Nottingham University

School of Health Sciences

Recognition of Other Learning (ROL)

An Example of Reflective Writing

Using Autobiography, Personal Narrative and Poetry to Reflect on a Critical Incident in Care of the Older Person

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Looking Back on My Life's Career

As a child I was an unremarkable scholar. I was single minded, wilful and I had a poor attention span. My yearly comprehensive school reports were littered with comments such as "could do better" and "needs to pay more attention". However, my current approach towards helping others has undoubtedly been shaped by my early encounters with my biology teacher. I had obtained a Grade One GCE in Human biology (the only subject I had an interest in, and had done well in) and Mrs Young was keen to encourage me further - to undertake "A-Level" Biology. This course was not usually offered as part of the School's curriculum. However, Mrs Young's advocacy and unconditional support ensured that I was able to undertake this further study.

Many of the initial feelings I experienced as a result of Mrs Young's individual attention could have been explained by others (at the time) as a teenage infatuation. However, I have since had an opportunity to explore the of adult learning theorists such as Carl Rogers and Malcolm Knowles and I now appreciate just how much Mrs Young's patience, encouragement and individual support empowered me and influenced my decision to enter the helping professions. This was in complete contrast to the assistance offered by the School's Careers Teacher. He assured me that: *"Nursing was not an appropriate profession for a man."* However, his advice made me even more determined to embark on a career as a nurse, and later to become a nurse teacher.

The literature typically defines career through the concept of: "Career Stages." These are seen as developmental phases of working life, which help to identify the challenges individuals face as they progress from the early stages of their career through to retirement. A theory of career for the teaching profession (my current field of practice) has been identified by Steffy et. al. (2001). This theory acknowledges that professional growth happens through a process of reflection and renewal. This view is supported by Larrivee (2000) who suggests that it is the act of reflective practice that can move teachers to a stage in their careers where they are able to modify their skills to suit specific contexts and situations, and eventually to invent new strategies.

Steffy (2001) identifies the following developmental stages for the teacher. Firstly, the teacher as novice this is characterized by the first practicum experience and includes student teaching and internship. Secondly, the teacher as apprentice this includes the first two to three years of the new teacher's career. Next, the anticipatory stage the new teacher is enthusiastic and eager to perform the tasks of teaching. This eagerness is often confounded by frustrations of the first years of teaching. After the initial years of teaching, the novice or apprentice teacher may move into the next stage of career development, which is the professional stage the teacher grows in confidence about his or her teaching ability. Also, respect from students, parents, and other colleague is evident. Successful completion of this stage leads to the expert stage and at this stage the teacher has reached a level of expertise that would meet national certification. Finally, the teacher may enter the distinguished stage

a teacher who exceeds all expectations of current practice whom is often involved in national educational decision-making (Steffy et al., 2001).

One relatively common feature of career stage theory is its cyclical pattern. Miller and Form (1951) have argued that many careers are characterized by alternating trial and stable work periods. Levinson (1986) also notes that adults experience alternating periods of stability and transition. Similar observations are made by Steffy et al. (2001) who describes the frustration of the anticipatory stage and how this evolves into the professional stage of teaching. It is during these periods of stability and instability that individuals examine and then re-examine their values and beliefs with a view to making some kind of career change. This cyclical patterning is certainly a feature of my own career, which if represented as chapters in a book would probably look like this:

