

# Critical analysis of gibbs reflective cycle



This is intended to be a critically reflective essay based around Gibbs reflective cycle (Gibbs 1992) on the ability to foster empowerment of myself and of the learner I worked with, to develop our skills and, through reflection, promote lifelong learning. Reflection is an active process that enables health care professionals gain a deeper understanding of their experiences (Conway 1996) and serves to extend our professionalism and develop our confidence in a bid to make sense of clinical experiences (Ghaye, Gillespie & Lillyman 2000).

It can aid us in our ability to resolve the contradictions between what is desirable and what is actual practice, making us more self aware and thus become empowered to respond differently in future situations (Johns 1995 & 2004). Fundamental to promoting learning and the increase in standards and quality this brings is the concept of empowerment. Mason (1991) suggested that empowerment includes enabling people to recognise their strengths, abilities and personal power. Nicklin & Kenworthy (2000) identified three elements to this concept, capability i. e.

the learner has the appropriate knowledge, skills and attitude to fulfil their role, confidence to be able to work unsupervised and have the confidence to innovate, and congruence i. e. for the learner to have commitment to and confidence of support within their area of work, being involved in future developments. Development of these skills and the subsequent increase in confidence and dedication to the work area, including wanting to continue to improve, promotes the concept of lifelong learning i. e. continuing to acquire knowledge and skill lasting much or all of ones life.

This can be through academic study, by self managed learning such as reading journals, outside interests e. g. hobbies and experiential learning both through work and life experiences.

This concept affects not only our work environment, giving job satisfaction, but can facilitate self improvement both personally and professionally. I had undertaken this course to increase my knowledge and improve my skills as a mentor to other colleagues. I knew I had the ability to act as a preceptor to others as I possessed the desire to encourage others to learn, and was prepared to support them (NMC 2002), but lacked some confidence in how to deliver and pass on skills I had. I also felt that sometimes my own lack of confidence prevented me developing further skills and was a barrier to my own lifelong learning.

The learner I worked with (RM) is a care assistant I had worked alongside for three years. She too lacked confidence both in her own ability as a care assistant, and also in her life skills. She was very reluctant to undertake study because of this lack of confidence and I felt I could empathise with this. Cahill (1996) states that the single most crucial factor in creating a positive learning environment is the relationship between teacher and learner, RM and I had always got on well and I knew she saw me as a positive role model as we had previously spoken of this, and whilst I was aware of the responsibility this role brings, I also knew that being positive in my attitude, and willing to learn from my own mistakes, was more important than being perfect.

Welsh & Swan (2002) stated that by developing a trusting relationship, mentors can become more aware of the intrinsic factors affecting the motivation of the learner. The more comfortable and safe a learner feels within the environment, the more likely it is that effective learning will take place and the learner will become a motivator for learning (Kenworthy & Nicklin 2000). Within my work area we regularly have student nurse placements and our aim is to make it a positive learning environment. Quinn (2000) identified that qualified staff are a key factor influencing the learning environment. I believe that highly skilled well motivated permanent staff, whether formally qualified or not, are key to achieving this and RM found it hard to be a part of the learner's experience because of her lack of confidence. I wanted to facilitate a change in her beliefs about what she could achieve, and I felt that if met, this would benefit both her and the work environment and therefore any student nurses' placement experience. Obviously, by choosing a care assistant rather than a student nurse there are some differences in what she needs to achieve i.

e. that she has no formal placement objectives, but she had her own objectives she wanted to meet. Kenworthy & Nicklin (2000) describe the well known needs satisfaction theory of human motivation by Maslow. Maslow identifies a hierarchy of human needs, physiological, safety, love and belongingness, self esteem and eventual self actualisation, and the satisfaction of these needs. He suggested that as lower level needs are fulfilled, that there will be a drive to satisfy higher level needs. During a shift we worked together RM mentioned that she felt she needed to learn more about taking someone's blood pressure, and we identified this as a

learning need. As a result of this chat we agreed to make this a formal relationship with RM as learner and me acting as her mentor. According to the English National Board (ENB) (2001) the term mentor is used to denote the role of the nurse who facilitates learning and supervises and assesses learners in the practice setting.

The Nursing & Midwifery council (NMC) (2004) identifies eight mandatory standards that must be achieved to become a mentor. These are; communication and working relationships, facilitation of learning, assessment, role modelling, creating an environment for learning, improving practice, knowledge base and course development. Within the standard for communication and working relationships, the provision of ongoing support for learners has been identified (NMC 2004), and support skills are seen as essential in wanting to provide high quality clinical education to the nurses of tomorrow (Davison 2005), which care assistants potentially are. Morton-Cooper & Palmer (2000) identified that a good mentoring relationship occurred when the two parties were drawn together naturally by their personal characteristics, attributes and common values.

