

AN EDUCATIONAL PROGRAMME TO FACILITATE  
REFLECTIVE PRACTICE FOR REGISTERED  
NURSES IN TRAINING HOSPITALS IN WINDHOEK

DISSERTATION SUBMITTED IN FULFILLMENT  
OF THE REQUIREMENTS FOR THE DEGREE OF  
DOCTOR OF NURSING SCIENCE

OF

THE UNIVERSITY OF NAMIBIA

BY

L.N.NELUMBU

9208623

JULY 2013

Main Supervisor: Prof. A van Dyk

Co-Supervisor: Dr. L. Pretorius

**DECLARATION**

I, Lucia N. Nelumbu declare that the study on “An educational programme to enhance reflective practice for registered nurses in training hospitals in Windhoek” is a true reflection of my own research and that neither this work or nor any part thereof, has been submitted for any degree in any other institution of higher education.

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## **ACKNOWLEDGEMENTS**

I would like to thank God for giving me physical strength and mental health. It was through the guidance of the Almighty that I could succeed to complete this study.

I would like to thank the following people who contributed to the success of this study.

I would like to express my heartfelt gratitude towards my supervisor, Prof. A. van Dyk who, through her scholarly and educative advice, helped me to produce this work. I also would like to acknowledge with appreciation the assistance of Dr. L. Pretorius for her continuous input and valuable advice. I also would like to thank my colleagues in the School of Nursing and Public Health for their encouragement.

My words of thanks are especially extended to my colleague Dr. P. Angula for assisting in programme implementation. I also would like to thank Dr. J. Kloppers and Dr. K. Amakali for their assistance during the programme evaluation. My words of thanks are also extended to the registered nurses in training hospitals in Windhoek who responded to my interviews and participated in evaluating the developed programme. Their cooperation and prompt responses have enabled me to complete this study. My heartfelt thanks are also due to Mrs. Sally Kauluma who proofread my study.

My utmost gratitude goes to my husband, Rev. Dr. M. Nelumbu, who has been by my side encouraging and helping me with technical aspects of the dissertation. Last but not least, I would like to thank my dear children, Haitange, Meke and Pena for their encouragement and patience to accept their mother's busy schedule which deprived

them of her adequate attention.

**ABSTRACT**

Illness is an evitable part of life for the vast majority of people. The nurses' reactions to people who are ill or who are in need of health care are influenced and shaped by their own personal qualities, such as sensitivity, understanding and honesty as well as the professional attributes, skills, competencies, attitudes and cognitive abilities necessary for effective practice.

Problems or incidents occurring in clinical settings are often seen as indicators of poor nursing care and even indicators of a lack of reflective practice skills. The purpose of the study was to explore and describe how reflection is practised by registered nurses. The objectives of the study were to explore and describe how reflection is practiced and conceptualised by registered nurses in Namibia.

A qualitative, explorative, phenomenological, descriptive and contextual approach was used. Data were collected from the population, including all registered nurses purposively selected from different disciplines in training hospitals, through in-depth interviews. The data were analysed according to themes based on the ideas of Tesch's model, and revealed inadequate knowledge of reflective practice among registered nurses as they only expressed the execution of their daily activities without paying attention to how they reflect in daily practice.

Hence the reflective practice programme was developed and implemented to offer knowledge and skills to effectively address the clinical challenges which registered nurses may encounter in terms of reflection. The evaluation of the programme was conducted sixteen weeks (4 months) after the programme implementation, with the overall results showing that reflective practice would assist registered nurses to think critically and to engage in reflection upon professional practice activities that would lead to the improvement of their performances. The main recommendations made were among others, that nursing education in Namibia must make reflective practice a compulsory competency of registered nurses and all health care providers, and should be included in the curriculum of all student nurses.

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## **CHAPTER 1**

# **INTRODUCTION AND THE BACKGROUND TO THE RESEARCH PROBLEM**

### **1.1 INTRODUCTION AND RATIONALE**

Illness is an inevitable part of life for the vast majority of people. The nurses' reactions to people who are ill or who are in need of health care are influenced and shaped by their own personal qualities, such as sensitivity, understanding and honesty, as well as the professional attributes, skills, competencies, attitudes and cognitive abilities necessary for effective practice.

A profession in order to continually develop as a discipline, needs to generate knowledge that can evolve from education and practice. It is also expected that registered nurses be competent practitioners able to render quality care. This implies that nurse practitioners must have critical analytical thinking abilities as well as empathy and moral values (van Vuuren and Botes, 1999). One of the processes that can accommodate these thinking skills is reflective practice.

Reflective practice is commonly used by professionals as they meet new and different situations as well as challenges but reflective practice is more than just thoughtful practice. Reflective practice is understood as the process of turning thoughtful practice into a potential learning situation (Finlay, 2008). Reflective practice has been used to bridge the gap between nursing theory and practice and to articulate and develop nursing knowledge embedded in practice (Chong, 2009).

The concept of reflective practice has been described in literature but it may not be known to all concerned and is also not rigorously tested or applied in practice. In order to understand the concept of reflective practice well, it would be better to look at its derivation.

The educationalist and philosopher John Dewey developed his ideas on thinking and learning and focused on the concept of thinking reflectively, defining reflection as “active persistent and careful consideration of any belief or supposed grounds that support it and the further conclusions to which it tends.” Dewey made some important assumptions about people, emphasizing their tendencies towards quick solutions, traditions, and ‘mental ruts’ and the pervading influence of culture and the environment upon their thinking. He also emphasized the need for thinking to be directly linked with action, demonstrating the pragmatic nature of his philosophy, and suggested that any

thinking can be intellectual, thus emphasising the importance of the practical as well as the theoretical (Bulman & Schutz, 2004).

Dewey (as cited in Kinsella 2009) viewed reflection as an important aim of education and believed that people should acquire the general habit of reflecting. He explained the concept of reflection in terms of reflective thought which he said is “active, persistent and careful consideration of any belief or supposed form of knowledge in light of the grounds that support it and further conclusions to which it tends.” Dewey maintains that reflective thought converts action that is merely appetitive, blind and impulsive into intelligent action. Therefore, Dewey’s work had a major influence on educational ideas and influenced the works of many authors like Schön (1983, 1987), Boyd and Fales (1983) and Boud et al. (1985) (Bulman & Shutz, 2004, p. 2).

Furthermore, the concept of reflection also had an influence on nursing education which provides a foundation for reflection on nursing practice worldwide in terms of the developing expertise of nurses in action.

Reflective practice is considered a professional development process incorporating different assumptions. For example, it assumes that professionals are competent and

able to assume responsibility for detecting and addressing weaknesses in their practice (Osterman & Kottkamp, 2004).

Schön (cited in Bulman & Schutz, 2004, p. 2) identified two types of reflection, reflection-in-action and reflection-on-action which he defines as follows: ‘reflection-in-action’ happens where we may reflect in the midst of action without interrupting it. In other words our thinking serves to reshape what we are doing while we are doing it, while reflection-on-action is: “thinking back on what we have done in order to discover how our knowing in action may have contributed to an unexpected outcome”. We may reflect after the fact in tranquility, or we may pause in the midst of action-stop and think. Similarly reflection-in-action has been described in literature as the process whereby the nurse practitioner recognizes a new situation or problem and then thinks about it while still acting (Burns & Bulman (2000).

Furthermore, reflection was defined as learning from events and incidents experienced during a course or practical professional programme and learning from analysis of experience gained in the clinical setting. It is also important to recognise that reflection involves the students and the experience with the aim of building bridges between past and present experiences to determine future nursing actions (Durgahee, (1998).

The above-mentioned definitions of the great philosophers can support and shape our understanding of the concept of reflective practice. These can help us to understand that when we talk about reflective practice we mean the process of thinking in practice where one examines or reflects on experiences and during which one makes sense of experiences and comes to a stage of making a decision for a proper plan of action.

Reflective practice, in contrast, views professional development as a more complex process that requires change in held theories. To be able to address weaknesses in practice the skill of self-awareness is needed. To address the weakness, the will to change and improve practice is necessary. While reflective practice shares a common goal with other more traditional approaches to professional development—that of improved practice—its approach is noticeably different. In traditional professional development there is an assumption that changes come about through access to new information. For reflective practice to take place there are underlying personal skills involved (Osterman and Kottkamp, 2004). According to the theorists these underlying skills are self-awareness, description, critical analysis, synthesis and evaluation and are briefly described below (Bulman & Schultz, 2004).

**Self-awareness**

Self-awareness is referred to as knowing oneself, being conscious of one's character, including one's beliefs, values, qualities, strengths and limitations. Self-awareness may be described as the foundation skill upon which reflective practice is built (Bulman & Schutz, 2004).

**Description**

Description is an act of describing something whether it be, a person, an object, a situation or an abstract concept or idea, to state its characteristics or appearance without expressing a judgement (Bulman & Schutz, 2004).

**Critical analysis**

Critical analysis is a key skill for both reflective practice and academic work. Examples of using critical analysis in professional practice include assessing the needs of an individual patient as well as making a broader contribution to service and policy development (Bulman & Schutz, 2004).

**Synthesis**

Synthesis is defined in the Oxford Dictionary as the "process or result of building up separate elements, especially ideas, into a connected and coherent whole". It has been

further described that when using reflection, synthesis is the ability to integrate new knowledge, feelings or attitudes (Bulman & Schutz, 2004).

### **Evaluation**

Evaluation is the ability to make a judgement about the value of something. It entails a “looking back”. Evaluation is a personal process in which one examines oneself, frequently over time. This is an important component of reflective practice and professional education. Evaluation is future-orientated it may involve finding discrepancies between what is said and needed, and what is actually done in order to make necessary changes (Bulman & Schutz, 2004).

The importance of these underlying skills has been reinforced by a number of small-scale research projects that examined the development of reflection in nurses. The purpose of reflective practice is to enhance awareness and understanding of one’s own thoughts and actions as a means of professional growth. To be able to understand your own thoughts and actions, an environment conducive to professional growth which includes support, guidance and opportunities is necessary (Bulman & Schultz, 2004).

Nursing is dynamic and is constantly changing into responsibilities to developments in health care, social needs and professional needs. In order to achieve the aim of nursing education the provision of quality care should be based on the appropriate theory and its proper application into practice, the vehicle being reflective practice. If registered nurses cannot apply reflective practice to provide quality patient care, then they have to make sure that they possess the knowledge and skills in the integration of both processes of reflection-in-action and reflection-on-action, into their daily work. Each registered nurse should be able to learn to be reflective or introspective about their own thinking focused on deciding what to do. The attentive commitment to a self-reflective process of examining one's thoughts ensures that the thinking occurring meets intellectual standards (White & Duncan, 2002).

Proper nursing care is based on identification of priority needs. Incomplete information or analysis of client needs will result in inappropriate or inadequate nursing care. Thus the ability to identify and prioritize client care problems depends on the completeness of registered nurses' knowledge base and reflection.

Reflective practice is more widely applied in some countries such as in Australia, New Zealand, and the United Kingdom. It transcends mere "doing" and is often emphasised with a concentration on "being". Now reflective practice is fundamental to Australian

clinical nursing practice. In the United Kingdom, reflection is used as a tool for learning that integrates theory and practice; a means to both develop and research practice that is essential to effective learning and caring (Sherwood, Freshwater, Horton-Deutsch & Taylor, 2005). Therefore there is a need to introduce this concept in Namibia to facilitate the application of reflective practice by health staff for better patient care. It was also stipulated in literature that reflection is the process used to analyse and raise the students' level of awareness and insight into nursing situations. It is also important to look at how a reflective process is facilitated, and what conditions are necessary for students to be able to reflect in groups (Durgahee, 1998).

Reflective practice in nursing can be a valuable problem-solving process for individuals and small groups. It can improve interpersonal relationships and thereby enhance the process of care-giving. Reflective practice can form an essential process within professional and personal development.

In nursing education reflective practice is also an opportunity for learners to identify what connections they have made, evaluate what they have learnt in their practice and consolidate their knowledge (Henderson, Winch and Heel, 2006). Furthermore, students seek deep engagement in learning, and relevance produces engagement. A relevant problem rivets attention and arouses the need to learn (Osterman & Kottkamp, 2004).

It has been advocated that reflective practice is an opportunity for learners to identify what connections they have made, evaluate what they have learnt in their practice and consolidate their knowledge (Henderson, Winch and Heel, 2006). Doing this will produce competent registered nurses. Effective clinical reasoning in nursing practice depends on the development of both cognitive and meta-cognitive skills. Cognitive refers to critical thinking which involves reasoning while meta-cognitive refers to reflective thinking which exists through explanation of the dynamics of problem-solving and clinical reasoning in nursing practice (Kuiper & Pesut, 2004). This means reflecting upon the patients' problems that the registered nurses have identified and the nursing interventions that were used to solve the identified problems, as well as the results of these interventions.

For learning to occur, experiences must be transformed. Transformation happens through either extension or intention. Extension is further described as a process achieved by active external experimentation, while intention is achieved through internal reflection of the experience (Lisko & O' Dell, 2010).

Reflection not only applies to students, but is relevant to anyone who is about to learn. Therefore some authors described critical reflection as the process by which adults identify the assumptions governing their actions, locate the historical and cultural

origins of the assumptions, question the meaning of the assumptions and develop alternative ways of acting. As such, reflective practice aims at producing competent, knowledgeable and skilful health professionals who can provide nursing care which is based on sound knowledge and proper skills. Experiences in 'real life' settings need to be effectively facilitated to obtain the desired outcomes (Stein, 2000-2001; Henderson, Winch and Heel, 2006).

Some arguments were made that for reflection to be successful it has to be shared, either with oneself at a later date or, preferably, with others. It was also mentioned that reflection in nursing is an important learning tool in clinical teaching and it is necessary to show us that we are aware about ourselves, events and people around us. Pertaining to clinical practices, reflective learning is an important process that enables the discovery of knowledge for practice. Lyons also argued that reflective learning challenges human abilities to examine their actions. Again reflection is described as a process that encompasses cognitive and affective skills (Cruickshank, 1996; Lyons, 1999).

To further our understanding of the concept there is a need to have a look at descriptions of some authors who defined three levels of reflectivity and supported each other. Level one, or non-reflection, is the absence of reflective thought. In level two,

reflection is defined as awareness of judgements, observations, and descriptions, evaluation of planning and assessment of decisions. Critical reflection, or level three, is the process of reflection and includes assessment of the need for further learning and awareness that routines are not adequate and a change in perspective is needed. They also pointed out that the aim of clinical teaching is to produce competent registered nurses capable of giving expert nursing care which is based on sound knowledge and practical skills (Kuiper & Pesut, 2004; Mellish, Brink and Paton, 2004).

If reflective practice is not exercised even in a small way and there is also no support or guidance from the health care institution for practicing registered nurses, then the quality of care that is provided would be questioned. A question can also be raised with regard to the professional growth and development of nurses. Even when registered nurses are involved and committed, translating new ideas into practice is a complex process and a goal that has largely eluded professional development efforts (Osterman & Kottkamp, 2004).

Work can be satisfying and meaningful or it can be repetition and tedious. When work is a checklist routine and boring or a source of constant anxiety, people are viewed as procedures focused and are easily dismissed thoughtlessly with little appreciation for how or why the tasks are being done. Thus daily habits and routines are rich areas for reflection, because they show you why you are practicing in a taken for granted ways

and how you might be able to make changes, given the constraints under which you work (Taylor, 2000).

## **1.2 PROBLEM STATEMENT**

It is currently not clear whether registered nurses in Namibia exercise reflective practice during their daily practices or not. This concern is raised by some incidents that often occurred in clinical settings which could be an indication of poor application of reflection. Furthermore, people have individual learning styles and may learn in different ways depending on their personality, maturity and experience. It is also not clear what kind of support and guidance are provided by the health care institutions to develop a culture of reflective practice.

It has been noted that registered nurses in nursing wards are de-motivated due to many factors, one of which could be lack of proper reflective practice. These registered nurses are often required to guide students and to improve the quality of nursing care. Registered nurses surveyed expressed their needs in this regard. The latter situation is also confirmed in the literature as follows:

- Problems or incidents occurring in clinical settings are often seen as indicators of poor nursing care and even indicators of a lack of knowledge and skills to develop reflective practice.
- Despite a great deal of academic debate and some research, the concepts of reflection and reflective practice remain poorly understood and applied (Hargreaves, 2004).
- Lack of continuous staff development training and not trying to remain up to date with current trends in nursing care and professional development (Hargreaves, 2004). Some of the registered nurses are performing activities as a routine without reflection-in-action or reflection-on-action taking place.
- Ineffective interpersonal relations between nurse managers and registered nurses about reflective practice.
- Registered nurses are not encouraged to reflect on their daily experiences or to analyse their reactions and feelings towards issues raised in practice. Thus information about reflection is needed for nurses to perform their nursing duties more effectively.

Reports of patients receiving poor nursing care, as well as unethical treatment by nurses seem to be common. This type of behaviour leads not only to disciplinary hearings, as reported by the Nursing Council of Namibia, but also to a decline in nursing care, which has an effect on the image of the nursing profession.

There is a gap in the literature regarding research on reflective practice by registered nurses. Many of the studies have been carried out by educationalists who are often researching their own students and thus there may be unattended issues when it comes to reflective practice. The other evident factor in the literature is that researchers on the whole do not offer a great deal of detail or evidence about how nurses were actually prepared and facilitated to develop reflection. This was supported by Bulman and Schutz (2004) who noted that they tend to focus on the outcome, and thus there is less nursing research evidence about the process of reflection.

Although critical reflection is described as the process by which adults (registered nurses) identify the assumptions governing their actions, locate the origin of the actions, question the meaning of the assumptions and develop alternative ways of acting, it seems that this is not always done to ensure quality of nursing care (Stein, 2000-2001). The provision of a high standard of nursing care is expected from registered nurses.

Some examples of texts written by educationalists in the area of reflection and reflective practice such as Schön and Ghaye and Lilliman (cited in Hargreaves, 2004) were highlighted; yet they do not explicitly provide examples of how they assess reflection. Several attempts in this area have been made by scholars such as Burns and Bulman (cited in Hargreaves, 2004), especially in the area of nursing education, without their

offering all solutions to this problem. Wong et al. and Jasper (cited in Hargreaves, 2004) have also propounded valuable ideas in the area of reflection but they too do not provide solutions (Hargreaves, 2004). The above observations constitute substantive reasons to describe reflection and reflective practice as educational aspects for which further research needs to be conducted, specifically in the area of self-evaluation of registered nurses.

The literature confirms that reflective practice is one of the most popular theories of professional knowledge in the last 20 years and has been widely adopted by nursing, health, and social care professions. But despite its popularity and widespread adoption, a problem frequently raised in the literature concerns the lack of conceptual clarity surrounding the term “reflective practice” and indeed surrounding the notion of reflection itself (Kinsella, 2009).

Some nursing research has been done relating to reflection and the education of student nurses. These studies explored undergraduate students who reflected on practice via journal writing; it was found that most of the journal entries of students were at the lower levels of reflection (Epp, 2008). This observation is confirmed by Lyons (1999) who holds that reflection has been a frequently used but inadequately defined concept in nursing and midwifery. There are few studies done on the investigation or exploration

of the reflective practice by registered nurses. Just as it was pointed out that although there is much nursing literature on reflection, there is limited specific information for registered nurses about reflective practice (Asselin, 2011).

In the context of the above concern, several authors suggested that there is a need for an experienced mentor, guide or facilitator to assist nurses in the process of reflection (Asselin, 2011). Without any exception, to date there has been no study conducted on reflective practice of registered nurses which identified the extent to which reflective practice was utilized in nursing education or clinical practice in Namibia. Therefore the researcher has taken this initiative to take a critical approach in investigating and assessing the status of reflective practice in a clinical setting within Namibia.

Concerning the above mentioned challenges the following questions are asked:

- “Do registered nurses reflect on their daily practices and how do they do it?”
- “How can reflective practice in nursing care be facilitated?”

### **1.3 PURPOSE OF THE STUDY**

The purpose of the study was to explore and describe whether reflective practice is demonstrated in practicing nursing, and to develop, implement and evaluate an educational programme which can facilitate reflective practice for registered nurses in order to improve the provision of nursing care.

## **1.4 OBJECTIVES**

The objectives of the study were to:

- explore and describe reflection as practiced by registered nurses;
- develop a conceptual framework to facilitate reflective practice;
- develop and implement an educational programme of reflective practice for registered nurses;
- evaluate an educational programme of reflective practice.

## **1.5 SIGNIFICANCE OF THE STUDY**

This study would improve reflective practice in nursing and thus facilitates professional and personal development of nurses. It would also stimulate the cognitive level of the registered nurses on the concept of reflective practice that will enable them to see their practice in a different and unique way.

The development of a professional conscience is rooted in reflective practice. The development of a reflective practice culture seems to be influenced by various factors and the nursing educators and registered nurses form an integral part of this process. It

is therefore important that registered nurses need to be supported in the development of reflective practice to enable them become competent registered nurses who will reflect on the qualities needed to provide quality patient care and uphold the image of the nursing profession.

This study endeavoured to provide registered nurses with an educational programme of reflective practice that would support the process of reflective practice in nursing care. Furthermore, applied knowledge of reflective practice would also be developed and by that a culture of reflective practice could be established by registered nurses.

## **1.6 FOUNDATION OF THE STUDY**

The foundation of the study was discussed in terms of the philosophical paradigm and conceptual framework.

### **1.6.1 Philosophical approach**

For any study to have a meaningful outcome it should be conducted within a disciplined format. Thus the programme of this study would also be based on one of the philosophical paradigms of nursing research.

The Naturalistic or Constructivist paradigm was selected for the study. Constructivism assumes that knowledge is maximised when the distance between the inquirer and those under study is minimised. It emphasises that the voices and interpretations of study participants are important to understanding the phenomenon of interest, and subjective interactions are the primary way to access them (Polit & Beck, 2012).

The data for this study were collected within the framework of the constructivist paradigm. This was particularly employed in the interviews done by the researcher to obtain data from the participants on how they perceive and apply the concept of reflective practice in clinical practice.

The constructivist perspective is founded on the idea that humans actively construct their personal realities and create their own representational models of the world. In this view, professional practitioner is like an artist, a maker of things (Kinsella, 2009). For this study, it is understood that registered nurses construct their own world of the meaning of nursing practice and reflection.

### **1.6.2 PARADIGMATIC PERSPECTIVE**

“Paradigmatic is a world view, a general perspective, a way of breaking down the complexity of the real world” (Polit & Beck, 2012, p. 11). It is an interpretational framework that influences the research because it is guided by specific beliefs,

perceptions and feelings (Mouton and Marais, 1993). The paradigmatic perspective for this study would be based on meta-theoretical assumptions.

### **1.6.2.1 Meta-theoretical assumptions**

Meta-theories are defined as theories about the description, investigation, analysis or criticism of the theories in a domain. As such, they are broader and less specific than theories. Thus they are more or less conscious or unconscious assumptions behind theoretical, empirical and practical work and are connected to philosophical views. Nurses deal with persons in need (Lor, 2011). In this study meta-theoretical assumptions are contextualised in the light of nurses who are providing nursing care to the patients in practical settings.

According to Polit and Beck (2008) paradigms are world views characterised in terms of the ways in which they respond to basic philosophical questions such as the following:

- Ontologic: What is the nature of reality?
- Epistemologic: What is the relationship between the inquirer and that being studied?
- Axiological: What upholds subjectivity and values of the study?

Each of these philosophical assumptions is discussed here in turn.

- **Ontological assumptions** refer to the inquiry about the realities as constructed by individuals. Polit & Beck (2008) are of the opinion that for the naturalistic inquirer, reality is not a fixed entity but it is rather a construction of the individuals participating in the research; reality exists within a context (hospital) and many constructions are possible—for example, patient care. Within this context, the study would take into cognisance different views of the participants with regard to their perceptions and own views of reflective practice.
  
- **Epistemological assumptions** refer to the way the researcher as an inquirer interacts with those being researched and the findings which would result from this interaction process. In the context of this study, epistemological assumptions imply the researcher's approach and conduct before the participants, the way she engages and motivates them in the discussion on reflective practice and how she collects the necessary information on this concept. What should be borne in mind here is the fact that epistemologically, the naturalistic paradigm assumes that knowledge is maximized when the distance between the inquirer and the participants in the study is minimized (Polit and Beck, 2012). In other words, the opinions and suggestions of the participants are to be recognised and respected by the researcher. This would only become a reality when the researcher provides an environment conducive to the participants to expressing themselves freely.

- **Axiological assumptions** refer to the particular assumption which upholds subjectivity and values of the study (Polit & Beck, 2012). Within this context, the study adheres to the principles of subjective findings and it also honours what the participants perceived as valid and necessary for the improvement of nursing practice, based on their own values.
  
- **Methodological assumptions** refer to the best way of obtaining evidence or knowledge. Evidence for a scientific study is gathered according to a specified plan, using formal instruments to collect the needed information (Polit & Beck, 2012). Accordingly, it is essential for a scientific study to understand phenomena, not in isolated circumstances alone, but in a broad and general sense. With regard to this study, the primary aim of the researcher is not necessarily to find out the individual participants' narrow understanding of reflective practice which is confined only to their individual situations, but to obtain a wider perception of reflective practice which is applicable to other broader contexts (see Chapter 2).

## **1.7 Theoretical basis of the study**

### **1.7.1 Conceptual framework**

According to the literature, the term “conceptual model” refers to interrelated concepts or abstractions assembled in a rational and often explanatory scheme to illuminate relationships among them; it is sometimes called a conceptual framework. It was further

explained that in a study that has its roots in a specified conceptual model, the framework is a conceptual framework (Polit & Beck, 2012). The practice-oriented theory, which is an aspect of the conceptual framework of Dickoff, James and Wiedenbach (1968), is used in this study to conceptualise the findings. This framework concentrates on the following questions:

- What or who performs the activity?
- What or who is the recipient of the activity?
- In what context is the activity performed?
- What is the guiding procedure?
- What is the energy source for the activity?
- What is the end point (product) of the activity?

The application of this framework is described in detail in chapter 4.

Nursing science is a human science, and according to Mckenna, Richardson, & Manroop (2011) human science values subjective opinion, beliefs, personal knowledge and descriptions of experiences and feelings, many of which are not amenable to objective verification. Intuition, understanding, reflection, meanings and experiences are central components of the human science approach. This statement correlates with the values of the nursing profession which can be summarised as beliefs held about worth, truth and principles that could serve as guidelines and directives for personal choices and decisions in our lives and daily practices (Kotze, 2008). The theoretical basic aspects of the study are discussed below:

The educational programme which was developed is based on the following: Kolb's theory of experiential learning, Rolfe's reflective practice framework, and Knowles's andragogy for learning as well as the nursing process and humanistic philosophy.

### **1.7.2 Kolb's experiential learning**

Experiential learning is defined as the process whereby knowledge is created through the transformation of experience. Kolb, who is the pioneer of the theory of experiential learning, developed four stages of the cycle namely: concrete experience, reflection, abstract conceptualization and active experimentation (Johnson, Sonson and Golden, 2010). The reflection stage from this cycle is seen as the core for reflective practice, and the developed reflective practice programme would be facilitated through the experiential learning approach. Detailed discussions on this learning cycle are found in Chapter 5 of this study.

### **1.7.3 Rolfe's reflective practice framework**

Frameworks of reflection are devices to help a person with reflection and it was advocated that the use of a reflective practicum is a way to operationalise the process of thinking. Rolfe's framework consists of the three questions: "What?", "So what?", and "Now what?". It was pointed out that reflective practice is a conscious process of

thinking, analyzing, and learning from work situations (Bolton, 2008; Forneris & Peden-McAlpine, 2006; Cirocco, 2007).

The relationships between these three questions are illustrated and discussed in Chapter 5 of this study.

#### **1.7.4 Knowles's andragogy assumptions**

Andragogy assumptions were developed in order to differentiate learning in childhood from learning in adults. This also can be applied to the registered nurses involved in this study, because they are also adult learners. Knowles's andragogy focused on the following assumptions: self-concept, experience, readiness to learn dependent on need, problem-centered focus, internal motivation and that adults need to know why they need to know something (Keese, n.d.; Caruso, 2010; Atherton, 2011; Smith, 2002).

#### **1.7.5 Nursing process**

The nursing process can be described as a problem-solving approach that enables the nurse to provide care in an organised manner. Its goal is to minimise or prevent actual or potential health problems. This process is applied to this study to underscore the relationship between Kolb's experiential learning cycle and Rolfe's reflective practice framework and their application into clinical practice.

These assumptions, with their relevant application to this study, are described in Chapters 4 and 5.

## **1.8 OPERATIONAL DEFINITIONS**

### **1.8.1 Facilitate**

To facilitate is to assist or influence positively, for example, to facilitate the utilization/ implementation of the programme.

### **1.8.2 Programme**

Programme is defined as a planned series of events, a set of related measures or activities with a long term aim (South African Concise Oxford Dictionary, 2007).

### **1.8.3 Reflection**

Reflection is variously defined in literature as the process used to analyse and raise the practitioners' level of awareness and insight into nursing situations. It is also explained as a process of re-organizing knowledge and emotional orientations in order to achieve further insights. In practice, it can be defined in terms of learning from recognised mistakes or ineffectiveness in practice (Durgahee, 1998; Moon, 2004). As such,

reflection is also the process of examining and exploring an issue of concern triggered by an experience, which creates and clarifies meaning in terms of self and which results in a changed conceptual perspective (Heather & Cuevas, 2008).

The use of reflection on practice is described extensively in the literature and there is often an assumption that health professionals regularly reflect on their practice. As such, reflection in the practice of nursing can be understood as a process of thought whereby nurses think seriously about the condition or problem which they have observed and analysed in order to find a possible solution to a particular condition or problem. It was also underscored that emphasis has been placed on reflection as a means of ensuring that practitioners are competent. It is believed that the reflective process encourages critical thinking and problem-solving. Furthermore, it was pointed out that in order to develop reflective practitioners, educators needed to be adept at reflection (Smith, Gray, Raymond, Catling-Paull and Homer, 2011; Manning, Cronin, Monaghan and Rawlings-Anderson, 2009).

#### **1.8.4 Reflection-in-action**

The above term is used by Schön for reflection in the practice setting whilst still engaged in practice, with the aim that the reflection would be immediately employed to reflexively shape and modify that practice (Rolfe 1996). It was furthermore defined as

happening where we may reflect in the midst of action without interrupting it. In other words, our thinking serves to reshape what we are doing while we are doing it (Bulman & Schutz, 2004). The concept was modified by Jasper (2003) as the way that people think and theorise about practice while they are doing it.

### **1.8.5 Reflection-on-action**

Reflection-on-action is described as the retrospective contemplation of practice undertaken in order to uncover the knowledge used in a particular situation by analysing and interpreting the information recalled (Rolfe 1996). This was also defined as thinking back on what we have done in order to discover how our knowing in action may have contributed to an unexpected outcome. We may do so calmly after the fact, or we may pause in the midst of action to stop and think. Some authors modified this concept as the process of analysis, interpretation and the combination of information about the experience so that new perspectives are found about what has happened (Bulman & Schutz, 2004; Jasper, 2003).

It was noted that reflection-on-action can be used to improve practice, to generate new knowledge in nursing and to facilitate shared learning. Again it was further pointed out that through reflection on clinical situations nurses improve their practice by enhancing

problem-solving, identifying strengths and opportunities for additional learning and acquiring different ways of approaching clinical situations (Asselin, 2011).