> Chapter One: The Nurse. An introduction to the knowledge; skills; values and beliefs underpinning my role as a nurse. My transition from a novice to an expert -including my initial training as a student nurse, and my subsequent employment and professional development as a Staff Nurse, Charge Nurse and Nursing Officer across several adult nursing specialities.
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> Chapter Two: The Teacher. An outline of the knowledge, skills, values and beliefs I developed during my transition from clinician to teacher and the early socialisation I experienced during my induction to the nurse teaching profession.
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> Chapter Three: The Academic. An outline of my socialisation into Higher Education (HE) and the personal development I undertook as an undergraduate and postgraduate teacher in order to maintain my position as a Lecturer in HE.
>
> Chapter Four: The Explorer. An outline of how university life enabled me to experience other cultures for the first time, and my professional and personal experiences of travelling to British Columbia as a result of receiving two British Council Scholarships.
>
> Chapter Five: The Researcher. My introduction to the knowledge, values, and beliefs of a researcher and the work I undertook to develop myself within this role. Including the commissioned research I undertook for the UK Department of Health, Human Resources Development Canada, and Canadian Association for Prior Learning Assessment, and the Canadian Human Technology Human Resources Board.
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> Chapter Six: Maintaining my Professional Independence. My experience of taking early retirement due to organisational change and turning this into a positive opportunity to work as an independent researcher in Canada, South Africa , and the UK.

Chapter Seven: Returning to Practice. My experience of returning to nursing practice in order to maintain my professional registration as an Adult Nurse and the personal and professional conflicts that arose as a result of uncovering safeguarding issues relating to the care of older people.

Chapter Eight: Returning to University Life. The opportunities that have become open to me as a result of returning to Higher Education as a Nursing Lecturer - including international travel, research, and authorship - whilst still resolving personal and professional conflicts relating to the safeguarding of students and older people.

My Personal Values

Throughout each Chapter of my life I am reminded of the individualised attention and respect given to me during my formative years by Mrs Young my biology teacher. The commitment and unconditional support offered to me by her has provided me with a grounding for the helping relationships I have developed over many years, both as a nurse and more recently as a nurse teacher; which have been underpinned by my own theory of person centred care - what Thompson et al (2008) call: "praxis" – a personal and open form of knowledge that has been developed through my own practice that is open to continuous scrutiny by myself and others.

These personal values and beliefs have previously been reflected in my writing on person centred care (Day, 2010:10) and are expressed within the mnemonic PRICID. That is:

"**P** respecting Privacy

R expecting the Rights of individuals

I recognising Individuality

C working Collaboratively with individuals and enabling them to make Choices

I encouraging Independence

D preserving Dignity"

They are also expressed through a poem I have recently written:

Care Values

As I get older (and more frail)

and I rely on you (increasingly) for my daily care,

please spare a thought for the characteristics we both share

- as human beings.

To you my life is largely done.

To me it is still incomplete.

For, I too have hopes and fears

I am (daily) challenged to meet.

My fear is I become institutionalised

- seen as a burden through your eyes.

My hope is you treat me with respect and humility

- so that you can truly see the worth of me.

As a person I value my right choose.

When to wake. When to snooze.

When to be quiet, and alone.

What to do in my own home...

These are values I've held so dear

throughout my life's career.

Choice, Privacy, Dignity -

these are the wholly trinity."

It is my belief that these values are at the very core of a professional helping relationship. However, it is my experience that these values do not sit comfortably with organisations and cultures that are more institutionally focussed and (if practiced) can give rise to conflict and dilemma. It is for this reason I am returning to a later stage in my career for my reflection. That is: *Chapter 7: Returning to Practice*. The aim of my reflection is to re-evaluate the personal values and beliefs I have developed to test how my theory of person centred care "holds up" within a contemporary environment. I will refer to *"Harvey's story"* in order to do this.

Harvey's Story

Nurse: "Good morning Harvey, I'm just going to give your medication into your feeding tube. Is that OK?"

Narrative: I had returned to practice as a Clinical Lead in Care of the Elderly. I was caring for Harvey who was a quiet and uncommunicative individual that had suffered from Schizophrenia most of his life. He was unable to swallow food or drink as he has an obstruction to his oesophagus. He was fed via a gastrostomy tube and also received his medication via this route. Harvey had been a resident in the care home for several years and had always been reluctant to socialise with other residents as this would mean that others would be able to see his feeding "paraphernalia". He was extremely conscious of the tubes, the plastic feed bags and the electric feed pump that were "attached" to him during the day. Consequently, he spent all of his time in a side room away from other residents. Over many months, Harvey had become increasingly isolated and withdrawn. After discussion and agreement with his relatives and the family doctor, Harvey was referred to a Psychiatrist who prescribed some antidepressant medication for him. The aim was to improve Harvey's mental state, and subsequently his quality of life, by slowly re-introducing him to other residents and the social activities within the home, once the new medication had started to take effect.

