Reflecting on ones practice nursing essay

Striving to become better at what one does entails reflecting on both the positive things that one has achieved and the mistakes committed in the process of performing one's duties and responsibilities. Reflective practice focuses on the learning that has evolved and correcting what has been done wrong. This essay assesses my professional, clinical development through an analytical reflection from a patient seen in the Emergency Care Centre (ECC), as part of the holistic health assessment module. The assessment model used in the consultation will be examined, together with theoretical and evidence based practice, and how this has helped developed my approach, linking decision-making and best practice outcomes.

Following Gibbs' (1988) model of reflection, I shall establish the integration between theory and practice. This model identified six stages involved in reflective practice where at each stage the I would ask myself a number of questions leading to the final stage of an action plan. It begins with selecting a critical incident to reflect upon followed by keen observing and describing of the incident, then analyzing my experience. This is followed by interpreting the experience and exploring alternatives leading up to an action plan. This is is a cyclical process which enables continual retrospective reflection.

II. Reflective Practice

Reflective practice has been a key underpinning of qualified nurses since the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1992) required them to keep a professional portfolio. As professionals, we are accountable for our ongoing learning and self

development, providing the best care to our patients. To ensure this, we need to focus on our actions and skills to be able to meet the demands of patients, colleagues and professional bodies. In order to be reflective practitioners, we need to be reflective thinkers. “ Reflective thinking is thinking that is aware of its own assumptions and implications as well as being conscious of the reasons and evidence that support the conclusion” (Lipman, 2003, p. 26). John Dewey defined reflective thinking as “ an active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends” (cited in Martin, 1995, p. 167). Reflective thinking leads one to be more self-aware so he can develop new knowledge about professional practice.

Reflective practice has been recognised to be an important tool for professional development. Rowls and Swick (2000) agree and observed that practitioners who regularly reflected enabled them to develop their skills and the way they deal with patients. Schunk and Zimmerman (1998) describe how a self- reflective practice allows us to monitor, evaluate and adjust our performance during learning. Adjusting strategies based on assessment on our learning helps to achieve the goal of learning and identifying the activities well suited to our situations (Schunk & Zimmerman, 1998). However, practitioners often found the process quite time consuming and there was a greater fear of becoming introspective or being critical of oneself too much in practice. It is likely that one can be too engrossed in his reflection that he gets to neglect the delivery of a great work performance.

Schon’s theory outlines two different types of reflection that occur at different time phases: reflection on action (Schon 1983) and reflection in action (Schon 1983). ‘ Reflection in action’ is often referred to the colloquial phrase as ‘ thinking on your feet’ a term used to being able to assess ourselves within a situation, making appropriate changes and still keeping a steady flow in the process. Reflection on action is when reflection occurs after the event. This is where the practitioner makes a deliberate and conscious attempt to act and reflect upon a situation and how it should be handled in the future (Loughran 1996). This means while performing a professional task, and one keeps thinking if what he is doing is right, he is doing reflection-on-action. After the task, he gets to evaluate what he has done right or wrong, and at that point, he is engaging in reflection-in-action. I am aware that I practice both kinds in my profession.

However , Fry, Ketteridge and Marshall (2003) seem to take a balanced view and define reflection to be an integration of existing knowledge and new knowledge. This implies that as a reflective practitioner, I should always evaluate if my current knowledge is still applicable, and in updating myself, should be able to incorporate my new learning with what I already know.

My Own Practice

I have been an Emergency Nurse Practitioner for the past 6 years. My task was mostly seeing patients in the emergency setting with minor injuries. I took this course to gain further knowledge and revise what needs to be improved in what I previously learnt during my 15 years as a nurse.

Basically, I assess patients with localized problems (i. e, sprained ankles, lacerations, painful joints, minor head injuries etc.). I found it very daunting having to deal with the person as a “ whole ” again and investigate multiple systems (respiratory, cardiac, muscular, etc). Having attended tutorials regarding the assessment of these systems using the inspection, palpation, percussion and auscultation (IPPA) methods, I was eager to practice what I have learned and felt ready to assess a patient.

Reflecting on One’s Practice

In the tradition of Gibbs’ (1988) reflective practice, the first step is concentrating on one particular example from my own work experience. One incident that is worth reflecting on was my encounter with a patient with left-sided chest pain. I immediately thought that the patient was suffering from cardiac chest pain, but upon further examination, I found out that the patient actually had a recent chest infection which was treated by a GP with antibiotics. The chest infection was resolved, but the patient was left with residual chest pain. It turns out that it was mild pleuritic chest pain after all.

In this incident, I initially felt confident in my diagnosis of cardiac chest pain due to my years of experience as an emergency nurse. Such vast experience exposed me to a variety of symptoms and its diagnosed illnesses. My confidence also came from having attended enough tutorials regarding the assessment of symptoms manifested by different body systems. Upon reading the patient’s notes, the symptom of left-sided chest pain immediately made me conclude that it was cardiac chest pain. I know that merely reading the patient’s notes is not enough in coming up with conclusive diagnosis. The clinical evaluation may include the basic