Reflection-on-action was also described as a retrospective that allows practitioners to recount an event in order to discover the knowledge used by analysing and interpreting the information recalled. This contributes to the improvement of the outcomes of reflection (Sherwood et al., 2005).

### **1.8.6 Reflective practice**

Reflective practice is the process of reflecting on or in practice (Rolfe, 1996). This means that reflective practice is nursing practice that is guided by reflection. Reflective practice is seen as one of the ways that professionals learn from experience in order to understand and develop their practice (Jasper, 2003). Nursing education must ensure that nurses learn from clinical experience. This can be done through the proper integration of theory and practice. It would therefore require lecturers in the classroom and clinical settings to ensure the preparation of future competent reflective practitioners (Palmer, Burns & Bulman, 1994).

Reflective practice involves the examination of practice that needs to be undertaken alongside open discussions with peers on pertinent issues, an examination of texts from

the larger field of work and politics, and discussions with colleagues from outside the practitioners' own milieu (Bolton, 2005).

Reflective practice emphasises the use of reflection in professional or other complex activities as a means of coping with situations that are ill-structured and or unpredictable (Moon, 2004). As such, reflective practice encourages the seeking of understanding and interpretation of principles, justifications and meanings. It involves interrogating both our explicit knowledge such as known and quantifiable evidence-based knowledge and implicit knowledge a collection of information, intuitions and interpretation based on experience and prior knowledge (Bolton, 2005). Thus, reflective practice is nursing practice that is guided by reflection.

Dewey described reflective practice as having its foundations in the cognitive theory of education (Mackintosh, 1998). The suggestion was made that reflective practice is a critical process in refining one's artistry or craft in a specific discipline (Killeavy & Moloney, 2010). Schön (1987) developed this view further some years later as he suggested that reflective practice involves the thoughtful consideration of one's own experiences in applying knowledge to practice while being coached by professionals in the discipline.

Reflective practice can be viewed as the call to awake. It is also a process of being with the unfolding moment. Reflective practice helps us to explore what is just beyond the line of vision; it encourages not to share straight ahead, but to turn around. Reflective practice can be seen as a way of viewing the unfolding drama of the nurse becoming (Sherwood et al., 2005).

### **1.8.7 Nursing process**

Nursing process can be described as a problem-solving approach that enables the nurse to provide care in an organised manner.

### **1.8.8 Registered nurse**

“Registered nurse” refers to a person registered as such in terms of Section 20, or regarded to be so registered in terms of Section 64 of the Namibian Nursing Act, No 8 of 2004.

### **1.8.9 Training hospitals**

Training hospitals refer to the state hospitals in Windhoek where student nurses attend clinical teaching under the supervision of lecturers and senior registered nurses.

## **1.9 SUMMARY**

This chapter provides the reader with the background and the rationale of the study. The problem statement, the purpose of the study and the objectives and significance of the study have been clarified. The chapter also looked at paradigmatic assumptions and operational definitions. The research design is discussed in the following chapter.

## **CHAPTER 2**

### **RESEARCH DESIGN AND METHOD**

#### **2.1 INTRODUCTION**

The methodological approach in this study guided all the processes that a research study followed in order to achieve the articulated purpose and objectives when investigating the research problem (Mouton, 2006). The encompassing purpose of this chapter is to describe the research design and method for the study which led to the development of an educational programme on reflective practice for registered nurses. The research method is the manner in which the research study is approached. The study was conducted in four phases, namely:

- Situation analysis
- Development of the conceptual framework
- Development of an educational programme
- Implementation and Evaluation of the educational programme.

A brief discussion of each of the phases would now follow.

## **2.2 PHASE 1: SITUATION ANALYSIS**

The situation analysis was carried out by conducting field research. During this phase the researcher approached the participants to assess the situation in terms of the status of reflection in clinical practice.

### **2.2.1 Purpose**

The purpose of this phase was to gather and explore data by conducting in-depth interviews with the participants to determine how they reflect on their experiences in their daily practice. The interview method was applied because it is a proper tool for analysing the conversations and interactions which the researcher had with the participants.

### **2.2.2 Objectives**

The objective of this phase was to explore and describe reflection practiced by registered nurses.

### **2.2.3 Research design**

A qualitative, explorative, descriptive, and contextual design was selected for the study using a phenomenological approach.

#### **2.2.3.1 Qualitative approach research design**

The qualitative research approach seemed to be the most appropriate design to obtain the level of understanding required in the stated objectives. It was said that the daily existence of the participants is the laboratory of the qualitative researcher who must become familiar with it, meaning, learning from their experiences and their reflection thereon as practicing nurses (Morse, 1994). Thus the distinguishing characteristic of qualitative research is that the researcher studies people from their definition and understanding of their world, in this case reflective practice of registered nurses (Krefting, 1991). Qualitative research is described as a multi-dimensional process, which means that it is not a one-way process but a process whereby the researcher can move forward and backward between the different steps. The definition of Burns and Grove (2007) was adopted, that qualitative designs are used to explore, interpret and understand topics where very little is known or information is unavailable. The above scholarly definitions of the qualitative approach have also been adopted in this study. The researcher has selected this approach because through it the experiences of

registered nurses on the concept of reflective practice would be holistically obtained (Setswe, Naude & Zungu, 2011).

### **2.2.3.2 Explorative research design**

The study is exploratory because the area was relatively unknown and it aims to gain new insights into the comprehension of the phenomenon (Mouton, 2001). Although reflective practice may be not an unknown phenomenon to health care practitioners, in general registered nurses are not necessarily acquainted with its dynamics and processes. In this study the purpose of explorative research is to gain insight into the perspectives and experiences of a specific group of registered nurses in specific hospital wards and to determine what their practice is in regard to reflective practice.

### **2.2.3.3 Descriptive research design**

The objective of descriptive research is to describe what was, as accurately and exactly as possible—the description of phenomenon in the real-life situations in order to get accurate characteristics of people (Burns, & Grove, 2009). Descriptive researchers focus on the ‘how’ and ‘who’ questions (Newman, 1997). In this research the researcher describes how registered nurses interpret and use reflection in their practice to improve patient care.

#### **2.2.3.4 Contextual research design**

In qualitative research a contextually bound strategy, rather than a universal strategy, is followed (Mouton & Marais, 1993). This implies that the phenomenon researched is in accord with its immediate context. Being concerned with the content of real life experiences, it follows that this study is of a contextual nature. Registered nurses within the context of hospital wards which offer patient care are crucial contexts where reflective practice takes place.

#### **2.2.3.5 Phenomenological approach**

A phenomenological approach was selected because it helped in understanding the experiences, perspectives and process whereby registered nurses indicated how they have captured reflective practice. The phenomenological approach focuses on lived experiences which refer to everyday experiences of an individual in the context of normal pursuits. In this study experiences of registered nurses concerning reflective practice were obtained. This data were essential in developing a programme that would facilitate reflective practice.

## **2.2.4 TARGET POPULATION**

The population of Phase 1 included all 560 registered nurses working in different departments in both training hospitals in Windhoek.

### **2.2.4.1 Sampling and the sample**

The purposive sampling was used to select participants. The reason why purposive sampling was used was to obtain rich information from registered nurses practicing in the field daily. The registered nurses, being those who experience different situations during their daily practice and who would benefit the study, were selected from each discipline, namely: Surgery, Gynaecology and Obstetrics, Internal Medicine, Paediatrics and Orthopaedics in both hospitals. These units were selected because the participants practising there would be able to provide a wealth of information. The sample of this study consisted of the registered nurses from the above departments who indicated their willingness to participate in the study after the researcher explained the purpose of the study to them.

### **2.2.4.2 Selection criteria**

‘Selection criteria’ refers to plans that state the exact characteristics of those who are selected to participate in the research (Burns & Grove, 2005). In this study the selection

was confined to registered nurses who have two (2) or more years of experience in the field and who would be a valuable source of information for this study. The responses of these nurses would maximize the researcher's understanding of the phenomenon, namely, reflection. The researcher visited the wards and explained the purpose of the study to the registered nurses. After the explanation, the nurses who indicated their willingness to participate in the study were then selected as the participants of the study.

#### **2.2.4.3 Sample size**

The sample size was determined by the information needed. The purpose was to generate enough in-depth data that could illuminate the patterns, categories and dimensions of the phenomenon under study (Polit & Beck, 2012). The sample size entailed 15 registered nurses which was determined by data saturation. 'Data saturation' means no new themes were emerging from the participants and the same data were repeating. Sample size was dependent on the type of research question and probing/exploratory questions until the data saturated. In this study the researcher observed the repetition of the same data from the participants, which was an indication of saturation (de Vos, Strydom, Fouche, & Delport, 2005).

## **2.2.5 DATA COLLECTION**

### **2.2.5.1 Data collection instrument**

The study used a phenomenological approach whereby the researcher conducted in-depth interviews as the data collection instrument with the participants on the experiences they had during their daily practice regarding reflection. This approach aimed to understand and interpret the meaning of reflective practice as the participants applied it to their daily practices. This technique is highlighted in literature by many authors such as Botma, Greeff, Mulaudzi, & Wright, (2010) who described the in-depth interview as taking an interest in understanding the experience of other people and the meaning they make of that experience. The researcher made use of the in-depth interview to obtain sufficient information about the participants' experiences on reflection, which enabled the researcher to have a thorough understanding of these phenomena.

### **2.2.5.2 Field preparation**

Before approaching the hospitals the researcher obtained a permission letter from the permanent secretary of the Ministry of Health and Social Services. With this letter the researcher went to the hospital managers to explain the purpose of the study, as well as to receive their permission to conduct research among the registered nurses.

Participation was voluntary and all registered nurses who took part in the study agreed to answer the questions.

The purpose of the study was explained to the registered nurses and consent was obtained from those who showed an interest in participating in the study. The appointment dates for the interviews were availed by the registered nurses according to their off-duty schedules. The researcher reassured the participants that their information would be handled confidentially and their identity kept anonymous. The researcher undertook to conduct each interview in a comfortable and calm environment in a quiet and private office so that the participants could have a relaxed and peaceful mind to provide the intended information.

### **2.2.5.3 Conducting interviews**

#### **2.2.5.3.1 Pilot testing**

A pilot testing is described as a small-scale study designed to test methods to be used in the actual study (Polit & Beck 2012). An interview was carried out in September 2009 as pilot testing. The purpose of piloting was to determine whether the central question was clear and understandable to interviewees. The central question was, “Tell me about your thoughts or perceptions and experiences regarding the application of reflection during your practice”. The pilot testing involved 13 participants. This number was

determined by the frequency of repeated responses received from the participants. These responses were mainly related to routine activities, and did not refer to the concept of reflection. During this technique the researcher observed that the reflective practice concept seemed new to many who participated in the piloting process because all of them asked about the meaning of reflection. After this technique the researcher collated all the answers from the participants, and the results showed a poor understanding of the concept by the participants. This situation prompted the researcher to make thorough explanations of the concept of reflection during the actual data collection process. The participants who took part in the piloting process were not involved in the actual interview process.

#### **2.2.5.3.2 Interview techniques**

The actual interview was carried out in February 2010, targeting a purposive sample of registered nurses working at the training hospitals in Windhoek, specifically in Paediatrics, Surgery, Internal Medicine, Orthopaedics and Obstetrics and Gynaecology wards.

Further explanation about the purpose of the study was extended to the individual participants before in-depth interviews were carried out. The 15 participants agreed to be interviewed and were interviewed by the researcher. The in-depth interview used a

guide consisting of an open question: “Tell me about your thoughts or perceptions and experiences regarding the application of reflection during your practice”. This question invited the participants to tell stories about how they experience specific reflective practice in work situations. The interviews were held face-to-face and all participants were interviewed in their respective departments. Each interview lasted for 15 to 20 minutes, during which the interviewer took notes. The data were summarised later. Interviews were also audio-taped and later transcribed.

An audiotape was utilised to record the information provided by the participants. Consent to make use of an audiotape was sought in advance. This device was used with the purpose of not missing any aspect of the participants’ comments.

During each interview the researcher was interested in the participants’ perceptions and experiences and listened carefully to their expressions and descriptions. Each participant was asked the same question. During the interviews the researcher also used probing questions. The purpose of probes was to search for elaboration, meaning and reasons, and this could also be understood as exploratory questioning. De Vos et al. (2005) have also explained that the purpose of probing is to deepen the response to a question, to increase the richness of the data being obtained and to give clues to the participants about the level of responses that is desired.

The participants clarified their comments which were deepened by questioning and probing in order to elicit more useful information from them and to promote discussion and ensure that the researcher gained an accurate perception of the experiences of the participants.

### **2.2.6 DATA ANALYSIS**

Data analysis proceeded after data collection, allowing for clarification of issues and development of categories and themes. The purpose of data analysis is to organize, provide structures to, and elicit meaning from data. It was further pointed out that analysis of qualitative data begins with a search for broad categories or themes. A theme is thoroughly defined as an abstract entity that brings meaning and identity to a current experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole (Polit & Beck, 2012).

On the other hand, data analysis is also described as dwelling with the data, whereby the researcher becomes immersed in the participant's descriptions in order to identify the themes, essence, or meaning structures of the lived experience (Fain, 1999).

The method of analysis employed in this research is based on Tesch's model, which focuses on the meanings, coding of data and identification of themes and sub-themes (Tesch, 1990). A literature control was made to validate the results. Babbie and Mouton (2004) emphasised that the above structure allows us some clarity on the research process and specifically on which qualitative data analysis approaches to consider first when making methodological decisions about a study.

Tesch's eight steps for data analysis are described as follows:

*Read through the transcripts and make notes*

This step guided the researcher to read the data carefully in order to have an understanding of each part of the data. The researcher should read the transcripts in their entirety several times and immerse him- or herself in the details, trying to get a sense of the interview as a whole before breaking it into parts (De Vos et al., 2005).

*Pick the shortest and most interesting interview and find underlying meaning*

At this step the researcher was guided on how to pay attention to each part of the information, for example, focusing on what was short and interesting in order to capture the meaning of each part.

*Write notes in the margin; do the same with other transcripts*

This step provided the researcher with skills on how to jot down the important aspects in the margin of the document to make it easy to find them when needed. De Vos et al. (2005) pointed out that writing of memos in the margins of field notes or transcripts helps in the initial process of exploring a database.

*Make a list of all the topics and cluster similar topics*

During this step the researcher was guided to make a list of all topics in appropriate columns in order to be able to compare all the themes. The researcher can list on note cards the data available and perform the minor editing necessary to make field notes retrievable (De Vos et al. 2005).

*Classify into major, unique and leftovers*

This step helped the researcher to go back to the listed themes and choose the best name for the themes and sub-themes. About this category, De Vos et al. (2005) clarified that classifying means taking the text or qualitative information apart and looking for categories, themes or dimensions of information. Classification involves identification of general themes. Polit and Beck (2012) also pointed out that during analysis, qualitative researchers must distinguish between ideas that apply to all people and those that are unique to particular participants.

*Give codes and see if new codes emerge*

During this step the researcher was guided to go back to the original information and assign codes and also to discover new codes. About this category, De Vos et al. (2005) said that coding data is the formal representation of analytical thinking. The work of analysis is generating categories and themes. The researcher then applies some coding scheme to those categories and themes, which may be in the form of abbreviation of key words, coloured dots, or numbers the choice is up to the researcher.

*Find the most descriptive words for topics; make categories and sub-categories*

Here the researcher was guided to place the topics that she remembers occurring most in the data document in one list then make a list of categories and sub-categories. It was pointed out that as the researcher codes the data, new understandings may well emerge, necessitating changes in the original plan. (De Vos et al., 2005).

*Analyse each category and recode if necessary*

After the development of all categories and themes, as well as the coding system, the researcher begins with the process of evaluating the plausibility of her developing understandings and exploring them through the data (De Vos et al., 2005). During the analysis process the researcher could do recoding if necessary. During this step the researcher was guided to synthesise the data in each category and perform analysis.

The results from the data analysis served as the framework on which the programme was developed.

### **2.2.7 REASONING STRATEGIES**

‘Reasoning strategies’ refer to strategies used in logical reasoning which is a problem solving method combining experience, intellectual faculties and formal systems of thought (Polit & Beck, 2012). Again, logic is described by Burns and Grove (2005) as a science that involves valid ways of relating ideas to promote understanding and to determine truth or to explain a phenomenon.

The reasoning strategies that are used in this study are analysis, synthesis, and inductive and deductive reasoning. The use of these strategies enabled the researcher to formulate logical arguments in assisting with exploration and description of the phenomenon under study (Polit & Hungler, 1999). In this study the phenomenon is the application of reflective practice by registered nurses. The following reasoning strategies were used during the study in order to assist the researcher to make use of good reasoning, for example, during the validation of the results.

**Analysis**

‘Analysis’ refers to the process of organizing and synthesizing data so as to answer research questions and test hypotheses. It requires one to take of a complex whole and break it into parts so that the interrelated constructs that are relevant to an understanding of the main concept are isolated (Polit & Beck, 2012; Mouton & Marais, 1996). In this study analysis was done during data analysis after data collection.

**Synthesis**

‘Synthesis’ refers to forming up categories and relationships developed between these categories. It was described as sifting out important factors and relationships (Walker & Avant, 2005). Synthesis in this study took place after analysis of data to combine the concepts which enabled the researcher to formulate the themes.

**Inductive reasoning**

In literature, inductive reasoning is the process of developing generalizations from specific observations (Polit & Beck, 2012). Burns & Grove (2005) further described inductive reasoning as moving from the specific to the general, whereby particular instances are observed and then combined into a larger whole or general statement. Botma, et al. (2010) pointed out that with an inductive strategy the researcher will

embark upon the study without working from an explicit conceptual framework, and merely use a central theoretical statement to guide the research.

In this study inductive reasoning was used to find out the experiences and feelings of participants regarding the concept of reflective practice. It further assisted in identifying the themes of the study which provided guidance to the researcher for the development of the educational programme. It was also used during the description of the conceptual framework in Phase 3 and the development and verification of the educational programme in Phase 4 (Mouton, 2009).

### **Deductive reasoning**

In literature, deductive reasoning is described as the process of developing specific predictions from general principles (Polit & Beck 2012). Burns and Grove (2005) described deductive reasoning as a process which moves from a general premise to a particular situation or conclusion. Deductive reasoning is further explained by Botma et al. (2010) who say that the researcher will embark upon research with a clear conceptual framework in mind.

In this study the researcher used deductive reasoning to develop and verify the educational programme on reflective practice. Literature control was conducted to explore the phenomenon with regard to aspects concerning the results of the study.

### **Bracketing**

‘Bracketing’ is defined by Polit and Beck (2012), Botma et al. (2010) as the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study. It was also defined as qualitative research technique when the researcher suspended what was known about an experience being studied to allow the data to convey undistorted information as described by participants themselves (Burns & Grove, 2005).

In this study the researcher had to identify and write down her own beliefs, assumptions and descriptions according to own perceptions and what was known about the topic before the interview sessions for the purpose of bracketing these factors during the interview sessions.

**Reflexivity**

Reflexivity was described by Polit and Beck (2012) as attending systematically and continually to the context of knowledge construction—and in particular to the researcher's effect on the collection, analysis and interpretation of data. They further explained that reflexivity involves awareness that the researcher as an individual brings to the inquiry a unique background, set of values and a social and professional identity that can affect the research process.

Reflexivity was continuously used during this study because the researcher guarded against the potential influence that she might have had on the research design and participant selection, by revealing her own behaviour during data collection, data discussion, interpretation and presentation (Hennik, Hutter & Bailey, 2011). This was achieved by:

- continuously submitting the research work completed to the two research supervisors and
- involving a co-coder during data analysis and during the research seminar where the research proposal and study findings were presented.

## **2.2.8 TRUSTWORTHINESS OF THE STUDY**

It has been pointed out that all research must respond to canons that stand as criteria against which the trustworthiness of the project can be evaluated. These canons can be phrased as questions to which all research must respond and as such they serve to establish the true value of the study, its applicability, consistency and neutrality (De Vos et al., 2005).

The neutrality of the findings of the research is viewed in light of the influential work of Lincoln and Guba (1985), who put up a set of criteria for qualitative research: credibility, transferability, dependability and confirmability (Babbie & Mouton, 2004).

### **2.2.8.1 Credibility**

Credibility is ensured by the following activities:

- Prolonged engagement of the researcher in the field as a registered nurse. This enabled the researcher to understand the culture and views of the registered nurses and it enhanced trust and rapport with participants. The purpose here is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al., 2005).

- Persistent observation by the researcher in the field supported the focus of the study, namely, reflection.
- Member-checking validation was carried out during data collection through probing questions to ensure the correct interpretation of the participants' responses.
- The researcher's credibility is assured by the accessibility which the researcher had to the registered nurses to whom the questions were directed for data collection. The information provided by the participants was clearly noted for proper interpretation. And the researcher confirmed the credibility of the findings by looking at whether the analysis accurately described the participants' experiences.

#### **2.2.8.2 Transferability**

'Transferability' refers to the probability that the findings of the study have a meaning to others in similar situations. The expectation for determining whether the findings fit or are transferable rests with the potential user of the findings and not with the researcher (Polit & Beck, 2012). The literature proposed this as the alternative to generalisability, in which the burden of demonstrating the applicability of findings to another context rests more with the investigator who would make the transfer than with the original investigator (De Vos et al., 2005).

The findings of this study were utilised in directing the development of a programme that was implemented by the researcher to be used by the registered nurses in the clinical environment with the specific focus on the integration of reflective practice in their daily work.

### **2.2.8.3 Dependability**

‘Dependability’ refers to the criterion which is met through obtaining credibility of the findings. This is the alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study, as well as changes in the design created by increasingly refined understanding of the setting (De Vos et al., 2005).

The dependability of this study was assured through performing an inquiry audit by analysing and categorising data in key themes and sub-themes and presenting them to a co-coder for scrutiny. The researcher described the research method in detail and used the same question for each participant.

#### **2.2.8.4 Confirmability**

The literature described confirmability as the construct which captures the traditional concept of objectivity (De Vos et al., 2005). It is also referred to as the criterion concerned with data representation of the information provided by the participants and their proper interpretation. (Polit & Beck, 2012). In this study the degree of confirmability is based on the real data collected from the participants. The method of interpretation of data was used carefully in order to avoid misinterpretation.

#### **2.2.9 Ethical consideration**

Proper consideration was given to ethical issues concerning the participants. Consent was solicited from them. The researcher clarified the purpose of the study to the participants as well as the confidentiality of information and anonymity of the participants. The study was governed by the principles of informed consent, confidentiality, beneficence, non-maleficence, respect and justice.

- **The principle of respect for autonomy**

This principle involves the right to self-determination and the right to full disclosure and this is seen as the basis of informed consent and respecting of human dignity and confidentiality (Polit & Beck 2012; Dhai & McQuoid-Mason, 2011). The participants in this research made a free, independent and informed choice without

coercion. The informed consent is an agreement by the research participants, given without threat or inducement, based on information which any reasonable person would want to receive before consenting to participate (Holloway & Wheeler, 1996). Fain (1999) explained informed consent as the knowledgeable and expressed choice of an individual to participate in a research project without coercion, deceit or duress. This principle involves, for example, specific permission to tape-record the interview. This is well stipulated in literature as it was an argument of De Vos et al. (2005) that nobody should be coerced into participating in any research, because participation must always be voluntary.

- **The principle of beneficence**

Beneficence means doing good for others and promoting others' interests and well being. Participants were assured that their information will not be used against them but will benefit them. Polit and Beck (2012) pointed out that beneficence imposes a duty on researchers to maximize benefits. Human research should be intended to produce benefits for participants.

- **The principle of non-maleficence**

This principle is described as the principle of avoiding, preventing or minimizing harm (Polit & Beck, 2012). Dhali and McQuoid-Mason (2011) defined this principle as the principle of avoiding harm or doing as little harm as possible. This again is referred to as doing no harm. The good derived from the research must be weighed

against the potential harm, and the benefits must outweigh the risks for the individual and the wider society (Holloway & Wheeler, 1996). The participants should not be exposed to discomfort during the study, for example, during the interview. This ethical principle was adhered to in this study.

- **The principle of justice.**

This principle refers to the participants' rights to fair treatment and to privacy. Fair treatment means that the researcher should respect the participants' backgrounds and beliefs, while the right to privacy means that participants should be assured that their information will be kept as confidential as possible, with no name attached to individual responses (Polit & Beck, 2012). This ethical principle was adopted and applied to this study.

The principle of justice also implies that the research strategies and procedures are fair and just to the participants (Holloway & Wheeler, 1996). Fain (1999) advocated that the participant's freedom to withdraw from the study without penalty and to ask questions should be respected. The literature pointed out that the selection of participants should be based on the study's requirements and not on a group's vulnerability. It was further explained that the right to fair treatment means that researchers must treat those who decline to participate, or who withdraw from the study after initial agreement, in a non-prejudicial manner (Polit & Beck, 2012). De Vos et al. (2005) have also explained that respondents should be thoroughly informed beforehand about the potential impact of the investigation.

The permission of the Ministry of Health and Social Services was requested in order to conduct a study among the registered nurses. The research findings would be accessible to interested participants. These procedures are in line with a number of principles listed by Richard Winter in O' Brien (2001), that the researchers must pay close attention to ethical considerations in the conduct of their work and make sure that the relevant persons, committees and authorities have been consulted, and that the principles guiding the work are accepted in advance by all.

## **2.3 PHASE 2: DEVELOPMENT OF A CONCEPTUAL FRAMEWORK**

From the data analysis certain concepts were identified that guided the researcher on the content of the programme. Then the conceptualization framework follows.

### **2.3.1 Purpose**

The purpose of Phase 2 was to develop a conceptual framework of the study.

### **2.3.2 Objectives**

The objectives of this phase were to:

- Establish the relationship between the concepts in a conceptual framework.

Conceptualisation is explained by De Vos et al. (2005) as a process of labelling concepts with words which allow us to think about them and communicate them to other people. The researcher collated and compared the information provided by the participants. This information was used to guide the development of the programme. The conceptual framework was developed based on the elements of nursing theory as described by Dickoff, James and Wiedenbach (1968), which is described in Chapter 4 of this study.

## **2.4 PHASE 3: THE DEVELOPMENT OF AN EDUCATIONAL PROGRAMME**

Data from Phases 1 and 2 served as the basis for developing a programme that would facilitate reflection in practice.

### **2.4.1 The purpose**

The purpose of this phase was to develop the educational programme for reflective programme

### **2.4.2 Objectives**

The objectives of the phase were:

- to develop the programme
- to outline the content of the developed programme

### **2.4.3 Programme development**

In programme development the following steps were followed:

- a description of the programme
- an explanation of the educational approach, and
- an outline of the educational programme.

Detailed explanation of the educational programme development is dealt with in Chapter 5.

## **2.5 PHASE 4: IMPLEMENTATION AND EVALUATION OF THE DEVELOPED EDUCATIONAL PROGRAMME AND ADJUSTMENTS**

### **2.5.1 Introduction**

Implementation and evaluation tell decision makers what is going on in the programme, how the programme was developed, and how and why the programme deviated from the initial plans and expectations. According to De Vos et al. (2005), one important way of studying programme implementation is to gather detailed descriptive information about what the programme is doing. Implementation evaluation answers the following questions: What do clients in the programme experience? What services are provided to clients? What does staff do? What is it like to be in the programme? How is the

programme organised? As these questions indicate, implementation evaluation includes attention to input, activities, process and structures.

Programme evaluation is defined by De Vos (2005) as the systematic collection of information about activities, characteristics and outcomes of a programme to make judgments about it in order to improve its effectiveness and or inform decisions about future programming. The full description of the evaluation is done in Chapter 6 of this study.

### **2.5.2 The purpose**

- The purpose of phase four was to implement and evaluate the effectiveness and relevance of the developed educational programme regarding the application of reflective practice in clinical practice.

### **2.5.3. Objectives**

The objectives of this phase were:

- to evaluate the appropriateness of aspects identified in the programme by the participants and
- to assess the usefulness of the implemented programme.

- to determine the efficiency of the programme.

#### **2.5.4 Method of implementation**

The researcher organised a two-day workshop focusing on the highlighted aspects of the developed programme regarding reflective practice. At this workshop the purpose of the programme was explained, after which the participants were engaged in work sessions. After the workshop the participants were requested to go into the practical field and apply reflection during their daily practice over a period of two months. It was imperative that the particular participants give the researcher their feedback for the improvement of the programme.

#### **2.5.5 Population and sample**

Registered nurses from training hospitals participated in the implementation workshop. The researcher together, with selected registered nurses participated in the evaluation of the educational programme.

#### **2.5.6 Method of evaluation**

The focus group discussion was used as the method of evaluation of the programme. The tape recorder was utilised with permission obtained from the participants in order to capture the discussions. The discussions were guided by the following question: How do you evaluate the programme, its strengths and weaknesses?

### **2.5.7 Data analysis**

The researcher has analysed the themes identified by the participants during the implementation of the programme.

## **2.6 SUMMARY**

This chapter focuses on the research design used for the study. Qualitative research design and methods were discussed. Aspects for clarifying trustworthiness in the qualitative approach were described as credibility, transferability, dependability and confirmability as applied to this study.

Chapter 3 deals with the outcome from the interviews conducted in Phase 1 and the literature control.

## **CHAPTER 3**

### **DATA ANALYSIS OF PHASE 1 AND LITERATURE CONTROL**

#### **3.1 INTRODUCTION**

The previous chapter dealt with the research design, its description and the measures taken to ensure trustworthiness of the phenomenological and qualitative study. This chapter focuses on data analysis and discussion of the data. The results of the interviews on the perceptions and experiences of the registered nurses with regard to reflective practice, as well as the literature control, are described. These were viewed in terms of reflection-in-action, where understanding of new ideas occurs during experience and reflection-on-action, where the registered nurses look back over an experience and review what has happened and how they have acted.

The results of Phase 1 of the study were verified with the findings of other similar research, as well as the information from other literature. In doing so, the similarities, differences and uniqueness of the findings in this research were identified.

## **3.2 DATA ANALYSIS**

Data analysis was performed for clarification of issues and development of themes and sub- themes. The data of all in-depth interviews were analysed with regard to the meanings of separate passages and then organized into themes which constituted the main topics.

Since this study was phenomenological, explorative, and descriptive, themes and sub-themes were developed using coding, classifying and categorizing of data. Therefore the method of analysis employed in this research was based on Tesch's model (as cited in Babbie & Mouton, 2004). This model is already discussed in Chapter 2 of this study.

This particular method highlights the existence of the research interests such as characteristics of language, discovery of regularities, comprehension, of meaning of text or action and reflection as research interests. The transcripts were read several times to obtain an overall impression of the data as a whole. After careful reading, themes of meaning were formulated and identified in a proper understanding and units were identified and structured based on the registered nurses' experiences and understanding of reflective practice. From this, a creation of subthemes based on the themes was conducted. This means that the subthemes were derived from the main themes. After the creation of subthemes and critical in-depth interpretation based on proper

understanding, a structural analysis was done in order to try to understand the phenomenon. The focus was put on the meanings, coding of data and identification of themes and sub-themes.

The aim of the analysis was to produce a detailed and systematic record of themes and experiences about reflection that has been addressed in the interviews. Data were analysed and grouped into themes and sub-themes, which focused on the observations, analysis and discussions of the collected information. Structural analysis showed the following three main themes:

- participants reflected on their daily practices and experienced concerns and attributes of caring;
- participants experienced different emotions during reflection and expressed their meaning; and
- participants reflected on resolutions to correct irresponsible behaviour and internalize values in their daily practice.