Harvey: "What medication nurse? "I don't want it, and you can't make me have it. If you do try and give it to me I will sue you."

Narrative: Over several weeks Harvey's depression had started to lift. Gradually he had become more communicative. He talked to me about the football shown on the television and would get excited about some of the results of his favourite team. I therefore decided to gradually introduced Harvey to the residents TV lounge and then began to involve him in some card playing with other residents, which he enjoyed immensely. His relatives were also pleased with his progress. One morning, I entered Harvey's room and asked him if I could give him his medication through his tube, as usual. Harvey replied by stating "What medication nurse?" I explained to Harvey the purpose of his medication and again asked if it was OK for me to give him this? He replied: "I don't want it, and you can't make me have it. If you do try and give it to me I will sue you."

Nurse: "The medication is helping you to feel better in yourself Harvey, and it seems to be working, don't you think…."

Narrative: From my discussion with Harvey it was clear that he understood the purpose of the medication and my request to administer the drug. It was also clear that he did not want the medication. I telephoned the relatives and they visited Harvey and discussed his refusal with him. Harvey was adamant that he didn't want any medication at all as he was now feeling better.

Harvey's Relatives: "Could you hide his medication in his tube feed, Nurse?"

Narrative: The relatives asked if I could "hide" Harvey's medication in his tube feed. I explained that this was known as "covert" administration of medicines and that without Harvey's agreement this was unethical. Further, if I was to do this against Harvey's wishes I would be committing an assault. I suggested that we contacted Harvey's Social Worker to initiate a case review with the Psychiatrist.

Harvey's Relatives: "But if he doesn't get his medication he will become worse again. If you don't give it aren't you abusing him?"

Narrative: The relatives indicated that in their view I was "abusing" Harvey by refusing to administer the drugs covertly. I therefore contacted the local adult safeguarding team and referred the case to them. I also informed the home owner (a local GP, but not Harvey's family doctor) of the incident.

The Home Owner: "You must give the medication covertly; I don't want another (bolded for emphasis) safeguarding investigation in my home"

Narrative: The homeowner insisted that I should administer the medication covertly as he didn't want the safeguarding team investigating "another" complaint in his home. I explained that in my view Harvey had the capacity to make an independent decision therefore I could not administer the medication until a case review was held with the psychiatric team.

The Home Owner: "I am a Doctor and I am instructing you as a nurse to give the medication."

Narrative: I explained to the home owner that he was not Harvey's family doctor. Nor, was he a Psychiatrist. Therefore, it would be inappropriate for me to accept any advice or direction from him concerning Harvey's medication. The home owner suspended me my from duties. I resigned from my post.

My Initial Thoughts and Feelings

I was shocked by Harvey's refusal. Possibly, more at his implied threat to sue me. However, I was also pleased that he was now more communicative. His response to me concerning his medication clearly showed he was improving and taking an active interest in his own care. The reactions of his

relatives were understandable. They were concerned that if the medication was discontinued then Harvey would regress. They therefore saw my actions as a barrier to Harvey's progress.

I had concerns regarding the home owner's response. I had assumed that as he was a practising health care professional he would support my decision to refer Harvey to the Psychiatric team. However, he seemed more concerned about the possibility of dealing with Social Services rather than Harvey's individual well-being. Why should issues concerning residents choice and independence be regarded by him as a negative issue i.e. "…another safeguarding complaint." Surely if care home staff were doing their job well they should be open to an external review and willing to learn from this? Any review might be painful, but it could also be developmental and beneficial for Harvey and the other residents. For example it might challenge the organisation's culture and bring about some change in its perception of older people. After all, is this not the basis for becoming what Thompson et? al. (2008) calls a reflexive practitioner?

