would like to start a conversation with them (Riley, 2000). I have realised that by not making eye contact with new people, I was probably halting any chances I could have had to acquaint myself with them.

However, I am now more aware and conscious of my non-verbal cues. I rarely stand with my arms folded and when speaking to people, I maintain eye-contact with them whether I know them or not. Riley (2000) argues that many of the unconscious judgements we make in regards to other people are based on the amount and type of eye-contact we make. In other words, communication is essential to our development as social beings. The ability to relate and communicate with others enables the development of either

short or long-term relationships (Miller, 2002). ENQUIRY BASED LEARNING (EBL): Through the use of enquiry based I have developed the following Intellectual skills; Demonstrate a commitment to continuing professional development and lifelong learning through the development of skills in relation to self directed and independent study; use problem solving skills and decision making strategies to support sound clinical judgement, use skills of reflection, evaluation and critical thinking to support the delivery of care to people with mental health and their families / carers. I use scenarios to develop an understanding of practice theory links and inter-professional learning, which I can apply in my professional role in the future and the wider context of Health and Social care.

I used a variety of learning methods such as lectures, student led seminars, small group work, skills based practice sessions, self directed studies including internet resources and through practice to promote the ethos of lifelong learning and take the responsibility for my own learning (Glenn and Wilkie, 2000). Summary The reflective learning has allowed me to enhance my personal learning, which has improved the way I will care for my patients in future and it has improved my confidence and ability to critically think and act while being self aware of the situation. More importantly, however, it reminded me to be more aware of patients' right to make a personal, informed choice about their nursing care and treatment. I know that failure to obtain informed choice and consent is a serious breach of conduct. NMC (2004: clause 1.) In conclusion therefore, through reflective practice, I have heightened my awareness and increased my understanding of the true essence and value of nursing. It has also contributed to my professional

development by helping me to recognise, understand and value my abilities, strengths, achievement and experiences.

It also created opportunities for me to identify areas for improvement and self-development. Reflective practice therefore, should involve thinking consciously and systematically about professional actions and experiences in order to learn from and maintain/improve high standard of practice (Hinchliff et al, 2003).