

Reflection has
become an important
concept in nursing
nursing essay



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Introduction

In recent years, reflection has undoubtedly become an important concept in nursing, stimulating debate and influencing nursing practice and education around the world. Much has been written about the theory of reflection, the majority of which has been applied to the educational setting (Price 2004). However, the process of reflecting has been described as a transferable skill which may be incorporated into clinical practice, enabling practitioners to better understand themselves and others, and solve problems (Mantzoukas & Jasper 2004). Indeed, the capability to reflect consciously upon one's professional practice is generally considered important for the development of education and, hence, for clinical expertise (Mamede & Schmidt 2004).

Reid (1993) defines reflection as ' a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice' (Reid 1993, p. 305). The nursing profession seems to advocate the need for nurses to be educated and practice in ways that develop their critical thinking, autonomy and sensitivity to others (Reed & Ground 1997). Bulman (2004) contends that reflective practice may provide a means of achieving this. Within an intensive care setting, some evidence exists to suggest a strong relationship between lived experience and learning, with most critical care practitioners learning from previous experience (Hendricks et al 1996). More recently, reflection has been closely associated with the concepts of critical thinking and deconstruction. It is argued that a combination of these principles create a retrospective and prospective dimension, giving the practitioner the ability to deconstruct events, to reason

the origins of situations, and to consider what has gone before and what may happen yet (Rolfe 2005).

In order to be effective in practice there is a requirement to be purposeful and goal directed. It is suggested therefore that reflection cannot just be concerned with understanding, but must also focus on locating practice within its' social structures, and on changing practice (Bolton 2001). This suggests that a structured approach to reflection is of benefit to the practitioner. Indeed the use of a model or framework of reflection is advocated as a tool which can aid and facilitate the practitioner in reflection, promoting a process of continuous development (Bulman 2004).

Reflection is seen as a dynamic process and not a static one (Duke 2004), and thus the use of a framework which adopts a cyclic approach to reflective practice seems appropriate. One such framework is Gibbs' (1988) Reflective Cycle, which is adapted from a framework of experiential learning, and uses a series of questions to guide, and provide structure for the practitioner when reflecting on an experience. Gibbs (1988) highlights 6 important areas of consideration when reflecting on a specific situation, encouraging the practitioner to consider what happened, why it happened and what could be done differently in the future. The 6 components of the Reflective Cycle are outlined below:

Description - What happened?

Feelings - What were you thinking and feeling?

Evaluation - What was good and bad about the situation?

Analysis – What sense can you make of the situation?

Conclusion – What else could you have done?

Action Plan – If the situation arose again, what would you do?

It is clear that the idea of reflective practice has come to have a considerable impact on the nursing profession. This paper will focus on 2 clinical scenarios occurring within an intensive care setting. The issues raised will be discussed within the context of Gibbs' (1988) Reflective Cycle. The aim in doing so is to highlight the benefits of a structured reflective process, and to identify ways in which clinical practice may be improved in the future.

Scenario 1

Description

The first scenario concerns the care of an elderly, critically ill patient, who was being treated in a surgical intensive care unit. At the time of this scenario the patient had been in intensive care for almost 3 weeks, having been admitted with respiratory failure requiring intubation, and displaying clinical symptoms consistent with sepsis. The patient had many other underlying medical problems, was morbidly obese, and despite antibiotic therapy was requiring high levels of inotropic and ventilatory support. Despite the patients' symptoms, no definite source of sepsis had been identified.

The above patient was being cared for by the author on a 12 hour day shift and at the morning ward round it was noted that the patients' condition had

deteriorated significantly over the previous 2 days, with increased inotrope dependence and worsening renal function. With few treatment options left to try, the consultant anaesthetist decided that the patient should have a CT scan to identify or rule out an abdominal problem as a source of the sepsis. The patient was reviewed by a consultant surgeon who felt that in view of the patients' co-morbidity, surgery of any kind would not be appropriate, despite potential positive findings on CT.

Knowing that a CT scan had been carried out 1 week previously with no significant findings, the author raised concerns about the benefit of such a procedure, and suggested that at the very least the patient's family should be informed or consulted about the planned investigation. The patient's son had been spoken to the previous day and informed that the prognosis was very poor. Withdrawal of treatment had been mentioned as a possibility in the event of no improvement in the patient's condition. The son however was not informed about the scan which went ahead the same day.