I was concerned that I should remain true to my professional values and beliefs and although the conflict with the owner was stressful, I did feel that I was making the right decision. I felt I was behaving ethically by respecting Harvey's choice. However, now that I had resigned how could I be sure that medication would not be given covertly by others? I felt my decision to refer to the adult safeguarding team would ensure that Harvey's best interests would be taken into account during my absence. However, I still had a major concern. How could I be sure that my own values and personal beliefs were consistent with current practice? What was acceptable contemporary practice within the field of Adult Social care?

Making Sense of Harvey's Story

An ability to be "ethical" or to behave "ethically" towards colleagues and patients is summarised in the medical literature by Beauchamp and Childress (2008) as doing well (beneficence), doing no harm (non-maleficence) respecting choice (autonomy) and fairness (Justice). Further, The Mental Capacity Act (2005) provides a statutory framework to empower and protect adults who lack the mental capacity to make decisions for themselves because of illness, a learning disability, or mental health problems. According to current UK law, a person is defined as being unable to make decisions if they are not able to: understand information given to them; retain that information long enough to be able to make a decision; weigh up the information available to make a decision; communicate their decision through whatever means appropriate. The Mental Capacity Act is based on the following principles.

Firstly, every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise. In Harvey's case I assumed that he did have capacity. His behaviour was quite lucid and I had no other information to suggest otherwise.

Secondly, all reasonable help and support should be provided to the person so that they make their own decisions before it can be assumed that they have lost capacity. In Harvey's case I felt it appropriate to make a referral to the Psychiatric team so that appropriate support could be given in assisting Harvey to make an informed decision about his medication. This was not a "cop out" on my part. Rather, I felt that specialist individual support was now required for Harvey, and this was outside my scope of practice.

Thirdly, it should not be assumed that someone lacks capacity simply because their decisions might seem unwise or eccentric. Although Harvey had a long history of Schizophrenia it was inappropriate to assume that his refusal was the result of altered cognition. Quite the contrary, his decision to refuse appeared quite rationale and he was quite articulate in defending his right to refuse. Therefore, in my view there was a primae facie case to support the idea that Harvey did have capacity.

Fourthly, If someone lacks capacity, anything done on their behalf must be done in their best interests. In Harvey's case it appeared he was benefitting from the new medication and I could understand the relatives view that this should be given covertly. However, I am not a mental health practitioner therefore I felt there was a need to obtain a psychiatric opinion so that an appropriate decision could be made as to whether the medication should continue as requested by the relatives. Or, indeed could be discontinued, or modified now that there was some noticeable improvement in Harvey's condition. In this respect, I was acknowledging a deficit in my own scope of practice as required by my professional code (NMC, 2008).

Finally, before making a decision on the person's behalf, all reasonable alternatives must be considered and the final option that is chosen should have the least impact on their human rights. In Harvey's case all medication was being given via a tube by a third party. Therefore, he would be totally unaware that medication was being given unless he was told. Harvey's freedom of choice was therefore potentially at risk and needed to be safeguarded.

As a registered nurse I am guided by my professional code of practice (NMC 2008) which clearly states that I have a professional duty of care. This includes protection and advocacy for vulnerable individuals in my care. Therefore, from a professional point of view I was unable to accept the home owner's direction to give Harvey's medication covertly without first obtaining specialist support and advice. Also, there appeared to be a conflict between the owner's values and beliefs as a Managing Director and the professional values and beliefs he held as a practising GP. His direction that Harvey's medication should be administered covertly appeared to be based on an assumption that he had an unquestionable authority as a medical practitioner. However, he was not Harvey's family doctor therefore his assumption was (in fact) entirely questionable. Further, by removing me from the situation the home owner was attempting to use his authority as a manager to control the situation and prevent it from escalating. In this respect, he was acting in the best interests of his organisation.