### **3.2.1 Description of main themes and sub-themes**

Main themes were formulated based on the primary data provided by the participants. Each of these themes has supporting sub-themes. These themes represent aspects of the participants' experiences on reflective practice and are displayed in the table below.

**Table3 1: The Main Themes and Sub-Themes**

THEMES	SUB-THEMES
<p><b>THEME 1</b> Participants reflected on their daily practices and experienced concerns and attributes of the care rendered.</p>	<p>Through reflective interviews the following concerns were noted:</p> <ul style="list-style-type: none"> <li>- Participants did not always experience a proper sense of responsibility concerning their roles and functions. For example: observations are not done properly, shortcuts, intervals of giving medicines are not adhered to, ineffective teaching, uncompleted tasks</li> </ul> <p>Through reflective interviews attributes of caring were noted:</p> <p>-Participants experienced a sense of caring in their daily practice. for example: determination and meeting the basic human needs of patients, to prioritise the conditions, clinical supervision, record keeping and report giving, maintaining of proper communication, serving as a role model, giving of advice and acting during emergency cases</p>
<p><b>THEME 2</b> Participants experienced different emotions during reflection and expressed their meaning</p>	<p>Positive and negative emotions were experienced</p> <ul style="list-style-type: none"> <li>• Positive emotions were experienced by participants <ul style="list-style-type: none"> <li>- Feeling happy or good, self-worth and being encouraged</li> <li>- Provision of loving care</li> </ul> </li> <li>• Negative emotions were experienced by participants <ul style="list-style-type: none"> <li>- Feeling guilty/bad about ineffective practices</li> <li>- Encountering conflict</li> <li>- Work- related stress</li> </ul> </li> </ul>
<p><b>THEME 3</b> Participants reflected on resolutions to challenges in their daily practice.</p>	<ul style="list-style-type: none"> <li>- Reflection on resolutions was highlighted. For example: provision of nursing care according to the patients' conditions, checking procedures of administering of medicine.</li> </ul>

The discussions reflected the experiences of participants about their own reflection on the nursing practice they render. The central story line revealed that participants were sharing a paradoxical coexistence of both negative and positive experiences about their actions in the process of ensuring the provision of quality care to patients. The descriptions focussed on integration, a consolidated picture of similar and unique experiences of registered nurses on their reflective practice. The participants had related stories of constraints related to reflective practice. The dominance of these stories was evident in the way participants described their experiences. Some participants expanded on their experiences with specific reference to the perceived constraints embedded in their role and functions as registered nurses, which sometimes resulted in “professional” suffering, while others had a more positive story to tell about their reflective practice.

Three main themes and several sub-themes emerged during data analysis are discussed as follows:

### **3.3 Discussions and literature control on themes and subthemes**

#### **3.3.1 Theme 1: Participants reflected on their daily practices and experienced concerns and attributes of caring**

The theme under discussion here focuses on the different concerns of the nurses surrounding the concept of reflective practice and the obstacles which impact on its fulfilment in their daily practice as well as their achievements. It was found that

registered nurses usually reflect on their concerns, challenges and specific achievements within the clinical setting based on the principles of reflective practice. However, not all participants reflect effectively. The data portrayed reflective practice as a story with past and present realities, indicating a specific process to ensure quality care to patients.

If the registered nurses do not reflect effectively on their daily practices, it implies that they cannot invent new approaches to complete clinical problems, or develop principles of self-evaluation (Bulman & Schutz, 2004; Lyons, 1999). On the other hand, an attribute is if they do reflect although not properly, it can be considered as a positive move to at least think about and analyse what one has done or is doing.

Thus reflection is a very important aspect for any nurse's daily practice. Its process includes cognitive and affective skills. Reflective practice is a professional development process incorporating a very different set of assumptions. It assumes that professionals are competent and able to assume responsibility for detecting and addressing weaknesses in their practice and also that organizational concerns stimulate reflective practice (Ostermann & Kottkamp, 2004).

Early on Durgahee (1998) and Lindahl, Dagborn and Nilsson (2009) pointed out that reflection is the process used to analyse and raise the practitioners' level of awareness

and insight into nursing situations. They further asserted that it is also important to look at how reflective process is facilitated, and what conditions are necessary for people to reflect either individually or in groups. Reflective practice shapes nursing practice as an art and craft and develops sensitivity for patient care.

In a study done by Gustafsson and Fagerberg (2004) categories to reflect were indicated. The categories that were pointed out were experiences in nursing care situations, ethical considerations to develop unique empathy development. In the same trend Henderson, Winch and Heel (2006) stated that reflective practice aims at producing competent, knowledgeable and skilful health professionals who can provide nursing care which is based on sound knowledge and proper skills. Experiences in 'real life' settings need to be effectively facilitated to obtain the desired outcomes.

The importance of reflection in teaching and learning is stipulated by authors in the literature. According to Lyons (1999), reflection is an important learning tool in clinical teaching and it is necessary to show that we are aware about ourselves, events and other people around us. Pertaining to clinical practices, reflective learning is an important process enabling the discovery of knowledge for practice.

Reflective practice in nursing can be regarded as a valuable problem-solving process for individuals and small groups. It can improve interpersonal relationships and thereby enhance the process of care-giving. Reflective practice can also form an essential process within professional and personal development. Hence it was asserted that a key in the development of the professional is the ability to reflect on practice as the basis for learning. It has been also explained that if professional practice is about change, development and meaningful conscious action, the art of reflection becomes a pre-requisite (Killeavy & Moloney, 2010; Coward, 2011).

In this study it was found that the participants had experienced concerns and attributes of caring in their daily practice, which came out during reflection. The following sub-themes were identified as factors or concerns contributing to the poor reflection of registered nurses as well as their specific attributes of caring affecting the patients positively in their daily practice. This is derived from the following statements.

### **3.3.1.1 Sub-themes**

*Sub-theme 1 Participants did not always experience a proper sense of responsibility concerning their roles and function*

Registered nurses have specific roles in terms of the patient's physical, emotional, psychological and spiritual well being. Their functions are stipulated as dependent,

independent and interdependent. Registered nurses should be clear regarding their individual responsibilities. Each institution is expected to have an outline of the specific responsibilities. Each registered nurse is expected to be clear with the description of expected roles, for example, setting up of schedule for activities, problem identification within their respective units, provision of feedback to other stakeholders, participation in meetings concerning the development of the institution, as well as patient care and evaluation of nursing care programmes.

Based on this sub-theme some participants reflected on some concerns and have indicated that they **do not do proper observations** because they have many patients.

*“As a registered nurse I do reflect but I do not do observations properly because of many patients.”*

Registered nurses are expected to provide specialized assessment through proper observation of the patients. After proper observations are done the nurses need to reflect on the action to be done in order to provide patient care and to monitor and prescribe nursing care according to nursing process.

Observation is regarded as a skill that practitioners must possess to develop insights needed to make wise decisions. Observations should be ongoing, systematic, and developed to the point that a focus can be established, note taken, and actions explored in a relatively short amount of time with high effectiveness (York-Barr, Sommers, & Ghere, 2006). By implication, it means that if observations are not done properly complications or progress of the patient could not be detected early and the patients might not receive their interventions on time.

Observation is an accurate, timely and objective report, verbal or written, of a patient's condition. To observe the patients properly, registered nurses should use all their senses. An observation includes observation of normal values, for example, normal ranges found in respiration and blood smelling of strange odour and hearing of moaning from a patient as well as observation of the environment, for example, wet floors and the state of equipment such as the level of an intravenous infusion.

By describing what we know about current nursing observation practice through the process of a systematic literature review, we can better understand the context within which ward nurses work and more fully appreciate the factors that may hinder or promote effective observation practice (Odell, Victor, and Oliver, 2009). The question

to be asked is if observations are not done properly due to workload, is there any way to overcome the challenge, for example, by proper prioritising of the patients.

Looking at the statements made by the participants one can conclude that patients are often affected negatively because their vital signs are not monitored properly in order for symptoms and complications to be detected early.

The participants further reflected on the concern of using **shortcuts** as a quick method used in order to finish the work. Registered nurses found themselves in situations where they could not follow proper techniques for some procedures because of insufficient time and an excessive workload caused by an overwhelming number of patients in the wards. The reason for taking shortcuts, according to the participants, was to attend to all patients. The following statements are evidence of this.

*“There are some challenges, for example many patients that cause me to cover half of the work.”*

*“I cannot act immediately on some of the prescribed treatments because of many patients.”*

*“I just use shortcuts in order to finish the tasks for example if I happened to be in full and busy ward I sometimes find myself moving from a patient to another without washing my hands in between.”*

Most participants identified an overwhelming number of patients as one of the challenges negatively impacting the registered nurses' reflection in action. In this regard many participants resorted to making use of shortcuts as a way of completing the procedures, although this would hamper the provision of quality care to patients when hygienic standards and other nursing procedures are compromised.

Participants presented various interpretations with regard to using shortcuts. Some, for instance, indicated that registered nurses use shortcuts in order to finish tasks such as moving from one patient to another without washing their hands in between. This practice could spread infection among the patients.

Treating patients without washing hands, registered nurses demonstrated restricted knowledge of hygienic aspects, specifically of the danger of cross infection; they did not realise that shortcuts have a negative effect on the patients. For example in HIV/AIDS and hepatitis patients, registered nurses should make sure that they treat and care these conditions with proper caution in order to reduce cross infection among patients.

These reasons why registered nurses in general take shortcuts when caring for patients are explained in the literature. This problem is identified by Heath (1998) who noted

that the external pressure of poor staffing levels can affect practice and also by Schön who discussed an internal process which he called selective inattention; whereas knowing in practice becomes spontaneous, those aspects of a situation that do not fit knowing-in-action are ignored. Workable solutions may result but these will not be the best course of action (Heath, 1998).

The above observation concurs with the results of the studies done in the United States of America which showed that higher nurse to patient ratio and a 'richer' skill mix of registered nurses are associated with improved patient outcomes (Shuldham, Parkin, Firouzi, Roughton, and Lau-Walker, 2008).

The situation as described above may be substantiated by a study done on nurse-patient ratio in terms of the workload. Such conditions as described in this study could give rise to burnout and attrition of the experienced nurses working in the emergency unit as they cannot adequately resolve the conflict between the workload and the provision of quality nursing care. This could be in line with what is explained by Lyneham, Cloughessy and Valmai (2008), that emergency nurses cannot work under such pressure as it may compromise the care given to patients and consequently have a negative effect on the nurse personally.

The workload figure is higher than the number of nurses allocated in the specific ward when nurses spend more time with dependent patients while the majority of patients, who are not as dependent on the nurses, receive little attention.

According to the literature, as pointed out by Hurst (2008), studies show that “richer” staffing is cost effective and leads to better nursing outcomes. Thus, nurses need to monitor patients at all times because this influences not only patients’ welfare but also staff performance.

The responses of the participants indicate that there is an unbalanced ratio between patients and nurses in clinical settings. This can lead to the conclusion that nursing activities, workload, staffing and quality affect patients’ care. It is therefore necessary to improve the provision of care so that it may be both patient; and staff-centred. This can be achieved only if the workload is balanced with the number of nurses in the wards.

Many participants have experienced and reflected that the **process and intervals of administering the medicine to the patients were not adhered to as required**. They claimed that this was caused mainly by insufficient time to care for patients, as well as the shortage of staff, meaning that the training hospitals are covered by few registered nurses. This situation prevents nurses from doing reflection on nursing actions, as one

cannot properly focus on procedures while burdened with overload. Thus time is the most valuable and non-renewable resource, even in the context of nursing. The implication is that if medicines are not administered at the right intervals it would affect the healing of the patients negatively. The following are evidence of the finds:

*“As a registered nurse, I have noticed that some patients receive their medicines early and some late which affects patients negatively.”*

*“When the ward is full the procedures are also slow, for example, administration of medicine which sometimes prevents me from reflecting properly on what I did or should do.”*

The majority of registered nurses who participated in this research expressed that they did not have sufficient time to administer medication according to the prescribed intervals. What is not clear from these statements is how the participants handle this kind of challenge in order to grow and develop professionally. A counter-question can also be asked: “If they had enough time would they be able to reflect on their practice,” since reflection also provides data for self-evaluation and increases learning from experiences.

Thus why York-Barr et al., (2006) maintained that the perspective most needed in reflective practice is that of time as a valuable resource which should be shaped and reshaped to meet reflection needs rather than as a closed-ended bag into which practice has to be stuffed. Similarly, it was pointed out that time management is about planning to make time for everything in one's life. In the same vein, it has also been underlined that one should use daily check lists to prioritise the important tasks, which must be done within a certain time limit, especially if one has many jobs competing for her attention. One should sort activities into categories, for example, those that could be delegated to other people such as colleagues or students and those that can only be performed by oneself, those that must be given priority daily. One then apportions approximate amounts of time that one should spend on various activities in order to avoid spending too much time on one item (Taylor, 2000; Mashaba & Brink, 1994).

There is of course no formula for time-management. It all depends on the nature of the work, the type, variety and complexity of tasks to be performed (Mashaba & Brink, 1994).

It has been attested by other researchers that a professional nursing practice environment characterized by quality leadership and management, sufficient staffing, positive nurse-physician relationship, reasonable workload and appropriate working

conditions is required to ensure and sustain high quality patient care (van Bogaert; Meulemans; Clarke; Vermeyen; and De Heyning, 2009).

According to these researchers, such conditions appear to reduce the experience of burnout among nurses and to improve their job satisfaction, as well as their intention to stay in the hospital and nursing profession. It will also allow for registered nurses to reflect on their practices.

It can be concluded looking at the implication involved that if medicines are not administered at the right time it would affect the healing of the patients negatively. Therefore if the conditions of the patients are to improve, registered nurses need sufficient time to practice, observe and reflect on their daily activities

Some participants reflected on **ineffective teaching** as a concern that inhibits the transfer of knowledge and skills to students and new nursing staff. Some participants however expressed that even though the time for teaching purposes was not enough, they still tried to teach students and new nursing staff to develop their knowledge and skills and also to learn in turn, but this was not sufficient. There are many aspects that need to be taught to students, for example, “reflection”.

*“After I have assured that the patients have received their treatment, I spend the remaining time teaching the students.”*

*“I try to provide teaching to students in the right manner in order to prevent negative consequences.”*

*“I try to be responsible for teaching and advising my colleagues in order to develop their knowledge and skills and also to learn in turn.”*

*“I try to teach new staff even though time is against me because I believe that this is part of my responsibility.”*

Professional teaching in nursing education is an intentional enterprise that aims to facilitate learning, so that students can develop the appropriate knowledge and skills that would enable them to deliver high quality care to patients (Quinn 2007). It is, however, important that lecturers understand the concept of reflection. Braine (2009) did a study on this topic and found that lecturers need more preparation on this complex concept.

It is evidently the responsibility of all registered nurses to support student learning in the clinical environment. The clinical environment has long been recognized as the key site of learning for nursing students, with clinical support structures in the form of

designated personnel serving as one of the chief facilitating factors to help them link theory to practice (Lambert & Glacken, 2004; Duffy, 2009).

Thus the ward sisters have the role of influencing teaching and learning in the clinical environment through reflection. Teaching and learning are critical aspects within clinical environments as they promote the evolution of knowledge, skills and attitude and the amalgamation of theory with practice, ensuring the development of competent practitioners (Lambert & Glacken, 2004). In a study that was done by Chong (2009) it was found that although student nurses were sometimes sceptical about reflective practice, they found it useful.

It has been pointed out that clinical supervision, preceptorship and mentorship are all concepts germane to reflective practice. The literature review offered a comprehensive description of the benefits of using guided reflection in the preceptorship process in nurse education (Duffy, 2009).

Henderson, Winch and Heel (2006) in particular, advocated that reflective practice is an opportunity for practitioners to identify what connections they have made, to evaluate what they have learnt in their practice and to consolidate their knowledge. Therefore in reflective practice, a person seeks deep engagement in learning, and relevance produces

engagement. A relevant problem rivets attention and arouses the need to learn (Osterman & Kottkamp, 2004). Doing this would lead to competent registered nurses. McClure (n.d.) pointed out that reflection is an integral part of practice, and thus students need time to develop this skill.

The literature refers to reflection to as learning from events and incidents experienced during a course or practical professional programme, in other words as learning from analysis of experience gained in the clinical setting. It is also important to recognise that reflection involves the students and their experience with the aim of building bridges between past and present experiences to determine future nursing actions (Durgahee, 1998).

If registered nurses are not skilled in or committed to reflection, it may be problematic in two ways. In the first instance students may not be fully supported through the process of learning. In the second, the exposure to contrasting philosophies may be confusing to the students. Students must be prepared for the possibility of divergent beliefs and values in practice (Bulman & Schutz, 2004). Therefore Kuiper and Pesut (2004) stated that effective clinical reasoning in nursing practice depends on the development of both cognitive and meta-cognitive skills. Furthermore Carlson, Wann-Hansson and Pilhammer (2009) described nursing as a profession where practical and

theoretical knowledge need to be highly integrated and clinical practice is significant for the professional development of undergraduate nursing students.

In another study that was done by Mc Carthy, Cassidy and Tuohy (2011) it was pointed out that participants felt that it was important to have knowledge and understanding of facilitating skills to teach reflection.

In the light of reflective practice it is said that this is mostly based on an assumption that all professionals want growth opportunities. Thus individuals need to experience themselves as capable of producing desired outcomes and avoiding negative outcomes. Nursing practice depends on staff support, supervision and teaching. Registered nurses should support, supervise and teach student nurses as well as the newly graduated registered nurses allocated to their wards.

In conclusion one can point out that even though the registered nurses find themselves in busy situations they manage at least to set aside a little time to teach the students and the new staff.

According to the participants' explanations, **uncompleted tasks** refer to tasks left undone after the nurses ended their daily shifts, for example unattended wound dressings. Uncompleted tasks were categorised as some of the factors which influence the registered nurses to do reflection positively. Some registered nurses expressed that they reflect when they are off duty on what uncompleted tasks meant for patients. They stated that some nursing tasks were left uncompleted due to increased patient load and nursing tasks, and insufficient time to complete the tasks.

*“When I am off duty and recall an uncompleted task meant for a patient I immediately call my colleagues who are on duty and ask them to complete it.”*

The responses of the participants in this context reveal that some registered nurses in the training hospitals in Windhoek do reflect on their actions even when they are off-duty. In fact, they leave work feeling dissatisfied because they are aware of what was left undone or not given sufficient time, meaning that they are conscious of having acted in an undesirable manner. The participants were not only aware of negative practice when working under pressure but they were also aware of the dangers of negative practice which always have an effect on the care of patients.

The above-mentioned awareness motivated the registered nurses to call their colleagues who were on duty and instruct them to carry on and complete certain tasks or duties

which were left uncompleted. When patients do not receive their treatment or nursing care on time this has dangerous consequences as it can easily compromise the healing process of the patients.

The factors contributing to uncompleted tasks in the wards as mentioned above have been interpreted in a study conducted in general hospitals of Kuwait. The study looked at factors contributing to the incompleteness of nursing tasks as perceived by nurses themselves. The results of that study revealed that increased patient loads, resulting in increased frequency of both nursing and non-nursing tasks, were positively correlated to incompleteness of nursing activities during the shift (Al-Kandari, & Thomas, 2009).

The above type of situation has prompted nursing experts to advise that if the registered nurse has realized that she for some reason was not able to complete her work, should make sure that she reports it to other colleagues (Hegner & Caldwell, 1992).

Commenting on the problem of uncompleted tasks Hegner and Caldwell (1992) had the following to say: If the nurse is unable to complete her or his assignment, make sure that the nurse knows exactly what remains to be done and never leave the task delegated to without giving a report to colleagues.

In light of the above information it seems that registered nurses observed some degree of reflection on their nursing tasks, even though they might not have an idea that what they were engaged in was reflective practice.

*Sub-theme 2 During reflective interviews the following attributes were indicated:*

It is important for registered nurses to possess a potentiality in human caring process. Searle and Pera (1992) pointed out that the caring aspect is the central concern of nursing—its expressive dimension. According to Watson's caring theory in Riehl-Sisca (1989), human caring is the moral ideal of nursing. As such it consists of transpersonal, inter-subjective attempts to protect, enhance and preserve humanity in the hospital setting by helping one person find meaning in illness, suffering, pain and existence, and another to gain self-knowledge, self-control and self-healing.

The ideal of caring is the human-to-human, subject-to-subject process where the nurse is a co-participant (Riehl-Sisca 1989). Furthermore Riehl-Sisca (1989) held that the process of human-to-human caring illuminates the mystery of humanity and the possibility of a higher power, order or energy in the universe that can be activated through the nurse caring process that can in turn potentiate healing and health and can facilitate self-knowledge, self-reverence, self-control, self-care, and possibly even self-healing. As such, the process of human caring goes beyond the basic educational competency level toward higher-level professional care processes that potentiate health

and healing in individuals and society (Riehl-Sisca, 1989). Therefore registered nurses are expected to have knowledge and skills in the development of nursing process which includes all aspects to be followed and carried out during patient care.

The following sub-themes were identified where the participants commented on their different determinations and commitments to meeting the needs of patients: prioritising of nursing care, record keeping and report giving, serving as a role model, maintaining of proper communication, clinical supervision, giving of advice and acting during emergency cases.

The participants indicated that they try to maintain the hygiene of the patients and their environment, feeding them and maintaining their social, physical and psychological well being. As the participants have indicated, it appears that the registered nurses provide some degree of care to their patients which they do in a routine way without reflecting on what they are doing. **The basic human needs** of the patients as mentioned here are discussed below.

*“I keep in mind the maintenance of the hygiene of my patient and it is one of my priorities.”*

*“When I provide nursing care to my patients what comes first to my mind is feeding as I believe that nutrition supplements the effect of medicine and enhances recovery.”*

*“I usually make sure that the needs of the patients are met and patients are satisfied.”*

*“I always think about patients’ social, physical and psychological well being, and after they are discharged I want to see them returning home healthy and satisfied.”*

*“I usually reflect on the cleanliness of the environment where I nurse the patients in order to prevent infections.”*

From the above statements it is clear that some nurses really care for their patients through reflection. Rees (2012) pointed out in a study how engagement with reflective practices enabled participants to manage the distressing emotional challenges and labour of nursing work.

Basic human needs are those necessities required by all people to successfully and satisfactorily live their lives. The needs are the same for all people at all ages. Thus the literature suggested that they are the same whether the person is healthy or unwell. Human needs are described by Maslow as physical, psychological and sociological. He placed the needs on a continuum in which physical needs had to be satisfied first and followed by psychological and spiritual or sociological needs (Hegner & Caldwell 1992; Berman & Snyder 2012).

The evolution of modern nursing clearly demonstrates that professional nursing is not only a highly technological service, but also an intermediary, interventive, supportive

and coordinating service at the point where the health needs of persons and the services provided by the community to meet these needs intersect (Searle and Pera 1992).

Registered nurses are expected to reflect on the patients' needs as mentioned below in order to satisfy them.

*Physical needs:*

Physical needs of the patient include: a proper and clean environment, proper and adequate ventilation, provision of a balanced diet, encouraging of adequate sleep, encouraging and provision of help needed for body elimination, physical activity (mostly passive exercise) and temperature maintenance are important for patients in order to promote the functioning of the body systems and survival (Hegner & Caldwell, 1992; Berman & Snyder, 2012).

Cleanliness of the healthcare environment is one of the paramount responsibilities of a nurse. She has to maintain the healthcare environment in all settings. This is part of the creation and maintenance of a therapeutic environment that promotes healing and a speedy recovery (Mogtlane, Manaka-Mkwanazi, Mokoena, Chauke and Young, 2004). Thus registered nurses and other health providers should realise the importance of reflection on the patients' physical needs in order to satisfy these needs.

*Psychological needs:*

Psychological needs include: emotional needs, the need to be loved, to be treated with respect and dignity as well as to feel that self-esteem is protected whereby the patient can be able to take care of him- or herself (Hegner & Caldwell, 1992; Berman & Snyder, 2012), the need for intimacy, a feeling of closeness with another person—the feeling of love. Human touch can be referred to as one of the best pills for a sick person. Nowadays it is experienced and expressed by many patients that most nurses and doctors are not touching patients any more. This is an indication of poor reflection from the nurses, as they never reflected on their actions and never realised that patients need to be treated with respect and with care by touching them.

It has been stipulated well that “a friendly hug and smile, a pat on the shoulder, a clasp of hand and a back rub” are ways nursing assistants or professionals can satisfy the patient’s need for human contact (Hegner & Caldwell 1992). Berman and Snyder (2012) advocated that the patient needs to feel safe, both in the physical environment and in relationships.

*Spiritual needs:*

These needs arise when the patient is in fear of death or complications of illness. Thus registered nurses should reflect on what should be done and should be prepared to call for a spiritual person if the patient has indicated a need for spiritual support. Again this

involves love and belonging through giving and receiving affection, attaining a place in a group and maintaining the feeling of belonging (Berman & Snyder, 2012).

*Social needs:*

Social needs are the needs for socializing with other people. In the case of a patient, she or he needs other people to communicate with. There is a need to be understood. This need can be met by health professionals, family members and friends. It has been argued that this should involve the feeling of independence, recognition and respect from others (Berman & Snyder 2012).

Patient-centred care calls for self-awareness, reflective listening, and the use of empathy and the development of excellent communication skills by clinicians. It includes practising such behaviours as exploring the social and psychological aspects of the patient's health status, understanding the personal meaning of the illness for the patient by eliciting their concerns, ideas, expectations, needs and feelings and promoting the understanding of the patient within their unique psychological context (Drach-Zahavy 2009). So, registered nurses and other health providers should reflect on the importance of satisfying the social needs of the patients as well as the patients' expectations.

To conclude, the participants revealed that they do reflect on meeting patients' social, physical and psychological needs in order to see them returning home healthy and satisfied.

Some participants indicated that they usually try **to prioritise** the conditions, with the understanding that patients in critical condition should receive treatment and nursing care first in order to save their lives. Prioritising of nursing care refers to the identification of priority needs of the patients and the provision of proper nursing care. Prioritising of tasks was reflected upon as a necessity in the situation of a workload. The following was stated by some of the participants.

*“I usually try to prioritise the conditions, with the understanding that patients in critical conditions should receive treatment and nursing care first.”*

The above attribute is supported by Odell, et al. (2009) that effective observation of ward patients is the first key step in identifying patients whose condition is deteriorating and effectively managing their care. White (2001) again pointed out that establishing priorities requires an understanding of the importance of different problems for the nurse, the client, the family, and other health care providers. The work of Benner (1984) has provided a foundation for reflection on nursing practice worldwide, in terms of the

expertise of nurses in action. The ability to make sound clinical judgments and intervene in nursing care contexts requires reflection (Sherwood et al., 2005).

Clinical judgement includes critical thinking and, according to a study that was done by Cirocco (2007), it seems that reflective practice encourages critical thinking.

One can conclude that proper nursing care is based on identification of priority needs. Incomplete information or analysis of client needs would result in inappropriate or inadequate nursing care. So the ability to identify and prioritise client care problems depends on the completeness of registered nurses' knowledge base.

Registered nurses have indicated that they **keep records and give reports** to other colleagues about what they have performed and any activity that needs to be done. The statements made by the participants gave a good impression that registered nurses are trying at least to maintain a proper way of communication through reflection.

*“I try to keep the record of all the activities.”*

*“I reflect on maintaining a record after performing an activity.”*

*“When I finish treating the patient I always go back and check if I have recorded all the activities in the patient's file which is important for my*

*colleagues to know about the patients' progress and activities performed and to be done."*

'Record keeping' is described by Hegner and Caldwell (1992) and Berman and Snyder (2012) as the written information concerning the care given to the patient, the patient's reactions and all observations made. 'Report giving' is the oral report given concerning the name of the patient, bed number, diagnosis and instructions for patient care. The importance of record keeping and report giving is to ensure that all staff members fully understand the nursing care required for each patient. They further clarify that communications with other staff members take three forms; oral communications or reporting, written communication in the form of nursing care plans and body language. Communication between staff members must be effective if the patient is to receive the safest and best care.

Registered nurses and other health professionals always need to consider the importance of record keeping such as the recording of any special factors that appear to affect the patient or the patient's response to treatment, as well as to aid communication between the team members (Pullen & Loudon, 2006).

To conclude this attribute we can state that some of the registered nurses are trying to reflect on record keeping by going back and checking if they have recorded all the

activities in the patient's file, as it is important for colleagues to know about the patient's progress and activities already performed and those yet to be done.

**Good communication** was experienced as a vital attribute among the staff members in order for them to work as a team. Some of the participants reflected and pointed out that they even try to counsel the patients as well as to maintain the culture of respect towards their colleagues through being calm and having understanding. Thus communication is a two-way process that would promote the proper care of patients

*"I try to maintain good relationship among the staff."*

*"I like to keep good communication with my colleagues."*

*"I try to counsel the patients, for example when they are going for an operation."*

*"I try to maintain the culture of respect towards my colleagues being calm and have understanding."*

Information, whether it is facts or feelings, is shared. Information can be sent orally, in writing and through body language (Hegner & Caldwell, 1992; Berman & Snyder, 2012). Collegial reflective practice in the workplace can enrich the process practice. It is complicated in an organisational setting where widely accepted norms seriously constrain the ability of individuals to engage in open and critical dialogue about actions,

feelings and thoughts that constitute the core of reflective practice. Reflective practice requires open communication about thoughts, observations and feelings. It is important to understand communication as a two-way process involving inquiry-learning about others' positions and advocacy-stating one's own position (Ostermann & Kottkamp, 2004).

Listening facilitates the articulation of ideas. It is also critical for developing social awareness and empathy and building strong interpersonal relationships; it is a key component of emotional intelligence. Attending is the most basic listening strategy. Through a combination of posture, gesture, eye contact, nods and murmurs the listener tells the speaker that she or he is being heard. Therefore attending conveys interest and acceptance and thus encourages the person to be more forthcoming. Reflecting can be another way of listening that helps to shift perspective and encourage reflective practice. The reflective practitioner asks questions. Doing this, she strives to deepen her own understanding of the other's message (Ostermann & Kottkamp, 2004).

Effective communication is emphasised as a fundamental component of nursing and is recognised as an integral part of delivering high-quality patient-focused care. Communication is essential as it allows nursing staff to assess the unique needs of patients (Boscart, 2009).

If each nurse uses effective communication with peers as well as clients, the unit would run more efficiently and client care could be more effective (White, 2001). The need for nurses to be effective communicators has been acknowledged repeatedly within the literature (Ashmore & Banks, 2004). It is also emphasised that effective communication enables the nurse to form a caring relationship based on warmth, empathy and respect (Burnard, 1997).

In conclusion, this attribute provides a sense of maintaining the culture of respect towards colleagues through being calm and having understanding, as well as providing of counselling to the patients.

Some participants reflected and pointed out that one of their roles is to be **a role model**, acting in a polite way and respecting patients and colleagues and wishing others to do the same. Thus registered nurses are expected to demonstrate the ability to be a role model of professional practice, for example, being able to perform all the skills, such as patient-caring, organizational skills, problem-solving skills and interpersonal skills with patients and colleagues. Some participants had these to say:

*“My focus is to be a role model, acting in a polite way and respecting the patients and colleagues.”*

*“I try to be a role model for my colleagues and wish them to do the same.”*

The role model is referred to as a concerned, compassionate, competent, comprehensive nurse practitioner who enacts her role in a way that can be observed (Searle & Pera, 1992).