inspection, palpation (feeling with the hands), percussion (tapping with the fingers), and auscultation (listening) (IPPA) (The Free Dictionary, 2013); CURB 65, which is a simple well-validated tool for the assessment of severity in community acquired pneumonia (CAP) is another essential evaluative method in checking the presence of a deadly respiratory disease. The Ohio State University College of Medicine (2012) shares its guideline in the use of this approach. CURB is short for checking the patient's confusion, blood urea nitrogen, respiratory rate, and systolic blood pressure. If the patient seems to be delirious or confused, then he is given a score of 1 on the confusion item. If his blood urea nitrogen value is greater or equal to 20 mg/dL, then it also garners a score of 1. A respiratory rate that is more or equal to 30 breaths/minute is also credited for 1 point. The same is true for the systolic blood pressure if it is less than 90 mm Hg or a diastolic blood pressure less than or equal to 60. If the patient is 65 years old and above, then it also gains 1 point. Computing all the points, if the patient's score is 0 or 1, then he can safely be treated as an outpatient. However, a score of 2 may indicate that he needs closer supervision when receiving outpatient treatment, or he may be recommended for inpatient observation admission. Most of the time if the collated score of the patient is 3, 4 or 5, then this usually means the patient needs to be confined to inpatient treatment (Ohio State University College of Medicine, 2013). Clinical judgment of the professional is necessary for a decision to be made for the patient. (Karmakar & Wilsher, 2010).

Still another evaluative method in examining the patient is the Pulmonary Embolism rule-out Criteria (PERC) (Hugli et al., 2011). The thorough process

it entails determines if there is a potentially life-threatening cause of chest pain which may include “ pulmonary embolus, acute coronary syndrome, aortic dissection or tension penumothorax” (King et al., 2012, para. 3). If the patient’s chest pain becomes worse when he is applied deep inspiration and recumbency, then it is likely that it is due to a pleuritic cause.

With Gibbs’ reflection model, so far, the first three steps of identifying a critical incident, observing and describing of the incident have already been done. Now comes analyzing my experience. Triage notes stated a 57 year old female who was suffering from left sided chest pain. Observations were blood pressure ; 184/78, pulse ; 74, respiratory rate; 16, saturations on O2; 98%. I had decided to take this patient and perform an assessment on her.

The immediate thoughts were of cardiac chest pain as it was stated to be left sided in nature. Since starting the health assessment module the cardiac patient was the system I was least confident in, in the assessment process. I was anxious before seeing the patient. I had concluded that she was suffering from a cardiac chest pain, and imagined her to be requiring some form of intervention from the cardiac team. However, when meeting the patient and gaining further medical history it was clear that she was in fact a stable patient with a different complaint from my first impression.

She had recently been treated for a chest infection by her GP, she had undergone a course of anitbiotics, amoxicillin 500mg for 1 week, after which she had felt much better, but over the following week had been left with a residual left sided chest pain which was worse on deep inspiration. She had initially had an expectorating cough, which had now resolved to an

occasional dry cough. After a thorough assessment including IPPA, baseline observations, chest x ray, bloods including D Dimer, full blood count, U&E's, cardiac enzymes, and a Wells score to rule out PE, the patient was diagnosed with pleuritic chest pain or pleurisy by the Doctor. (see appendix 1)

Initially, I was uncomfortable evaluating the patient's condition because it was my first patient with a cardiac problem. Throughout the assessment process I felt uneasy with the knowledge that I had initially made a judgement about the patient without even meeting her. It made me revise my approach to patients as a whole and not jump to conclusions before all avenues had been investigated. I was humble enough to accept my mistake when it was confirmed that it was a mild pleuritic chest pain, garnering from the information from further examination and history taking. I felt the need to read up on cardiac chest pain and push myself into seeing patients with that particular problem so that I can overcome my apprehensions.

Next in Gibbs' model is the interpretation of my experience. The interpretation of the patient's condition from the initial triage notes made me aware of myself making a judgement before setting eyes on the patient. This concerned me and made me question my actions. I understood that I was nervous and uneasy at the thought of assessing a patient unaccompanied, and with hindsight put too much pressure on myself regarding responsibility and duty of care. I recognised the need for me to understand that I was gaining knowledge and skills as part of the degree module that I was completing, this didn't require me to diagnose the clinical conditions of the patients, but facilitated in the learning process of assessment skills and putting into place ideas of diagnosis / differential diagnosis. It also made me

reflect on my thought processes regarding making snap judgements without gaining further information.

The last stage in Gibb's model entails creating an action plan. The experience I have just analyzed made me realize that the current knowledge and experience I currently have are not enough. I need to learn to be more open in my evaluation of the patients' symptoms, and hold my judgment until I have completed the necessary information derived from both examination tests and consulting the medical history of the patient. The fast rate of change in the medical field necessitates health practitioners like me to constantly update myself of current trends and the latest methodologies in nursing care. I should also remind myself all the time that the patient's welfare comes way before my own ego in terms of priority.

Conclusion

Through reflective evaluation I was able to adjust the way I assessed patients with chest pain. I relaxed considerably more and let myself enjoy the assessment process. I was able to consolidate the new skills I had learnt and put in place a methodical process of evaluating differential diagnosis. I understood that the official diagnosis was going to be made by the Doctors mentoring my practice which considerably lessened the pressure I put on myself.

Through this reflective process it became evident that good and bad working practice can be monitored and evaluated. Mistakes can be avoided and good working practice can be upheld. Although the feelings initially were disheartening, support from colleagues and my own learning outcomes have

helped me progress and develop my skills of assessment. As Atkins and Murphy (2003) suggest that reflection should be made in times of uncomfortable feelings and thoughts surrounding a situation.