

# Reflection | percutaneous endoscopic gastrostomy (peg)



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This reflective essay describes my experience in achieving my learning outcomes pertaining to care of percutaneous endoscopic gastrostomy (PEG), giving feed through PEG and administration of medicines through PEG that I have taken as part of the Overseas Nurse Program. It flows as a reflective practise as it incorporates the concept of learning. According to Bolton (2010) reflective practise involves utilising practical values and theories which influence everyday actions, by examining contemplatively and unreceptively geared towards developmental insight. Therefore, experience only does not lead to learning but deliberate reflection on the experience is essential.

Consequently, to further discourse my understanding and involvement with this concept, I have adapted on a certain framework of reflection. I have chosen David Schon's Model of Reflective Practise to reflect on my experience. I directed this framework on my experience because it enables me to recapture the events in a manner where learning occurs during the process of experiencing handling patients with PEG, gaining insights from them with the application of the theories and concepts I know and building new perspectives and understanding of doing things in relation to PEG. Schon's model (1983) is focused on two major concepts, reflection-in-action and reflection-on-action. In the reflection-in action activity, reflection happens while in the act of doing the task (cited by Killion and Todnem, 1991). Reflecting-in-action requires me to think on my feet, be able to work instinctively by drawing on similar experiences to solve problems or make necessary decisions. It involved looking to my experiences, connecting with my feelings, and attending to the theories and principles in use. It entailed

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building new understandings to inform my actions in the situations that were unfolding. Whereas in reflection-on-action, it requires looking back on what one has accomplished and reviewing the actions, thoughts, and product (cited by Killion and Todnem, 1991).

As I am working in the medical unit, I was assigned together with my mentor in one of the patients in the unit who has percutaneous endoscopic gastrostomy (PEG) surgically clasped on her abdominal area. As we entered the room to do PEG care, specifically changing the PEG dressing on a new one I was confronted with a different practise from what I used to do back in my home country. She told me that in United Kingdom normal saline is used to cleanse the PEG site instead of antiseptic solution. And now this is where the reflection-in-action came into play. Instead of insisting what I think was the best practise for me (using antiseptic solution for disinfection), I stood up and followed what my mentor told me believing that what she knows is within the standard of practice within United Kingdom. When I tried to engage myself in performing changing the PEG dressing, I tried to think on my feet and did the principle of disinfection using normal saline. I needed to reflect to ensure that this will not happen again.

In another incident where reflection-in-action occurred that became my second learning outcome happened when we have to give a feed through PEG. All the while I was expecting an asepto syringe to be used to deliver the feed to the patient but to my surprise my mentor got this special set attached on what she called a Kangaroo pump to deliver the feed at a desired rate and paced time (at that time for 12 hours). It was my first time to encounter this method of administering a PEG feed to a patient. What I did  
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was to stand back and observe how my mentor did all the attachments from the Kangaroo pump up to the PEG tube, but rather than just standing I offered my mentor if she can supervise me on how to enter the transcript (total volume, rate and running hours) on the pump which she gladly did to me. I was really surprised with the whole process and needed a reflection to establish my competence with this new process of giving PEG feed to patients.

In the last incident that happened that became my third learning outcome transpired during administering medicines via PEG. I was caught off guard with regards to the preparation of medicines to be given to the same patient who got a PEG. We are giving an Aspirin dose for this patient and all we've got in the medicines cupboard is an enteric-coated form of this medication. Knowing that enteric-coated tablets should not be crushed when administered, I immediately asked my mentor if we can request to the pharmacy an effervescent form of Aspirin. And that's where reflection-in-action occurred wherein I have to think of a solution on how not to breach the standards of safe medicines administration in the United Kingdom. Instead of crushing and giving it to the patient, I asked my mentor about an alternative solution to address our needs for the medicines administration. In that way I was able to think on my feet and learned something out of the experience.

According to Schon's model what I felt when those incidents happened was part of the learning process. Schon (1983) gives further information that the practitioner allows himself to be surprised, puzzle or confused in a certain situation which is unique or uncertain to him. He reflects on the event before <https://assignbuster.com/reflection-percutaneous-endoscopic-gastrostomy-peg/>

him, and on the prior considerations which have been imbedded in his attitude. He conducts an experiment which allows him to formulate both a new understanding of the situation and a change in the situation. After all the incidents that transpired during my clinical placement in relation to my three learning outcomes, I have done a reflection-on-action in every learning outcome that I have identified. I made researches on them and took my time to recall the series of events that transpired and based the lapses I made on evidences I have come across during my reflection process. In this way, reflection-on-action was evident.

On the first learning outcome, I have observed a different practise back in my home country cleansing the PEG site. We use chlorhexidine in cleansing the PEG site instead of just plain normal saline but after finding evidences about which is safe and efficient in usage, I was fully convinced that normal saline has a better concept ground than chlorhexidine. Sibbald et al (2000) emphasises that although chlorhexidine has been identified as less harmful to tissues and have effective antibacterial activity against both gram-negative and gram-positive bacteria causes damage to new tissues and should not come close to meninges and mucous membranes for it will cause permanent damage. This concept is applicable with my patient as there is an open mucous membrane where the PEG was inserted and exposure to chlorhexidine would increase the risk of microbial invasion and growth, which may precede to sepsis. Furthermore, the work of Sibbald was strengthened by Edmonds et al (2004a) and Jacobson that physiological saline is a widely recommended in irrigating and wound dressing solution since it is found to be compatible with human tissue. Thus, the practice of using normal saline in

cleansing the PEG site was evidence-based practice and I have fully get an excellent grasp of why normal saline is used for PEG care. In this way, I am ensuring patient safety and embracing better understanding of evidence-based practise.