Facilitators may prepare themselves by following/studying some guidelines being a role model or by participating in all exercises. It is essential that the facilitator demonstrates an openness and willingness to share experiences (Bulman & Schutz, 2004).

Role-modelling was also described by Myrick, Yonge and Billay (2009) as the key to doing good in the moment which implies a particular individual style, behaviour, way of speaking and thinking one would inevitably like to emulate.

In light of the above attribute, registered nurses pointed out that their focus was to be a role model, acting in a polite way and respecting patients and colleagues.

Some of the participants reflected on taking part in **clinical supervision**, which is regarded as peer support for practitioners in clinical and community settings.

*“I try to supervise the colleagues who work under my supervision.”*

Clinical supervision is defined as a formal process of professional support and learning which enables the individual practitioner to develop knowledge and competence,

assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations (Quinn, 2007). It is further described by NMC (Nursing Midwifery Council, 2006) in Quinn (2007) as an important part of clinical governance; it allows registrants to develop their skills and knowledge and helps them to improve patient/client care.

The following statements from the literature also have something to say regarding supervision. The purpose of clinical supervision, among other aspects stipulated in (Quinn, 2007) as adapted from Grant and Quinn, is for professional support and learning, development of knowledge and competence, responsibility for one's own practice, enhancement of consumer protection, helping the practitioner to examine and validate his or her practice and feelings, formative assessment, ensuring high standards of clinical and managerial practice, improving quality of patient care, improving staff performance and reducing stress and burn-out.

Quinn has also pointed out that clinical supervision is carried out in two ways: by one-to-one supervision and by group supervision. One-to-one supervision is the type in which the experienced nurse acts as the clinical supervisor for a less-experienced colleague. Group clinical supervision is an approach in which one supervisor is designated for the group; the advantages claimed are that it exposes supervisors to

alternative modes of helping and fosters an appreciation of the widespread nature of their concerns (Quinn, 2007).

Right supervision is described as the processes where an appropriate monitoring, implementation, evaluation and feedback are provided. In an effective organization, reflective practice takes place in supervisory conference meetings in problem-solving situation (White, 2001). Effective supervisors use reflective practice to foster professional growth. Reflective practice should be an integral part of organizational life in clinical settings (Osterman & Kottkamp, 2004). McClure (n.d.) pointed out that the important pre-requisites for effective supervision and reflective practice are honesty and openness. If the clinical supervision is not done properly one can predict the effects on the consumers, for example poor staff performance and a poor standard of patient care. Clinical supervision was further described as one way to acquire the skills of critical reflection (Sherwood et al., 2005).

One can conclude that the above explanation regarding supervision highlights the importance of supervision and endorses what was reflected upon by the participants: that they try to supervise the colleagues who work under their supervision in order to provide proper nursing care to the patients.

Concerning the **giving of advice**, the participants reflected and indicated that their advice was mostly applied to the doctors; for example, if the registered nurses find out that the doctor's prescription is not correct, they advise them to change it. They also try to advise them on the treatment of the specific condition if it was not properly done.

*"I also have a responsibility to advise the intern doctors because they are still learning."*

*"I tried to give advice to the doctor concerning the patient who was suffering from a cardiac problem."*

*"Whenever the medicine has been prescribed by an intern doctor I assure that the dosage is correct; if not I inform him/her about it."*

'Advice' is defined in the Oxford Dictionary as "an opinion or a suggestion about what somebody should do in a particular situation."

Thus the importance of giving advice is to protect the patients from harm. It means that advice is very important for the professional in order to provide and perform a secure and safe practice. If professionals are not advised on the proper techniques for good practice, then they may cause harm to the patients whom they are taking care of.

To conclude this attribute, one can state that there is teamwork in hospitals as mentioned by the participants who said that they could reflect on the doctors' prescriptions and advise them if the dosage meant for the patient is not proper.

Some of the participants reflected and indicated that it is important for them to **act during emergencies**. They regard such action as a way of saving the lives of affected patients.

*“When I see that a patient is experiencing difficulty in breathing, I usually give him / her O<sub>2</sub> before I call a doctor.”*

Emergency cases are cases that require urgent care that must be given right away to prevent loss of life. Emergency cases can occur at any time to anyone.

Emergency nursing is defined as the care of clients who require emergency intervention. So the emergency nurse must be capable of rapid assessment and history-taking, of formulating immediate intervention, implementing and utilising the nursing process. Clinical knowledge, communication, client teaching and empathy skills are essential to effective emergency care (White, 2001).

The above statement corresponds with the idea of Curtis, Murphy, Hoy and Lewis (2009) that nurses require in-depth knowledge and clinical expertise to provide care across the life span and to manage situational events such as patient overcrowding and complex technology.

In conclusion, participants indicated that they reflect during emergency cases although this may not always be the case, when one looks and makes some conclusions regarding some incidents that have happened in the wards and units.

To conclude the discussion on theme one, one can state that the registered nurses, although they attempted to reflect about their roles and functions they did not always do observations properly. At times they resorted to shortcuts. Not only did nurses not always adhere to prescribed intervals for administering medicines to the patients, but they also sometimes left tasks uncompleted. These concerns and shortcomings are attributed to ineffective teaching of students as well as new staff.

### **3.3.2 Theme 2: Participants experienced different emotions during reflection and expressed their meaning**

‘Emotion’ is defined in the Oxford Dictionary as “the part of a person’s character that consists of feelings”. This entails positive emotions, such as joy, and negative emotions, such as frustration and guilt. Quinn (2007) has pointed out that both positive and negative emotions can equally disrupt normal functioning in an individual, including the person’s relationships with others and his or her ability to make judgements and take decisions. This has been explained further by Abe (2011) who points out that, theories of emotions focus on how negative emotions help us cope with immediate threats by narrowing our thought-action patterns. According to the literature, explicitly addressing emotions in the curriculum is an essential requirement for educating the emotionally intelligent practitioner (Smith & Allan, 2010).

In reflective practice, it is necessary to gain an appropriate balance between the analysis of knowledge and thoughts and the analysis of feelings. In order for the process to be constructive it is also important to focus on positive feelings as well as trying to deal with negative feelings. Therefore, analysis of one’s own feelings may be a process which one engages in only so far as it affects and illuminates practice situation, and enhances learning from those situations. Reflective practice does involve an analysis of feelings, and without this understanding you may miss real opportunities in your experience to learn about yourself. Increasing self-awareness and the ability to analyse

your feelings would give you insight that may enhance your professional practice. (Bulman & Schutz, 2004).

### 3.3.2.1 Sub-themes

*Sub-theme 1 Positive emotions were experienced by participants as discussed below*

The participants in this research indicated that they experience **emotions of happiness, self worth and encouragement** when they have completed their work and reflected on it. In the background of these emotions is love for the patients and for the profession. Motivated by love, registered nurses at the training hospitals would normally be satisfied to witness the recovery of their patients and to see them leaving the wards in good health. These kinds of feelings would naturally motivate a nursing professional to strive to deliver good service and thus to reflect on what was done and what ought to be done for the wellbeing of the patients.

*“I expect the patients to be happy about my activities and this encourages me to do and love my work.”*

*“I feel good when I have completed my duties, because I believe that this would help the patient to become well and go home being happy.”*

*“I feel happy when the patients are satisfied with my work.”*

Registered nurses in the training hospitals are inclined to bring about happiness among their patients and among themselves as professionals.

According to the theory of positive emotions, positive emotions do not merely reflect momentary happiness or satisfaction, but, more importantly, serve the evolutionary adaptive function of widening a person’s scope of attention and cognition as well as expanding the array of possible behaviours (Abe, 2011). Abe further argued that in support of the ‘broaden and build’ theory of positive emotions, studies have found that individuals who are induced to feel positive emotions exhibit wider visual search patterns and more flexible mindsets, and also report higher levels of feelings of self-other overlap (Abe, 2011).

Participants have reflected and indicated that they believe that the cure of patients is mainly based **on loving care**, and they also pointed out that they love what they are doing and also love to work with patients.

*“I believe that the cure of a patient is mainly based on loving care.”*

*“I love what I am doing, I love working with patients.”*

*“My focus is to be friendly and feel empathy towards the patients and colleagues.”*

Empathy is the ability to identify the effective emotional message sent by someone else and to acknowledge it verbally. It refers to the practitioner's sensitivity, awareness and understanding of another person's feelings—her or his ability to notice that a patient is desperate, afraid, sad, or in pain. The practitioner is able to identify the positive feelings that the person reflects, such as happiness as well as the negative feelings of sadness and anger (Muller, 2009).

Underlying the scientific services is a motivational force of compassion, empathy, concern, sympathy and love for one's fellow men. This is interwoven with an extensive range of knowledge and skills (Searle & Pera, 1992).

One can conclude that the focus of registered nurses is to be friendly and to feel empathy toward the patients and colleagues. Thus the provision of loving care to patients has been observed by some participants as mentioned above.

*Sub-theme 2 Negative emotions were experienced by participants as discussed below:*

Reflection also brought out negative emotions. Some of the negative emotions were feelings of incompetence as well as frustration. Actions to manage negative emotions are described as emotionally focused strategies which are aiming at improving of the person's mood, for example counselling. Registered nurses, for example should ask themselves about the negative emotions—questions such as: How serious is it? How does

negative emotion from past experience interfere with their daily activities? Can you control it? What was the cause? What did you do about it?

Participants reflected on **guilty feelings** experienced when there was incompleteness of duties. Most of the participants expressed the same feeling when they did not complete all the daily activities because they know that this affects the condition of the sick patients.

*“When I am off-duty I still feel guilty if I did not complete everything for the patient because of time.”*

*“I feel bad when I did not do what I was supposed to do. For example when I observed that a patient looks pale it means that I need to do the haemoglobin test immediately, but because of an overload I may do it later.”*

*“I feel guilty if I do not perform the procedure according to the prescribed time because I know that the medicine can only work perfectly within the prescribed intervals.”*

*“Another example is when I was in a busy situation where I felt tired and could not turn the patient, when I went back home I felt guilty because I did not do my job.”*

Powerful emotions sometimes arise within practice and within reflection upon practice. These can be difficult to handle, but it can be more developmental to work through them rather than to push them away as inappropriate to a professional enquiry. Very strong emotion can initially appear to inhibit the ability to reflect and understand (Bolton, 2001).

In the light of the above, reflective practice is an appropriate tool for exploring emotions; therefore registered nurses need to express their emotions. By reflecting, nurses would learn how to handle their emotions, for example, feeling of guilt.

It was reflected and mentioned by the participants that when there is **conflict** among them as colleagues they usually try to communicate with one another so that they can understand each other and work as a team.

*“When there is a conflict among us as colleagues I always try to communicate with my colleagues so that we can understand each other and work as a team.”*

The following literature highlighted some of the important statements which could help people to understand the nature of conflict. ‘Conflict’ is defined in the Oxford Dictionary as “a situation in which people, groups or countries are involved in a serious disagreement or argument.”

At the core of conflict is difference: reflective thinking offers a way to understand differences and to support productive engagement of conflict. Understanding can result in decreased judgment and in recognition of different values, experiences and priorities. It can also reveal points of agreement that often serve as common ground for moving forward (York-Barr et al., 2006).

Again, James and Clarke (1994) pointed out that the value conflicts that arise from particular nursing actions are considered in the context of the social, political and economic constraints on action. An example of this in nursing would be a critical analysis of the implications of a new and imposed funding policy which adversely affects the quality of patient care. Where reflective practice occurs, people are willing to share sensitive information about their work with their colleagues and discuss those areas of their practice where they may be weak or at least not as strong as they would like to be (Osterman & Kottkamp, 2004).

To act in a rational manner is to suppress emotions. To avoid emotional reactions, organizations adopt protective strategies. The pattern of withholding particularly applies when information might create conflict or hurt others. Withholding, particularly of critical information, presumably reduces the likelihood of conflict. By withholding information, we keep things calm and under control--our control (Osterman & Kottkamp, 2004).

In conclusion we can state that resolution of conflict is part of good administration. If needs be, an outside expert can be invited to conduct workshops on human relations for groups consisting of clinical staff (Bolton, 2005).

Some participants experienced **stress** as a result of many factors. They have expressed themselves as follows:

*“Due to stress caused by a sometimes unmanageable workload, I realised that I am not able to assist every patient as intended.”*

Gibbons, Dempster and Moutray (2009) supported this saying that the main clinical sources of stress for nurses and student nurses include working with dying patients, conflicts with other staff, insecurity about one’s clinical competence, interpersonal problems with patients and heavy workload.

Thus stress is defined by White (2001, p. 290) as a “nonspecific response to any demand made on the body, those demands are termed as stressors; any situation, event, or agent that produces stress is considered a stressor”.

Lu, While and Barriball (2006) have indicated in their study on a model of job satisfaction of nurses, that nurses’ job stress and the organisational commitment have strong relationships with job satisfaction. Based on the above statement, they further

suggested that nurses' role identification and acceptance of that role are primary variables influencing their feelings about their working lives.

In spite of the stressful situation, some of the nurses, however, seem to have trained themselves to cope with the workload. It was argued in literature that adequate stress not only brings about proper learning motivation but also helps to maintain physical and mental health; however, too much stress can have a negative influence. It is of course obvious that a situation like this would demand a nurse to reflect both in action and on action in order to give necessary care to the patients (Yune So Young & Eunjing, 2009).

Wallac, McAnn, Queen, Madigan and Letvak (2009) argued in support of the aspects discussed in other literature that the current and projected nursing shortage has been significantly linked to burnout, frustration, increased workload and a lack of respect and support for nurses.

White (2001) pointed out that not all stress is harmful. The way one responds to or copes with stressors dictates whether the situation is healthy or harmful. Stress results not from an individual's life situation, but from that individual's reaction to and perception of the life situation.

One can conclude this sub theme by noting that even though the registered nurses at the particular hospitals would like to serve their patients in a professional manner they were frequently inhibited by stress as a consequence of being overloaded with too much work.

To conclude theme two, it can be said that registered nurses, when reflecting on their roles and functions, said that they experienced positive emotions where they felt happy and motivated to provide quality nursing care. Besides this they also experienced negative emotions when they felt guilty and stressed due to ineffective practices which led them into conflicts. Both discussions and the literature review on this theme indicate that by reflecting, nurses learn how to handle their emotions, including stress resulting from an excessive workload.

### **3.3.3 Theme 3: Participants reflected on resolutions concerning challenges in their daily practice**

The purpose of reflective practice in clinical settings is to facilitate improvement in clinical performance. This theme encompasses the action plans the participants reflect on for the provision of nursing care during their daily practice. Different views were marked across the participants concerning their resolutions.

The literature stated that nurses who are reflective practitioners would operate at all four levels; the technical, the practical, the moral-ethical and the personal. It is only through reflection in all domains that nurses will come to a full understand of their own practice (James & Clarke, 1994).

In order to achieve the aim of nursing care, the provision of quality care should be based on appropriate theory and its proper application practice, the vehicle being reflective practice. If registered nurses cannot apply reflective practice to provide quality patient care, then they have to make sure that they possess the knowledge and skills in the integration of both process of reflection-in-action and reflection-on-action into their daily work.

Registered nurses need to assess their situation and would be in a position to reflect on how they respond to the particular situation. Reflection has a quality of personal involvement where the registered nurses' feelings and cognitive aspects are concentrating on problem solving and learning.

For change to take place in practice there are underlying skills involved. According to the theorists Bulman and Schutz (2004) these underlying skills are self-awareness, description, critical analysis, synthesis and evaluation. The importance of these

underlying skills has been reinforced by a number of small-scale research projects that examined the development of reflection in nurses.

Reflection as a learning process can be understood in the light of Gibbs' model of a reflective cycle, in which Gibbs (1988) proposed six stages of the reflective cycle. These are: description, feelings, evaluation, analysis, conclusions and action plan (Bulman & Schutz, 2004).

Clinical registered nurses are expected to possess skills that would enable them to assess the real situation in order for them to learn from what they see. They also should be able to **describe** the situation and to **reflect on their thoughts and feelings** on the particular situation—which is reflection in action. They should be able to **evaluate** and **analyse** the cases—which is reflection on action. Subsequently the registered nurses would be in the position to make their **conclusions** on the situation and to draw up **plans of action or resolutions**.

Thus the challenge of applying reflective practice remains with both the individual practitioner on the one hand and the health care institution on the other hand. The purpose of reflective practice is to enhance awareness and understanding of one's own thoughts and actions as a means of a professional growth. To be able to understand

one's own thoughts and actions, healthcare institutions should facilitate support guidance and opportunities for practicing registered nurses where the underlying skills necessary for reflective practice can be developed.

Each registered nurse must learn to be reflective or introspective about their own thinking and focus on deciding what to do. The attentive commitment to a self-reflective process of examining one's thoughts ensures that the thinking occurring meets intellectual standards (White & Duncan, 2002).

Nursing is dynamic and is constantly changing into response to developments in health care, social needs and professional needs. Reflective practice is considered as a professional development process incorporating different assumptions. For example, it assumes that professionals are competent and able to assume responsibility for detecting and addressing weaknesses in their practice (Osterman & Kottkamp, 2004).

To be able to address weaknesses in practice, the skill of self-awareness is needed. And to address the weakness, nurse practitioners would change and improve practice as necessary. While reflective practice shares a common goal with other more traditional approaches to professional development—that of improved practice, its approach is noticeably different. In traditional professional development there is an assumption that

changes come about through access to new information. According to Osterman and Kottkamp (2004), reflective practice, in contrast, views professional development as a more complex process that requires changes in held theories.

### 3.3.3.1 Subthemes

*Sub-theme 1 Reflection on resolutions to challenges was highlighted.*

The participants described some action plans by which they pay attention in terms of reflection during the provision of nursing care, in order to have some resolutions.

The participants reflected on **the provision of nursing care** according to the patients' conditions. These are their responses:

*“I always try to reflect and think of the situation in order to improve it, for example to provide the quality patient care.”*

*“When a patient is complaining about pain at the site of the drip, for example, I firstly think about what I should do. In such situations I would carefully check if that site is not swollen and if a patient is still complaining I take the initiative to stop the drip and inform a doctor.”*

*“When a patient is complaining of a headache, I usually give a patient Panado and do observation after 2 hours. If the condition is not improving I call a doctor for his/her opinion.”*

*“When I see that a child is vomiting after getting the medicine I insert a nasogastric tube so that a child can get the right dosage.”*

*“When a patient fell from a bed, I immediately asked myself about what has happened, what to do and examine the patient carefully for any pain or sore.”*

*“When a patient is vomiting for example I reflect on which action to take such as being at a patient’s bedside to assist him/her.”*

Observation of patients’ conditions and the effects of medications were the participants’ focus.

This can also be seen in the light of individualized care which recognizes the uniqueness of the individual and the importance of providing care which is tailored to meet individual needs. The nurses need also to demonstrate support of patient individuality in their daily care (Suhonen, Gustafsson, Katajisto, Valimaki and Leino-Kilpi, 2010). Individualised care is a part of nursing practice; therefore nurses should value its development, the evaluation of individualized care processes, activities and working environments (Aiken, Clarke, Sloane, Sochalski, Busse, Giovannetti, ... Shamian, 2001). Holistic health care is a comprehensive approach to health care. It considers physical, intellectual, socio-cultural, psychological and spiritual aspects, the response to illness, and the effect of illness on a person’s ability to meet self-care needs (White, 2001).

The functions of a registered nurse or midwife practitioner are described as the constellation of key activities perceived as essential for the delivery of knowledgeable, competent and legally and ethically based nursing care to a patient, family, group or community (Searle & Pera, 1992).

Reflecting on some of the above-mentioned aspects, one can have a clear understanding that registered nurses need to assess patients carefully in order to attend to their problems.

In order to reduce the discomfort of a patient, some authors have described the management of pain as follows: Pain is a common accompaniment of many illness situations and can be a major impediment to an adequate quality of life. A key component of effective pain management is the nursing assessment of the patient's situation. Nurses generally have a high degree of responsibility for implementation of pain-relieving strategies and the evaluation of their effectiveness. However, studies conducted in various clinical settings have consistently shown that nurses' assessments of patients' pain do not always match the patients' own assessments of their pain (Appleton, 1993).

Planning effective pain and distress management is a crucial part of the nurses' profession. In order to achieve this it is necessary to identify and assess the level of

patients' pain and distress in an attempt to identify a potential course of action (Hall-Lord & Larsson, 2006).

In conclusion of this sub-theme, some of the participants pointed out that they always try to reflect and think about the situation in order to improve it; for example, to provide quality patient care. They also mentioned some of the examples like when a patient is vomiting they reflect on which action to take, such as being at a patient's bedside to assist him/her.

The participants indicated that they do **check the procedures of administering of medicine** before administering it to a patient. Their responses were as follows:

*“Before administering any medicine to a patient I usually make sure that the right dosage of the right medication is given at the right time to a right patient.”*

*“When a doctor has prescribed the wrong dosage, I would carefully double-check and calculate it in order to give the right dosage to a patient.”*

*“When I administer medicine to a patient I usually make sure that the right medicine is used, also checking its expiry date thoroughly.”*

*“When administering the medicine, I observe the patient's condition before and after giving him the medicine in order to detect any side effects.”*

*“When I am giving treatment to a patient I always ask myself whether the treatment I am giving would help him or not.”*

*“When I am administering intravenous injection, I always make sure not to force the medicine because it can damage the patient’s vein. When I am done I observe the condition of a patient and keep a record.”*

*“What first comes to my mind is that the prescription should guide me before I attend to a patient, in terms of the correct dose, time and how to give the particular medicine.”*

*“I always ask the patients whether they are allergic to some medications before I administer any medicine and I tell them to report any reaction occurrence.”*

*“I also try to observe the effect of the medicine on a patient, for example, when I see that a patient has been on the treatment for five days without an improvement I consult a doctor.”*

Registered nurses are accountable for their practice and are responsible for providing nursing care directly and through others. They advocate patients, collaborate with other health care disciplines and continue learning over the course of their careers (Wolf & Hoerst, 2007).

With the above statements in mind one needs to look at the study of Fields, Tedeschi, Foltz, Myers, Heaney, Bosak, et al. (2008) on reducing preventable medication safety events and recognize the renal risk caused by certain medication when administered erroneously especially to elderly women who are more likely to have hidden renal risks.

Erroneous prescriptions involving a wrong dose affect more often negatively in patients with a hidden high renal risk.

The registered nurses in the training hospitals, being accountable for the patients, as noted in the responses of the participants, take a cautious approach when administering medicine to patients. White (2001), for example, has pointed out that medications must be given within a specified time frame, usually no more than a half hour before or after the established time.

One can conclude that the participants described their reflection in action and reflection on action in terms of taking initiatives to double-check on important aspects such as prescriptions, right doses, right patient, right time, expiry dates as well as the observations of the effects of medications on the patients before administering medications to patients.

To conclude theme three and its sub themes, the registered nurses indicated how they reflected on the provision of nursing care embracing their role in administering medicine to the patients. It was found out that registered nurses have resolved to provide quality care and this can only be achieved when these professionals engage in both “reflection-in-action and reflection-on-action” in their daily practice.

### **3.4. COMMENTS ON THE ABOVE RESPONSES**

According to the participants' responses as it appears above one can draw a conclusion of uncertainty on the concept of reflection among registered nurses. This is indicated by the statements made by some of the participants such as "I am not sure or I do not understand the concept of reflection well...." Even though some of the participants did not make the same statements, it can be concluded that the concept of reflection and its application are not well known and properly applied as it supposed to be done by registered nurses in clinical practice.

Different interpretations of reflective practice were obvious. For some, it was perceived as a consideration of their daily practices without paying attention to reflection-in- and reflection-on-action. The registered nurses interviewed demonstrated a fairly restricted understanding of reflective practice.

Despite a great deal of academic debate and some research, the concept of reflection and reflective practice remain poorly understood (Hargreaves, 2004). Several attempts in this area have been made by scholars such as Burns and Bulman (2000), especially in the area of nursing education, without offering all solutions to this problem. Besides the above scholars, other authors such as Wong et al. (1995) and Jasper (1999) have

propounded valuable ideas in the area of reflection but they too do not provide solutions (Hargreaves, 2004).

The above observations constitute substantive reasons to describe reflection and reflective practice as educational aspects for which further research needs to be conducted. The responses provided by registered nurses who participated in this study were merely based on their daily routine activities. It was noted that the participants described more the ways in which they performed nursing activities than how they reflected on clinical conditions. It is obvious that there is a need for the development of reflective practice programme in order to enhance the application of reflection during the nurses' daily practice.

The above need is underscored by Lindahl, Dagborn and Nilsson (2009) who expressed that registered nurses do not in practice carry out their work according to a lesson plan. Instead the happenings in their everyday work are the "palette" from which they choose the way they will work with patients.

### **3.5 SUMMARY**

The outcome of this analysis has identified the participants' definitions of reflective practice, the factors that affect the application of reflective practice both negatively and positively. Registered nurses sometimes could not perform their duties as expected due to a variety of reasons which range from understaffing, unrealistic patient-nurse ratio in the wards and insufficient time. Some registered nurses had difficulty reflecting upon the complexity of their roles.

The challenge picked up from the analysis is how registered nurses can be encouraged to reflect upon their work relationships and share their different perspectives of care, reflecting upon and describing their everyday relationships and roles in their practice, not just to think of these as their routine work. Based on the responses from the participants, the conclusion can be made that registered nurses have not been familiar with the concept of reflective practice or reflection. Even where registered nurses were familiar with these concepts they have been unable to apply them to the context of clinical practice. Resolving these issues, rendering ongoing support and in-service training to registered nurses are considered by the researcher as important ways to make reflective practice in the hospitals more productive and effective. Supportive trainers, clear objectives, enough staff and sufficient time would enhance the proper demonstration of reflective practice.

## **CHAPTER 4**

### **CONCEPTUAL FRAMEWORK**

#### **4.1 INTRODUCTION**

The second phase is dedicated to the development of the conceptual framework of the study and focused on the agent (researcher) and recipients (registered nurses) characteristics, context, procedure and terminus. Each has been discussed with emphasis on an impact on the patient.

The conceptualization provides us with the framework for what we do and why we do it. It renders us the guiding principles. A framework is the abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the findings to nursing's body of knowledge (Burns & Grove, 2005). The conceptual framework would be discussed based on the results analysed in Chapter 3. The presentation of the elements of nursing theory as described by Dickoff, James and Wiedenbach (1968, p. 438) have been adopted as the conceptual guide for this research. These entail:

- Agent = what or who performs the activity?
- Recipient = what or who is the recipient of the activity?

- Context = in what context is the activity performed? (Clinical settings)
- Procedure = what is the guiding procedure?
- Dynamics = what is the energy source for the activity?
- Terminus = what is the end point of the activity?

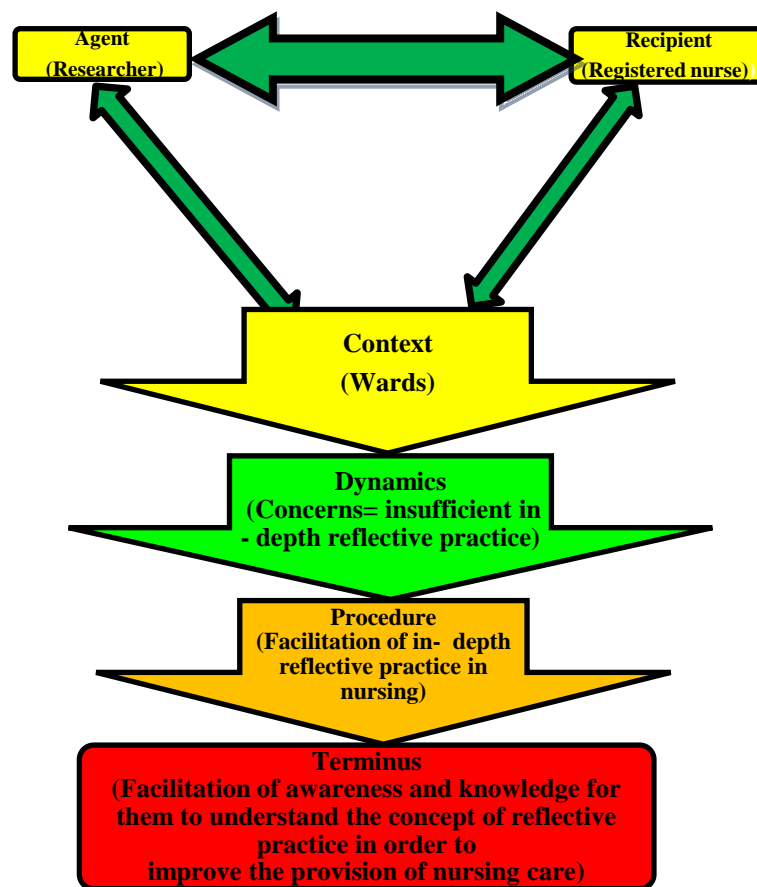


Figure 4.1: Conceptual map of reflective practice

The application of the above conceptual map to this study illustrates the processes involved in programme development and its application in clinical practice in order to improve the provision of nursing care. Each of the elements involved is described here in turn.

## **4.2 AGENT: (RESEARCHER)**

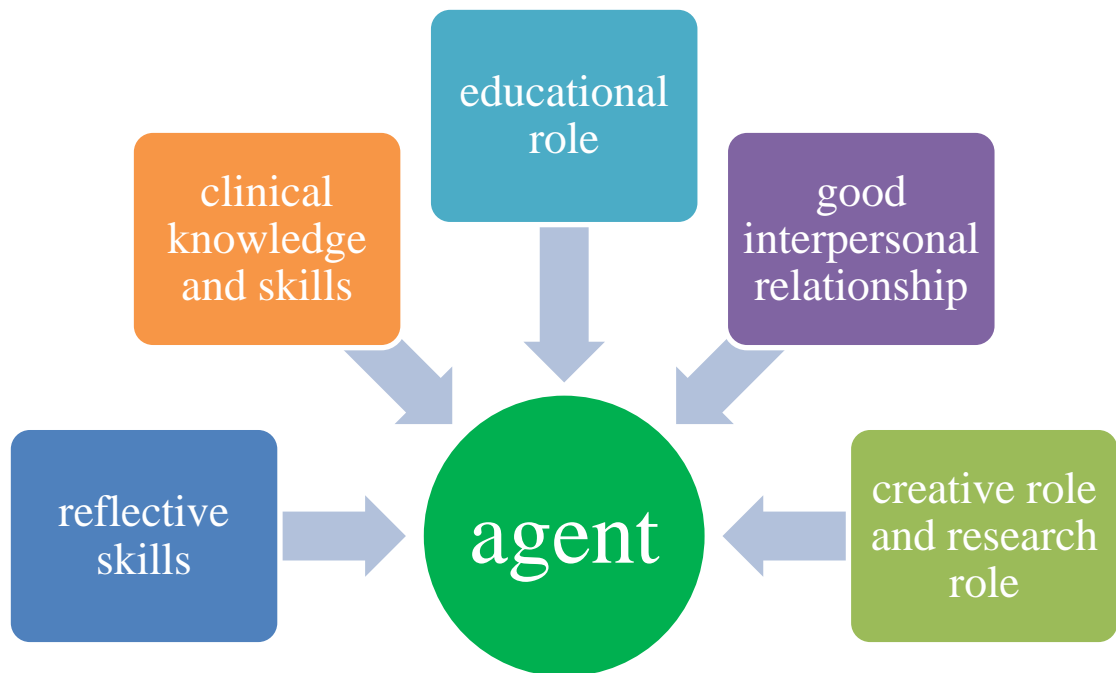
An agent is defined in the Oxford Dictionary as “the person or thing that does an action”. It is further defined as “an active and efficient cause, capable of producing a certain effect”, “a representative who acts on behalf of other persons”

In this study the researcher is the agent who would develop the reflective practice programme for registered nurses in order to improve reflective process in clinical settings.