Transferring the patient to the radiology department for scan proved difficult. The patient was sedated for transfer resulting in a need for increased inotropes due to further hypotension caused by the sedation. The patients' large size also created a problem in finding an appropriate transfer trolley to take the patients' weight. Again the author voiced concerns, stating that perhaps transfer was inadvisable in view of the patients' unstable cardiovascular status. The anaesthetist decided that we should proceed with the scan.

The patient remained unstable throughout the transfer, requiring a further increase in inotropes on arrival at scan. Whilst on the CT table, the patient became dangerously hypotensive and bradycardic, and it seemed that cardiac arrest was imminent. Adrenaline boluses were administered, and large fluid boluses of gelofusine were also given. In view of this, the CT scan was abandoned midway, and the patient was quickly transferred back to ICU. Further adrenaline boluses were needed during transfer.

On arrival back to ICU, the author was met by the patient's son, who was not aware that the patient was being scanned. He was made aware of the patients' poor condition. Back in ICU it was decided that further resuscitation was not appropriate. The son was present when the patient died a few minutes later.

Feelings

On the day these events took place, the predominant thoughts and feelings of the author were ones of guilt and inadequacy. Having considered the multiple health problems faced by the patient at this time, the author felt that the process of transferring the patient to CT scan and carrying out the scan itself may cause the patient stress, discomfort and potential danger, and ultimately be of little or no benefit.

During the transfer and scanning process, the author became increasingly anxious about the immediate safety of the patient, and the potential for deterioration in the patients' condition. When the patient became dangerously bradycardic and hypotensive, the authors' thoughts were concentrated on trying to prevent cardiac arrest.

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On returning to ICU and meeting the patients' son, it seemed that neither the dignity of the patient or the concerns of the family had been respected. The author felt an inadequacy and felt that the interests of the patient had not been properly advocated. The patient passed away in a distressing and undignified manner, and the son did not have the opportunity to spend personal time with the patient prior to this happening. The author felt guilty, as it seemed that the CT scan should not have happened and that the undignified circumstances surrounding the patients' death need not have occurred.

Evaluation

Looking back on the events of scenario 1, it seems that there were both positive and negative aspects to the experience. During transfer to CT scan and the emergency situation which followed, the author felt that there was good teamwork between the different professionals involved in the care of the patient. Because of this, prompt action was taken, preventing cardiac arrest.

However, it seems that this situation may have been avoided, which in turn raises many questions relating to the care of the patient. Ethically, one must question how appropriate it was to scan a severely septic, unstable patient, especially when corrective treatments would have been inappropriate in the event of an abnormality being discovered. Should the author have advocated the interests of the patient and family more forcefully? Was there a lack of communication and consensus between the critical care team? The events of this incident culminated in a clinical emergency situation which led to the

patients' death. Thus, the author feels that the patients' clinical condition and the ethical issues and dilemmas surrounding the patients' care must be examined and discussed, in the hope that lessons can be learned through the reflective process.

Analysis

Sepsis

Most illness and death in patients in intensive care is caused by the consequences of sepsis and systemic inflammation. Indeed, sepsis affects 18 million people worldwide each year (Slade et al 2003), with severe sepsis remaining the highest cause of death in patients admitted to non-coronary intensive care units (Edbrooke et al 1999). Sepsis is a complex condition that results from an infectious process, and is the body's response to infection. It involves systemic inflammatory and cellular events that result in altered circulation and coagulation, endothelial dysfunction, and impaired tissue perfusion (Kleinpell 2004).

Dellinger et al (2004) define sepsis as the systemic response to infection manifested by 2 or more of the following:

High or low temperature ($> 38^{\circ}\text{C}$ or $<36^{\circ}\text{C}$)

Heart rate > 90 beats per minute

Respiratory rate > 20 breaths per minute or $\text{PaCO}_2 < 4.3\text{kPa}$

High or low white blood cell count ($> 12,000$ or $< 4,000$)

In severe sepsis impaired tissue perfusion along with micro vascular coagulation can lead to multiple organ system dysfunction, which is a major cause of sepsis-related mortality (Robson & Newell 2005). While all organs are prone to failure in sepsis, pulmonary, cardiovascular, and renal dysfunction occur most commonly (Hotchkiss & Karl 2003). When multiple organ system dysfunction occurs, Dolan (2003) promotes evidence-based sepsis treatment whereby patients should receive targeted organ support. This includes mechanical ventilation, renal replacement therapy, fluids, vasopressor or inotropic administration, and blood product administration, to maximize perfusion and oxygenation.

