How do nurses experience reflective practice?

In this article...

- How reflective practice (RP) can sustain compassionate care
- Frontline nurses’ views on, and experiences of, RP
- How RP and clinical supervision can be nurtured

Authors
Gary Wilshaw is freelance consultant nurse; Ian Trodden is executive director of nursing and healthcare professionals, both at Pennine Healthcare Foundation Trust.

Abstract

Background
Reflective practice can raise the quality and consistency of nursing care, but there is little evidence of it being part of everyday culture and practice.

Aim
To improve the incidence and quality of guided reflective practice.

Method
Nurses from three trusts attended a focus group to gather experience, views and ideas of reflective practice/clinical supervision. The team also looked at supervision policies of nine trusts, best-practice examples and consulted nurse experts and leaders.

Results
Quantitative results showed that most nurses had some form of supervision but had little opportunity to question and discuss. Qualitative results revealed seven common themes.

Discussion
Project findings show a lack of organised and systematic reflection.

Conclusion
New models of supervision and strengthened nurse leadership are needed to increase reflective practice among nurses.

Guided reflective practice can raise nurses’ understanding of themselves and improve nursing care (Oelofsen, 2012). However, its use as a model of clinical supervision is neither consistent nor widespread (Harrison, 2005).

In response to recent national reports on NHS care failings (Francis, 2013; Cavendish, 2013), the North West Directors Nursing Network for nine mental health and learning disability trusts embarked on work to improve the quality of nursing care. This included improving the incidence and quality of guided reflective practice.

Aims
The project aimed to:
» Ask nurses about their experience of clinical supervision/reflective practice to test the assertion that its use is “neither consistent nor widespread”;
» Learn from trusts, teams and staff;
» Seek ideas on new and creative approaches to reflective practice from individuals, teams and the literature;
» Develop new visions of reflective practice grounded in the lived experience of nurses and the realities of clinical settings.

Literature review
Sawbridge and Hewison talk of the “emotional labour” of nursing (2011). Many studies suggest the failure of some nurses to maintain a compassionate approach towards patients is intimately related to stress, burnout and feelings of not being supported (Maben et al, 2007; Department of Health, 2009). This can lessen their “compassion satisfaction” or pleasure in being effective caregivers (Wallbank, 2013; Wallbank, 2012) and cause emotional disengagement (Bennett, 2009). Therefore, sustaining nurses’ ability to deliver compassionate care is indisputably linked to nurturing their wellbeing (Ballat and Campling, 2011).

Wallbank, a clinical psychologist, shows how well-organised “restorative” supervision – which gives practitioners “constructive space” in which to think

5 key points
1 Guided reflective practice (RP) can raise the quality of nursing but is not part of healthcare organisations’ everyday culture and practice
2 As part of clinical supervision, RP can sustain and nurture nurses’ ability to maintain compassionate care
3 Improving the incidence and quality of RP requires cultural change and the strengthening of clinical nurse leadership
4 A way to promote the habit of RP is to normalise it within the cultural life of the organisation
5 New nurse-led models of clinical supervision are needed in mental health

Reflective practice can raise the quality and consistency of nursing care

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Research

about and process their experiences and devise coping strategies – can help maintain and enhance compassion satisfaction, reduce compassion fatigue and improve staff’s resilience and sense of wellbeing (Wallbank, 2013; Wallbank, 2012).

Method

Twenty-nine nurses from three of the nine trusts were invited to attend a focus group. These included a questionnaire and facilitated discussion to gather quantitative and qualitative information on participants’ experience, views and ideas of reflective practice/clinical supervision.

The project team also looked at supervision policies of all nine trusts, best-practice inpatient examples from Star Wards (www.starwards.org.uk) and Wardipedia (www.wardipedia.org) and conducted a literature review. It consulted four nurse leaders from academia, clinical commissioning, the local area team and the North West project team, as well mental health matrons in Central and North West London Foundation Trust.

Results

Quantitative results

The focus group questionnaires showed that out of 29 participants, 80% (n=23) were engaged in supervision. However, just 22% of these described this as “clinical”, while the remaining 78% (n=18) said it was “managerial”. Of those in supervision, 78% (n=18) described it as regular, 5% (n=15) reported monthly contact and 96% (n=22) described it as one-to-one. Only 4% (one respondent) had experience of group supervision.

Most participants (78%; n=18) said their supervisor was more experienced and/or more skilled than them, but this was largely managerial rather than clinical, with the remaining 22% (n=5) saying their supervisor was less experienced than them. A total of 83% (n=19) were supervised by someone not of their choosing, often their line manager, with only 17% (n=4) choosing their supervisor based on their clinical skills.

Of those in supervision, 91% (n=21) valued the experience and 9% (n=2) did not; 74% (n=17) felt it helped them learn, develop and think more carefully about their work, while 25% (n=5) said it did not. Of the 29 respondents as a whole, only 55% (n=16) believed supervision was valued by their organisation, with 35% (n=10) saying it was not and 10% (n=3) declining to respond.

Discussion

The results showed most nurses had some form of supervision. However, for most this was organisational procedure and performance checking, usually one-to-one, with their line manager. There was a noticeable lack of nurses engaged in a process where their patient care and skills were the focus of sensitive scrutiny, or where they could as individuals, or as a team, share and develop a culture of enquiry, thoughtfulness and empathy towards service users’ needs and team culture or practices. The opportunity to question and discuss “what is going on” in a dynamic sense was almost absent.