On the second learning outcome, I have also witnessed a different way of giving PEG feed to our patients in our home country. We have bolus tube feeding rather than continuous tube feeding using a Kangaroo pump. Aside from observing each time a PEG feed will be given to the patient during my clinical placement, I also did researches on the efficacy of continuous feeding via pump and differences of using a pump from bolus feeding. I have done this in order to develop my competency in using the Kangaroo pump and giving continuous PEG feed to patients. Abbott Laboratories NZ Ltd (2011) gives further information that pumps continue to use microprocessors that allow the delivery of controlled enteral feeding. Its array of flow rate selection gives incremental increases in delivery which is very essential in critical care settings where low infusion rates are vital in maintaining the integrity of the gut and where maximising the feeding volume are fairly balanced. On the contrary, Bankhead et (2009) matched that gravity feeding is considered as the first-line delivery of enteral feeding in some countries but the Dieticians Association of Australia (2011) slashed the idea of Bankhead et al and proved that the usage of enteral feed pumps is now known as the most accurate way of enteral feeding provision across all healthcare settings and patients. Also, I have found out that using Kangaroo pumps instead of asepto syringe in delivering feed to patients lessen complications associated with giving feed to patients via abdominal ostomy

tube. Niv et al (2009) found out that established benefits have been shown to prevent aspiration in critically ill patients. Furthermore, the jejunum produces fluid in conjunction to hyperosmolar solutions, and rapid delivery of a hyperosmolar formula will lead in hyperperistalsis, diarrhoea and abdominal distention. Thus, a more controlled delivery to the intestine via continuous pump infusions can lessen or prevent these symptoms.

On my third learning outcome, medicines administration via PEG has many aspects but the one that got me on my feet was about my competency in giving the right drug, specifically its form and preparation. According to Nursing and Midwifery Council (2008) 'As a Registered Nurse or Midwife you are accountable for your actions and omissions. In administering medication you should think through issues and apply your professional expertise and judgment in the best interests of patients.' As I have recalled what I did when the incident happened wherein I immediately asked my mentor if we can request to the pharmacy an effervescent form of Aspirin since enteric-coated tablets should not be crushed when administered, I considered the best interest of the patient. As a professional nurse I have a duty of care to my patients in ensuring their safety under the sphere of my care. I need to follow what is appropriate and right for the patient. Also, my mentor was able to practise within the scope of her practise as she was able to directly supervise me in everything that I did with the patient. The Department of Health (2005) stressed that as a Registered Nurse you have a duty of care and are professionally and legally accountable for the care you provide. In line with the administration of the appropriate form of medications to be given to the patient, the Nursing and Midwifery Council (2008) has

developed protocols for medicine management on the area of tablet crushing. It stipulates in the policy that nurses should not crush any medicines or break capsules that are not specifically indicated for that purpose and by so will alter the chemical properties of the medicine. Thus, as I have reflected with what I and my mentor have done is fitting and legally right.

The reflection-on-action that happened to me on the three learning outcomes gave me the opportunity to evaluate my competency and efficiency as an overseas nurse on adaptation program. Prior to my reflection, I have never realised how crucial it is to do PEG care, administering medicines through PEG and giving feed through PEG until I experienced the three incidents that changed of how I do and view things in the clinical field. According to Schon (1983) when a practitioner becomes aware of a situation he sees to be unique, he perceives it as something already found in his range. The familiar situation acts as a standard for the unfamiliar one.

With regards to strengths and areas of development, I believe I was able to achieve a certain level of competency in carrying out procedures related to PEG. The learning outcomes I and my mentor identified have helped me to improve myself in terms of skills, knowledge and attitude. After the reflection process happened, I was able to build my confidence in performing procedures related to PEG. I also need to be at ease with operating the Kangaroo pump although I was able to familiarise myself with the process of hooking the PEG feed on the pump and setting the rate and dosing of the feed in the equipment. It was complicated at first but after the reflection

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process and supervision of my mentor, I was able to get through and learned operating the pump appropriately. Medication administration through PEG has provided me with new perspectives on how to establish a process in checking the medicines to be given and how critical thinking will help me in my decision-making and if I was able to observe the six rights of medication administration.

As a future plan, I need to project competency, professionalism and efficiency in everything that I do be it with the patients or other allied healthcare workers who are part of the organization. It is essential for me to maintain the standards of my profession as it will mould me into a competent registered nurse of United Kingdom. Nursing and Midwifery Council (2010) highlighted that ' All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights. They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks.'

In a nutshell, reflective practice became the backbone of my learning outcomes in relation to PEG. It provided me with basis in which area needs to be improved and enhanced. Reflection-in-action and reflection-on-action are learning processes that guided me to evaluate my decisions before and after the incidents happened. These incidents gave birth to learning and turned to acquisition of new knowledge and concept that became an enriching experience for me.