In recent years new therapies have emerged which have been shown, in some cases, to increase the chance of survival from severe sepsis. Recombinant human activated protein C has been shown to have anti-inflammatory, anti-thrombotic and pro-fibrinolytic properties (Dolan 2003). In a randomised controlled trial, Bernard et al (2001) found a significant reduction in the mortality of septic patients who had been treated with activated protein C. The National Institute for clinical excellence (2004) now recommends this treatment for adult patients who have severe sepsis resulting in multiple organ failure, and who are being provided with optimal ICU support. Steroids, the use of which in ICU has long been debated, have also been shown, in low doses, to reduce the risk of death in some patients in septic shock (Annane 2000).

Despite the development of specific treatments to interrupt or control the inflammatory and procoagulant process associated with sepsis, its management remains a major challenge in healthcare (Kleinpell 2004). The <https://assignbuster.com/reflection-has-become-an-important-concept-in-nursing-nursing-essay/>

patient in scenario 1 was clearly in a state of severe sepsis, with respiratory, cardiac and renal failure, and receiving some of the supportive treatments mentioned above. Indeed it seems that the severity of this condition should not have been underestimated. In view of this, the ethical issues surrounding the decision to take this patient to CT scan must now be considered.

Ethical Dilemmas and Consensus

Ethical issues have emerged in recent years as a major component of health care for critically ill patients (Friedman 2001). Thus, caring for these patients in an intensive care setting necessitates that difficult ethical problems must be faced and resolved (Fisher 2004). Traditionally, much of the literature in biomedical ethics comes from theoretical perspectives that include principled ethics, caring ethics and virtue ethics (Bunch 2002). Although these perspectives provide an ethical awareness, which can be helpful, they do not of necessity give much direction for clinical practice. Melia (2001) supports this notion, suggesting that many discussions of ethical issues in health care are presented from a moral philosophical viewpoint, which as a consequence leaves out the clinical and social context in which decisions are taken and carried through.

Beauchamp & Childress (1994) identify 5 principles pertinent to decision making in intensive care. These are: salvageability, life preservation, non-maleficence, beneficence, and justice. Ethical dilemmas occur when two or more of the above principles come into conflict. The principles of beneficence (doing good), non-maleficence (doing no harm) and justice (fair treatment) are well established within the field of bioethics. Within a critical

care context however, the dilemma between salvageability and life preservation becomes an important focus for health care professionals. Indeed, Prien & Van Aken (1999) raise the question of whether all medical means to preserve life have to be employed under all circumstances, or are there situations in which we should not do everything that it is possible to do. This question becomes particularly relevant when a patients' condition does not improve but rather deteriorates progressively. Curtin (2005) suggests that at some point in the course of treatment, the line between treating a curable disease and protracting an unpreventable death can be crossed. In such incidences Prien & Van Aken (1999) identify a transitional zone between the attempt to treat the patient, and the prolongation of dying, in which a conflict between the principles of life preservation and non-maleficence develops.

These concepts seem particularly relevant to scenario 1 where the interests of the patient may have been neglected in favour of further attempts to treat the patients' condition. This, in turn created a conflict between the principles of salvageability and life preservation. The decision to perform a CT scan on a patient with such cardiovascular instability and a very poor prognosis, meant that the patient was subjected to dangers and harms when there were few, if any benefits to justify this. Hence, the conflict between the ethical principles was not resolved, and the professional duty of non-maleficence toward the patient was not respected.