They demonstrate a willingness to spend time together, to learn from each other and to share experiences. RM and I had already been through this process, and having achieved this I now needed to undertake a process to ensure I was going to offer the best package of learning to RM in order for her to achieve. Firstly, I had to look at the learning environment.

A positive learning environment depends on many factors e. g. the allocation of resources, access to relevant equipment, appropriate study areas and

time. In reality the perfect learning environment is hard to achieve, but through analysis, improvements to the current environment could perhaps be achieved. To identify this I undertook a SWOT (strengths, weaknesses, opportunities and threats) Analysis as recommended by Welsh & Swan (2002) and formulated an action plan to address those factors over which I had influence. Within my area I identified that although there was suitable time for learners to study, they often felt guilty accessing this time when their colleagues who were choosing not to study at that time were undertaking other daily tasks. There was also no internet access available within the work setting. The plan of action was to publically specify times when anyone undertaking any type of learning was able to do so, and that this was formally recognised as appropriate work to benefit the work environment.

If the learner still felt unable to utilise this time and chose to start or finish a shift earlier or later than required in order to study it was agreed that this would be paid as extra hours. I felt that the extra financial cost would be outweighed by the ultimate benefits for the work environment. I was unable to solve the problem of no internet access completely, but agreed to provide a lap top that could connect to dial up under agreed times and that should the learner require particular information from the web, this would be accessed for them within 24 hours. My next consideration was to assess RM??™s educational needs, be aware of her preferred learning style and the required learning outcomes in order to ensure effective learning (Quinn 2000). My teaching method had to be suitable to her needs. Reece & Walker (2003) argue there is much written about the way people learn and

numerous theories on the way to teach people effectively. They offer five main schools of thought, namely, Behaviourism, Neo Behaviourism, Gestalt, Cognitive Development and Humanists. Behaviourism is concerned with the notion that we learn by receiving stimulus that instigates a response (Reece & Walker 2003).

The main element of this theory that could be applied to RM is that of conditioning and reinforcing, which involves the rewarding of behaviour that is considered positive e. g. giving positive feedback if RM performs a practical task such as taking a blood pressure.

This would increase her confidence in not only succeeding in the task, but in the way in which she approaches her next client. The Gestalt theory on the other hand, looks at the value of viewing the learning situation as a whole picture, rather than concentrating on one part (Reece & Walker 2003). It is often called the insight method of learning, for it presents the situation as a whole and leads the person to find the solution from the elements presented (Walkin 1990). In practice this method would be utilised by allowing RM to handle the blood pressure machine and become familiar and comfortable with it. This could help any learner gain self assurance for self directed learning. The cognitivists theorise that the learning experience is more holistic in nature, whereby the learning experience is more than learning something but reflecting on its relevance and learning from this process (Reece & Walker 2003).

The benefit of this type of learning is that it takes advantage of the learner's quest for knowledge, which has a personal significance. The humanistic

approach is perhaps the most holistic as it takes into account the motivation and drive of the individual to learn and encompasses Maslow's (1975) hierarchy of needs. This theory depends on the overall influence of the environment, which may aid or hinder the learning process (Reece & Walker 2003).

Considering this theory, I feel I have acted as facilitator within the learning process to encourage and assist the education process of RM. This will hopefully assist the achievement of self-actualisation and fulfil the maximum potential for growth which, in turn, would lead to whatever had been learnt being remembered, utilised and valued. Because of the different number of learning theories and models regarding teaching practical skills I found it hard to decide which one would be the best. Based on what RM had told me she wanted to learn, I decided on utilising the neobehaviourism theory, which consists of sequential stages, founded upon prerequisite abilities or intellectual skills (Gagne 1983), which I felt was appropriate to a practical setting, with some drawing from the Gestalt theory i. e. the whole is greater than the sum of its parts (Atherton 2002) and taking a blood pressure entailed more than just operating the equipment.

Initially, I felt an androgogical approach i. e. teacher and learner having an equal relationship with the learner accepting responsibility for their own learning (Knowles 1994) was the most appropriate. Further discussion with RM however, suggested that due to her lack of confidence she would prefer a pedagogical approach, where emphasis is placed on the teacher and the learner assuming a passive role (Knowles 1994). I agreed to this, but hoped I could perhaps utilise both styles and use this to prove her abilities to her



through feedback. Having done it informally through discussion RM and I drew up a formal learning contract (APPENDIX 1). This is a document used to assist in the planning of a learning project, and is a written agreement negotiated between the learner and the mentor in which learning needs are identified (Lowry 1997).