Therefore, based on the above assumptions, I felt my decision to refer was correct. Further, I felt my decision to resign from my position as clinical lead was a righteous decision. It was based on my personal values and beliefs I had developed as a member of the helping professions and my concern regarding the values and beliefs of the owner, which created a major dilemma for me i.e. "How could I continue to work as a lead nurse in an organisation that failed to recognise an individual's fundamental right to choose? Similar questions have been have recently been raised by the Francis Report (2013) which advocates for dignity and compassion - placing the patient at the centre of all healthcare decisions within the NHS.

The Importance of Reflective Practice for me as a Professional Helper

Dewey (1933) has described the importance of reflective thought, which he said consisted of: developing a sense of the problem at hand; enriching that sense with observations of the relevant condition; developing a conclusion; and testing the conclusion in practice. According to Dewey reflective thinking transforms a doubtful and unclear situation into a situation that is clear, coherent and harmonious.

Boud et.al. (1985) describe reflection as an activity during which people attempt to re-live or recapture their experience, think about it, mull it over and then evaluate it. However, the process of reflection is quite different from simply recalling an event. For example, Conway (1994) indicates that reflection is a conscious and deliberate act of "looking back" on what has been done and learning lessons from what did or did not work.

Clouder (2000) indicates that reflective practice involves the critical analysis of everyday working practices in order to improve competence and promote professional development.

Taylor (2000) indicates that the reflective process involves both thought and contemplation in order to make sense of past memories and events, followed by some form of action to make appropriate or required changes.

Within Nursing it is Schön (1983) who is often regarded as the grandfather of reflective practice (Thompson et al 2008). Schon described the process of reflection as a strategy used by individuals to solve complex problems arising from their practice. He refers to the idea of practice as:

> *"The swampy lowlands, where situations are confusing messes incapable of technical solution and usually involve problems of greatest human concern" (Schön 1983:42).*

Schön believed that knowledge derived through critical reflection is equally important as other and more traditional forms of scientific knowledge. He described the processes involved in generating this knowledge as: reflection in action during an event; and reflection on action after an event.

Since the earlier work of Schon (1983) a general consensus regarding the nature of the reflective process has emerged within the nursing profession .For example, Rolfe, Freshwater and Jasper (2001) state:

> *"Reflection in action involves two distinct components. The practitioner thinks about what she is doing as she does it. She also thinks about how she is doing it, the practical knowledge that underpins her practice. This synthesis of knowing and doing Schön called 'knowing in action'."*

While Burns and Bulman (2000: 5) state:

> *"Reflection on action is the retrospective contemplation of practice in order to uncover the knowledge used in a particular situation, by analysing and interpreting the information recalled. The reflective practitioner may speculate how the situation might have been handled differently and what other knowledge would have been helpful."*

There is a connection between the way an individual practices and how they think about their practice. The performance and worth of a practitioner can be improved by reflecting on his or her actions, and by making sense of what they have experienced (Ghaye and Lillyman 2000).

It is through the process of reflection that practitioners learn about the feelings and knowledge associated with a situation. Further, they also learn something about themselves and other individuals; as well as their own and other's personalities (Rolfe & Gardner 2006).

Thus, the process of reflection can facilitate new learning; this learning then becomes more explicit and allows practitioners to create a set of personal experiences and a knowledge base that can be applied to new situations (Rolfe & Gardner 2006).

Jasper (2003) indicates that the act of reflection is important in developing autonomous, qualified and self-directed professionals. Further, she suggests that engaging in Reflective Practice is associated with the improvements in care delivery and the stimulation of personal and professional growth.

Davies (2012) also identifies the benefits of reflective practice. These include: increased learning from (and through) an experience; promotion of deep learning; identification of personal and professional strengths and areas for improvement; identification of educational needs; acquisition of new knowledge and skills; further understanding of own beliefs, attitudes and values; encouragement of self-motivation and self-directed learning; could act as a source of feedback; and possible improvements of personal and clinical confidence

Price (2004) indicates there are several reasons why nurse would engage in reflective practice. They are to: (1) further understand yourself, motives, perceptions, attitudes, values and feelings associated

with patient care; (2) provide a fresh outlook to practice situations and challenge existing thoughts, feelings as well as actions; and (3) explore how a practice situation may be approached differently.