Such conflicts and dilemmas in intensive care can be made all the harder by the availability of advanced technologies. Callahan (2003) writes that one of the most seductive powers of medical technology is to confuse the use of <https://assignbuster.com/reflection-has-become-an-important-concept-in-nursing-nursing-essay/>

technology with a respect for the sanctity of life. In addition, Fisher (2004) contends that it has become all too easy to think that if one respects the value of life, and technology has the power to extend life, then a failure to use it is a failure to respect that value. This is particularly true of diagnostic technologies (such as CT scanning) which must be used with caution, especially in cases where the diagnostic information will make little or no difference to the treatment of the patient, but can create or heighten anxiety and discomfort for the patient (Callahan 2003). Medical technology is a two-edged sword, capable of saving and improving life but also of ending and harming life (Curtin 2005). Good critical care medicine carries the responsibility of preserving life, on the one hand, and making possible a peaceful death, on the other. Callahan (2003) concludes by warning that any automatic bias in favour of using technology will threaten that latter possibility.

Consensus between members of the intensive care team is also highlighted as an important issue in ethical decision making. Effective communication and collaboration among medical and nursing staff are essential for high quality health care (Woodrow 2000). Collaboration can be seen as 'working together, sharing responsibility for solving problems, and making decisions to formulate and execute plans for patient care' (Gedney 2000 p. 41). In intensive care units where ethical problems are faced frequently, care has to be a team effort (Fisher 2004).

In a qualitative study, Melia (2001) found that there was a strong desire within the intensive care team that ethical and moral consensus should be achieved in the interests of good patient care, even though it was recognised

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that there is no legal requirement for nurses to agree with ICU decisions.

Cobaoglu & Algier (2004) however, found that the same ethical dilemma was perceived differently by medics and nurses with the differences being related to the hospitals' hierarchical structure and the traditional distinctions between the two professions. Similarly, it has been observed that differences between doctors and nurses in ethical dilemmas were a function of the professional role played by each, rather than differences in ethical reasoning or moral motivation (Oberle & Hughes 2001).

It seems therefore that while the medical and nursing professions share the same aims for patient outcomes, the ideas surrounding how these outcomes should be achieved may differ (Fisher 2004). These differences have contributed to the development of the concept of the nurse as patient advocate, which sees advocacy as a fundamental and integral role in the caring relationship, and not simply as a single component of care (Snowball 1996). The role of the nurse advocate should be that of mediator and facilitator, negotiating between the different health and illness perspectives of patient, doctor, and other health care professionals on the patients' behalf (Mallik 1998).

Empirical evidence is sparse and philosophical arguments seem to predominate in the field of patient advocacy. There is some evidence to suggest that nurse advocacy has had beneficial outcomes for the patient and family in critical care areas (Washington 2001). Hewitt (2002) however found that humanistic arguments that promote advocacy as a moral imperative are compelling. Benner (1984) writes of advocacy within the context of ' being with a patient in such a way that acknowledges your shared humanity, which <https://assignbuster.com/reflection-has-become-an-important-concept-in-nursing-nursing-essay/>

is the base of nursing as a caring practice' (Benner 1984, p. 28). It has been argued that advocacy, at least in a philosophical sense, is the foundation of nursing itself and as such should be regarded as an issue of great importance by all practitioners (Snowball 1996).

Conclusion

It can be concluded that sepsis in a critical care environment is a complex condition with a high mortality rate, requiring highly specialised treatments. As such, the ethical issues and dilemmas faced by health care staff caring for a septic patient can be both complex and far reaching. It must be noted, that there can be no general solutions for such ethical conflicts; each clinical case must be evaluated individually with all its associated circumstances.

A study of ethical principles would suggest that it is important that the benefits of a specific treatment or procedure are established prior to implementation, and that these benefits outweigh any potential harms or risks to the patient. The ultimate decision maker in the scenario under discussion was the consultant anaesthetist, who should have provided a clearer rationale for performing a CT scan on such an unstable patient. As the nurse caring for the patient, the author recognises that the final decision regarding treatment rested with the anaesthetist. However, the author could have challenged the anaesthetists' decision further, advocating the patients' interests, with the aim of reaching a moral consensus within the team. Perhaps then the outcome would have been more favourable for all concerned.

Action Plan

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By reflecting on this scenario, the author has gained an understanding of sepsis and the potential ethical problems which may be encountered when caring for a septic or critically ill patient. As a result, the author feels more confident to challenge those decisions made relating to treatment, which do not seem to be in the best interest of the patient, or which have the potential to cause more harm than good. The author now has a greater understanding of the professional responsibility to advocate on a patients' behalf, with the aim of safeguarding against possible dangers. It is hoped that this will result in improved outcomes for patients in the authors' care.