In this study an agent is a researcher and lecturer who teaches student nurses and follows them up in clinical settings. She is expected to assist and guide the registered nurses in the clinical setting, where they can reflect on what they are doing, including the teaching of students, as one of their roles as well as the provision of quality nursing care to the patients. A nurse educator is the provider of information and a demonstrator

of skills. These are the skills that the nurses need when they are providing care to patients.

The researcher/agent can be well described according to the characteristics he/she possesses. The researcher would have the following characteristics: reflective skills, clinical knowledge and skills, educational role, good interpersonal relationship, creative role; and research role these are discussed as follows:



**Figure 4.2** The characteristics of an agent (researcher)

#### **4.2.1. Reflective skills of an agent**

Reflective practice can be viewed in many ways. Reflective practice is described as a cognitive (thinking) process which brings together several stages of deliberate explorations focused on practitioner skills and outcomes (Chong, 2009). According to Burns, O'Donnell and Artman (2010) problem-solving and critical thinking skills form the foundation of all nursing practice and are essential for safe and competent nursing care. It means that a lecturer or nurse educator needs to examine his/her own understanding of the events encountered in clinical practice.

The above concepts need to be understood in light of Professor David Boud's explanation that reflective learning will not occur unless you reflect, and to do this a person must think of a particular moment in time, ponder over it go back through it and only then the person will gain new insights into different aspects of that situation (McClure, n.d.). Again Forneris and Peden- McAlpine (2009) further pointed out that the literature suggests that nursing practice and patient outcomes are improved by nurses' critical thinking.

Reflective practice is necessary in the development of the therapist's self-awareness and "therapeutic use of self". It is a pre-requisite of helping others. Journal keeping where

one identifies, describes and reflects on one's reactions, feelings and thoughts facilitates this (Curtis, n.d.).

Mentors or lecturers of student nurses, and registered nurses should develop a commitment to reflective practice and be skilled in that process. To reflect is an intentional and skilled activity requiring an ability to analyse practice actions and make judgments regarding their effectiveness (Bulman & Schutz, 2004). Again here, Manning, Cronin, Monaghan & Rawlings-Anderson, (2009) emphasized that the reflective process encourages critical thinking and problem solving. Problem solving and reflective skills dominate the nursing process.

It is now widely understood that reflective practice includes experiences, thoughts, feelings, actions and knowledge. These authors and others emphasise that reflection involves reviewing one's own values, challenging assumptions and considering broader social, political and professional issues that are relevant but may be beyond personal practice experience (Bulman & Schutz , 2004).

Killeavy and Moloney (2010) described an accomplished teacher as a member of a professional community who is ready, willing and able to teach and to learn from his or her teaching experiences. The above-cited authors further argued that developing a

reflective approach to practice is now viewed as one of the key activities in the development of the professional.

There is a need to facilitate reflective practice processes in experienced registered nurses in order to raise critical awareness of practice problems, work systematically through problem solving processes to uncover constraints and improve the quality of care given by nurses in light of the identified constraints and possibilities (Sherwood et al., 2005).

Bulman and Schutz (2004) suggested that there are underlying skills involved in reflective practice. These authors developed models and theories in which the skills of **self-awareness, description, critical analysis, synthesis and evaluation** are implicit. These skills are categorized as some of the important characteristics the nurse educator should demonstrate as a reflective practitioner. These skills are discussed here in turn.

#### **4.2.1.1 Self-awareness**

Self-awareness is referred to as knowing oneself, to be conscious of one's character, including beliefs, values, qualities, strengths and limitations. Self-awareness may be described as the foundation skill upon which reflective practice is built. It forms part of

the entire process of reflection because it enables people to see themselves in a particular situation and honestly observe how they have affected the situation and how the situation has affected them. It is also important to state that self-awareness is essential, not only for reflective learning, but also for skilled professional nursing practice. In particular, knowledge of one's own beliefs, values and behaviour and how these affect others is essential for developing good interpersonal skills and building therapeutic relationships with patients (Bulman & Schutz, 2004).

#### **4.2.1.2 Description**

Description is an act of describing something whether it be a person, an object, a situation or an abstract concept or idea, to state its characteristics or appearance without expressing a judgement. When using reflection-on-action, description is the skill with which one recollects the important events and features of one's practice. Good description is about giving a clear, accurate and comprehensive account of a situation, the key elements should be included: significant back ground factors (context), the events as they unfolded in the situation, what one was thinking at the time, how he/she was feeling at the time, and the outcome of the situation (Bulman & Schutz, 2004).

#### **4.2.1.3 Critical analysis**

Critical analysis is a key skill for both reflective practice and academic work. Examples of using critical analysis in professional practice include assessing the needs of an individual patient, as well as making a broader contribution to service and policy development (Bulman & Schutz, 2004).

The skill of critical analysis involves the following activities:

- Identifying existing knowledge: analysing one's knowledge and, where necessary, actively seeking out the ideas, theories and research of others.
- Exploring feelings related to the situation: In reflective practice it is necessary to gain an appropriate balance between the analysis of knowledge and thoughts and the analysis of feelings.
- Identifying and challenging assumptions: It is about recognising when information is taken for granted or presented as fact without the supporting evidence.
- Imagining and exploring alternative courses of action: Central to this is the idea of constantly looking for new ways of thinking and new ways of doing things (Bulman & Schutz 2004, p. 37-38).

#### **4.2.1.4 Synthesis**

Synthesis is defined in the Oxford Dictionary as the “process or result of building up separate elements, especially ideas, into a connected and coherent whole”.

When using reflection, synthesis is the ability to integrate new knowledge, feelings or attitudes. This is necessary in order to develop a fresh insight or a new perspective on a situation and therefore to learn from it. The skill of synthesis is necessary which may include the clarification of an issue, the development of a problem of a new attitude or way of thinking about something, the resolution of a problem, a change in behaviour or a decision (Bulman & Schutz, 2004).

#### **4.2.1.5 Evaluation**

Evaluation is the ability to make a judgement about the value of something. It entails a looking back. Evaluation is a personal process in which one examines oneself, frequently over time. This is an important component of reflective practice and professional education. Evaluation is future-orientated; it may involve finding discrepancies between what is said and needed, and what is actually done in order to make necessary changes (Bulman & Schutz, 2004).

Further explanation or descriptions can also be viewed as important for an agent. The following questions can be used for the description of an agent, the nurse educator as the reflective person:

- How does the reflective educator behave?
- How would you recognize a reflective educator?

These questions can be answered if the person develops a good list of reflective educator qualities. Some of the qualities are as follows: Interest in learning; serving as a role model; possessing teaching skills; encouraging exploration and questions; possessing effective communication and questioning skills; knowledgeable about subject matter; providing frequent feedback; discovery and inquiry skill (Bulman & Schutz, 2004).

Reflective educators' inquiry focuses not only on the effectiveness of their instruction or leadership but also on the underlying assumptions, biases and values that they bring to the educational process. Reflective educators consider issues of justice, equity and morality as they design and reflect on their practice. They also carefully examine, analyse and reframe the new information or ideas in terms of specific context variables, previous experiences and alignment with desired educational goals (York-Barr, Sommers, Ghore and Montie, 2006). Reflective educators are decision makers who develop thoughtful plans to move new understandings into action so that meaningful

improvements results for students ((York-Barr et al., 2006). These authors have offered the profile of a reflective educator as one who:

- stays focused on education's central purpose,
- is committed to continuous improvement of practice,
- assumes responsibility for his or her own learning,
- demonstrates awareness of self, others and the surrounding context,
- develops the thinking skills for reflective inquiry,
- takes action that aligns with new surroundings,
- holds great leadership potential within a school community, and
- seeks to understand different types of knowledge, internally and externally generated.

Sherwood et al. (2005) argued that the ability to make clinical judgments and intervene in nursing care contexts requires reflection. Effective nursing practice, education, research and leadership are grounded in the complexity of human relationships and therefore require systematic and careful thinking in order to achieve successful outcomes. They further concluded that reflection has been linked to the cognitive behavioural skills of self-monitoring, self-evaluating and self-reinforcing goal-oriented behaviours that are aspects of meta-cognition.

#### **4.2.2 Clinical knowledge and skills**

The nurse educator or lecturer should possess adequate clinical knowledge and skills. This trait is very important as it implies that a nurse educator or lecturer aids the registered nurses and students to identify, mobilize and develop their own strengths in clinical practice—in particular, the concept of reflective practice. A knowledgeable nurse educator would serve as a role model to other colleagues in the teaching and nurse education sector as well as in the clinical setting, by showing his/ her competency and professionalism, being a skilled person and showing him/herself to be a dedicated person.

Nurse educators should pay attention to their educational role and instructional ability. Their skills must include competency in teaching—that is, knowing how to deliver the clinical and subject content to the students and colleagues in a clinical setting with the aim of providing quality care to the patients. It is also expected that they should be able to provide timely constructive and specific feedback concerning practical skills and knowledge of the course to their colleagues as well as to students. The nurse educator or lecturer should be involved in course planning, designing clinical experiences for students and participating in teaching in the clinical area, as well as providing advice to other professionals in clinical settings in order to keep up the standards of nursing care.

Several core competencies such as direct clinical practice, expert coaching and advice, consultation, research skills, clinical and professional leadership, collaboration and ethical decision making are important qualities for a nurse educator.

The nurse educator should demonstrate that she has a sound theory based on the body of knowledge she learnt from classrooms and should be able to transfer this knowledge into practice.

The above mentioned statements are supported by Lathlean (1997) who holds that as in everyday life, our knowing is embedded in our action, and reflection-in-action involves making conscious the tacit 'knowledge' incorporated in the routines of practice, and subjecting that 'knowledge' to critical examination, to make sense of situations of uncertainty and uniqueness.

#### **4.2.3 Educational role**

The educational role of the lecturer or nurse educator can be seen as the role of an educational manager of practice. Lathlean (1997) describes the role of the nurse educator by saying that she needs to ensure that other practitioners within the organization generally and deliberately act as models or examples for the learners; to

have the ability to draw on resources, especially other people in the provision of educational opportunities for the learner, and above all to possess a clear conception of what is required to develop the learning environment. She further explains that lecturer practitioners can be educational managers of practice in that they themselves are skilled educators and practitioners, with the required credibility and expertise in both settings—educational institution and the clinical area. Thus nursing education or in particular, a lecturer, has the opportunity to give the student nurses insights into the variety of knowledge sources needed in the work environment. Lecturers should realize that their role must shift from instructing to facilitating. They have to develop the perception that attaining skills, attitudes and positive outcome is important. The quality of work, based on learning experiences, is more important than the volume of work covered.

A lecturer's attitude and enthusiasm have an important effect on the students' motivation. Commitment is very important. If a lecturer is not committed she/ he can't do a good job. A lecturer should be knowledgeable about the subject and well prepared.

Forneris and Peden-McAlpine (2009) pointed out that effective educational strategies are needed to assist in facilitating reflective practice as novice nurses transition into practice. This view is also underscored by Ahern and Hawthorne (2008), who maintained that a major way in which a teacher can accommodate an individual student's needs is through reflective practice.

Sherwood et al. (2005) concluded that problem-based learning can help develop reflection and critical reflection as professional practice skills. They further argued that learners who participated in problem-based learning are more reflective and critically reflective in their learning experiences derived from professional practice encounters.

With the above understanding in mind Borneuf and Haigh (2010) quote the statement of Longley et al. (2007) that ‘service and education must work together to provide quality education.’ Quality education is an element which must always underline the nursing process which is about solving any nursing problem. The steps of the nursing process are applied in a cyclical manner and are designed to teach students to be responsive to new information and challenges that arise during the course of patient care (Burns, et al., 2010). As such it requires students to participate in clinical studies.

Skar (2010) pointed out that through participation in clinical studies, student nurses should learn to grasp the patients’ specific needs and to generalize experiences from similar situations.

It should therefore be borne in mind that enhancing the capacity of registered nurses to facilitate the learning of students and new staff is a key component in enhancing clinical teaching (Henderson & Winch, 2008). In the same context Burns, et al. (2010) have

pointed out that facilitating an understanding of the nursing problem-solving process and critical thinking skills through a hands-on learning approach would help nursing students acquire a more thorough foundation and higher level of comfort for future clinical placements.

Lindahl, Dagborn and Nilsson (2009) have indicated that practical skills are developed during clinical training within various clinics, hospitals and health centres and in community care. Baird (2008) quoted by Hamilton and Druva (2010) argued that knowledge construction occurs as students struggle to reconcile the theories and concepts found in textbooks with clinical realities and practical experiences. Ultimately it is an engagement with the process of reflection that makes the creation and integration of knowledge possible.

According to Mann, Gordon and McLeod (2009) the emergence of reflective practice is part of a change that acknowledges the need for students to act and to think professionally as an integral part of learning throughout courses of study, rather than insisting that students must learn the theory before they can engage in practice.

Having the students and their learning in mind Bengtsson, and Ohlsson (2010) argued that the teacher's mission today is to facilitate the students' learning and thinking by

creating a reflective way of teaching through dynamic activities by the students. The learning process needs to embrace active application of different strategies of learning.

Strategies of learning may include on-the-job learning styles. Berings, Poell, Robert-Jan Simons and van Veldhoven (2007), in their presentation of the background to the study on the development of the on-the job learning styles pointed out that current on-the-job learning styles, instruments are inadequate for our purpose as they do not take into account the workplace setting, usually ignore the influence of different learning situations and have serious psychometric weaknesses.

Skar (2010) pointed out that the knowledge and approaches acquired in formal education should properly prepare individuals for their professional responsibilities. Therefore it is important for registered nurses to develop the desire and ability to continue learning in all situations.

Hence Hegney, Tuckett, Parker and Robert (2010) indicated that mandating compulsory continuing professional education for nurses may be a way to ensure continuing competence of nurses and protection of the public. A similar opinion is also shared by Heshmati-Nabavi and Vanaki (2010), who pointed out that nursing is a practical discipline and clinical education is considered an indispensable part of professional

nursing education. Earlier on, Ashworth and Longmate (1993) have also postulated that clinical teachers must possess effective clinical teaching characteristics if they are to facilitate students' entry and learning in the multifaceted world of clinical practice.

#### **4.2.4 Interpersonal skills**

'Interpersonal skills' refers to those interpersonal aspects of communication and social skills that people (need to) use in direct person-to-person contact. Kagan and Evans (1995) interpret professional interpersonal skills in nursing as those particular interpersonal skills nurses have to employ to be effective practitioners, managers or teachers.

Good interpersonal skill is another important trait that the nurse educator or lecturer as an agent needs to demonstrate. This implies good mentoring approaches, objective motivation, non-judgmental support, as well as a respectful attitude toward his/her colleagues, as well as students in clinical practice. 'Interpersonal skills' in this context refers to actions and words used when communicating with others. Good interpersonal skills enable people to maintain good working relationships and a productive manner among nursing staff in order to improve patient care. A nurse educator needs time to reflect on her/his actions and receive feedback on her/his performance from other staff.

#### **4.2.5 Research role**

An agent should develop her-/himself as a researcher. This trait implies that an agent should demonstrate the knowledge and skills of the nursing research process.

The above characteristics of an agent are to be understood in light of the definition of nursing research as a scientific process that validates and refines existing knowledge and generates new knowledge that directly and indirectly influences clinical nursing practice (Burns & Groves, 2005).

The nurse educator or lecturer needs to have a thorough knowledge of research so that she/he will be able to differentiate between problem-solving, the nursing process and the research process, whereby the first two processes can be dealt with or understood as the basis of the research process.

The nurse educator should encourage the registered nurses and students to investigate the aspects that need to be improved in the health sector. Both collaborative and individual approach need to be encouraged with the aim of improving health, moving toward holistic health and quality care.

Mapanga and Mapanga (2008) pointed out that a clinical nurse specialist focuses on clinical expertise in evidence-based nursing practice. This means that the practice is based on research findings and is more likely to result in desired patient outcomes across various settings.

An agent is expected to assist students and nursing staff to be able to apply theory into practice and to find ways to draw theory from practice, thus encouraging new discoveries.

In brief, the researcher discussed in this section some of the important characteristics of an agent, such as reflective skills, including the underlying skills of self-awareness, description, critical analysis, synthesis and evaluation.

The researcher has also focused on clinical knowledge and skills, the educational role, good interpersonal relationships and creative and research roles as some of the prominent characteristics of an agent imbedded in reflective practice.

Sherwood et al. (2005) concluded that reflective methods and processes not only guide practice, practice development, education and leadership; they can also provide research evidence for supporting changes in these areas.

An agent's research role should involve the notion that he/she should have time to conduct research and mentor others in conducting research. She should use mentoring opportunities to overcome barriers to professional growth through seeking support and advice.

### **4.3 RECIPIENT/REGISTERED NURSE**

As the researcher develops the reflective practice programme, the registered nurses are expected to adopt this programme and implement it in order to improve their reflection in clinical practice.

A recipient is defined in the Oxford Dictionary as "a person who receives something". In the context of this research, the recipient is a registered nurse who provides nursing care to the patients in the wards; therefore clinical knowledge and skills are important to her/him. Registered nurses should have good interpersonal relationships in terms of respecting others and having trust in them. They need to exhibit good communication

and active listening skills. Registered nurses should have responsibility and accountability in terms of teaching, supervision as well as an advisory role. It is also important for a registered nurse to serve as a role model to her colleagues as well as his/her patients.

Leadership skills are important for registered nurses so that they can manage all the activities in the wards regarding to health care economics, health policy, personnel management, service monitoring and effective decision making. Registered nurses have the role to promote and facilitate in order to ensure quality nursing care for the best possible patient outcomes. Areas of registered nurses' leadership include designing, developing, implementing and evaluating of interventions and clinical programmes, and teaching and mentoring nurses in critical thinking and reflection. Empathy, which can be described as an understanding of clients—their feelings, beliefs, values and thoughts, is one of the important characteristics a registered nurse needs to possess. Ivarsson and Nilsson (2009) pointed out that registered nurses have a well established role to provide information and education because patients and their relatives need information in all phases of the nursing process.

The following are characteristics of a recipient: reflective skills, clinical knowledge and skills and teaching role, coordination and collaboration, communication and active

listening skills, leadership and management role and empathy and are displayed and discussed as follows:



**Figure 4.3** The characteristics of the recipient (registered nurse)

### 4.3.1 Reflective skills of recipient

Registered nurses should develop the ability to responsive and reflective in their practice. This can only be achieved by fostering an ability to be critical in clinical aspects and by enhancing self-awareness.

It is important for registered nurses to have an understanding of the word ‘reflection’ which according to Lindahl et al. (2009) means ‘a bending or turning back’. The concept is further explained as living with uncertainty and remaining open to the possibility of being wrong.

There is a need for reflective practice skills because registered nurses are dealing with sick people and not only carrying out routine in their daily practice. Bulman and Schutz have pointed out that some of the important skills are active listening, empathy, assertiveness, supporting and challenging, planning and management change (Bulman & Schutz 2004). McCarthy, Cassidy & Tuohy (2011) expressed that reflective practice can assist nurses to draw on experiences and to link theory to practice.

#### **4.3.2 Clinical knowledge and skills and the teaching role**

Practical knowledge is defined by Burnard (1995, p. 57) as “knowledge developed through the acquisition of skills”. Practical knowledge is seen as “knowing how”, which is gained by experience from practical training and doing things (Ehrenberg & Haggblom, 2007). Thus learning from experience through reflection would promote effective learning.

Practical knowledge is a very important attribute in clinical practice. It is therefore essential that registered nurses should assist student nurses in clinical settings to learn.

Registered nurses need to be educated about how to engage students or new nurses to think at higher levels. This can be viewed in the light of transferable skills, which according to Shirey (2009), refers to the skills, abilities and personal attributes that an individual can use in a wide range of activities. This has been further being interpreted to mean that registered nurses should be able to transfer into practice what they have learned in theory or should be able to transfer learned skills from one department to another where the same conditions are found. Registered nurses also have the responsibility to assist their sub ordinates in wards for the improvement of patient care. Thus registered nurses should have knowledge and skills in reflective practice, which is a tool for the improvement of nursing care.

Lev, Kolassa and Bakken (2010) argued that mentoring occurs when a senior or person or mentor provides information, advice and emotional support to a junior person or student over a period of time.

According to the study done on pressure ulcers in Spain, the authors saw a decrease in the level of knowledge among professionals with many years experience (over 20 years). This finding was supported by other authors and it was due perhaps to the lack of updating in nurses' education (Pancorbo-Hidalgo, Garcia-Fernandez, Lopez-Medina

and Lopez-Ortega, (2007). Thus education and training as a continuing process is the most influential factor on the level of knowledge and skills of registered nurses.

Registered nurses should possess knowledge and skills of knowing both how and why so that they can answer questions from the students. Baxter, Akhtar-Danesh, Volaitis, Stanyon and Sproul (2009) pointed out that student nurses must have many opportunities to practice their clinical skills and to apply their theoretical knowledge in order to become safer and more competent practitioners. Clinical knowledge and skills are needed so that the nurses can develop the understanding of reflective practice process. Through reflective practice they can develop the concept of self-awareness, which would guide them throughout their practice. If the registered nurse is demonstrating good clinical knowledge and skills, she /he is referred to as being a role model for nursing staff and student nurses, which means that registered nurse is modelling clinical care that can be emulated by others.

Registered nurses should possess certain capabilities in order to be able to protect and improve health, prevent illnesses and plan and implement the necessary care during illness and rehabilitation. Some of the capabilities, among others, are: effective communication, critical thinking, self-determination, commitment to continuous learning and development of leadership skills.

Registered nurses are expected to educate their subordinate staff through the provision of informal bedside teaching, facilitating teaching rounds, providing orientation for new staff, facilitating teaching for new staff and students, and providing role modelling and mentoring.

### **4.3.3 Coordination and Collaboration**

It is very important for registered nurses to realise and understand that within their working environment they need proper coordination of activities and collaboration with all other health professionals. Registered nurses need to foster collaboration and cooperation as well as leading multidisciplinary teams. They also need to be able to facilitate movement of patients across health care settings as well as to facilitate communication among interdisciplinary team members.

Nursing care alone is not regarded as sufficient care for patients. It needs other hands from allied health professionals, for example, doctors, pharmacists, occupational therapists and physiotherapists, as well as nurse educators or lecturers who are responsible for student teaching in clinical settings. It is also important to promote collaboration so that all those responsible for patient care can be able to examine the effects and results of all activities meant for the provision of care to the patients. This can only be achieved through regularly scheduled times, such as monthly team

meetings, staff development meetings. Multiple viewpoints are effective in terms of the improvement of patient care. The registered nurses need to collaborate on clinical research projects as well as with academic institutions to educate student nurses and newly graduate nurses.

Restructuring of nursing service, staff roles and responsibilities is important. Supervision plays an important role in ensuring a process of professional practice. To meet the challenges noted in the section above, the next step was to examine the gap in the current role of registered nurses between the areas of knowledge and practice.

The above-mentioned statements are supported by Taylor (2000), who maintained that reflective practice can work for individuals and it can work for collective; all you need to do is work together to intensify the effects of individual efforts.

#### **4.3.4 Communication and active listening skills**

Communication's meaning is derived from the Latin word, *communicare*, which means to share, to import, to take part in, to join, to connect and to unite. "Communication is the bond of humanness, that makes man one with his fellow men" (Searle & Pera 1992, p. 262).

Listening is defined and explained by Burnard (2000) as the process of hearing what the client is saying, and hearing encompasses not only the words that are being used but also the non-verbal aspects of the encounter. Kagan and Evans (1995) also explained that when we listen to somebody who is obviously emotional, we need to be more active and use the skill of reflecting.

A registered nurse needs to learn and be able to demonstrate listening skills so that she or he can communicate and be able to solve the patient's problems accordingly. She also has to pay attention to what other staff members are advising her/him regarding the care of the patients. With no exception, registered nurses in clinical practice should use effective communication mechanisms in order to promote quality care. The same line of thought is expressed by Mapanga and Mapanga (2008) who held that clinical nurse specialists can use effective communication strategies to achieve effective positive health outcomes and promote quality care. Communication among staff members is very important in order to prevent conflict among them, which can sometimes lead to stress. Registered nurses should prepare themselves so that they can assist in conflict resolution among staff through the development of forums for staff communication. Registered nurses need to prepare themselves to accept advice from others and not simply to see it as criticism.

Registered nurses should learn and have insight into different types of communication such as written and verbal communication and gestures so that she/he can be able to understand the meaning of each communication style among colleagues as well as the patients to whom they are rendering the service. This would include paying attention and reflecting on the patient's needs and the provision of quality nursing care, drawing up proper nursing care plans and keeping all the necessary records.

#### **4.3.5 Leadership and management role**

'Leadership' is defined in the Oxford Dictionary as "the state or position of being a leader". The concept can be explained further to refer to a leader as a person who can keep good interpersonal relationships, who can give clarity of the work or task and have a strong sense of task planning, as well as implementation and evaluation. Walker, Cooke, Henderson and Creedy (2011) defined leadership in nursing as a multifaceted process of identifying a goal or target, motivating other people to act and providing support and motivation to achieve mutually negotiated goals.

Hendricks, Cope and Harris (2010) pointed out that integrating leadership practices throughout the curriculum or introducing structured leadership programmes earlier in the undergraduate nursing programme provides participating student nurses with a

broad base of leadership knowledge and skills which can be nurtured and developed in practice.

Registered nurses should take into consideration that they need to be role models to other colleagues and students in terms of the way they are managing the wards and caring for patients. Registered nurses should develop a sense of responsibility regarding the provision of care to patients, supervision and teaching of colleagues and students. They need to develop the understanding of being accountable to their own actions. Their teaching roles should be focused on the teaching of students in the wards, paying attention to specific patient-oriented tasks so that the students can gain specific clinical skills. Giving feedback to students and colleagues is the most important aspect that needs to be focused on, for it leads to effective learning.

The ability to facilitate change is an important asset in the registered nurses' leadership competency. Registered nurses have the ability to be influencers among others. Here they have to understand that influencers do not use forceful methods to produce change, they rather create new experiences and new motives. The ability to create new ideas or experiences involves encouraging others to try new things.

Kelly-Thomas (1998) has explained that leadership principles such as motivation, change management, delegation and meeting management are necessary elements of successful managers of development.

Shirey (2008) pointed out that clinical nurse specialists often assume leadership roles in designing, implementing and evaluating population-based programmes to achieve quality, cost-effective, nurse-sensitive outcomes. This is exactly what registered nurses should do and reflect on during their clinical practice in order to provide quality patient care.

Gallagher and Tschudin (2010) explained that leadership in nursing can be said to span four quadrants: clinical, academic, executive and political. Again Gallagher and Tschudin (2010) wrote that leadership is about enabling ordinary people to produce extraordinary things in the face of challenge and change, and to constantly turn in superior performance to the long-term benefit of all concerned.

#### **4.3.6 Empathy**

‘Empathy’ is defined in the Oxford Dictionary as “the ability to understand another person’s feelings and experiences”. This aspect is very important in the provision of

care situations. Registered nurses should develop a sense of such understanding so that they may be able to provide proper and effective care to patients. On the other hand, empathy can also be demonstrated within the relationship among staff members. It can be seen in the light of understanding of others' strengths and weaknesses. It means that registered nurses should understand others and try to assist them so that they can learn a better way of providing better nursing care.

Yu and Kirk (2009) clarified that empathy is a fundamental component of the nurse–patient relationship and of quality nursing care. Again Yu and Kirk (2009, p. 1791) defined empathy as the “ability to sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality”.

In order for registered nurses to understand the patients better, they must develop a sense of listening skills so that they may be able to reflect on the patient’s feelings and experiences.

Kagan and Evans (1995) has pointed out that reflecting is the ability to let our partner know that we really have heard both the factual and emotional content of what they have said or communicated non-verbally. Kagan and Evans (1995) further argued that empathic understanding is characterized by sensitively and accurately understanding

another person's feelings and personal meanings and by communicating this to him or her in a way that does not suggest any attempt at external control.

In summary, the researcher discussed in this section the characteristics which are required of a recipient who in the context of this study is a registered nurse. These involve clinical knowledge skills, coordination and collaboration, communication and active listening skills, leadership and management roles as well as empathy.

#### **4.4 CONTEXT**

'Context' is defined in the Oxford Dictionary as "the situation in which something happens and that helps you to understand it". In the perspective of this study, context refers to the clinical settings where registered nurses apply reflective practice in order to improve their practice for quality patient care.

Context is also perceived as the care environment. This is the context in which care is delivered and includes an appropriate skill mix, systems that facilitate shared decision-making, effective staff relationships, supportive organizational systems, the sharing of power, and the potential for innovation and risk-taking (Mc Cormack & McCance, 2006).

According to Forneris, Peden-McAlpine (2006) context is described as the foundation upon which knowledge is built and as the nature of the world in a given moment, which includes culture, knowledge, underlying assumptions, facts, rules and principles shaping how knowledge is constructed.

Clinical environment is also regarded as the context, a place where interaction with clients and families are taking place for the purpose of acquiring cognitive skills, such as problem solving, clinical decision making and psychomotor and affective skills.

#### **4.5 DYNAMICS**

‘Dynamics’ is defined in the Oxford Dictionary “as a force that produces change, action or effects”. It is further defined as “the branch of mechanics concerned with the forces that cause motions of bodies.”

In this study registered nurses are playing a very important role in clinical practice. They are involved in the implementation of reflection during their daily practice, where reflective practice (in-and on-action) becomes the dynamic process through which clinical practice can be improved. It means that they should make plans in order to take

action. These plans refer to securing good facilities, materials, guidelines, strategies and policies, as well as knowledgeable and skilled personnel.

#### **4.6 PROCEDURE**

‘Procedure’ is defined in the Oxford Dictionary as “a formal way of doing something”. It is also defined as a written, approved specification for execution of some activity—often composed of steps using established methods or forms designed to achieve a uniform approach in **compliance with applicable policies or directives**.

Procedure can also be termed as action strategies, which refers to the moves and plans used by people to keep their governing values within acceptable range (Smith, 2001).

The registered nurses indicated during interviews that they do reflection during their daily practice, paying attention to their achievements; at the same time they also expressed some concerns that prevent them from engaging in proper reflection. These responses are used as the guide procedure for programme development. This involves making sense, investigating and theorizing about the proper strategies; capacity building means to develop and conduct appropriate training through workshops and discussions. The performance of good practice is based on the appropriate standards and coordinating of the activities with other health teams.

The aim of this study is to develop a programme of reflective practice for registered nurses. If we go back to the literature, Lyons (1999) suggests that the constitutive components of reflective practice are reflection-in-action and reflection-on-action. He asserts that an expert practitioner's professional practice through a process of refining their skills and examining the problems encountered in clinical practice and then devising strategies to overcome them.