Somerville and Keeling (2004) state that Reflective Practice can help an individual to develop personally. It allows professionals to continually update their skills and knowledge and consider ways to interact with their colleagues. They give suggested ways for professionals to practice reflection. These include: keeping a journal; seeking feedback from colleagues; taking time at the end of each day, meeting, or experience to reflect-on-actions; anecdotal notes; and group discussion.

However, unlike most academic writing a reflection is usually presented in the first person. (Moon 2004:190). Also, it need not necessarily be described (or refuted) through the process of scientific enquiry – what Schon refers to as: *"Technical rationality"* (cited in Johns, 2004:14).

For example, in this paper I have used storytelling and poetry (Moon, 2004: 230) in order to give a personal account of how my own theory of person centred care has been used to support Harvey - how *"I"* felt before and during his care – the conflict and dilemma that arose - and my feelings of: *"self- righteousness"* which appeared to have be supported by my own praxis. However, any evidence generated as a result of this process is not necessarily a source of knowledge that can be generalised and applied to everyone's practice. Although a recent review of patient care within the NHS (Francis 2013) does tend to support the values and beliefs I have expressed.

My Personal Values Re-Visited

Ghaye and Lillyman (2000) have identified at least 3 key domains within a reflection. These include: *Power* – an individual's potential to influence others and their practice; *Politics* - the ways and means an individual uses to influence actions; and the *Sociological domain* - where groups merge and relationships and alliances are formed. In addition to these domains I also advocated a clinical domain- the importance of action in providing care for patients – and an instructional domain - action taken to support students within the classroom, or during their practice based learning -see part one of my assignment. However, as a professional helper involved in the practice of nursing and teaching I feel must also take into account an *ethical* domain for my practice. This idea is discussed by Larraivee (2000) who describes how the teacher might study his or her own teaching methods and determine what works best for students - she states that this should include a consideration of the ethical consequences of classroom techniques on students.

However, the idea of an underpinning ethic for my role as a nurse and a nurse teacher is best illustrated by the Nursing and Midwifery Council Code of Conduct (NMC 2008). This clearly defines the underpinning values and ethics of a Registered Nurse and Registered Nurse Teacher, thus:

> *"Make the care of people your first concern, treating them as individuals and respecting their dignity (p.3) Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community (p. 5) Provide a high standard of practice and care at all times (p.6) Be open and honest, act with integrity and uphold the reputation of your profession (p.7)"*

I believe that my personal values and beliefs (as expressed through Harvey's story) are fully supported by the community I work with. For example, shortly after my resignation as a clinical lead I was shortlisted for a junior position within a large group of care homes. At interview I disclosed my experience of Harvey and as a direct result of this disclosure I was offered a senior management position as the panel felt I had appropriate values and beliefs as a nurse leader to bring about necessary and fundamental changes to the practice of elder care within their organisation.

This peer affirmation was extremely powerful and quite liberating - and in a sense it was also a relief – as I had finally found a group of individuals with similar values and beliefs with whom I could work. Further, this sense of empowerment enabled me to turn my experience with Harvey into something more positive by writing a book on safeguarding vulnerable people (Day, 2009). This has included chapters for adult social care workers on: early socialisation patterns; person centred care; and professional roles and boundaries. Through this work I have gained a deeper understanding of the power relationships that exist across and between the differing health care professions that make up a multi-agency team, and how this might influence the care of vulnerable people.

Finally, this sense of empowerment has also given me the confidence to apply my personal values and beliefs to my practice as a nurse teacher - both in the relationships I have with my students - and in my research on the recognition of prior learning and the development of an holistic approach towards the assessment of prior learning – see Day (2011, 2012, 2013).

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