The use of expert practice to explore reflection


Summary
This article describes an experience, drawn from clinical practice, which has been used to expand personal knowledge and enable self-reflection. Johns’ (1995) model of structured reflection provides an analysis of the practice experience. Carper’s (1978) four ways of knowing is used to discuss personal learning and development.

Author
Nora O’Callaghan is nurse tutor, Mater Misericordiae University Hospital, Dublin. Email: nocallaghan@mater.ie

Keywords
Education: practical experience; Education: teaching staff; Reflective practice

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles and author guidelines visit the online archive at www.nursing-standard.co.uk and search using the keywords.

There is increasing literature on the benefits of reflecting on practice. Reflection enables the practitioner to explore, understand and develop meaning and also highlights contradictions between theory and practice (Johns 1995). Carper (1978) views nursing practice as applying different ways of knowing: empirical, aesthetic, personal and ethical. Therefore, understanding these patterns of knowledge allows the nurse to gain an increased awareness of the complexity and wealth of nursing knowledge (Wilkin 2002). This article uses Johns’ (1995) model to explore an episode from practice. Thereafter, connections are made to important themes within nursing that connect expertise and reflection.

Incident
The experience described in this article occurred while carrying out a clinical procedure. (The names have been changed to preserve anonymity.)

I decided that I would accompany Sarah, a third-year student, to dress Joan’s leg ulcer. Because Sarah had previous experience in undertaking wound dressings, I decided that she should take the initiative in the preparation of the equipment. Sarah went to the clean room to set up the dressing trolley for the procedure. In the meantime, I talked to some of the patients in Joan’s room, and had brief interaction with other students on the ward.

I did not feel I had to supervise Sarah in the preparation of the equipment and when she arrived with the prepared trolley we went to Joan’s bed. I told her that she could take the lead by carrying out the dressing and that I would be her assistant. We both helped prepare Joan for the dressing change. I loosened the dressing on her left leg while Sarah opened the sterile pack. After hand disinfection, I added a calcium alginate dressing and a secondary dressing to the sterile field. While Sarah was arranging the sterile field, I then proceeded to add the cleansing solution. I noticed that it was a solution of chlorhexidine 1:2000, which I remembered was not recommended for use with the chosen calcium alginate dressing (Watret and Armitage 2002, ConvaTec 2005). I asked Sarah why she was not using the recommended solution, 0.9% normal saline (Flanagan 1997, White et al 2001, Watret and Armitage 2002). She told me that chlorhexidine 1:2000 was the wound cleansing solution always used with this calcium alginate dressing on this particular ward, to debride leg ulcers. I told her that I did not think that the manufacturer recommended using chlorhexidine solution with this dressing.

After a pause, I again informed Sarah that 0.9% normal saline was the recommended
solution to be used. I did not wish to proceed
with the procedure and suggested to Sarah that
she should check the information with the
clinical nurse manager. She was hesitant but
agreed to ask one of the staff nurses about the
cleansing solution. The staff nurse promptly
came to me and we discussed the matter briefly.
She reiterated what the student had previously
told me about the ward policy. However, she
agreed to check it with the clinical nurse
manager, in light of my opinion on the use of
chlorhexidine.

After another delay, the staff nurse returned
with an answer, acknowledging that 0.9%
normal saline was the optimum solution to use
with this calcium alginate dressing. She informed
me that the clinical nurse manager had contacted
the pharmacy with the query and only then was
happy to allow the 0.9% normal saline to be used
to cleanse the wound. Sarah completed the
dressing and Joan was made comfortable and
given an explanation about her treatment.

Key issues
I did not know Joan before meeting her with
Sarah to carry out the dressing on her leg ulcer. If
the most appropriate cleansing solution was not
used, wound healing could be delayed (Flanagan
1997). Additionally, Sarah would have been
encouraged to perform poor nursing care rather
than evidence-based practice.

