Reflective practice: a learning tool for student nurses

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Abstract

Reflection is a vital skill in contemporary nursing with student nurses expected to engage in reflective learning from the very beginning of the nurse educational programme. This article demonstrates the meaningful learning that resulted as a consequence of using critical reflection on practice. Gibbs' (1988) cycle aided the process highlighting the practical application of this cyclical framework to the author - a first-year student nurse. Matters concerning gender issues in nursing and professional conduct emerged from the analysis and were inherently explored. The article concludes by demonstrating the personal benefits of using Gibbs' (1988) cycle to varying situations and thus promoting its excellence as a learning tool for student nurses worldwide as a consequence.

Key words: Gender ■ Intimate treatment ■ Learning ■ Reflection ■ Student nurse

The novice first-year degree nursing student encounters a steep learning curve in a relatively short amount of time. I am a first-year male student nurse who found the reflective process a cathartic exercise which helped me cope with a practice-related issue experienced during my first clinical placement. Reflection is a vital skill in modern nursing and its use is expected from the beginning of the programme.

This article highlights the deep learning that resulted as a consequence of using Gibbs' (1988) cycle, thus demonstrating the practical application of reflective practice to a first-year student nurse's clinical placement. Furthermore, the article also explores how the cycle was adapted and used to provide an effective learning experience, through which the author demonstrates that reflection is of worth – rebutting any claims regarding the learning potential of reflection, as some learning is better than no learning, particularly if it provides a vital step towards greater knowledge. The inclusion of the author's reflective piece within the text serves to evidence its efficacy in informing practice and provides the context for this critique.

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Background

Benner (2001) explains that nurses 'have not been careful record keepers of their own clinical learning'. Reflection provides a thorough record, and it is a well-established tool for learning. O'Donovan's (2007) review of the literature clarified the success of reflection as an aid to learning in nursing. Guided reflection has been defined as:

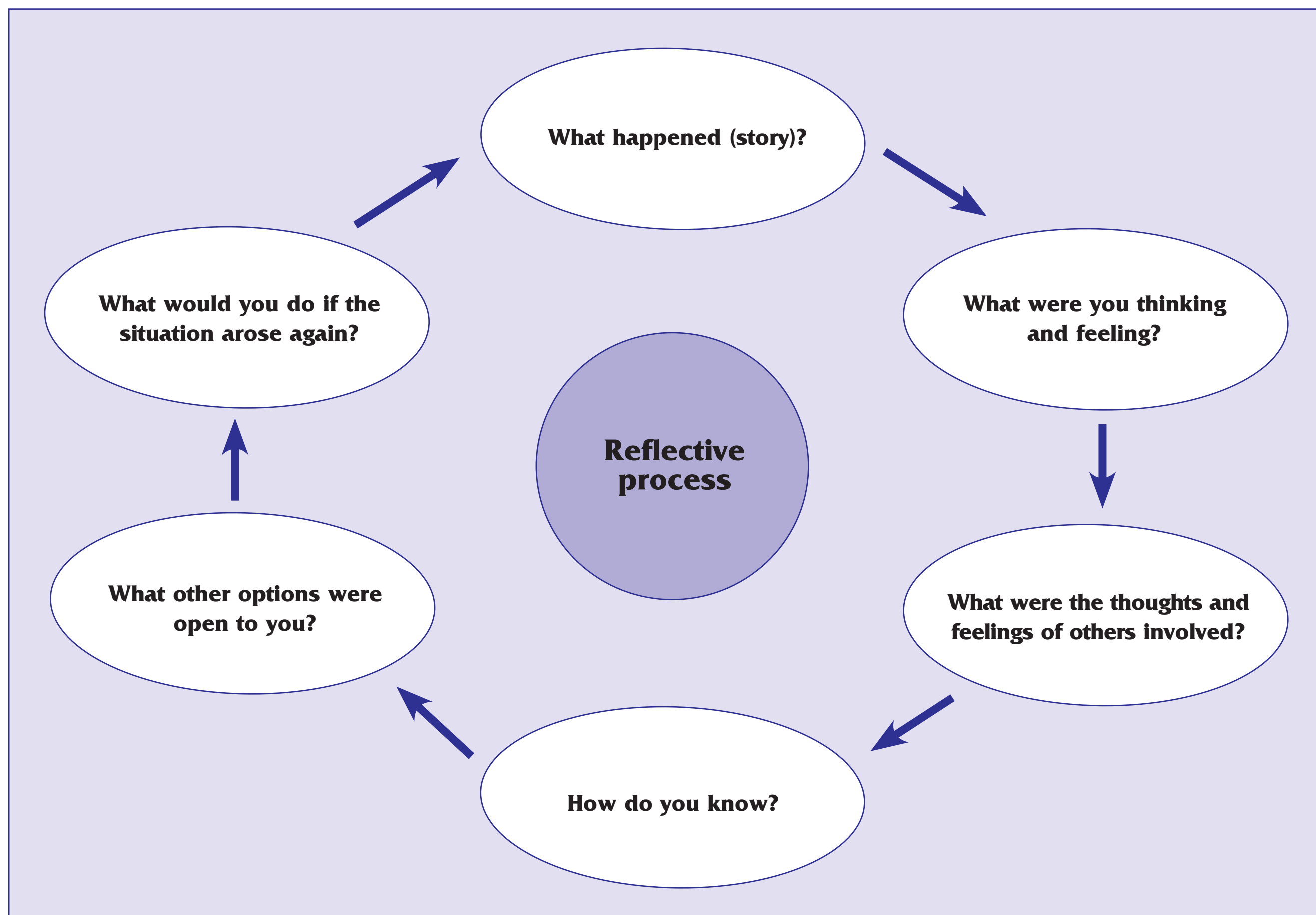
> **'… a journey of self-inquiry and transformation for practitioners … to realize desirable practice as a lived reality. The journey is written as a narrative that reveals the transformative drama unfolding. Along the journey, the vision of desirable practice is constantly explored and shifting as new understandings emerge' (Johns, 2006 p36).**