Registered nurses need to develop an understanding of the importance of reflective practice. This would aid them to be able to examine their own understanding of the experiences encountered in clinical practice. So nurse educators should also understand the significant notion of the importance of the facilitation approach in the clinical setting with the aim of improving the provision of quality nursing care.

Nurse educators need to emphasise critical reflection during their facilitation process. Critical reflection is defined by Stein (2000-2001) as the process by which adults identify the assumptions governing their actions, locate the historical and cultural origins of the assumptions, question their meaning and develop alternative ways of acting.

The facilitator understands that all professionals experience situations where they are not as competent as they would like to be and confront problems in their daily work that

require new and different strategies (Osterman & Kottkamp, 2004). Reflective practice is based on an assumption that all professionals want growth opportunities. This is well pointed out by some motivational theorists who viewed competence as a basic psychological need: individuals need to experience themselves as capable of producing desired outcomes and avoiding negative outcomes (Osterman & Kottkamp, 2004).

#### **4.7 TERMINUS**

‘Terminus’ is defined in the Webster’s School Dictionary as “the final goal of finishing point”. The purpose of this study is to develop a reflective practice programme for registered nurses in training hospitals in Windhoek. Registered nurses should adopt and implement this programme in order to understand the reflection-in-action during the activity and reflection-on-action after the performance of the activity. These are the important components of reflective practice which can be applied in order to improve the registered nurses’ daily practice for the provision of quality nursing care. Here the feedback or the output is expected from both parties—the giver (an agent) and the receiver/recipient. The outcome of this would be the proper implementation or application of reflective practice based on proper knowledge and skills which lead to provision of quality patient care (see Figure 4.4 below).

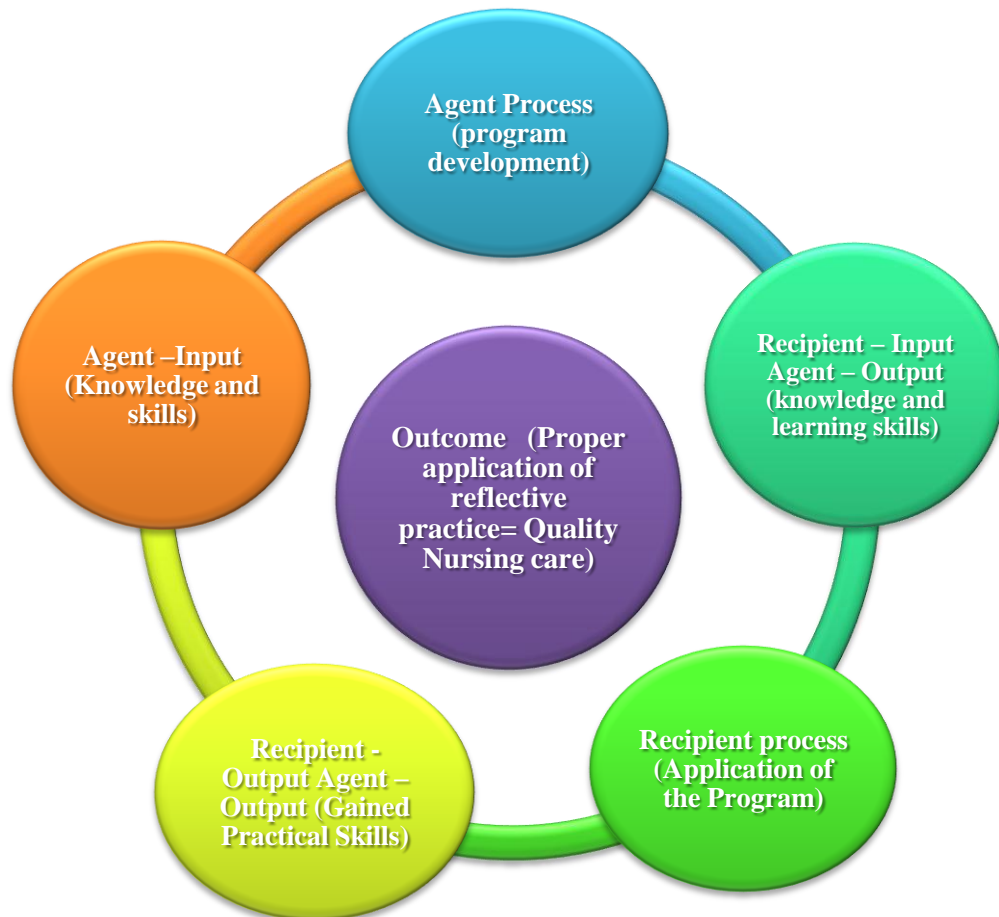


Figure 4. 4 Structural process of reflective practice

## 4.8 SUMMARY OF THE CHAPTER

This chapter discussed the conceptual framework. The focus was based on the presentation of the elements of nursing theory as described by Dickoff et al. (1968). These elements have been adopted as the conceptual guide of this study.

The chapter has defined and discussed elements separately. The elements are identified as: **an agent:** what or who performs the activity? **the recipient:** what or who is the recipient of the activity?, **context:** in what context is the activity performed? (e.g., clinical settings), **procedure:** what is the guiding procedure? **dynamics:** what is the energy source for the activity? and **the terminus:** what is the end point of the activity?

Based on the discussions of the above-mentioned elements, the researcher has identified and developed the structural process of reflective practice which entails the input and output of an agent and the input and output of the recipient, which lead to the desired outcome—the proper application of reflective practice with quality nursing care as the end product.

## **CHAPTER 5**

# **THE DEVELOPMENT OF AN EDUCATIONAL PROGRAMME TO FACILITATE REFLECTIVE PRACTICE**

### **5.1 INTRODUCTION**

Chapters 2 and 3 dealt with research design and data analysis. This phase entails the research design, interviewing techniques and analysis of the collected data. The second phase concentrated on the development of a conceptual framework of the study. This phase derived from the data gathered during the first phase, as well as the main concepts that formed the framework for the development of the reflective practice programme. The practice theory of Dickoff et al. (1968) was used to develop the conceptual framework.

This chapter introduces phase 3 of the study which deals with the development of an educational programme that facilitates reflective practice. The analysed data was used as the basis for the development of the reflective practice programme. As described in Chapter 3, the responses of registered nurses who were interviewed did not portray a reflective character. The participants described their routine activities without proper consideration of reflection. The focus of the educational programme as described in this chapter is to empower registered nurses to effectively use reflection in clinical practice for the improvement of patient care.

## **5.2 THE PROCESS FOR THE DEVELOPMENT OF THE EDUCATIONAL REFLECTIVE PRACTICE PROGRAMME**

### **5.2.1 Introduction**

During the first phase of the study, it was observed that the participants lacked insight into reflective practice. Failure to provide nursing care guided by the use of reflective practice could result into nursing of poor quality.

The researcher was convinced that the development of a reflective practice programme would enhance the proper application of reflective practice in clinical settings by the registered nurses and prevent them from performing daily activities simply as a routine without engaging in to reflection. This was also justified by the responses gained from the participants, who showed little insight into the concept of reflective practice, as they only expressed the execution of their daily activities without paying attention to how they reflect in daily practice.

### **5.2.2 Purpose of the programme**

The purpose of the programme was to:

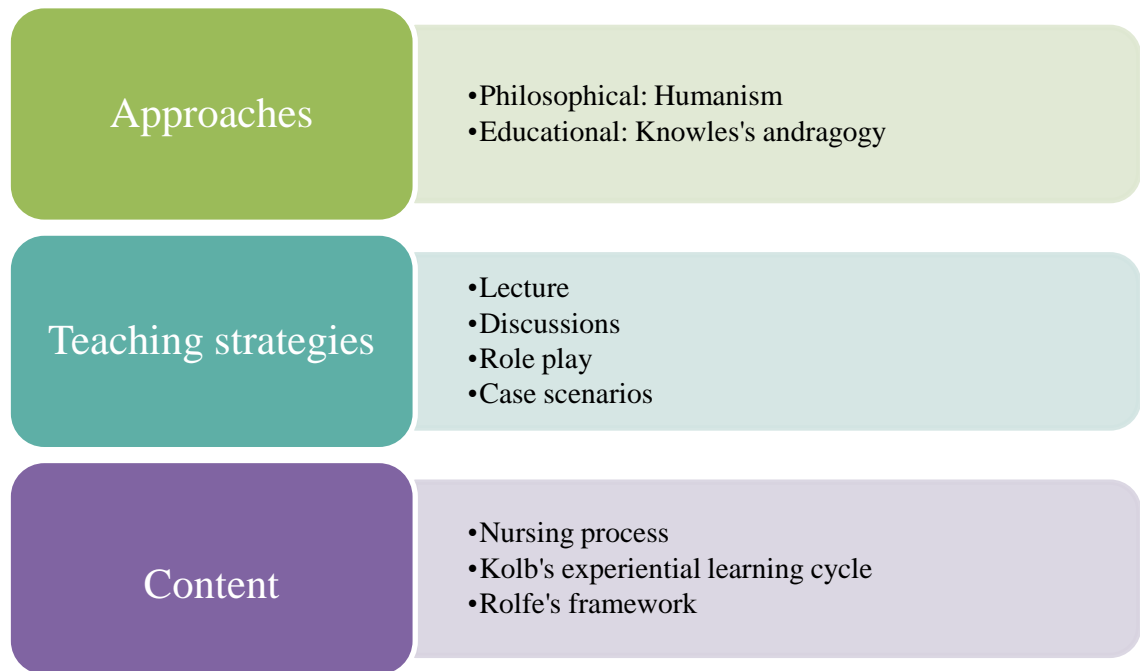
- enhance knowledge and skills to effectively address the clinical challenges which the registered nurses may encounter in terms of reflection;

- encourage them to develop reflection in order to deliver quality nursing care to patients;
- facilitate the nurses' abilities to be critical in order to facilitate useful change towards better patient care;
- consolidate existing knowledge and skills from the learned theory and practice and to grant the registered nurses an opportunity to gain wider and more varied knowledge and skills on the concept of reflective practice;
- educate registered nurses to learn from their practice, develop their thinking and ultimately to make a difference to their patients' care;
- promote the value of the registered nurses in the delivery of quality patient care and nursing care outcomes; and
- provide nurses with necessary information on the aspects entailed in the programme and how this programme would guide them throughout their daily practice, by paying attention to reflection.

The above stated points display the ideas described in chapter 3 which deals with the development of conceptual framework.

The rationale behind the development of an educational programme of reflective practice is presented in this study with a diagrammatic representation and discussion of each of the five steps of the nursing process which underscore the integration of reflective practice in the nursing process.

The framework for the development of the educational programme to facilitate reflective practice is displayed in Figure 5.1 below.



**Figure 5.1** Framework for the development of the educational programme to facilitate reflective practice

### 5.2.3 Philosophical approach of the programme

In the developmental phase of the programme the researcher employed humanistic philosophy. 'Humanism' as a term is defined by Traynor (2009) as a concept which includes the ideas of groups whose beliefs appear to be in direct contradiction to each other with its focus on the dignity, rational abilities and value of all people. The humanistic approach reflects an attitude of caring and respect for others, an attitude which finds value in all people. The central assumption of humanism is that people act with intentionality and values (Glassman & Hadad, n.d.).

In order for the implementation of the developed programme to be effective, the researcher as a facilitator was expected to conduct the workshop in a very humane way. The facilitator was expected to apply humanistic characteristics such as showing respect to the participants. On the other hand the facilitator was also expected to initiate a conducive environment for the participants where they could be involved and share their knowledge.

Traynor (2009) indicated that nursing and qualitative research share mutual goals of dealing with subjectivity, describing the complexity of lived experience and appreciating realities where holism and intuition are valued. Therefore qualitative research is categorised as a humanistic process which reflects the experiences of research participants.

The same opinion as held by Skar (2010), who pointed out that to gain knowledge of the meaning in human expressions a qualitative hermeneutic approach inspired by Gadamer's philosophy was recognised. According to Gadamer (1989) understanding is always historical, dialectical and linguistic. The hermeneutic principle states that understanding connects to the temporality of truth because understanding is different at different times and with different individuals.

In line with the above view, Lindh, Severissson and Berg (2009) suggest that nurses' moral strength is necessary to ensure humane and personalised care when nurses feel

this is at risk of being disregarded. In the literature which focused on the study on student nurses' reflection and moral responsibility, the suggestion was made that moral strength involves authority to act in nursing practice.

With the above background in mind, the researcher aimed to facilitate the full participation of the registered nurses in group discussions in order for them to share their views freely and make their contributions meaningfully.

#### **5.2.4 Educational approach of the programme**

The educational approach of the programme of this study is guided by andragogy as an approach of education. Andragogy is a set of assumptions about how adults learn (Fidishun, n.d.). As such it maintains that people become adults psychologically when they arrive at a self-concept of being responsible for their own lives, of being self-directing (Caruso, 2010).

How educators approach the subject matter and the students' motivation is determined by the andragogical philosophical underpinnings of educators' teaching practices. Nursing education as a component of tertiary education is a situation that requires andragogical dynamics. The concept of andragogy was popularised by Malcolm Knowles. This theory was an attempt to differentiate learning in childhood from learning in adulthood (Keese, n.d.). His ideas still provide a practical instructional guide for all ages, especially adults. This adult learning theory (andragogy) is also of

relevance to the registered nurses who participated in this study, for they too were considered as adult learners.

The following six assumptions under Knowles's andragogy namely, that self-concept, experience, and readiness to learn depend on need, a problem-centred focus and internal motivation, and adults need to know why they need to know something (Caruso, 2010; Atherton, 2011; Smith, 2002). These assumptions, with their relevance to this study, can be described as follows:

- **Self-concept.** The idea refers to an adult becoming more self-directed and independent as he/she matures. Adults may choose what they want to learn, why they want to learn it and how they want to learn it. This concept applies to this study because registered nurses need to be actively involved in the learning of new concepts and to understand the benefit of them.
- **Experience.** This refers to the situation where adult learners have a wealth of life experiences that they bring with them into new learning experiences. In this study it refers to registered nurses with vast nursing experience, who are expected to contribute to group activities and are seen as valuable resources for learning from and with each other.
- **Readiness to learn depends on need.** Whether or not an adult is ready to learn depends on what they need to know in order to deal with life situations. In this study registered nurses are expected to learn new

concepts like reflective practice in order for them to be able to apply it in their daily practice.

- **Problem-centred focus.** This concept refers to the fact that adults need to see the immediate application of learning. Therefore in this study it implies that registered nurses need to learn the application of reflective practice during their daily practice in order to provide quality patient care.
- **Internal motivation.** This means that adults would seek learning opportunities due to some external motivators, and the most potent motivators (self-esteem, better quality of life, and self-actualization) are internal. In this study active participation by the registered nurses should be driven by their intrinsic motivation to learn all about reflective practice and the rationale behind it in nursing practice.
- **Adults need to know why they need to learn something.** Adults need to know what's in it for them—how this new knowledge would solve a problem or be immediately applied. In this study it is important for registered nurses to know and understand the better results that emanate from the knowledge of reflective practice, the improvement of traditional provision of patient care.

### **5.2.5 Teaching strategies**

The researcher and facilitator of the programme employed different teaching strategies which in her opinion could be the best way to convey the necessary information, such as

the lecture with discussion method; group discussion; the guided discussion method, role play and case scenario.

The lecture method is the most common by used form of presentation and is used for the introduction of new subjects, summarising ideas, showing relationships between theory and practice, and re-emphasising main points. This was ideal to use during the introduction of the new concepts such as reflection, Kolb's experiential learning cycle and Rolfe's model of reflective practice.

In the guided discussion method the researcher expects the participants to provide ideas, experiences, opinions and information. This method was used for the presentation of the nursing process because this was a process known to them.

During role play the researcher asked the participants to demonstrate the roles of the nurse and a patient, from which the group could provide the outcome from their observations. The researcher planned to use role play to make scenarios lively and to bring participants to active participation and focus.

The case scenario refers to the method where the researcher provided the participants with cases from practice and the participants study the scenario in order for them to be able to reflect on it and analyse it to find possible solutions. In conjunction with role

play as discussed above, this was planned to facilitate active participation by all participants.

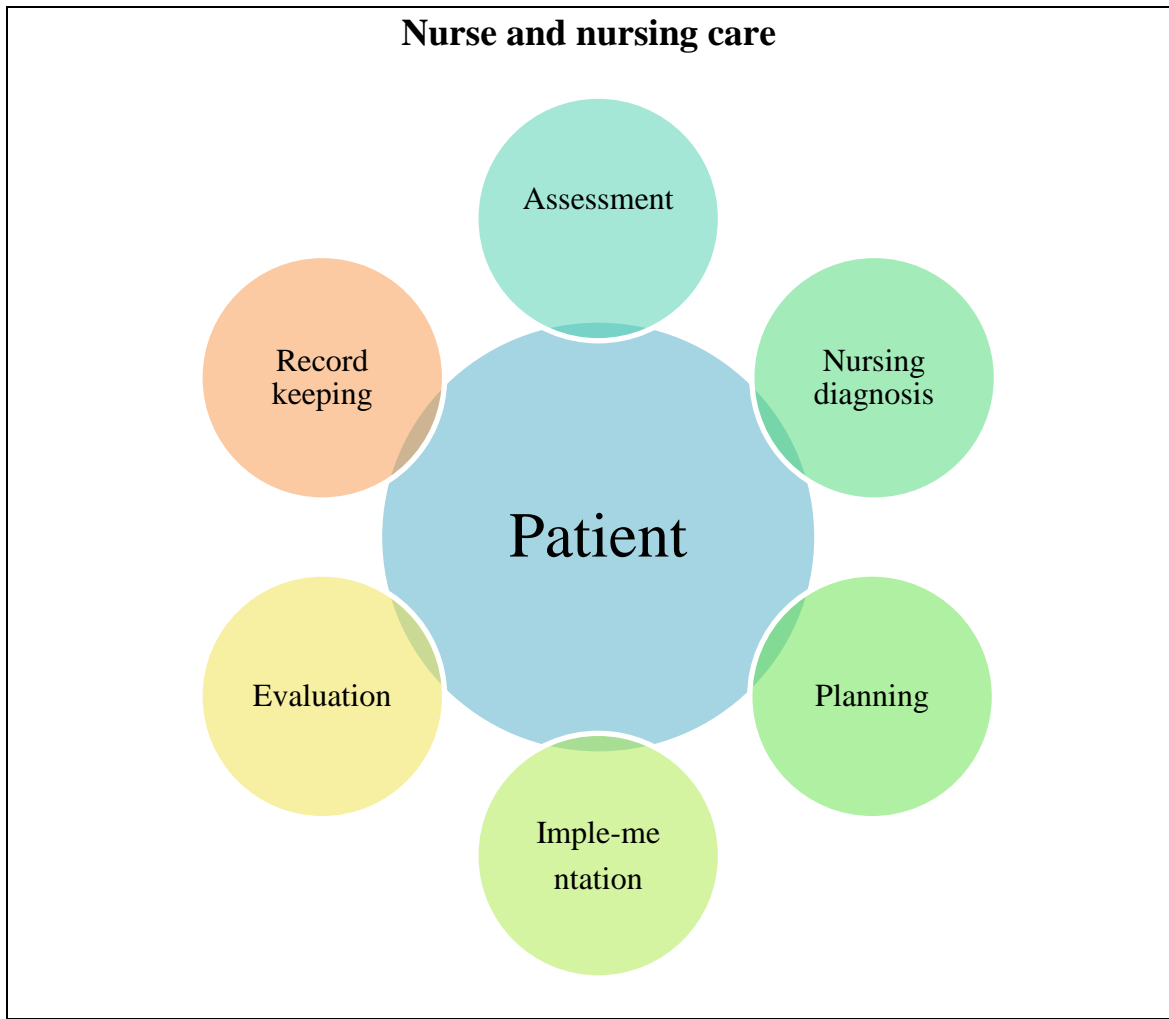
### **5.2.6 Outline of the content of the educational programme**

The content of the educational programme focuses on the concepts of reflective practice and its relationship to the nursing process. The educational programme demonstrates the process of reflective practice based on Kolb's experiential learning cycle and the framework of Rolfe. It addresses aspects pertaining to nursing education in order to provide quality patient care. The main focus of the programme remains reflective practice within the nursing process, with the aim of teaching registered nurses how to reflect during their daily practice.

The following formed the basis of the content of the programme with the proper reflection on the themes derived from the participants' results.

#### **5.2.6.1 The nursing process**

In order for the registered nurses to understand their roles and functions in caring for patients, they need to strengthen the nursing process and understand it so that they would be able to apply the knowledge of reflective practice in their daily practice. The results from Phase 1 revealed that "participants did not always show a proper sense of responsibility concerning their roles and functions" in the caring of patients.



**Figure: 5.2 The Nursing Process diagram**

The nursing process refers to the relationship or interaction between a patient and a nurse as shown in figure 5.1 above. As stipulated in the literature, this dynamic and efficient problem- solving technique need not be reserved only for patients but also for nurses to approach the problems in their lives (Bloniasz, 2011). The nursing process focuses on the domains of patient assessment, nursing diagnosis, planning care,

implementing care, evaluating care, and record keeping. The content of the nursing process would be described in the implementation section.

Bulson and Bulson (2011, p. 477) quoting an article by a nurse named Lydia Hall who publicly described nursing as a process said: “A professional nurse has the ability and responsibility to look at and analyse her practice, the process in which she has taken part, and use this evaluation in the improvement of future nursing care”. This phenomenon is also described by Bulson and Bulson (2011) as a deliberate, problem-solving approach to meeting the health care and nursing needs of patients. In the same vein Bulson and Bulson (2011) have indicated that the nursing process as a whole is cyclical, and the steps, being interrelated, are interdependent and recurrent.

In the literature the nursing process has been used as a framework for nursing and nursing documentation with the ultimate goal of preventing or resolving problematic situations (Hayrinen, Lammintakanen and Saranto, 2010).

Thomas, Bertram and Allen (2012) emphasized that competent critical reasoning, problem solving, decision making and professional communication are essential skills required for safe patient care.

Within the nursing process framework we can find the Structured Observation and Assessment of Practice (SOAP) described as a full-day holistic practice-driven clinical

competence assessment approach that motivates nursing students' learning, promotes critical reflection and confirms graduates' readiness for professional practice (Levett-Jones, Gersbach, Arthur and Roche, 2011). In order to successfully use this nursing process, reflection is an important element thereof. To enhance the concept of reflection within the nursing process participants of the programme should first understand the concept of reflection which would be taught through Kolb's experiential learning cycle. The relationship between nursing process, Kolb's experiential learning cycle and Rolfe's framework is illustrated in Table 5.2.

#### **5.2.6.2 Kolb's experiential learning cycle**

Experiential learning is defined by Johnson, Sonson and Golden (2010) as the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience. The concept is further described by Ayob, Hussain, Mustafa and Shaarani (2011) as the process whereby knowledge is created through the transformation of experience.

It is essential to develop a reflective practice programme of education benchmarked against a recognised model of learning. The aim of benchmarking is not mere exploration, but it is to motivate the improvement toward the goal. One of the recognised methods of learning, the standard of which would also help this study to achieve its objectives, is Kolb's experiential learning cycle. Kolb, being the pioneer of

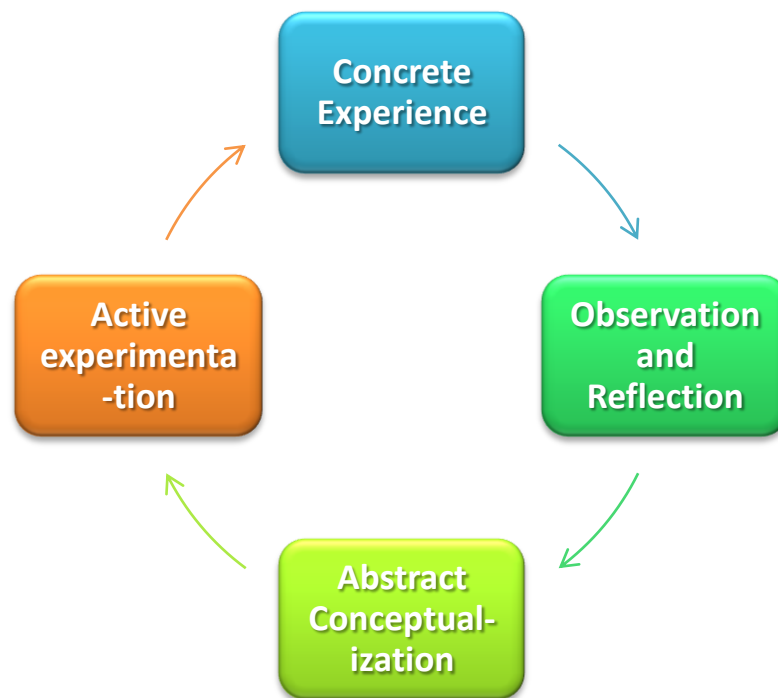
the theory of experiential learning, developed a four-stage cycle underlying learning. One of its elements is reflection upon which many authors based their theories of reflective practice. James and Clarke (1994) pointed out that many of the attractions of reflective practice are the reflection which is grounded in a growing understanding of forms of practical knowledge and of experiential learning. Again, these authors argued that in the status currently being given to reflective practice in nursing, it is an accepted view that reflection will lead to better practice and to greater competence.

Kolb's (1984) definition of learning describes knowledge as being generated through experience (Adamson, 2011). It is also highlighted elsewhere in the literature that there is growing recognition, of central importance, of the experiential learning that occurs in everyday clinical practice (Lamiani, Barello, Browning, Vegni and Meyer, 2011). Hence Fowler (2008) pointed out that both Dewey and Kolb appeared to agree that experiential learning is the product of reflection upon experience with the nature of the reflection and the quality of experience being significant to the overall learning.

The developed educational reflective practice programme is to be facilitated through an experiential learning approach. According to Wessels (2005), experiential learning is an extension to the formal education component normally provided by the educational institution; it may assume various forms. Experiential learning is furthermore defined

by Quinn and Hughes (2007) as learning by doing, rather than by listening to other people or reading about it.

The experiential learning cycle as described above is illustrated in Figure 5.3.

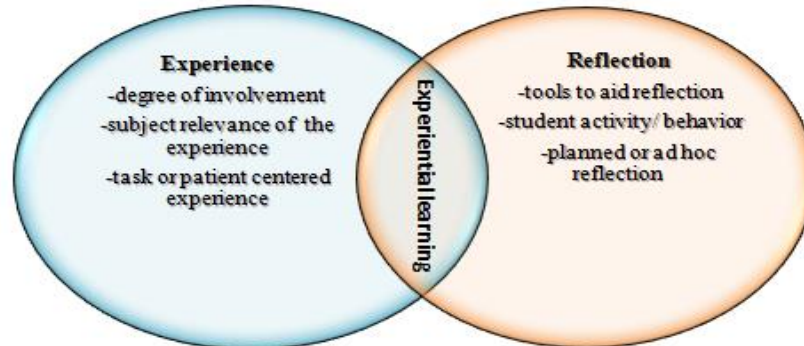


**Figure: 5.3 Kolb's experiential learning cycle**

The experiential learning cycle as illustrated above was initially developed for students who are still busy learning and encountering new experiences, so that they can learn from their experiences. Smith, Emmett and Woods (2008) viewed experiential learning as the situation where learners try out theory in practice and as a result form new knowledge that captures their social reality. In this study the experiential learning cycle is also regarded as the way of learning for professional practitioners to learn through reflection based on the four phases of this cycle so that they may become reflective

practitioners for better quality care (McClure, n.d.). Keene (2009) also sees experiential learning as enhancing the movement of new theory and the conversion of theory from short-term to long-term memory.

On the other hand, the idea of a taxonomy of experiential learning in which the learning experience moves from exposure through participation, identification, internalisation and finally dissemination was developed (Fowler, 2008). Thus learning results from the coming together of experience of a certain quality, with meaningful reflection (Fowler, 2008). The representation of this is shown in Figure 5.4 below:



**Figure 5.4 Experiential learning (Fowler 2008)**

As it is already mentioned above, experiential learning is learning which results from the coming together of experience of a certain quality with meaningful reflection

(Fowler, 2008). Therefore the result of experiential learning is the acquisition of new skills and personal development.

Experiential knowledge is knowledge gained directly rather than knowledge gained from the research done by others. Blunden clarified that reflection is a process of thought which takes place within a social context, but which also takes place according to the rationality of the agent, responsive in the context, yielding truth, both epistemic and moral (Blunden, 1996).

To explain the phase of reflection within Kolb's experiential learning cycle in greater depth Rolfe's reflective framework is used.

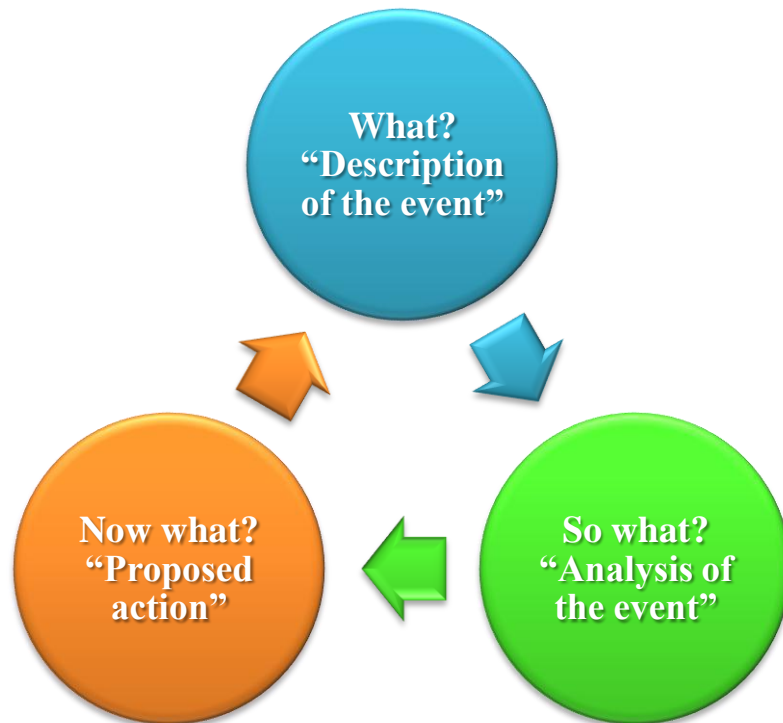
### **5.2.6.3 Rolfe's reflective practice framework**

Various models of reflective practice exist and descriptions thereof can be found in the literature. However, none can be categorised as the best; therefore each researcher has to decide which of these is most appropriate for her/his study. It is necessary to understand that frameworks or models on reflection are just regarded as devices which assist the individual with reflection and cannot be used as a prescription for what to do. A framework should be viewed and used with a critical mind (Bolton, 2005; Bolton, 2008; Fowler, 2008)).

The concept of experience plus reflection has become a common point of discussion in education literature. It is referred to as a combination that equals learning. Therefore experiential learning enables or allows the registered nurses to discover the possibilities or experience that may come from doing or practice. This is of extreme importance because it is believed that newly registered nurses often focus on improving technical skills rather than refining critical reasoning and communication proficiency (Thomas, Bertman and Allen (2012); Killeavy & Moloney, (2010)).

It is argued that the use of reflection in practice is a way to operationalise the process of thinking. It is further emphasised that the concept of reflective practice values the knowledge of the practitioner. As such, reflective practice models of nursing appear to value individual nursing practitioners and their contribution to nursing practice (Forneris & Peden-McAlpine, 2006).