As this was RM??™s first experience of this it was important for me to support her. Twentyman et al (2006) discuss assisted learning where the mentor asks the student to identify their goals and aim to secure learning opportunities that support the achievement. Learning contracts acknowledge individual differences, allowing the learners specific needs and interests to be targeted, this makes the subject more meaningful, relevant and interesting (Smith 1983).

The fact that RM had involvement in development of the learning contract gave me the chance to start to prove to her that she was already starting to take responsibility for her own learning. This was likely to encourage her to analyse and reflect on her learning more so than having an assignment imposed onto her. After agreeing a mutual appropriate date and time for the session to take place, I set about developing the teaching session. The United Kingdom Central Council (UKCC 1999) in Fitness for Practice report identifies that for students to learn in practice will depend upon well planned learning opportunities created by the mentor. Nursing procedures involve much more than merely motor skills. To be proficient in a skill, its underpinning theory must be understood, the skill then practiced, and then applied to various situations in order for it to become automatic (Quinn 1997). I planned and designed my teaching on Fitts & Posner??™s model of <https://assignbuster.com/critical-analysis-of-gibbs-reflective-cycle/>

skill acquisition (1967) as a framework, as it specifically focused on learning on motor skills. I knew complete proficiency could not be accomplished within a short teaching session but would be perfected over time; therefore I focused on the cognitive phase concerned with learning the procedure.

I knew what the learning objectives needed to be as we had drawn up a learning contract, I devised a short questionnaire (APPENDIX 2) based on the session for RM to complete at the end as a tool for assessing what had been learnt, and produced a set of notes (APPENDIX 3) detailing the session for RM to take away with her and a feedback form (APPENDIX 4). Finally, I ensured that RM and I had a quiet area available where the session could take place uninterrupted which is essential to promoting quality (Higgs & Edwards 1999), and at RM's request this was a one to one session. Before carrying out the teaching I felt extremely self conscious and nervous. This was eased slightly by the fact I new and liked RM, and the fact that she was feeling as anxious as I was. Rogers (1983) says that when the perceived threat to the self is low, learning can proceed.

I based my teaching mainly on the first phase of the Fitts & Posner model, the cognitive phase. Prior to starting the session I gave RM the questionnaire to look at based on the session we were about to undertake. I did not ask her to complete it, but wanted her to have a base on which we could assess how much she had learned. After explaining the aims and objectives of the session, I developed this by discussing the rationale of taking and interpreting blood pressure. This was done to help RM develop her knowledge about the theory underpinning the skill and not just taking a blood pressure in isolation. This was reinforced by demonstrating with actual

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equipment, to highlight the psychomotor skills needed in order to initiate the procedure. Before moving on to the final phase of the teaching I talked about skills needed to monitor this procedure such as trouble shooting, risks and documentation.

The teaching concluded by touching on the associative phase which is characterised by repetition and practice. To put this part of the model into practice RM experimented with the equipment and practiced taking my blood pressure until she felt comfortable with the procedure. The session concluded with RM completing the questionnaire I had shown her at the start and feedback from myself and RM. I found the feedback that RM gave me was positive, although she found some of the terminology used too technical which made her anxious, although they were essential to the subject. I had attempted to give positive yet constructive feedback to RM as this is influential on anxiety levels and future motivation (Cooke 1996).

It was interesting to be able to highlight to RM how confident and capable she was when dealing with client's feelings and personal needs and her weakness was understanding the technical terms, which over time and practice could become second nature. She had never knowingly reflected on her own practice before and was pleased to realise she had skills she had been unaware of. I was pleased when she said she would take home the session notes I had prepared for her to read at leisure and learn the technical terms.

She also asked if she could undertake the blood pressure readings for several clients that had been planned as routine screening for that

afternoon, under the supervision of the nurse in charge, a thing she had never wanted to do before. Having concluded the teaching I then needed to reflect on the session myself to assess if I felt I had achieved what had been agreed in the learning contract, i. e.

assess the quality of the session. There are two forms of quality, objective and subjective. Objective quality is the degree of compliance of a processor its outcome with a predetermined set of criteria, and subjective quality is the level of perceived value reported by the person who benefits from a process or its outcomes (Gibbs 1992). Quality is a hard principal to define, but I felt I had included all the necessary components needed to achieve quality i. e. learning contract, method of assessment in the form of a questionnaire, feedback form and supporting documentation relating to the session for RM to take away. On reflection however, I realised I had perhaps been too simplistic when drawing up the learning contract and that the goals were not specific enough. Quality implies fitness for use (Juran 1998) and conformance to requirements (Crosby 1979) and is a measure of excellence, but I had not encouraged RM to include specifics, just a general ??? to learn more about blood pressure???