Reflection
Reflective practice concentrates on practice as ‘it
is’ and I chose Johns’ (1995) model of structured
reflection to heighten my awareness of how I
think and act. This model has been found to be
attractive to use since the straightforwardness of
the cue questions allows an individual approach
(Heath 1998). These cue questions, which
expanded my thinking, are presented in the
framework of this model.

What was I trying to achieve? I wished to
provide Joan with the optimum psychological
and physical care while having her dressing
changed. My goal for Sarah was that by
encouraging creative, autonomous nursing
practice, she would witness expertise related to
the essence of nursing.

Why did I intervene as I did? I did not wish to
proceed with a practice that I knew was largely
based on ritual rather than current research
findings. My primary concern was for Joan
whose recovery was dependent on nursing
actions. It was also essential for Sarah to see the
need to question practices that may not concur
with current thinking on wound care.

What were the consequences of my actions for:
The patient? Joan was aware that I was willing to
be an advocate for her needs in relation to the
treatment of her leg ulcer. As a result of my
intervention, her hospital stay would be
shortened because of the change in her wound
care practice. Conversely, she may have less trust
in the other ward staff, which may have made her
anxious about her future care.

Myself? I recognised that I did not know Joan
except for a brief introduction by Sarah. Since
Sarah was a third-year student, I felt
disappointed that she had not attempted to apply
wound care theory to practice. Challenging
current practice might help to change attitudes
towards wound care practice on the ward.

The people I work with? The staff nurse on the
ward was pleased that I questioned the practice,
since I perceived that she may have lacked
confidence to do so. However, the clinical nurse
manager did not seem pleased with my
interference. Sarah realised that some practices
that are taken for granted need to be questioned
if nurses are going to provide quality nursing care
to patients.

How did I feel about this experience when it was
happening? I felt ashamed in front of Joan that the
procedure was delayed. The fact that Sarah set up
the dressing trolley and I had not checked it,
annoyed me further. If I had checked previously, I
would have discovered that the cleansing solution
was not the most appropriate for this wound. I was
also disappointed that Sarah had followed a ward
routine without question. I was reluctant at first to
challenge the practice but I knew that my duty and
responsibility (Sarvimaki 1995) required me to
intervene on Joan’s behalf in this instance. As a role
model for Sarah, I felt somewhat inadequate since I
perceived that she felt I was disorganised.

How did the patient feel about it? Since Joan did
not complain about her treatment, I perceived
that she was satisfied with it. However, she
appeared concerned about the delay in carrying
out her dressing. She waited patiently when I sent
Sarah to enquire from the staff nurse about the
cleansing solution on the trolley. She did not
question us about the dressing practice and said
she was satisfied when it was completed.

How did I know how the patient felt about it?
Joan appeared to be willing to wait until Sarah
and I were ready to carry out the dressing on her
leg ulcer. She appeared to have confidence in us as
professional nurses because, even though a
different solution was being used than had been
used previously, she did not question or complain
about anything while the procedure was being
carried out.
Influencing factors

What internal factors influenced my decision-making and actions? Since recognising and treating the patient as an individual is an integral part of nursing practice, I felt that Joan deserved the best of care. My knowledge of wound care and previous experience encouraged me to break ward rules since protocols and procedures can sometimes inhibit the development of patient-staff relationships (Morse 1991). It was important that Sarah observed good wound care practice and it was my duty, as a nurse teacher, to demonstrate an acceptable level of competence.

What external factors influenced my decision-making and actions? I knew Joan would not question her wound care because I perceived that she had a high level of confidence in the nursing staff. Her quality of life would probably deteriorate if there was delayed healing of her leg ulcer caused by incorrect treatment being administered. I knew that the most appropriate cleansing agent was readily available, at ward level, and could easily be obtained. In addition, if I had not challenged this practice, Sarah may have continued to adhere to the ward routine. Since she was a third-year nursing student, junior colleagues shadowing her may be exposed to an unacceptable practice.