Moreover, reflective practice and guided reflection are now a respected and required learning and assessment method in many nursing programmes worldwide. The Nursing and Midwifery Council's (NMC) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (NMC, 2008), states that nurses must keep knowledge and skills up to date throughout their working life. In particular, they should regularly engage in learning activities to develop and maintain clinical competence and performance. Reflection can aid the maintenance and achievement of clinical competence, hence an important tool in the nurse's 'repertoire of skills' (Matthews, 2004). Reflection has been used to explore and learn from issues concerning ethics, confidentiality, communicating with patients and relatives, and other critical matters (Keen, 2000).

There are numerous definitions of reflection with different purposes in mind (Chirema, 2007). Whatever differences exist around the definition, there appears to be a consensus relating to the importance of reflection in nursing. Reflection 'has maintained a high profile on the nursing agenda' (Williams and Lowes, 2001); this is further illustrated through advocacy for reflection by nursing and government professional bodies. Reflection requires self-awareness and analysis (Schutz et al, 2004), thus it is a skill that needs to be acquired, developed and maintained.

The personal nature of reflection and the fact that it is sometimes used as an assessment method for learning can be a barrier to truthfully accounting the story (Schutz et al, 2004). This was a major dilemma in my own reflective writing. I therefore made a pact with myself to let go of the barriers and inhibitions, so as to permit full reflection and allow a more expansive learning experience. Williams and Lowes (2001) described a lack of definition for reflection

Figure 1. Reflection practice of the author based on Gibbs' (1988) Reflection Cycle.



and an ambiguous approach as barriers to effective reflection. These authors purport 'the true process of reflection is only initiated once the primary stage of writing has finished' (Williams and Lowes, 2001), which suggests that reflection is a journey and not an ending (see *Figure 1* for outline of my personal reflective journey).

By engaging with Gibbs' (1988) model, I found many benefits and it suited my personal style of learning. Having the right reflective process has bonuses for the patient, nurse, and student. Hilliard (2006) also found Gibbs' model provided her with a focus by promoting her awareness of the skills she possessed, thus building confidence and enhancing her professional autonomy. In contrast to this, if reflection reveals a lack of skill, it may potentially leave the student feeling insecure and demotivated. O'Callaghan's (2005) reflective piece related to helping a student escape the bonds of ritualistic practice in wound dressings and make progress with evidence-based practice to benefit the patient. These statements mirror Mooney and Nolan's (2006) comments that reflection is seen as a method of liberating nurses and creating better understanding and building a greater body of nursing knowledge, which benefits the profession.

What happened (my story)?

During the course of my clinical placement, I encountered a patient, a middle-aged woman, who had recently undergone a vulvectomy and an operation on her inguinal lymph node. The nursing care required the daily cleansing and dressing of the excised area. I was introduced to the patient, and verbal consent was obtained from the patient for me to observe the dressing procedure.