Scenario 2

Description

This incident occurred in a surgical intensive care unit while the author was looking after a ventilated patient who had undergone a laparotomy and right sided hemi-colectomy 2 days previously. Around 10.30am the patient was reviewed by medical staff and was found to be awake and alert with good arterial blood gases, and requiring minimal ventilatory support. In view of this, it was decided that the patients' support should be reduced further, and providing this reduction was tolerated, that the patient should be extubated later in the morning.

In the intensive care unit in which the author works an intensive insulin infusion protocol is used (see Appendix A). This is a research based protocol which aims to normalize blood glucose levels and thus improve clinical outcomes for critically ill patients. All patients on this protocol require either to be absorbing enteral feed at $\hat{\text{a}}\%{\text{o}}\text{¥}30\text{ml/hr}$, on TPN or on 5% dextrose at

100ml/hr (Appendix A, note 2). The patient involved in this incident was receiving enteral feed via a naso-gastric tube, and was on an insulin infusion which was running at 4 U/hr. When it was decided that the patient was to be extubated, the author stopped the enteral feed as a precaution, to prevent possible aspiration during or after extubation. The author however did not stop the insulin infusion which breached the protocol guidelines.

About 12 noon the patients' blood gases showed that the reduction in support had been tolerated, and so the patient was extubated. Shortly after this the author was asked to go for lunch break and so passed on to a colleague that the patient had recently been extubated but was managing well on face mask oxygen. Returning from lunch 45 minutes later, the author found the patient to be disorientated and slightly confused. With good oxygen saturations, the author doubted that the confusion had resulted from hypoxia or worsening blood gases. The author then realised that the insulin infusion had not been stopped with the enteral feed earlier. A check of the patients' blood glucose level showed that it was 1.2mmol/L. The author immediately stopped the insulin infusion, administered 20mls of 50% dextrose intravenously, as per protocol, and recommenced the enteral feed. Twenty minutes later, the patients' blood glucose level had risen to 3.7mmol/L. The patient continued on the insulin protocol maintaining blood glucose levels within an adequate range. There were no lasting adverse effects resulting from the hypoglycaemic episode.

Feelings

When it was realised that the insulin infusion had not been stopped, the author felt a sense of panic, anticipating correctly that the patients' blood glucose level would be dangerously low. Thoughts then became concentrated on raising the blood glucose level, to ensure that no further harm would come to the patient as a result of the authors' mistake.

Following the incident, when the patients' glucose levels had risen, feelings of guilt were prominent. At this point the author realised how much worse the outcome could have been for the patient. The author felt incompetent, knowing that the patient could have been much more severely affected, or could even have died as the result of such a simple mistake.

Evaluation

The events of scenario 2 highlight the fact that clinical errors, while easily made, can have potentially disastrous consequences. This is especially true of those errors which involve the administration of drugs intravenously. In the interest of patient safety, it is important that all such errors are avoided.

The clinical error outlined above could easily have been avoided. It seems that there was not sufficient awareness, on the authors' part, of the insulin infusion protocol and the guidelines concerning the administration of insulin. As a result, the insulin protocol was not adhered to. The following analysis therefore will focus on the importance of insulin therapy in critical care areas, and will consider the safety issues surrounding intravenous drug administration.

Analysis

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Blood Glucose Control in Intensive Care

It is well documented that critically ill patients who require prolonged intensive care treatment are at high risk of multiple organ failure and death (Diringer 2005). Extensive research over the last decade has focused on strategies to prevent or reverse multiple organ failure, only a few of which have revealed positive results. One of these strategies is tight blood glucose control with insulin (Khoury et al 2004). It is well known that any type of acute illness or injury results in insulin resistance, glucose intolerance and hyperglycaemia, a constellation which has been termed the 'diabetes of stress' (McCowen et al 2001). In critically ill patients, the severity of this condition has been shown to reflect the risk of death (Laird et al 2004).