What sources of knowledge did or should have influenced my decision-making and actions? I did not know Joan but my past personal and professional experience helped me to establish a relationship with her. This involvement demonstrated concern for Joan, while striving to act in her best interest. I gave her reassurance which helped to establish trust between us. Acting as a role model for Sarah helped me to recognise the importance of demonstrating expert technical skills while at the same time empowering her to become an autonomous practitioner. Furthermore, by highlighting to Sarah that normal saline 0.9% is isotonic and non-toxic to wounds demonstrated evidence-based knowledge (White et al 2001, Watret and Armitage 2002).

Alternative strategies

Could I have dealt better with the situation? Regardless of Sarah being a third-year student, I should have checked the contents on the trolley. By doing so, I would have instantly recognised that the cleansing solution chosen was inappropriate to use with this calcium alginate dressing. This would have avoided disruption with Joan who, I am sure, must have wondered what caused the delay in performing her dressing, and perhaps have caused less embarrassment to Sarah by not questioning her in front of the patient. My intuition could have been used to establish a better nurse-patient relationship thereby making the situation less tense, while attempting to solve the problem. Furthermore, for the student, learning in practice is a ‘public performance’. Supporting the student in such a situation can, at times, be difficult, especially if it means questioning a colleague’s practice.

What other choices did I have? My desire to achieve a productive student-tutor relationship allowed me to delegate preparation of the dressing trolley to Sarah. However, while reflecting on this action, I realised that perhaps this was not the best practice. Although Sarah was a third-year student, it was evident that she was not a ‘knowledgeable doer’ (An Bord Altranais 1994) and still needed supervision. I could have reviewed up-to-date information on wound care with her and encouraged her to ask more questions while working in the clinical area.

What would have been the consequence of these other choices? The alternative approaches would have raised the issue of support and guidance for Sarah and better communication with Joan. A quicker recognition by me would have anticipated that Sarah did not tend to ask questions about wound care. If I had questioned Sarah on the rationale for cleansing solution choice, it may have stimulated her into thinking more analytically about her decision.

Since Joan had a calm personality, she may have felt isolated during the experience. If I had developed a better sense of closeness with her before the dressing change I would have felt less guilty after the procedure. Sarah’s shortcomings in her practice became my main priority and this did not help my relationship with Joan.

Learning

How can I now make sense of this experience in light of past experience and future practice? My responsibility in the student-tutor relationship is that the student continues to learn in a professional way while the patient receives high-quality care. The intuitive links between seeing the salient issues in this situation and the way I responded demonstrate good use of my own perception of what might happen. The use of practical reasoning, based on theory, allowed me to question Sarah before undertaking her intervention on Joan. This encouraged the student to gain insight into all the pertinent facts to harmonise her learning. Alternatively, the experience may have left the student feeling humiliated so it may have helped to explain that my role was to help her to learn and not to chastise her.
Above all, I recognise that students continue to follow what other staff members do in the ward and more often than not do not question practice (Perry 2000). In the past, I would not have reflected in any depth on my experiences with students or patients. This reflection has endorsed the importance of establishing a good nurse-patient relationship before undertaking nursing procedures.

**How do I now feel about this experience?** I still feel somewhat uneasy about the experience. The situation could have been easily prevented if I had acted sooner by supervising and questioning Sarah about her intentions before meeting Joan. My action in front of the patient may have left Sarah with a sense of uncertainty about herself as a competent nurse. Identifying the feelings of others is known as ‘emotional intelligence’ (Goleman 1995) and recognising that Sarah would have felt uncertain about which cleansing solution to choose in the situation described hopefully helped me guide her to take the corrective action. Sarah may have felt humiliated in the circumstances but hopefully she was able to use the experience to improve her future practice. I am also concerned that by acting in the way I did without knowing Joan, I may have decreased her trust in Sarah and me, as professional nurses.