Rolfe's framework appeared to be very applicable to this study. Therefore the researcher chose to apply it in this study. That framework is centred around the questions "What?", "So what?" and "Now what?" and the relationship between these crucial questions is illustrated in Figure 5.5 and Table 5.1.



**Figure 5.5: Rolfe's reflective practice cycle (2002)**

Some ideas about reflective practice were highlighted as follows. Reports from two studies of reflection in practicing nurses, were reported both of which used in-depth qualitative methods, and four nurses described reflection both as an individual activity and as mirroring, where ten members reflected together to exchange ideas and develop care. The nurses in the study further described an “anticipatory or pre-reflection occurring before an activity, as central to their practice” (Mann, Gordon and MacLeod, 2009, p. 601).

Mann, et al. (2009) found two correlates of reflective practice: that reflection appeared to decrease with increasing years in practice, and that it was lower in practice settings where reflective thinking was not reinforced. They further noted that time pressure in a busy clinical environment can act as a barrier to reflection. They also suggested that complex problems stimulate reflective thinking. In those findings practical barriers such as time pressures, shortage of staff and lack of support were also reported.




Cirotto (2007, p. 406) described reflective practice as “a conscious process of thinking, analysing and learning from work situations via journal writing or regularly meeting with colleagues to examine work situations and experiences”.

McClure (n.d.) highlighted the value of reflective practice as a means of learning. McClure (n.d.) also described reflective practice as the form of practice that seeks to problematize many situations of professional performance so that they can become potential learning situations and so the practitioners can continue to learn, grow and develop in and through practice.

The development of the reflective practice programme would facilitate deep reflection among nurses by challenging and discouraging negative emotions among them which may disturb proper practices and by promoting positive emotions which motivate them to practice in an accepted and conducive approach.

In this study the researcher adopted Rolfe’s framework of reflective practice as the best tool to facilitate the registered nurses’ comprehension of reflective practice. Rolfe used three simple questions to reflect a situation. He proposed a framework of reflection which consists of three interrelated levels: “What?” “So what?” and “Now what?” Each of the levels is underscored by the leading question: “What?”

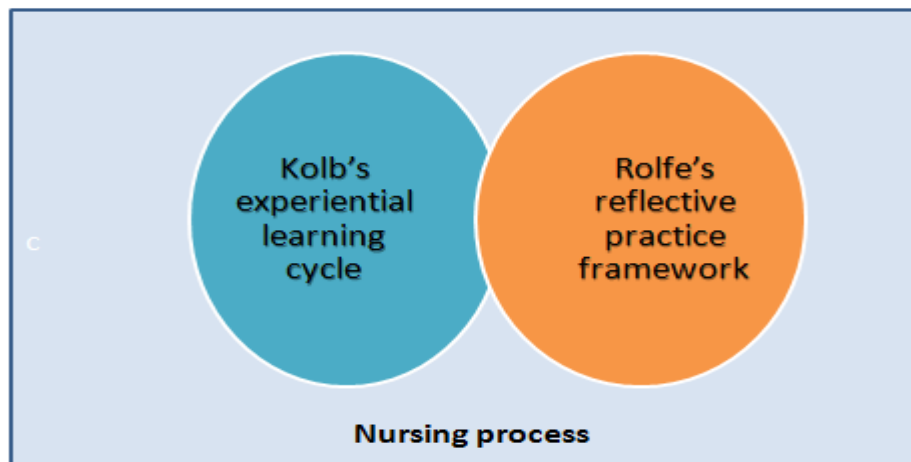
**Table 5.1. Rolfe’s framework for reflective practice:**

<b>Descriptive level of reflection</b>	<b>Theory-and knowledge - building level of reflection</b>	<b>Action-oriented (reflexive) level of reflection</b>
<b>What...</b> 	<b>So what ...</b> 	<b>Now what...</b> 
...is the problem difficulty reason for being stuck/reason for feeling bad/reason we don’t get on, etc.?	does this tell me/teach me/imply/mean about me/patient/others/our relationship/my patient's care/the model of care I am using/my attitudes/my patient's attitudes, etc.?	do I need in order to make things better/stop being stuck/improve my patient's care/resolve the situation/feel better/get on better, etc.?
...was my role in the situation?	...was going through my mind as I acted?	...broader issues need to be considered if this action is to be successful?
...was I trying to achieve?		...might be the consequences of this action?
...action did I take?	...did I base my action on?	
...was the response of others	...other knowledge can I bring to the situation? Experiential Personal Scientific	
...were the consequences... ...for patient? ...for myself? ...for others?	...could/should I have done to make it better?	
	...is my new understanding of the situation?	
...feelings did it invoke... ... in the patient? ...in myself? ...in others?	...broader issues arise from the situation?	
...was good/bad about the experience?		

A summary of the content of the programme and how its parts relate to each other is set out in Table 5.2 and Figure 5.6 below:

**Table 5. 2: The relationship of the content of the programme: Nursing process, Kolb's cycle and Rolfe's framework.**

NURSING PROCESS	KOLB'S CYCLE	ROLFE'S FRAMEWORK
Assessment of a patient: history taking, physical examination	Concrete experience: focus on identification of problems	What happened: What do I see?
Nursing diagnosis	Observation and reflection: consolidation	How is my relationship to the patient? How to resolve the situation?
Planning: planning of nursing care	Ability to construct a plan of action: nursing care plan	What action do I take?
Implementation	Transformation of the developed concepts, actions in new situations	What did I base my actions on? What other knowledge needed to solve the problem?
Evaluation	Evaluate whether the actions were successful	Possible consequences. What could I have done better?
Record keeping	Record keeping	Record keeping



**Fig. 5.6 Relationship between Kolb's experiential learning cycle, Rolfe's reflective practice framework and the nursing process**

The full details of the content of Nursing process, Kolb's experiential learning cycle and Rolfe's reflective practice framework will be described in the implementation section since it has been included as the content of the educational programme of reflective practice.

### **5.3 SUMMARY OF THE CHAPTER**

The process for the development of the reflective practice programme and the purpose of the programme were stipulated. The philosophical approach which focused on a humanistic approach as well as the educational approach of the programme, was explained. Teaching strategies to be used during the implementation of the programme were discussed and explained. The content of the programme was also outlined and the relationship between the key components of the content such as the nursing process, Kolb's experiential learning cycle and Rolfe's reflective practice framework have been displayed.

## **CHAPTER 6**

# **THE IMPLEMENTATION AND EVALUATION OF THE EDUCATIONAL PROGRAMME OF REFLECTIVE PRACTICE**

### **6.1 INTRODUCTION**

This chapter is divided into two phases which follow the previous chapter that concerns the development of educational programme of reflective practice. The first phase of this chapter deals with the implementation of the educational programme for the facilitation of reflective practice and the second phase is about the evaluation of the outcome of the programme implementation.

### **6.2 THE IMPLEMENTATION OF THE PROGRAMME**

The educational programme activities were implemented at one of the training hospitals in Windhoek as the venue for a workshop. Selected registered nurses who provide clinical care and who supervise clinical care attended the training. The application of reflective practice models was introduced to the registered nurses so that they could apply reflective practice in their daily practice in order to improve patient care.

### **6.2.1 The process of implementation of reflective practice programme**

The developed programme was implemented through a two-day workshop. A workshop is a strategy with teaching and learning that is structured in small groups to enhance active participation (Tiberius & Silver, 2001). Traditionally, workshops provided participants with some opportunity to practice skills and receive feedback. Therefore the researcher considered the workshop to be an ideal strategy for implementation, because reflection can only be facilitated and practiced through active participation.

The initial stage for the implementation of the programme included the planning of the two-day workshop. During planning the researcher collaborated with all relevant stakeholders by explaining the outcome of the findings of the study and obtaining permission to conduct the workshop with the registered nurses. The researcher compiled a workshop agenda entailing all aspects related to the developed programme. The researcher invited the registered nurses as participants from both training hospitals in Windhoek through their supervisors.

A specific schedule for the implementation of the developed programme was developed which was held on 16-17 March 2012 at one of the training hospitals.

The participants were drawn from various disciplines such as: Paediatrics, Surgery, Gynecology and Obstetrics and Internal Medicine. The selection of these participants

was done by the chief control nurses of both training hospitals, who explained that the selection of the participants was done according to the workload and the number of registered nurses in the wards or units. Due to the shortage of staff in training hospitals in Windhoek, the chief control officers managed to send only 15 participants.

### **6.2.2 Purpose of the workshop**

The purpose of the workshop was to explain the concept of reflective practice and its relationship to the nursing process which is the basis for providing nursing care. Furthermore the workshop aimed to assist the registered nurses to be able to reflect on their daily practices, to develop their awareness of the purpose of reflective practice and to highlight emphasis on their learning and development.

### **6.2.3 Objectives**

The objectives of the workshop were:

- to equip the registered nurses with the knowledge and skills of reflective practice and
- to facilitate the development of reflection in registered nurses.

### **6.2.4 Facilitation**

The researcher acted as facilitator during the workshop. Facilitation was an important activity during the workshop in order to encourage the registered nurses to participate

actively in discussions and to debate relevant topics regarding the improvement of reflective practice. The workshop would only be successful if the facilitator showed respect to the participants.

Facilitation is described as an interpersonal process by which an individual is enabled to explore opportunities and learn without being directed. It is also described as a well-directed and dynamic process in which participants interact in a clinical learning environment of genuine mutual respect in order to learn through reflective practice in the nursing context. Therefore it has been shown that facilitation can be a valuable problem-solving process for individuals and small groups (Murrel, 1998; Chabeli, 1998).

After the workshop the participants were requested to follow and apply the aspects covered in the developed programme as their guide during their daily practice over a period of twelve weeks (three months). The evaluation process of the programme would be properly explained to the participants as providing of feedback to the researcher for any adjustments to the programme.

#### **6.2.5 Workshop schedule**

During this workshop the implementation procedure of the developed programme was explained in detail. Work sessions were organised as per agenda compiled according to

the objectives. The sessions of the workshop are displayed in Tables 6.1(a) and 6.1(b) below.

**Table 6.1(a) Outlined programme phases and sessions for the workshop**

<p><b>Introductory phase</b></p> <ul style="list-style-type: none"> <li>• <b>Introduction</b></li> <li>• <b>Know each other</b></li> <li>• <b>Explanation of the purpose of the Programme</b></li> </ul> <p><b>Active phase</b> Focus of the workshop—reflective practice cycle into nursing process:</p> <ul style="list-style-type: none"> <li>• Kolb’s experiential learning</li> <li>• Rolfe’s three stages of reflective practice</li> <li>• Nursing process</li> </ul>	<p><b>Day 1</b></p> <p><b>Session 1</b></p> <ul style="list-style-type: none"> <li>• <b>Welcoming and introduction of the workshop</b></li> <li>• <b>Purpose and objectives of the workshop</b></li> <li>• <b>Rules of the workshop if applicable</b></li> </ul> <p><b>Session 2 The concept of reflection</b></p> <p><b>Session 3 Content</b></p> <ul style="list-style-type: none"> <li>• <b>Kolb’s experiential learning</b></li> <li>• <b>Rolfe’s reflective practice framework</b></li> </ul> <p><b>Session 4</b></p> <ul style="list-style-type: none"> <li>• <b>Nursing process</b></li> </ul> <p><b>Session 5</b></p> <ul style="list-style-type: none"> <li>• <b>Conclusion</b></li> </ul>
<p><b>Active phase continue</b> Focus of the workshop—reflective practice cycle into nursing process:</p> <ul style="list-style-type: none"> <li>• Integration of reflective practice in nursing process</li> <li>• Scenario (group work)</li> </ul>	<p><b>Day 2</b></p> <p>Day two activities</p> <ul style="list-style-type: none"> <li>• <b>Session 1</b> The integration of Rolfe’s reflective practice framework in Nursing process</li> <li>• <b>Session 2</b> Scenario (group work)</li> <li>• Evaluation of the workshop</li> <li>• Closing</li> </ul>

Table 6.1 (b) Detailed implementation schedule of the developed programme

Day	Session	Topic	Objectives	Content	Teaching strategies	Learning experiences
1	1	Welcoming Rules Purpose	Terms Write narratives on reflection	Orientation to workshop	Floor for exchanging ideas	Reflection on narratives
	2	Reflection	Explain the concept reflection	Introduction of the concept of reflection (see comments on p. 183)	Lecture Role play	Discussions on the outcome of the role play
	3	Reflective theories/ frameworks	Describe the learning cycle  Describe the reflective practice framework	Kolb's experiential learning cycle -Concrete experience -Reflection -Conceptualisation -Experimentation  Rolfé's model of reflective practice >Descriptive level—What? >Knowledge building—So what? >Action level—Now what?	Lecture Discussions  Lecture Discussions	Case case examples  Analysis of case
	4	Nursing process	Revision of the phases of nursing process	Assessment Nursing diagnosis Planning Implementation Evaluation Record keeping	Case example Lecture and discussions	Present a case example on the different phases based on their experience (based on Knowles)
	5	Conclusion	Recap of all sessions' objectives		Open discussions	
2	1	Integration of reflective practice into nursing process	Integrate and apply reflection during and after practice	Nursing process Rolfé's reflective practice framework	Group work Case scenario (see p.210)	Discussions on examples based on the integration process
	2	Case presentation				Discussions on presentations
	3	Conclusion	Recap of integration session			

## **6.2.6 Implementation of the educational programme activities**

The educational activities to facilitate learning of reflective practice by registered nurses were implemented in different sessions of orientation, explanation of the concept of reflection, reflective models and framework of reflection, and the nursing process. These sessions are described below.

### **Day 1**

#### **6.2.6.1 Session 1: Orientation**

Participants were welcomed, after which they introduced themselves to each other. In order to create a good atmosphere and to put the participants at ease, the facilitator has started the workshop with a prayer, after which the participants were provided with the programme schedule. The researcher explained the purpose of the workshop and the rules to be followed during the workshop.

Rules of the training workshop were set by the facilitator and the participants as follows:

- No one's idea is responded to negatively; everyone should respect others because we are all here to share and learn.
- Everyone can speak without interruption from others.
- Time for sessions should be adhered to.

Before the facilitator commenced, the participants were asked to share their opinions on the concept of reflective practice. Some of the answers provided were:

- “To go into the already existing practice or process and see whether new theories cannot be applied to better theories or processes.”
- “The type of service you give (poor or good), so will be the outcome.”
- “Looking back at the past.”
- “Reflection of your mind on daily things that happen.”
- “Refer to revise back or to check what you had already done and do some improvement on it.”
- “I think it is to my mind.”
- “It’s all about how we apply our nursing practice.”
- “Reviewing on teaching and practicing of nursing to give quality nursing care.”
- “Refreshing your mind to new concepts of nursing practice (nursing process).”
- “Your thought of mind about something.”
- “Is a reflection of your actions, for example if you do your work properly, you will get good job satisfaction as well as your employer and patient.”
- “It is an ongoing process of looking back or reflecting one’s mind after a certain activity (practice) is carried out.”

In light of the above responses it can be deduced that the general understanding of registered nurses on reflective practice needs to be uplifted.

The facilitator proceeded with the presentation of the reflective practice programme. The programme was offered by means of power point presentation, role play and group discussions. During the workshop the facilitator played an important role in facilitating the presentation, and discussion processes. The facilitator set clear objectives for each session and logical structures were followed according to the specific concepts.

The participants were provided with the opportunity to take part and contribute freely during the presentation. They were encouraged to draw examples, as patient scenarios from their wards or units, which were used for integrating practice and theoretical knowledge in clinical practice which could assist them to be able to apprehend the application of reflection in their daily practice. Cross-questions and responses were exchanged throughout all sessions of the presentation. Thereafter the researcher, as the facilitator of the workshop, proceeded with the explanation of the purpose of the workshop.

#### **6.2.6.2 Session 2: Definition of the concept “reflection”**

The purpose of Session 2 was for registered nurses to interpret the concept of reflection. The researcher started the teaching moment with the definition and an explanation of the concept of reflection. Reflection is variously defined by the scholars. It was important to emphasise the definition before embarking on any other content because

participants had come up with a variety definitions of reflective practice, some of them incorrect.

Reflection provides data for self-evaluation and increases learning from experience. Reflection is also defined as a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice. Furthermore reflection is a generic term for those intellectual and effective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation (Durgahee, 1998; Bulman & Schutz, 2008; Mann, et al., 2009).

Reflection can also be considered as an integral part of practice to which registered nurses need to have a commitment in order to develop such important skills. To do this, registered nurses should think of an experience at the moment, and go over it so that they can get insight into ways of providing solutions to different situations.

The concepts “reflection” and “reflective practice” are frequently noted in the general education literature and are increasingly described as essential attributes of competent healthcare professionals who are prepared to address the challenges. It can also lead to self-knowledge and emancipation as nurses come to understand their work in a

personal, social, economic and political context. Therefore reflection is construed as a means of empowerment (Mann, et al., 2009; James & Clarke, 1994; Blunden, 1996).

### **6.2.6.3 Session 3: Reflective models and frameworks of reflection**

#### **Introduction**

It is important for registered nurses to know their functions and responsibilities in terms of patient care. In order for registered practitioners to be able to provide proper patient care they should be guided by some theories like Kolb's experiential learning, which is "learning by doing" as well as Rolfe's reflective practice framework which would enhance the process of reflection.

As reflective practitioners, nurses can develop their skills, regardless of inappropriate management structures, or inadequate provision of time for further education and lack of financial resources for professional development (James & Clarke, 1994).

With the above background in mind, in this session, the researcher and the participants embarked on Kolb's experiential learning cycle and Rolfe's reflective practice framework, guided by the questions "What?", "So what?" and "Now what?". The researcher acted not only as a facilitator, but also as a teacher/instructor who is obliged to introduce and explain new concepts and practices to the participants. The participants

were allowed ample time to raise questions for clarification while the researcher, as an expert in the field, was ready to provide answers.

### **Objectives**

The researcher had the assumption that after this session the participants would be able to:

- interpret the meaning of Kolb's experiential learning cycle;
- describe the experiential learning cycle content;
- interpret Rolfe's reflective practice framework; and
- discuss the content of Rolfe's framework.

#### **6.2.6.3.1 Kolb's experiential learning cycle**

Experiential learning is defined as learning by doing, rather by listening to other people or reading about it. It is also defined as the process whereby knowledge is created through the transformation of grasping and transforming experience. The researcher has identified experiential learning as an appropriate mode of learning in the programme because it has served as an influential tool for many academics in learning, development and educational fields. Furthermore, this approach places more emphasis on learning by doing or learning from experience and reflection. It means the generating of knowledge through experience (Quinn & Hughes, 2007; Johnson, et al., 2010).

The concept of experiential learning explores the cyclical pattern of all learning from experience, through reflection and conceptualising, to action, and on to further experience. Individuals learn as they participate by interacting with, for example, assumptions and cultural values, the tools at hand and the moment's activity for practical challenges. Fenwick further pointed out that each different context evokes different knowing through very different demands of participation (Fenwick, 2012; Greenway, 2002a).

It was also pointed that according to Kolb experiences are grasped either through apprehension or comprehension. Apprehension is viewed as learning through participation in an actual experience, whereas comprehension occurs outside the actual experience through abstract conceptualisation (Lisko & O'Dell, 2010).

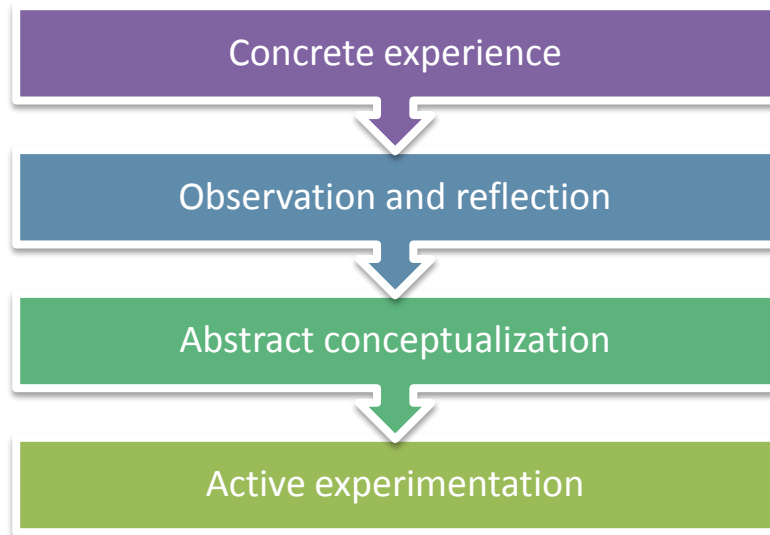
The experiential learning cycle as described above is illustrated in Figure 6.1.

In this study the experiential learning cycle is also regarded as the way professional practitioners learn through reflection based on the four phases of this cycle so that they may become reflective practitioners for better-quality care.

In the literature one study indicated that as many as 65% of new nurses lack the skills needed to make correct clinical decisions. So it is well accepted that experiential learning is the most effective way to teach clinical skills (Burns, et al., 2010).

Kolb argued that learning from experience involves using past experience to gain new insights, whereas learning through experience consists of experiences deliberately planned to facilitate learning. In addition to that, experiential learning is further described as an educational orientation which aims at integrating theoretical and practical elements of learning for a whole- person approach, emphasising the significance of experience for learning. It is further pointed out, however, that experience alone is not a sufficient condition for learning. It needs to be processed consciously by reflection (Kohonen, n.d.; Kolb, 1984; McClure, n.d.).

The elements of the experiential learning cycle as explained by Kolb, with special reference to registered nurses, are displayed and described here as follows:



**Figure 6.1 Experiential learning cycle**

### **Concrete Experience**

This first level as illustrated in Figure 6.1 is based on an inquiry concerning something which happened. It focuses on the identification of the problems of practice. Since the purpose of reflective practice is to improve the professional's performance and because problematic experience plays an important role in learning, inquiry is needed (Kolb, 1984). Therefore in this context registered nurses for example should involve themselves fully and objectively in new experiences, to enrich their nursing knowledge. At this level registered nurses are experiencing personal challenges and are involved deeply in thoughts about the specific challenge. The registered nurse should also be concerned about something or activity that she/he has done.

It is argued that the use of concrete experience refers to the testing of ideas and the use of feedback to change practice and theories. To support this it was also explained that experience gives food for reflective thinking, which in turn leads to abstract conceptualizations and hypotheses to be tried out through active experimentation (Smith, 2001; Kohonen, n.d.).

### **Observation and reflection**

This level as illustrated in Fig. 6.1 refers to learning by perception and emphasises the understanding of ideas and situations by careful observation. Registered nurses should describe their experiences, then reflect on them and consolidate them. Reflection exists to provide guidance and help registered nurses to look back over challenges or events which happened, to review them and change them into learning experiences. Reflection is described as a conscious, dynamic process of thinking about, analysing and learning from a clinical experience, enabling the nurse to gain insight into, itself and into practice. It is further viewed in the literature as a central level of professional practice and a mechanism for continued professional development (Gustafsson & Fagerberg, 2004; Jarvis, 1992; Jasper, 2003; Asselin, 2011.).

It has been pointed out that the experience of the students in any reflective practicum is that they must plunge into doing, and try to educate themselves before they know what it is they are trying to learn. Reflection has also been described as the process of critically assessing the content, process or premises of efforts in order to interpret and

give meaning to an experience, as well as a critique of our assumptions in problem solving (Binding, Morck, & Moules, 2010; Schön, 1987).

Reflection is described in the way that it includes thinking about what you are doing while you are doing it, trying to discover why things went wrong, considering what helped to make something go really well, and so on. They further pointed out that reflection is concerned with enhancing the efficiency and effectiveness of technical aspects of practice. In the nursing context this could be a consideration of minimising the time it takes to administer drugs to patients in the ward and reviewing the ways of ensuring that this is carried out accurately. Similarly it was pointed out that reflection is a way for nurses to explore the depth and complexity of their practice, to make sense of why they do what they do, to capture the art and creativity of practice, to explore the emotional aspects of a situation, and to attain a rich understanding of nurse-patient interactions (Asselin, 2011; James & Clarke, 1994; Jones, 2004; Levett-Jones, 2007; Thompson & Burns, 2008).

Reflection itself requires a dialogue, a reflective interactive conversation, that is never an end in and of itself; rather it is an interactive process of evaluating perspectives and assumptions within context in order to achieve situational understanding (Forneris & Peden-McAlpine, 2006).

The concept of reflection entails the aspects of recollection and the rehearsal of the content of what is recollected; experiential reflection involves remembering the event as it occurred and the associated feelings and thoughts—a revisiting of the experience. Reflection relates to the cognitive interest as moral and ethical reflection (Stein, 2000-2001; James & Clarke, 1994).

In this context it was stated that learners (registered nurses for example) need to reflect on experiences and be asked to observe the experiences, thinking of many perspectives. Thus registered nurses should reflect on aspects like the environment where they find themselves, who they are and what they are capable of through engagement with others. This is based on the notion that the ability to reflect and respond to our own and others' reflections is a skill that needs to be adopted by every registered nurse (Kolb, 1984).

### **Abstract conceptualisation**

During the third stage of Kolb's experiential learning cycle as indicated in Figure 6.1 the focus is placed on the definition or description and classification of abstract ideas and concepts in order to have precise conceptual categories. This level encourages learners such as registered nurses to make an appropriate decision by using the concepts formed so that they can make a conclusion from past and present experience. This involves the ability to construct a plan of action to address the problems. According to Kolb (1984) learners (here, registered nurses) should be able to develop concepts that enable them to integrate their observations into useful theories.

**Active implementation:**

In the fourth and last stage of the experiential learning cycle registered nurses are now at the stage where they can plan, and apply the new learning from their previous experiences. During this stage they might also try and record an event where they are aware of reflecting-in-action, and then also apply retrospective reflection to the same events. According to Kolb's experiential learning cycle, at this stage the registered nurses should be able to transform the developed concepts into decisions and to solve problems (Kolb, 1984).

Experimentation is well understood because it is based on application through action in a new circumstance within a range of generalisation. This means that action is taking place in a different set of circumstances and the learner is now able to anticipate the possible effects of the action. It is emphasised that caring is central to the philosophy of nursing and has offered theoretical frameworks for nursing care (Smith, 2001; Ranheim Kärner, Arman, Rehnsfeldt, & Berterö, 2010).

**6.2.6.3.2 Rolfe's reflective practice framework**

In order for registered nurses to understand better the concept of reflective practice, the researcher provided the participants with a definition of reflection according to some authors. Reflection is defined as a process of reviewing one's repertoire of clinical experience and knowledge to invent novel approaches to complex clinical problems. Reflection also provides data for self-evaluation and increases learning from

experience. It is further defined as a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice (Bulman & Schutz, 2004; Bulman & Schutz, 2008).

Reflective practice is also understood as a process of learning and development through examining one's own practice including experiences, thoughts, feelings, actions and knowledge (Bulman & Schutz, 2008). Reflective practice is further defined as a cyclical process involving a series of phases in which an individual describes a salient event, attends to his/her positive and negative feelings about the event and ultimately re-examines the experience in an effort to understand and to plan how he or she would act in a similar situation in the future. This means that reflection is important for the improvement of clinical reasoning and the development of clinical knowledge (Beam, O' Brien, & Neal, 2010).

James and Clarke (1994) argued that reflective practice is a frequently used but inadequately defined concept in nursing. On the other hand, they pointed out that the term reflection used in connection with nursing practice is becoming increasingly prominent in nursing and nurse education.

Reflective practice is described as a mode that integrates or links thought and action with reflection. It involves thinking about and critically analysing one's actions with the

goal of improving one's professional practice. In reflective practice, professionals can expose their actions to critical assessment to discover the values and assumptions underlying their practice. As professionals become more aware of their theories-in-use, they become more conscious of the contradictions between what they do and what they hope to do. It has further described that engaging in reflective practice requires both knowledge of practice and awareness of professional and personal philosophy (Imel, 1992).

In this study the researcher adopted Rolfe's framework of reflective practice as the best tool to facilitate the registered nurses' comprehension of reflective practice. Rolfe used three simple questions to reflect a situation. He proposed a framework of reflection which consists of three interrelated levels: "What?" "So what?" and "Now what?". Each of the levels is underscored by the leading question "What?". Rolfe's framework to enhance reflective practice is illustrated in Table 5.1. As the table demonstrates, the three main categories of Rolfe's framework are: (1) the descriptive level of reflection (What?), (2) the theory and knowledge building level of reflection (So what?), and (3) the action-orientated level of reflection (Now what?).

In alignment with Rolfe's framework at the descriptive level the registered nurses reflect on the nature of the problem with the aim of describing it. At this level the registered nurses reflect on the aspects surrounding their role in the situation and their feelings about the problem, as well as the feelings of the patients and those of their

colleagues. Aspects taken into account here also involve the actions which the registered nurses have initially tried to take with regard to the particular problem. Essential to this level of reflection is also the question about the consequences for all: the patients, the registered nurses and their colleagues.

The above level leads to the second level, “theory and knowledge building”, where the registered nurses reflect on the lessons they learned from the experience. At this level the registered nurses also reflect on their thoughts at the time of the experience, including the bases of their actions. They concentrate on the knowledge they could apply to the situation, whether personal, scientific or experiential knowledge. The focus is what the registered nurses could have done to improve the situation, as well as to gain new ideas about the situation.

The third level, “action-orientated” describes the actual strategising of the action plan. The nurses reflect on broader issues which need to be considered, including the consequences of their actions; they reflect on what they need to do in order to make things better.

The relationship between the three crucial questions in Rolfe’s framework is illustrated in Figure. 5.5.

The researcher's decision to use Kolb's experiential learning as a tool for teaching and learning is substantiated by the modified framework of Rolfe by Driscoll (2007) titled, "A, *Model of Structured Reflection*". Upon analysing Rolfe's modified model, the researcher was fascinated by a strong relationship between this model and Kolb's experiential learning cycle. The relationship between Rolfe's model and Kolb's experiential learning cycle is illustrated in Figure 6.2 below.