For the first stage of the cycle, Gibbs encourages a description of the events. The story was very simple and easy to convey. Gibbs' learning cycle is appropriate for accounts such as mine, as my thoughts and feelings were important aspects of this reflection. Following the description of the story I was in a position to concentrate on the important elements. Not all narrative accounts of incidents are succinct, but I consciously endeavoured to edit the description in order to benefit from an integrated approach dealing with my thoughts and feelings directly after the explanation of the incident. Otherwise I believe the complexity of writing and reading would be overwhelming and more time would be spent matching the story to the outcome and seeking clarity, rather than reflecting and learning.

What was I thinking and feeling?

On the way to the patient's house the staff nurse gave me a brief history of the patient. I was able to determine what a vulvectomy was for myself and the nurse simply confirmed it. It dawned on me that the cleaning would require the patient to be partly undressed. My first feeling was that of slight shock and I wondered how it would go. Many questions entered my head: Where should I look? When should I look? What body language and approach would be

most appropriate? Particularly because I am male. What are the implications that flow from this? How will I deal with this situation when I am a registered practitioner and might have to deal with this on my own? What will it be like? How will I respond? What is the paradigm of professional conduct in this area? All of which I thought, but I did not know the answers to all those questions, so my approach was a cautious one.

The Nursing and Midwifery Council's (NMC) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (NMC, 2008) states that the professional nurse is personally accountable for protecting the interests and dignity of patients and clients regardless of their personal characteristics or circumstances. Paramount in my mind was preserving the patient's dignity, not only because the Code says so, but human decency requires it. Dignity appears to be the guiding light of intimate treatment, guiding nursing practice. 'Dignity must be protected at all times' (Peate, 2005). One of Coller's (2006) four core values is respecting and protecting patients' dignity and sense of self-respect, especially when illness or other circumstances makes them particularly vulnerable and powerless (Coller, 2006). The Code is there to protect the public, and serve the client, including protecting their dignity. Without further experience on how best to act in these situations, I recognized and acknowledged my own limitations, mainly that I am only equipped to observe thus far and to take instruction from the qualified nurse, spraying dressings with saline solution, for example. I am still at the novice stage in learning and doing (Benner, 2001).

I kept my eyes down for most of it, looking could easily be misinterpreted and I kept a good distance back so as not to be too invasive. I looked now and then, so as to see and learn, but I reduced it to the bare minimum. Nurses must work together to bring about healthcare environments that are conducive to safe, therapeutic treatment and all within the gamut of ethical practice (NMC, 2008). My conduct, therefore, had to be ethical and this was achieved by directly observing periodically without staring.

I did feel slightly protected by my uniform and the fact that my uniform has meaning to others, thus requiring me to uphold the highest standards. Despite the uniform, my gender does make a difference. Women are seen as natural-born carers, and thus good nurses; the experience of men in nursing, in stark contrast, is a different story (Seed, 1995). Seed's study found that 'female nurses found it difficult to accept the fact that their male colleagues should be fully involved in the care of women'. Even though there are reports of instances where female patients see a male nurse as a breath of fresh air (Smith, 1992), societal expectations and stereotypes are in full force. Did the patient see a stereotype of a nurse observing the procedure or did she just see a caring person training to be a nurse before her? Does she have faith in my professionalism? Did I live up to the unspoken professional promise? I think that I did; I certainly endeavoured to. It reflects upon me as an individual as well as a future professional, as according to Fagermoen (1997), 'the nurse provides care in a form of self-presentation through which nurses actualize their values and communicate their personal meanings' (Fagermoen, 1997). Therefore, it follows that it is impossible to predict how gender plays a part in the professional nursing role and moreover it is impossible to generalize gender equity in caring relationships (Smith, 1992; Seed, 1995).

This second stage of the Gibbs cycle provides a section to explore how I felt and the thoughts I had. This and its complementary section were the most important part of my exploration and learning process. My comments were not directly restricted to my 'thinking' and 'feeling', accompanying them were some elucidation of the story and also evaluation, supported by evidenced-based research. This seemed to be the most natural and productive way of learning from the experience and enabling me to present the information in an informed manner. Gibbs' cycle, therefore, has undergone some expansion here, such an approach was necessary for learning to emerge and to enable the flow of accounts.

What were the thoughts and feelings of others involved? How do you know?