**Have I taken effective action to support others and myself as a result of this experience?** Through reflection, the implications of this situation are clearer. As a role model, my duty to the nursing student is of little value unless I can demonstrate that caring is central to nursing knowledge and practice. It has heightened my awareness of professional judgement and can help to transform practice for other students who are learning to deal with complex situations in practice by getting them to also reflect on their actions. Personal knowledge is essential to make ethical choices in patient care rather than merely following ward practices ‘blindly’.

**Ethics** Moral decision-making focuses on what ought to be done in a given situation (Davis 1995). Not following ward practices ‘blindly’ can assist patients to recover, as was the aim of my intervention for Joan. I recognise that all knowledge is subject to change and revision and new methods of enquiry will shape what is right and wrong.

**Personal** This reflective experience has given me more insight into the way that I think about practice. It has heightened my awareness of professional judgement and can help to transform practice for other students who are learning to deal with complex situations in practice by getting them to also reflect on their actions. Personal knowledge is essential to make ethical choices in patient care rather than merely carrying out procedures.

**Discussion**

This article focuses on exploring reflection on a clinical episode, through expert practice. To create understanding and wholeness of the experience, it focuses on (Radwin 1996, Lutz et al 1997):

- **Praxis**
- **Knowing the patient**
- **Clinical leadership**
- **Discourse with self**

**Praxis** Praxis is the act of thinking and doing and making values visible through purposeful action (Lutz et al 1997). The expert nurse turns doing and thinking to strategic use and learns through practising. Understanding knowledge and action underpins the concept of praxis (Ashburner 1996, Lutz et al 1997, Litchfield 1999). The process implies that thoughtful reflection and..
Knowing the patient

awareness of a situation by critiquing it. Mezirow (1981) identified this as critical oneself as an actor in a situation, can be appreciated as thought and action, seeing problem solving. Such an 1996), transcended theoretical and practical nurse. As a nurse educator, speculative thought, was evident because of the influences of a senior non-action (Jarvis 1992, Munhall 1993) by her had reasonable knowledge and experience, regular basis. Although it would seem that she repeated her actions on a problem solving.

Expert nurse include decision-making and decision-making in clinical practice (Radwin 1996). In the experience about the patient's response to his or her illness, I felt I knew the patient by means of a clinical relationship. This occurs when contact between the nurse and the patient is relatively brief (Morse 1991). This is not 'knowing the patient' in Jenny and Logan’s (1992) terms, where time is seen as necessary to accumulate knowledge of a patient’s current condition and concerns. From the brief introduction to Joan, a bond did occur by the development of an immediate ‘liking’ for her (Ramos 1992), which may be underestimated by practising nurses, but I considered it central to professional satisfaction in this particular situation. Indeed, this ability to connect rapidly with the patient is considered central to the nurse-patient relationship (Elcock 1997, Wilkin 2002). Perry (2000) perceives this involvement as the ‘art of nursing’ which is similar to Carper’s (1978) aesthetic way of knowing. The emotional bond between Sarah and the patient was well developed because of her previous experience on the ward. It was evident that she had developed a foundation of trust with the patient and treatment techniques were not challenged by the patient, because of a feeling of safety and containment (Mitchell 1995). This made it difficult for me to enter Joan’s conceptual world and to extract her viewpoint about her illness.

The concept of unknowing has been proposed by Munhall (1993) as a means of understanding others, which she equates to openness. This reflection revealed the presence of unknowing but I never admitted to the patient ‘I don’t know you’. Johns (1995) suggests the use of reflective questions such as ‘Who is this person?’ or ‘How can I help this person?’ as a way of getting to know the patient. While the incident described may be considered as a journey into the unknown with Joan, it did require well-developed self-knowledge and maturity (Titchen 1996). Indeed, development of a relationship between the patient and myself in this case could be considered as an accelerated one, because of the limited time available (Dowling 2000).