While this was only a small sample of nurses, facilitators gained a sense that their views were broadly representative. There was a slight inpatient bias, with 55% (n=17) of participants working in inpatients, compared with 38% (n=9) in the community.

Qualitative results

Information from the focus groups and other sources was analysed and organised into the seven themes below, drawing on the “grounded theory” qualitative research approach (Glaser and Strauss, 1967).

Good practice

Some of the best examples from informants and the literature emphasise looking after nurses’ own health and wellbeing.

Box-ticking versus sensitive self-scrutiny

Nurses felt little attention was paid to what it was like for them engaging in emotionally difficult work. Time spent discussing interaction with users was rare, and tended to be “technical”, around risk assessment or electronic records. Staff were usually only brought together to “go over things” when there was a problem; one participant described feeling the sense of emotional impoverishment (Box 2, p24).

Chore-based nursing

Reducing nurses’ work to a series of tasks can have a dehumanising effect, described by one informant as a loss of “one-ness” or connection with the patient. Reflective practice, through promoting “thoughtfulness”, can guard against nurses viewing their work as a series of chores and help them stay emotionally and intellectually engaged with their work. (Box 3; p24).

Clinical versus managerial

Only four of the 29 nurses experienced regular supervision that was clinical, supportive or educative, rather than managerial. Our research suggested this may partly be due to the challenging nature of reflective practice/clinical supervision, both for supervisors and practitioners, along with a common narrative that administrative work leaves “no time”. Two focus groups believed nurses could sometimes avoid it because they find it threatening.

Impoverished versus well-off teams

Community nursing seemed to offer more opportunities for ongoing personal development, in particular reflective practice, than inpatient settings. Informants partly attributed this to appointment-based community staff having greater diary control, engendering greater feelings of autonomy, self-esteem and professionalism. Reflective practice was largely absent in inpatient teams, with nurses observing that “skeleton” staffing and the need for one-to-one patient observation only left time to attend to patients’ basic physical needs. They felt this was causing a “brain drain” of mental health nurses into the community, leaving “inpatient units dominated by experienced healthcare assistants”.

The role of commissioning

Senior managers believed reflective practice needed to be addressed by commissioners to embed it in the culture. Two suggested linking quality targets to payment; another addressing it through the nursing leadership of commissioner and provider organisations. Our findings overall suggest it is important to address quality, not just uptake, and that compassion satisfaction could be one measure of quality (Wallbank, 2013).

Box 1. RECOMMENDED GOOD PRACTICE

Values-based team reflective practice

Developed at Calderstones Hospital, Lancashire, this involves monthly, structured reflected practice meetings of the ward team, including:

- Case study-led reflection by a team volunteer;
- Issue-based reflection;
- An evidence-based theme looking at a theory, concept or legal matter;
- Team members help plan topics and take responsibilities, with external facilitators and teachers invited to help educate and stimulate reflection.

Schwartz groups

This is a US model piloted in UK hospitals, providing a multidisciplinary forum for staff to explore psychosocial and emotional issues in caring for patients (Goodrich, 2011).

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Trusts involved in the research are now taking this work forward. For example, Pennine Care Foundation Trust has made supervision a priority and is working with Edge Hill University to redefine supervision, including developing outcome measures of uptake and satisfaction. It is also linking it into revalidation and the training of unqualified care staff.

Conclusion

Studies suggest guided reflective practice raises the quality of nursing and helps provide and sustain compassionate care. However, our research suggests a serious lack of organised and systematic reflection among nurses. Remedying this requires new models of supervision, but also a strengthening of clinical nurse leadership to create a culture in which reflection on practice is more likely to occur.

References


Sawbridge Y, Hevison A (2011) Time to Care? Responding to Concerns about Poor Nursing Care.


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A new model of reflection for clinical practice

Bit.ly/NTReflectiveModel

An appropriate model

There was support for a model developed at Calderstones Partnership Foundation Trust (Box 1) and some interest in coaching.

Asked what they most wanted to see from supervision and reflective practice, informants suggested:

» Strong clinical leadership, with supervision led by skilled and senior nurses rather than management;

» Addressing the whole team culture as well as individual skills and abilities;

» Including an evidence base to guide thinking and educative element;

» Leaders and participants to promote thoughtful and modelling of compassion;

» Organisational commitment;

» High-quality discussion and content;

» Promoting autonomy, accountability and challenge, and fostering a new confidence among nurses;

» A sense of collegiality.

Discussion

If our findings are representative of practice more generally, they show a serious dearth of organised and systematic reflection among nurses about nursing. Organisations may assume it happens more frequently than it does, and fail to address the factors and dynamics that truly and effectively promote thoughtfulness, and therefore compassion. It may also reflect a lack of value given to such processes, which could be indicative of a broader NHS culture in which “human skills” are at risk of falling off the agenda.

Recommendations

Our research suggests that remedying this situation requires more than just new models of supervision, but demands a strengthening of clinical leadership to achieve cultural change. From our findings, and consideration of the broader healthcare agenda, we recommend that trusts and nursing directors:

» Design, pilot and evaluate a focused and routine use of reflection as part of handover time or equivalent, drawing on the Schwartz round approach;

» Adapt and implement, as part of action-based research, an independently validated version of the supervision model at Calderstones Partnership Foundation Trust (Box 1);

» Work with commissioning organisations to strengthen nurse clinical and care leadership;

» Incentivise reflective practice, such as showcasing good practice, offering rewards such as vouchers, recognising leadership in grading and promotion;

» Ensure each ward has a clearly defined clinical leader, focused on patient care and compassionate nursing, rather than administration.

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