My intuition led me to believe that the nurse I accompanied had no discernable feeling one way or the other about the situation. She acted as a professional, i.e. a task had to be done and she did it. In many ways it is just another wound to be cleaned and dressed, albeit in close proximity to genitalia. On the other hand, the patient must have been embarrassed; in today's society, private parts remain private and exposure to others is restricted. Permitting strangers to see her genital area must have felt invasive. Especially with me observing the dressing procedure, and as a male student nurse, I felt superfluous to the process and only added to the patient's discomfort. But she seemed to accept my presence; more than likely because her priorities at that time were to make a full recovery and take life day by day. Professional caring properly understood, is a moral imperative, borne of altruism and a sense brotherhood (Dowling, 2004), a sense of which I had on this occasion. This poses no problem so long as the patient understands and has faith in her carers as professional practitioners.

The third section of the Gibbs process required me to delve into what others thought. As such it demanded an empathic view, putting myself in their shoes. This stage was useful because it allowed the fusion of what I observed: their body language, the things that were said, and the way I might have viewed things if I was in their situation. This stage of the cycle permitted me to analyse how I perceived the motives and reactions of others. I was enabled to tease out the 'commonalities and differences' in other's views (Benner, 1994), which is the very goal of interpretive phenomenology. It is here where personhood and individuality can be examined.

What other options were open to me?

Not many other options were open to me. I could have been less sensitive and stood closer, thus enabling me to obtain a more detailed view of the nursing care applied. However, at what cost? The patient's dignity could have been needlessly intruded upon, violating the principles

in the NMC (2008) Code. Hence, I felt that no better alternate options were open to me. This fourth stage of Gibbs' cycle therefore provided only the opportunity to explore the negative consequences of my presence. Learning, through reflection, enhances an ethical sense of the morals of nursing practice, and thus provides the answers to why. In the world of nursing knowing why is the difference between mechanistic repetition, and acting as a consequence of knowledgeable decision-making.

What would I do if the situation arose again?

My conduct would be similar. Patients are people and all people are different, some are indifferent, others are concerned. In the times subsequent when I revisited the patient my approach was similar (and will be in the future). To safeguard the dignity, respect and trust of the patient it is better to err on the side of caution and be aware of the sensitive nature of intimate nursing care. It seems that a chaperone, in any intimate examination/treatment, can be useful to both patient and nurse (Peate, 2005), especially in this age of lawsuits. The Royal College of Nursing (RCN, 2002) recommends actively providing a chaperone when attending to intimate nursing care procedures.

On balance, initially I need not have been so demure. It is easy to intrude upon a patient's privacy, especially if their preferences are not known (Back and Wikblad, 1998). Caution was appropriate here because space, touch and interaction are seen differently by different people (Edwards, 1998). Such views relate to varied criteria, such as gender, age and even height, more often unknown to the stranger (Edwards, 1998). My own personal values can have a profound influence on the way I interact with patients on whatever level, one must be aware of this and the potential for problems to arise, hence my cautious interaction with the patient in this case. Although, I think my inherent values helped, they could be a hindrance in other circumstances, for example, being needlessly cautious. But, by numerous visits and observing a little at a time, I have been able to put the treatment together in my head, like a jigsaw puzzle, so I have been learning without being too obtrusive.

One easily adjusts to situations. For example, in the area of leg ulcers, what at first repulsed, is now just another wound. Applied to this situation, one could easily lose sight of the sensitive nature of wounds such as this; the activity is loaded with great risk of becoming ritualized, habitualized and insensitive when applying treatment, at great cost to the patient.

At my latest visit, the nurse removed the dressing, the wound had healed, and we thus noted in the paperwork. Aware of the need to re-assess patients, as their situation could alter, the patient remains on file and we remain 'on call'. In areas related to this, I will try and keep an 'empathic attitude' (Rogers, 1980) to enable me to better tailor my response and better address the client's needs.

In the fifth and final stage of the Gibbs reflective process, I was able to explore the potential situations I could foresee arising again, perhaps with different patients. I could then apply what I learnt to those future situations. I am now, as a consequence of critical reflection, able to examine my philosophy as it applied to this event and how it could cascade to other future events. I was facilitated to look at myself and see where any impediments may be and thus how a remedy might be fashioned.