On reflection the outcomes were not easily measurable and in future I would change my learning contract to make it more specific and therefore measurable. Clear, shared and realistic goals are the cornerstone of focused and useful assessment practice. I knew when I first started this teaching session and indeed this whole course that I found it difficult to recognise different learning styles and the best one to utilise. I think I chose the correct one for RM, but had not appreciated her struggle with technical terms.

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Although I knew they were essential to the session, on reflection, I worried that this had spoiled some of RM??™s enjoyment of the session and therefore what she had gained from it.

I am not sure how I could have overcome this, but following the SWOT principles, I have resolved to reread and learn this area of the course to become more aware, knowledgeable and therefore confident in which style to utilise in the future. I also realised that improvement is best fostered when assessment entails a linked series of activities undertaken over time (Zamorano 2007). To some extent this had been achieved by RM wanting to undertake blood pressure checks under supervision following her session. On reflection however, I realised that I should have booked a follow up session with RM to go over what we had discussed, including going over the questions on the quiz sheet in an informal way, observe her practice, and answer any further questions that may have arisen as a result of her new knowledge.

I did in fact arrange this with RM and it was very useful to both of us, so in future I would incorporate this as a matter of course. During the course of this session which was about two weeks after our initial session RM confirmed that she had been able to answer a question posed to her by a student nurse on placement, albeit on a different, non technical subject, without feeling as much anxiety as usual and she stated she wanted to continue to increase her knowledge and eventually be able to act a mentor herself in future student placements. I felt this gave me proof that some of my desire to promote RM??™s self belief and desire to promote learning had been achieved. She has since asked to commence an NVQ in care. Using a <https://assignbuster.com/critical-analysis-of-gibbs-reflective-cycle/>

reflective cycle such as Gibbs (1988) I realise I learnt retrospectively, and identified learning and opportunities I had not expected when I started. The importance of the mentor's role in teaching and assessing practice cannot be over emphasised. The knowledge and experience of those involved in assessment in practice is essential in ensuring fitness for practice (UKCC 1999) and maintaining the mandatory standards as set out in the Standards for Mentors and Mentorship (NMC 2004). In the real world assessment can be ad hoc and opportunistic, but in order for it to be effective, certain criteria i.

e. validity and reliability must be met. The concepts of validity and reliability themselves can be open to different interpretation and subjectivity, but as a general rule, validity must be seen to measure what it is intended to measure (Quinn 2000), for example through direct observation. Knowledge of the learners stage of understanding will help facilitate assessment and the use of a taxonomy structure, for example Benner's (2001) Novice to Expert framework, will help in identifying different stages in the learning process. There are five levels to the taxonomy; novice, beginner, competent, proficient and expert and learners can be at different levels in different areas. The teaching session with RM has a degree of validity in that she was seen to be undertaking a clinical task correctly i.

e. taking a blood pressure, progressing from novice to beginner and working towards competent, and through a questionnaire to test her theoretical knowledge. Reliability refers to the consistency of measurement. The assessment should be objective, valid and reliable, but there is a certain amount of professional judgement and subjectivity (Quinn 2000). It is difficult

to give negative feedback, and in RM??™s case I was aware that negativity could lead to further destruction of her confidence.

I did however have a professional responsibility to ensure her practice was sound to ensure client safety. She was aware of her shortcomings in finding technical terminology difficult, and pointed this out for herself. This enabled me to concentrate on the positive aspects of the learning such as her efficient technique and sensitive understanding of clients needs. The fact that she was pointing out things for herself also enabled me to highlight the use of the androgical approach to teaching that she had been so scared of and sure she could not cope with.

In conclusion I feel that I have fulfilled the role of assessor and acted as a good mentor. I would justify this by the fact that RM can demonstrate a clinical skill she did not possess before, with some underlying theory. More importantly, I feel she has proved to herself that she has skills she was unaware of and this has led to an increase in confidence and a desire to continue learning. I identified not only what RM could achieve, but what she is now ready to achieve (Torrance & Pryor 1998). There were flaws in my practice, but I feel that the ability to recognise these and a desire to improve and develop can only strengthen my role. It is important to remember that the teacher can always be taught, that as a practitioner I have professional responsibilities and accountability and must protect the interests of my clients, learners, colleagues and myself. Through this course I have developed as a practitioner, which in turn will now allow me to help others to develop, hopefully as an ongoing, continually developing process.

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