Much has been learned recently about the negative prognostic effects of hyperglycemia in critically ill patients. Hyperglycaemia adversely affects fluid balance, predisposition to infection, morbidity following acute cardiovascular events, and can increase the risk of renal failure, neuropathy and mortality in ICU patients (DiNardo et al 2004).

Research suggests that there are distinct benefits of insulin therapy in improving clinical outcomes. Such benefits have been seen in patients following acute myocardial infarction, and in the healing of sternal wounds in patients who have had cardiac surgery (Malmberg 1997; Furnary et al 1999). More recently Van den Berghe et al (2001) conducted a large, randomized, controlled study involving adults admitted to a surgical intensive care unit who were receiving mechanical ventilation. The study demonstrated that normalisation of blood glucose levels using an intensive insulin infusion

protocol improved clinical outcomes in critically ill patients. In particular, intensive insulin therapy was shown to reduce ICU mortality by 42%, and significantly reduce the incidences of septicaemia, acute renal failure, prolonged ventilatory support, and critical illness polyneuropathy. The length of stay in intensive care was also significantly shorter for patients on the protocol.

It is unclear as to why improved glycaemic control has been associated with improved outcomes in several clinical settings. Coursin and Murray (2003) have summarized several leading hypotheses including maintenance of macrophage and neutrophil function, enhancement of erythropoiesis, and the direct anabolic effect of insulin on respiratory muscles. The potential anti-inflammatory effects of insulin have also been evaluated (Das 2001). There is also uncertainty over whether it is the actual insulin dose received per se, or the degree of normoglycaemia achieved that is responsible for the beneficial effects of intensive glycaemic management. Van den Berghe (2003) analysed the data derived from their 2001 study and have concluded that the degree of glycaemic control, rather the quantity of insulin administered was associated with the decrease in mortality and organ system dysfunction.

In a follow up to Van den Berghe et al's 2001 study, Langouche et al (2005) found that a significant part of the improved patient outcomes were explained by the effects of intensive insulin on vascular endothelium. The vascular endothelium controls vasomotor tone and micro-vascular flow, and regulates trafficking of nutrients and several biologically active molecules (Aird 2003). Langouche et al (2005) conclude that maintaining
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normoglycaemia with intensive insulin therapy during critical illness protects the vascular endothelium and thereby contributes to the prevention of organ failure and death.

Whatever the reasons for improved patient outcomes, the study by Van den Burghe et al (2001) has prompted much research in this field, all of which has yielded similar results. In a similar study, Krinsley (2004) found that the use of an insulin protocol resulted in significantly improved glycaemic control and was associated with decreased mortality, organ dysfunction, and length of stay in the ICU in a heterogeneous population of critically ill adult patients. Thus it seems that with the strength of the emerging data in support of a more intensive approach to glycaemic management, insulin infusions are being utilised with increasing frequency, and are considered by many to be the standard of care for critically ill patients (DiNardo et al 2004).

It is important to note that a well recognised risk of intensive glucose management is hypoglycaemia. Indeed Goldberg et al (2004) emphasise that in the ICU setting where patients often cannot report or respond to symptoms, the potential for hypoglycaemia is of particular concern. The events of scenario 2 highlight the authors' error in the administration of insulin resulting in hypoglycaemia. For this reason some issues surrounding intravenous drug therapy will now be discussed.

Intravenous Drug Therapy

There is an increasing recognition that medication errors are causing a substantial global public health problem. Many of these errors result in harm to patients and increased costs to health providers (Wheeler & Wheeler <https://assignbuster.com/reflection-has-become-an-important-concept-in-nursing-nursing-essay/>)

2005). In the intensive care unit, patients commonly receive multiple drug therapies that are prescribed either for prophylactic indications or for treatment of established disease (Dougherty 2002). Practitioners caring for these patients find themselves in the challenging position of having to monitor these therapies, with the goal of maximizing a beneficial therapeutic response, as well as minimizing the occurrence of any adverse drug-related outcome (Cuddy 2000).

The Nursing and Midwifery Council (NMC) (2004) identifies the preparation and administration of medicines as an important aspect of professional practice, stressing that it is not merely a mechanistic task performed in strict compliance with a written prescription, but rather a task that requires thought and professional judgement. Heatlie (2003) found that the introduction of new insulin protocols and regimes could g