Critical reflection (commentary)

I feel I need to learn and understand more about the plight of patients in this situation. Dealing properly with the aftermath of gynaecological surgery is important, it has significant implications, not only for physiological reasons, but also from a psychological perspective considering the loss of womanhood, femininity and sexuality for patients undergoing such evasive surgery. It is essential that nurses are aware of the consequences of vulvectomy surgery from both a physiological and psychological perspective. Sexual expression and self-esteem may be impaired as a result.

Almost 15 years ago a qualitative study was conducted that concluded some surgeries physically 'disfigure' the treated area (Corney et al, 1992). However, the fear of recurrent cancer in the future remained constant as 60% of patients in the study stated that fear of cancer recurrence did not dissipate over time. Potential for major distress was also uncovered, with 68% feeling markedly or severely distressed about their postoperation life, younger women especially. Sexual problems presented in 76% of the sexually active patients within 1 year of the operation, in contrast to 19% before operation (Corney et al, 1992). Hence, it seems to me that even those who are not sexually active may have trouble forming relationships, for fear of problems being encountered. The study concluded that support of emotional needs and information are the best tools to tackle these problems, and counselling should be freely available (Corney et al, 1992).

Allowing for questions and giving jargon-free explanations can also help the patient (Peate, 2005). As my clinical placement is in the community, I have noticed that nurses do play a counselling role in some way, offering information and support. I believe this is exactly what nurses should do and furthermore be observant of non-verbal communication, adopting a holistic approach, and offering support at the early stages of care. These needs should be recognized and addressed.

American sources claim that of gynaecological malignancies, 4% of them are vulvar cancer (Di Saia et al, 1979; Venes, 2005). Unfortunately, it is unlikely that prevention of this disease is possible, it is rare and as of yet there is no available effective screening method for vulval cancer (RCN, 2005).

I have learnt a lot from this experience, not just from my personal reflection but also from reviewing the evidenced-based literature, in particular relating to a topic I would otherwise not have researched. Gibbs' model does not advocate a concluding critical commentary. Although I had weaved critical elements into the actual reflection, I was compelled to add this section in order to evaluate the bigger picture, as in this case, to the related aspects I witnessed. I was looking to turn this learning experience into knowledge applicable in other situations related to intimate treatment. The critical reflective process permitted me to examine and

reflect on the psychological aspects of this type of surgery and thus transported me beyond this stage to engage in the thoughts and feelings of others involved, as that was based upon contemporaneous assessment and some afterthought and interpretation. My analysis uncovered real studies of real people exploring knowledge beyond what I could obtain from the patient. The efficacy of the Gibbs process stimulated me to learn more. Perhaps an interesting addition to the cycle would be a section that is updated at a later date, so progress can be gauged.

Conclusion

The foregone discussion demonstrated the potential power of reflection as a tool for discovery and possible learning. It is clear to me that Gibbs' cycle is of use in many circumstances. The cycle is cyclical, it can be altered and adapted to the varying situations and crises nurses are faced with, which means the cycle can be applied to almost any event or issue. Thus, such a structure is ideal for first-year student nurses, with the lack of complexity permitting better engagement with the process. It also follows that reflection should not be bound in a cast-iron structure, it may be better to have no structure at all in some cases. More than likely different reflective cycles will benefit different situations, much like a plumber selecting the right tool for the job. There is evidence of Gibbs' framework in many reflective models (Jasper, 2003), which illustrates that many models share a commonality, which implies a shared knowledge base, thus knowledge obtained from the Gibbs cycle would more than likely similarly emerge with the use of other reflective frameworks.

Reflection occurs as a result of a critical thought process; the written word will not fade and can be consulted to aid learning or mark progress. Reflection is the perfect medium to evaluate the 'what and how' of nursing care and the wider implications of inter-professional relations; thus informing other discreet issues. Reflection can be written evidence and the product of an inquiring mind. The time needed to effectively reflect is immense, and not withstanding the energy invested in recalling the experience, writing, researching, reading, synthesising, thinking, followed with more writing, is significant. But it is a worthwhile exercise, considering the theory-practice gap that Kyrkjebo and Hage (2005) found students witness in practice. Reflection can be used as a quality assurance method to evaluate both effective and poor practice. Moreover, as demonstrated from my personal reflection on my novice nursing practice, reflection is a potent weapon in the armoury of learning and development. BJN

KEY POINTS

- Reflection is a well-established tool in learning and is common to nursing programmes nationally.
- The Gibbs' cycle is ideally suited to the reflective needs of student nurses because of its simplicity and malleability.
- Gender plays a role in the application of intimate treatment.
- Reflection stimulates deeper exploration of topics.

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