Clinical leadership Benner (1984) considers that building and maintaining a therapeutic team is one of the competencies of expert practice. The clinical leader is pivotal to the maintenance of this team by promoting a culture that is collegial and supportive. Despite this assertion, for decades nurses have been rather powerless and have had difficulty taking control of their destiny (Roberts 2000). For this reason, the identity of nursing has been largely subsumed by medicine, resulting in medical and managerial domination (Rodgers 1991, Group and Roberts 2001).

Autonomy in nursing is associated with the freedom to make decisions about practice in conjunction with the freedom to act on those decisions (Johns 1990). This has to be practised within work-related boundaries where nurses can use their judgement in the provision of care. Reflection on the experience with Joan undoubtedly questions the autonomy of the nurse in a bureaucratic organisation because of constraints on his or her decision-making abilities. However, as the student’s leader, I could have been more proactive by supporting her in a better way to make her decision about the patient’s wound.

A culture of learning and support is vital for staff morale and team building (Ashburner 1996, Handy 1997). However, the ‘harmonious team’ approach is often used as a facade to
promote the image of teamwork rather than challenging problems in the work environment (Johns 1992). By confronting wound care practice on the ward, I challenged a ward ritual, which I knew was necessary to provide evidence-based care for Joan.

Advancing nursing practice and developing expertise are influenced by the culture that nurses work in and are significant factors in shaping their world view of nursing (Wilkin 2002). Conway (1996) asserts that a culture that fosters openness and allows nurses to challenge themselves and others promotes the development of confident practitioners.

**Discourse with self** Self-questioning or ‘discourse with self’ has been identified as a significant process within reflective thinking (Teekman 2000). By analysing questions that I asked myself after the experience with Joan and Sarah, I was able to explore my own performance and knowledge base. Indeed, this self-questioning could be linked with tacit knowledge (Benner 1984) gained through experience and personal knowing (Carper 1978), which is knowledge of self. An awareness of self must impinge on practice since our understanding influences our actions (Berragan 1998). While my actions with Joan may not have been perfect (making her wait while organising the correct solution for her dressing), they recognise aspects of experience that cannot be explained but had a positive influence on her. They could be seen as knowing more than one can tell (Polanyi 1967). I would consider that my practice was not only based on application of theory but also on the combination of theory and a knowledge base developed from practice.

In relation to the nursing student, discourse with myself has opened up the education debate for me. While Benner (1984) suggests that an expert nurse must trust his or her intuition, I am not sure whether I encouraged Sarah to develop critical thinking skills (Carney 2000), which is

**References**


considered an essential component of today’s nurse education. Emancipatory curricula with emphasis on adult learning and critical thinking are rapidly overtaking the traditional behaviourist curricula (Thorne et al. 1999). Learners are being encouraged to use knowledge and experience-based learning to provide holistic care. Relationships between students and teachers are based more on partnership, suggesting a paradigm shift in nurse education. It is not surprising that I needed to question Sarah’s performance in the situation described as I reflect and wonder: ‘Was she adaptable, innovative or autonomous?’ I would consider her practice to lack critical thinking and to reflect traditional positivist philosophy. On the other hand, her actions may have been grounded in structural and cultural orientation of the nursing workplace (Thorne et al. 1999). Perhaps the reaction of the clinical nurse manager prevented nurses questioning practice. This cognitive strategy of self-questioning can provide a more proactive stance towards my professional practice.

Conclusion
Reflecting on one’s practice is self-empowering as it provides an insight into personal understanding and control (Teekman 2000). This reflection on experience has recognised the beliefs, frustrations, complexities and contradictions inherent in nursing practice. It has revealed that nursing practice is complex and cannot be fully described.

However, using Johns’ (1995) framework for reflection aims to reveal the inadequacies of a positivist approach to knowledge and practice (Ashburner 1996) and thus lead to new understandings. In addition, it has unlocked creative thinking and allowed me to reinterpret meaning and search for new alternatives. It has also demonstrated that there is still a strong traditionalist view within nursing, which offers new challenges to me as a nurse educator. Carper’s (1978) ways of knowing broaden the scope of thinking and expand it beyond a technical approach NS.