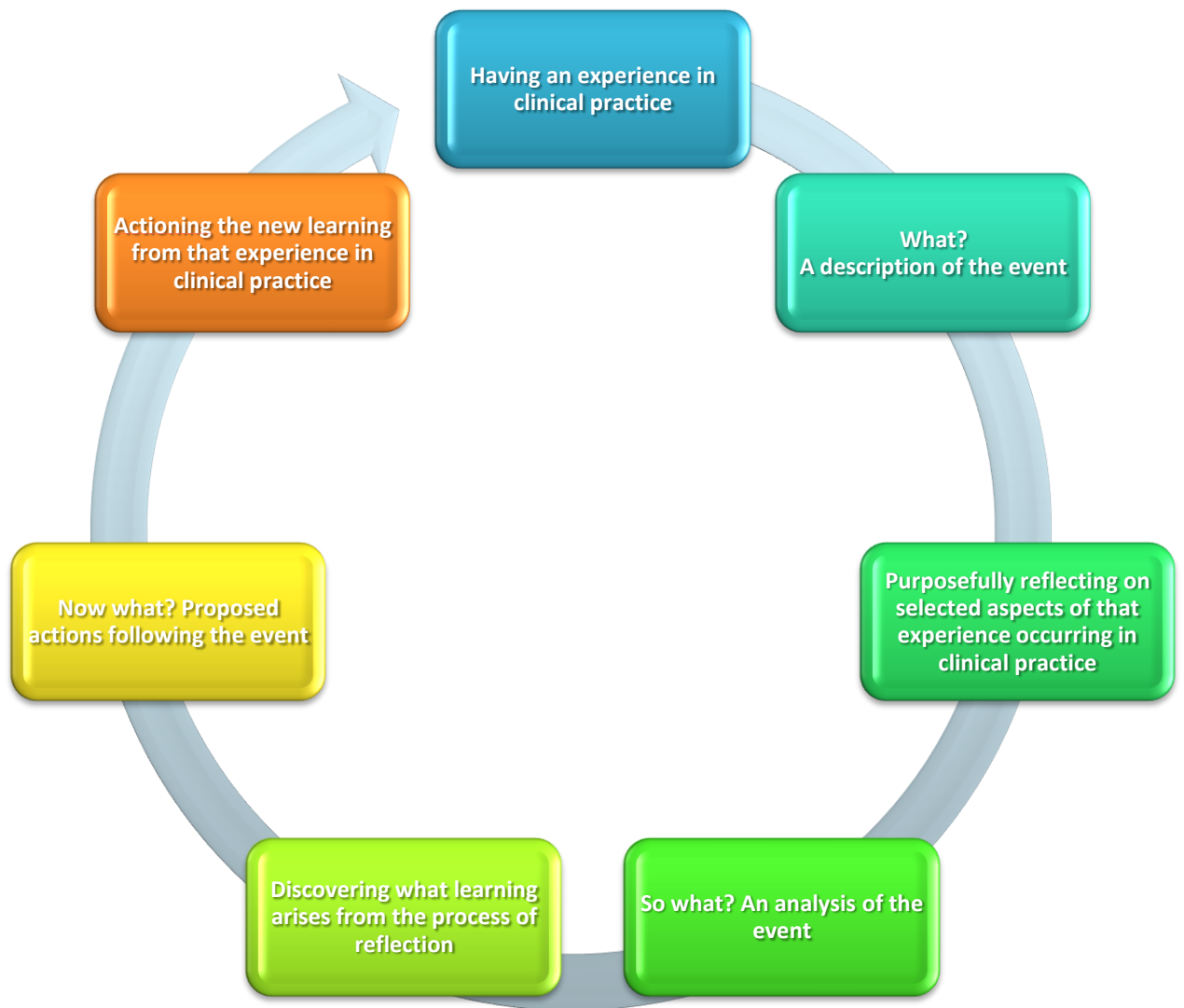


Figure 6.2 The What? Model of Structured Reflection (Driscoll 2007)

The above diagram can be understood by examining the stages guided by the trigger questions and other aspects involved as the following:

**What?**—A description of the event; led by the following trigger questions:

- What happened?
- What did I see/do?
- What did the other people do who were involved in this?

**So what?**—An analysis of the event; led by the following trigger questions:

- How did I feel at the time of the event?
- Do I feel troubled? If so, in what way?
- What positive aspects now emerge for me from the event that happened in practice?
- What observations does any person helping me to reflect on my practice make of the way I acted at the time?

**Now what?**—Proposed actions following the event described and analysed; led by trigger questions:

- What are the implications for me and others in clinical practice, based on what I have?
- Where can I get more information to face a similar situation again?
- How could I modify my practice if similar situation were to happen again?
- What help do I need to help me “action” the results of my reflections?
- Which aspect should be tackled first?

- How would I notice that I am any different in clinical practice?
- What is the main learning I take from reflecting on my practice in this way?

#### **6.2.6.4 Session 4: Nursing process**

##### **Introduction**

It has been understood that nursing care is distinguished from disease care in that nursing practices on identification of and intervention for health-related problems of patients, that is, the symptoms and functional needs of patients.

Each registered nurse is expected to be clear with the description of expected roles. For example, setting up of time schedule for activities; problem identification within their respective unit, provision of feedback to other stakeholders, participation in meetings concerning the development of the institution, as well as patient care and evaluation of nursing care programmes. In order to successfully use this process, reflection and correct judging are necessary. Nursing process is viewed as a systematic and goals-centred method (Stahl & Lewandowski, 2008; Nahid & Hasantehrani, 2012).

In order for the registered nurses to understand their roles and functions they need to revise the nursing process and understand it so that they would be able to apply the new concept of reflective practice in their daily practice. The literature pointed out that by following the steps of the nursing process with flexibility, curiosity and critical

thinking, registered nurses can plan the care so that they return balance, enthusiasm and satisfaction to their careers (Bloniasz, 2011).

The nursing process refers to the relationship or interaction between a patient and a nurse. The meaning of the nursing process is well acknowledged by the proponents of Modelling and Role Modelling theory as having two distinct meanings. The first is the formalized step-by-step problem-solving process that includes gathering and analysing data, planning and implementing interventions and evaluating outcomes. The second is an interactive process—the exchange between nurse and patient in which the nurse has a purpose of nurturing and supporting the client’s self-care. It has been rightly pointed out that the nursing process has distinctive characteristics that enable the nurse to respond to the changing health status of the client, and these characteristics include its systematic focus on problem-solving, dynamic and cyclic, cognitive, client-centred, action-oriented, goal-directed, flexible, holistic, problem-oriented, universally applicable, critical-thinking, decision-making, interpersonal and collaborative style (Karimi, 2011; George, 1995).

The researcher ought to facilitate the processes of reflection-in-action and reflection-on-action through specific aspects of nursing process as described below. The nursing process consists of the following five components: assessment, planning, implementation, evaluation and record keeping, each of which is described here in turn.

**Objectives**

After this session the participants will be able to:

- define nursing process and
- discuss the levels of nursing process.

**Assessment**

It is important for registered nurses to have knowledge and skills on how to perform needs assessment as part of their roles and responsibilities. They also need to develop health indicators and methods to measure patients' outcomes. During this stage all the available information about the patient's problems or needs should be determined accurately and factually. This also allows registered nurses a good chance to assess the likely impact of care on patients.

One way for nurses to maintain their ability to provide high-quality care to their clients/patients is to review aspects of their practice and determine what worked and what could have been done differently. In-depth assessment of their practice assists registered nurses to determine what they do well and what they could improve on. Registered nurses can also improve their practice by gaining feedback from their colleagues so that they can learn about aspects of their practice that they may have been unaware of before. Doing this will provide them with, a greater awareness of strengths and opportunities for learning.

Levett-Jones, Gersbach, Arthur and Roche (2011) state that they were determined to create an authentic, meaningful assessment process that not only measured students' clinical competence but also caused them to critically reflect on their practice and to learn from that experience.

In the literature it is said that this phase of nursing process for determining of nursing needs and nursing care aims comprises nursing diagnosis and aims for care, and expected outcomes are based on assessment data. It is argued that assessment needs to be integrated with teaching and learning and should not be separated from instruction (Hay & Buchner, 1999; Hayrinen, Lammintakanen & Saranto, 2010).

Assessment comprises the following aspects:

- the identification of different needs of patients,
- identification of patients' behaviour associated with unexpressed needs,
- assessment of the presence of a need and its effects on the patient and,
- recording of patients' needs.

During the assessment step registered nurses also need to look at their work environment. This is supported by Bloniasz (2011) that even a healthy work environment can be stressful; however, registered nurses should feel that they are

supported and respected, that their contributions are valued and that they have what they need to care for their patients.

According to Karimi (2011), assessment is described as the collection and interpretation of information and this information is used in the three types of professional judgment within the nursing process, which are: diagnostic judgment—the identification of potential health problems; therapeutic judgment—decisions about intervention, outcome and evaluation; and ethical judgment identification of an actual or moral problem. As such, assessment is important for establishing the severity of threat to life and hence the need for medical intervention. During the assessment stage the patient's needs become obvious and the registered nurses may identify opportunities for initiating simple and effective interventions. The reassessment of patients in response to nursing interventions as well as to potential deterioration is important.

### **Nursing diagnoses**

The facts about the patient's problems can be used to help predict an expected response. This diagnosis allows registered nurses' sense to determine how the response will affect patient care. Here the nurses use critical-thinking skills to interpret assessment information and identify client strengths and problems.

Nurses use nursing diagnoses as the basis for providing adequate nursing care. It was further pointed out that an accurate nursing diagnosis is essential for providing high quality nursing care. Nursing diagnoses are described as clinical judgments about individual, family or community responses to actual or potential health problems/life processes (Paans, Sermeus, Nieweg, & Van Der Schans, 2010).

The literature also indicated that reasoning skills include both inductive and deductive skills, such as skills in the analytical, inference and evaluation fields, that are essential for the diagnostic process. However, it was indicated that little information is available on how specific reasoning skills affect the formulation of accurate nursing diagnoses (Paans et al., 2010).

### **Planning**

For planning, registered nurses need to have knowledge of how to define their objectives, use their critical thinking skills, set priorities and come to the conclusion on what should be changed. The patient is the one who benefits from the knowledge and competence of the nursing staff in this regard. This involves the notion of accurate diagnosis that will allow registered nurses to begin to prepare for the plan of action.

According to the literature, the nurse refers to the client's assessment information and diagnostic statements for direction in formulating client goals and designing the nursing interventions (Karimi, 2011).

During the planning step the nurse does the following: assigning priorities to nursing diagnosis; specifying expected outcomes; specifying the immediate, intermediate and long-term goals of nursing action; identifying specific nursing interventions appropriate for attaining the outcomes; identifying interdependent interventions; documenting the nursing diagnoses, expected outcome, nursing goals, and nursing interventions on the plan of nursing care; and communicating to appropriate personnel any assessment data that point to healthcare needs that can best be met by other members of the healthcare team.

Some authors, among others Dennill, King and Swanepoel (2007), suggested that adequate planning should assure people that they will have input into organized health education efforts. They further pointed out that the planning process, ending with a plan, should give answer to the following three questions:

- What are we trying to achieve?
- What are we going to do?
- How would we know whether we have been successful?

Based on the abovementioned suggestions, planning should focus on the following:

- prioritising of the patient needs and deciding which needs urgent attention;
- assessing the presence of a need and its effects on the patient; and
- planning to meet the need which is the highest on the priority list.

The above ideas should be employed for the enhancement of the development of a reflective practice programme. This was implemented during the planned workshop whereby the registered nurses were reminded to realize their roles and responsibilities in planning the activities in their respective clinical settings.

### **Implementation**

The plan should be put into action once it is developed. Implementation should indicate how the knowledge and skills are to be applied to solve the problems. This is the implementation of the plan, the time for action. This is in line with Karimi (2011), who holds that in the nursing process implementation is the action phase through which the nurses need cognitive, interpersonal and technical skills. She further explained that while implementing nursing care, the nurse continually assesses the patient and his or her response to the nursing care.

At this stage, registered nurses are expected to put the programme into practice and at the same time they should evaluate the process through reflection-in-action. Authors in the field of nursing maintain that nursing practice requires the making of deliberate choices/actions that display the most effective and appropriate responses under challenging circumstances (Myrick, et al., 2009). The researcher fulfilled this vital role in the facilitation of this process.

### **Evaluation**

The portfolio is very important. Each registered nurse must complete and keep the portfolio. The purpose of the portfolio is that of an evaluative tool which includes outcomes achieved in clinical practice. This also includes the registered nurses' reflections upon performed activities during clinical practice. This reflective practice happens over time as the registered nurses practice.

Evaluation involves an in-depth analysis of the plan, concentrating on the following:

- evaluation of the success or failure of the plan and
- strategies of re-planning in case of the failure of the original planning.

The question should be asked whether the actions are meeting the need of solving the problem of the patient.

It has been stipulated that the judgement of the value of the programme can be about the outcome—what was achieved and about the process—indicating how it was achieved. The literature further clarified the components of evaluation as outcome evaluation focusing on the extent to which the goals and objectives of the health education programme have been met, irrespective of how well organized or how efficient the programme was. The process of evaluation examines programme performance by looking at what went on during the process of implementation and making judgements about it (Dennill et al., 2007). This is in accordance with Bloniasz (2011), who maintains that this is a dynamic process with no mistakes, just learning opportunities. Furthermore it was pointed out that during evaluation, the nurse and client together measure how well the client has achieved the goals specified in the plan of care (Karimi, 2011). In this context the nurse can answer the following questions:

- Were the nursing diagnoses accurate?
- Did the patient achieve the expected outcomes within the critical time periods?
- Have the patient's nursing diagnoses been resolved?
- Have the collaborative problems been resolved?
- Do priorities need to be reordered?
- Have the patient's nursing needs been met?
- Should the nursing interventions be continued, reserved or discontinued?
- Have new problems evolved for which nursing interventions have not been planned or implemented?

- What factors influenced the achievement or lack of achievement of the objectives?
- Should changes be made in the expected outcomes and outcome criteria?

Each phase of nursing process affects and depends on the other phases; they are closely interrelated interdependent and recurrent. It was further argued that the use of the nursing process provides a means of assessing nursing's economic contribution to client care (Karimi, 2011).

### **Record keeping**

Records and recording are essential elements of reflective practice. Registered nurses should decide what details to keep. These records should reflect the quality of their clinical role. Although recording is one of the essential aspects of nursing, this seems not to have been consistently maintained throughout the history of this profession. Earlier literature indicated that nursing documentation confirmed the nursing process, while later studies reported a deficiency in nursing documentation (Hayrinen, et al., 2011). However, registered nurses and all healthcare professionals, as well as student nurses should record all phases of the nursing process in the nursing care plan.

One aspect of nurse-patient relationships which needs more thought in this technological age is the increased emphasis being placed on the records of patients'

treatment. Searle and Pera (1992) indicated that what the diagnostic and therapeutic interventions were, what the nurse observed, how she assessed the patient's condition at varying times during the course of illness, must all be accurately recorded. The recording of observations, treatment and such relevant data constitutes a legal record.

#### 6.2.6.5 Session 5: Conclusion

Recap of Day 1 activities including Session 1 to Session 4 objectives.

The relationship between Kolb's cycle, Rolfe's reflective framework and Nursing process is displayed in Figure 6.3 below:

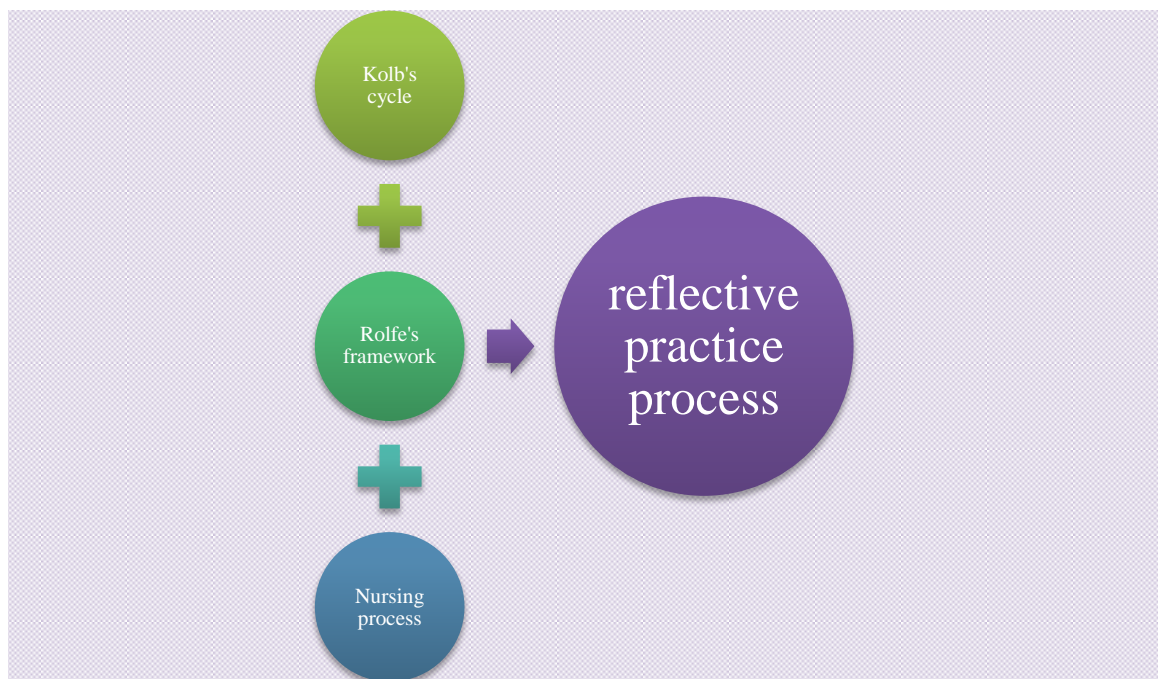


Figure 6.3 Relationship between Kolb's cycle, Rolfe's reflective framework and Nursing process

**Day 2****6.2.6.6. Session 6: Integration of Rolfe's reflective practice framework in nursing process****Introduction**

During this session the researcher and the participants would delve into the integration of Rolfe's reflective practice in the nursing process. This topic or aspect, being new and unfamiliar to the participants, would demand the researcher to apply relevant knowledge and skills in presenting the new ideas to the participants to enable them to grasp the concepts so as to be able to provide constructive feedback, especially for the scenario, which would be a component to be dealt with in the second session. A concern has been raised in literature regarding the lack of conceptual clarity surrounding the concept 'reflective practice' and the notion of reflection itself (Kinsella, 2009). Based on this observation the researcher noticed that it was appropriate to integrate Rolfe's framework in the existing nursing process in order to enhance reflection among registered nurses. The nursing process has been abundantly criticised in literature, noting for instance, that it stifles creativity and the development of expert nursing behavior (Curtis et al., 2009).

For this reason the researcher has decided to develop a reflective practice programme for registered nurses that will assist them to engage in the reflection process and apply it in their daily practice. It was mentioned in the literature that nurses are responsible for

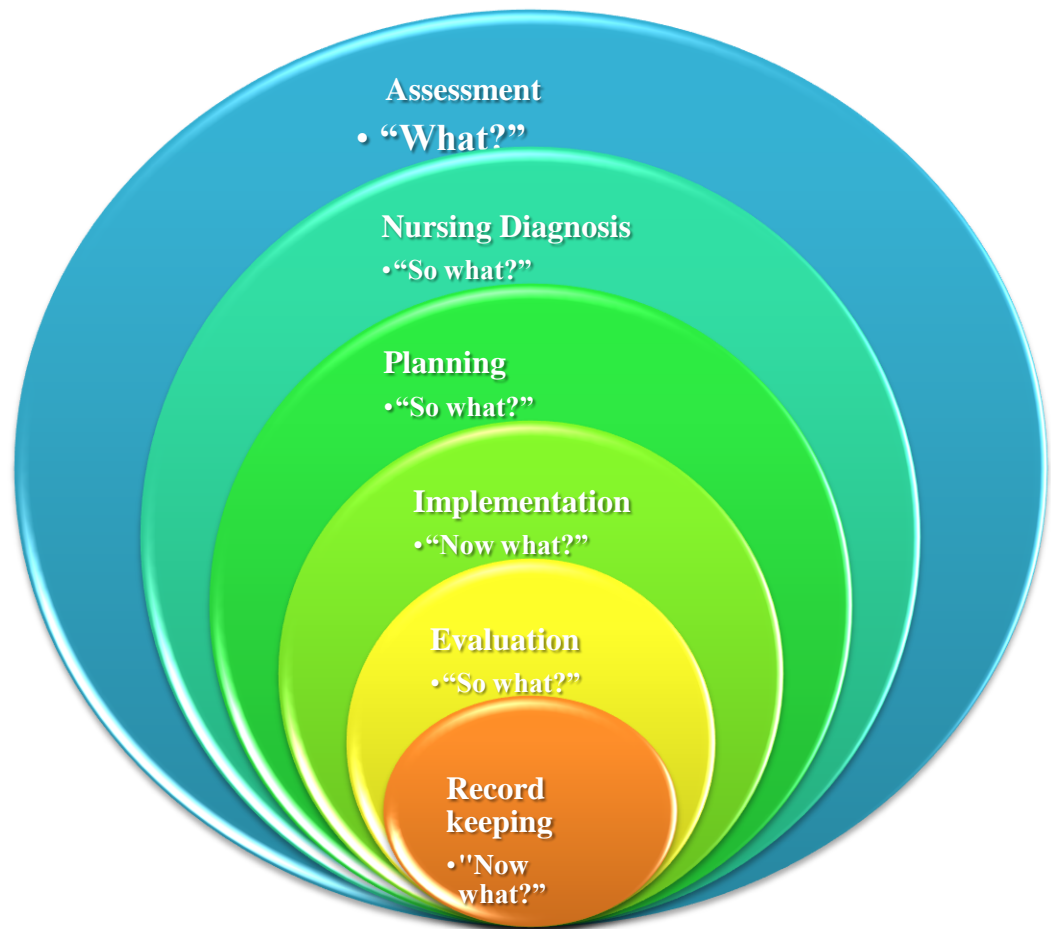
managing and integrating numerous sources of data, co-ordinating the services of multiple clinicians into the comprehensive daily management of individual patients and communicating with a variety of stakeholders (Demiris & Zierler, 2010).

### **Objectives**

After this session the participants will be able to:

- interpret the importance of integration of Rolfe's framework in nursing process and
- apply the integrated framework into practice.

The nursing process, as described previously in this study, can be improved when integrated with Rolfe's framework of reflective practice. This integrated process consists of six stages which are guided by Rolfe's trigger questions of reflection: "What?", "So what?", and "Now what?" This integrated reflective practice in nursing process is summarized in Figure 6.4 below.



**Figure 6.4 Nursing process and Rolfe’s reflective practice framework**

The above illustrates the integration of the nursing process and Rolfe’s framework of reflective practice which is further displayed in the following table, which outlines how registered nurses can integrate Rolfe’s framework of reflective practice in the nursing process in order to improve their daily reflection.

**Table 6.2 Integration of Rolfe's reflective practice framework in the Nursing Process**

<b>Nursing process:</b>	<b>Rolfe's reflective practice framework:</b>
Assessment:	What?
An example from practice: 52-year-old man suffering from stress. On day two, observation shows BP of 150/120.	Ask yourself about the experience. What happened? What are factors contributing to this problem (physiological and other, for example, psychological or social)?
Nursing Diagnosis:	So what?
Stress due to psychological problems	What would be my role as a registered nurse concerning the meaning of this experience? Do I have adequate knowledge about this experience? What kind of care is my patient looking for?
Planning:	So what?
Explain the problem to the patient. Develop the nursing care plan. Involve the doctor. Have the prescription in place according to the doctor's order. Prepare the environment—for example, a quiet and relaxing warm room.	Whom else do I have to involve? What have I learnt about this experience? What else I can think of as a solution to this problem? What action, based on my patient's and the family's feelings and needs? If I act in this way what would happen to my patient?
Implementation:	Now what?
Do observation: Blood pressure should be monitored 6-hourly. Position of the patient and position of the cuff. Accurate readings. Medication should be given as prescribed. Proper counselling	What else could I do? What do I need to do in order to improve my patient's care? What might be the outcome of my action?
Evaluation:	So what?
Does the treatment work or not? Is the problem addressed and improved?	What have I learned about this experience? What knowledge and skills have I gained? What more do I need to know about this?
Record keeping:	Now what?
Recording of the activities performed	What do I need to do after my actions?  What do I need to change for next time?

### **6.2.6.7 Session 7: Small group activities**

The seventh session consists of a scenario. This is done with the purpose of enhancing the participants' understanding of the integration of Rolfe's framework of reflective practice in the nursing process. Keene (2009) for instance, holds that creation and presentation of a scenario will provide an opportunity for registered nurses to apply advanced skills for assessment, diagnosis intervention and evaluation. At this stage the researcher therefore introduced a scenario for the participants. To secure the best outcome, the participants were motivated to break into discussion, groups each of which was assigned a scenario for discussion and feedback.

#### **6.2.6.7.1 Small group discussions**

The facilitator adopted the utilization of small group discussions during the presentation of reflective practice programme. Participants learn better from each other if they work in a small group but perform less well in a big group where they learn only from the facilitator. In a small group each participant can have a chance to participate and share his/her views.

For this study the researcher compiled a case scenario based on common nursing conditions. The case scenario facilitated the application of reflective practice to their

daily practice. This focused mainly on how the registered nurses could be able to integrate reflective practice in the existing nursing process.

#### **6.2.6.7.2 Scenario**

Mrs. Black visits the casualty department with her 6-month old baby girl. The baby looks very ill and tired. The mother says that the baby does not breastfeed actively as usual. The baby's weight is 5kg and is suffering from diarrhea. The weight taken 3 months back was 4.5 kg. The last immunisation (DPT & Polio) was given after ten (10) weeks.

#### **Objectives**

After this session the participants would be able to:

- analyse the given scenario accordingly and reflectively and
- demonstrate knowledge in the application of reflective practice in their daily practice.

The participants were asked to analyse the scenario in light of the integrated framework of Rolfe in nursing process and to indicate how they would apply the result of their analysis to a similar situation in their daily practice. The researcher opted for this

method because, simulated learning through the utilisation of clinical scenarios enables the development of conceptual understanding through problem solving of real world issues (Wiseman & Horton (2011)).

#### **6.2.7. Expectations from the analysis of the scenario:**

##### **Assessment:**

- consciousness level,
- vital signs,
- dehydration level through skin pinch, dry mucosa and compare weight for age,
- HIV status, and
- immunisations and if Vitamin A supplements have been started.

##### **Nursing diagnosis:**

- Weight loss, diarrhoea, immunisation not update

##### **Plan:**

- rehydration
- breastfeeding
- immunisation
- referral if needed

**Implementation:**

- oral rehydration solution according to the degree of dehydration, or intravenous therapy;
- health education on breastfeeding up to two years of age, referral when necessary.

**Evaluation:**

- Follow-up when necessary and in 5 days.

**Record:**

- All the information and treatment should be recorded.

**Reflection:**

- Reflection should be done by assessing the degree of dehydration. The registered nurses aim at identifying loss of body fluid, hypovolemia and the risk for shock.
- By assessing consciousness level the registered nurses aim at ruling out the loss of essential electrolytes and acidosis. By assessing the vital signs the registered nurses aim at ruling out the risk for subnormal vitals, for example heart arrest due to loss of electrolytes or low body temperature due to low metabolism from acidosis.
- By assessing weight the registered nurses aim at identifying growth default.

- By assessing HIV to rule out possible mother-to-child transmission, hence the risk of diarrhoea diseases.
- By giving health education on breastfeeding to ensure sufficient breastfeeding up to age 2 and supplemental feeding, since the baby is now 6 months old. The importance of immunisation—the diseases the child can get if not immunised.

#### **6.2.8 The application of Knowles' theory during implementation process:**

The sessions of implementation were guided by Knowles's following andragogical approach as described in chapter 2:

- Self-concept: Here the registered nurses actively participated in the discussions during the training workshop.
- Experience: The registered nurses shared their knowledge and experiences and learned from each other through the provision of case examples from their respective units/wards.
- Readiness to learn depends on need: The participants through their questions for clarity showed that reflective practice was a new concept about which they were ready to learn.
- Problem-centred focus: The participants learned the application of the new concept which is reflective practice in daily practice.
- Internal motivation: During the implementation process of programme the registered nurses showed enthusiasm in learning reflective practice.

- Adults need to know why they need to learn something: The participants demonstrated that the knowledge which they gained in the workshop on reflective practice would improve their nursing care.

### **6.2.9 The closing phase of the sessions**

The closing phase dealt with questions posed by the participants concerning the implementation and evaluation of the developed programme. This allowed the participants to make their input to the presentation of the programme. The participants' input would not only serve as their active contribution to the presentation of the programme but it also would create room for ownership. After each session of the presentation, important instructional points were again highlighted for open discussion and exchange of opinions. The phase concluded with the daily written evaluation and recommendations from each participant.

The evaluation focused on the presentation of the programme and the application of the case scenario as one of the teaching methods used during the facilitation of reflective practice programme. It looked at the objectives of the sessions, content relevance, time allotted for presentation, the utilisation of case scenario in the presentation of the developed programme and the effectiveness of the scenario.

The evaluation of the programme presentation consisted of ten questions. The first one was about the appropriateness of the number of days during which the workshop was conducted. To this question some of the participants responded that the workshop could be extended to a period of more than three days in order to provide ample time to discuss in details and learn from each other. Others felt that they could also be provided with an opportunity to set and present their own scenario to see if they understood the concept. Some participants, however, expressed that the period of the workshop was sufficient.

The second question concentrated on the clarity of the objectives of the sessions. Here the participants observed that the objectives were clear and concise.

With regard to the third question, which addressed the relevance of the content to nursing practice, the participants indicated that the content was quite relevant and well-integrated into the nursing process.

The fourth question focused on the relevance of the content to the participants, to which they responded positively. They pointed out that this was a sort of revision and was very relevant to them.

With respect to how the summary of the sessions was presented, the participants observed that it was well presented—clear, concise and to the point, to the extent that all the participants were able to provide their inputs on the clinical situation.

About the question whether the participants were encouraged to participate in the discussions, the participants expressed the opinion that all of them were encouraged to take part in activities such as role play, case presentations and group discussions. They furthermore expressed that they need more workshops of this kind.

Concerning the question if the participants had the opportunity to raise questions, they responded that everyone could interact and ask questions and give answers and share their views.

About the use of the clinical scenario, a question was directed to the participants to indicate whether it helped them to be able to apply reflection to the nursing process or not. In response, the participants highlighted that the clinical scenario helped them to understand the relationship between the nursing process and Rolfe's reflective practice and to be able to apply Rolfe's framework in the nursing process. They further pointed out that clinical scenarios should be conducted continuously and should be accompanied by follow-ups to find out if the participants have applied reflective

practice productively. They further indicated that the clinical scenario makes the nursing process clear and understandable and as such it helped them to gain knowledge enabling them to apply reflection in their daily patient care.

It was also asked whether the clinical scenario based on reflective practice improved the participants' ability to analyse the patient case. Here the participants responded that they were able to apply it to their nursing practice because they now know what it is all about: reflection, nursing process, and Rolfe's reflective practice, as well as how to integrate them together. The participants also indicated that reflection must be applied holistically by all health professionals in their daily activities. They again stated that the clinical scenario on reflection refreshed their mind and helped them to improve their critical thinking so as to be able to analyse any clinical situation.

With regard to whether the group discussion on the clinical scenario expanded the knowledge and skills of the participants on reflective practice, the participants stated that they gained more knowledge of what they never knew and appreciated the workshop because it helped them to understand how to manage time so that they can reflect, take records of all the relevant data, even under pressure of the workload. Furthermore, the participants stated that nursing process is usually not performed by means of reflection but this particular clinical scenario enabled or expanded their

awareness to reflect. Some participants confirmed that they strongly agreed with the points presented in the workshop and expressed their determination to use the skills and knowledge gained from this particular workshop in their daily nursing care practice. They further stated that clinical instructors must do follow-ups in every department to see whether reflection is applied on a daily basis. (See Appendix D).

The facilitator did not regard the outcome of the evaluation as a criticism but as a guide to the implementation process.

## **6.3 EVALUATION OF THE REFLECTIVE PRACTICE PROGRAMME**

### **6.3.1 Introduction**

Evaluation is the process of collecting and interpreting data to determine the accomplishments, strengths and weaknesses of the programme. The purpose of this chapter was to determine whether the developed programme has succeeded or not in the facilitation of reflective practice during the daily practice of registered nurses. It also intended to ascertain how the registered nurses viewed the application of the programme to their clinical practice. The evaluation focused on assessing the extent to which the programme objectives have been met. The chapter furthermore sought to determine whether the training of registered nurses was effective and whether the

programme is acceptable to the registered nurses. The purpose of discussions after the implementation was to evaluate the effectiveness and efficiency of the developed programme. The above purposes should be viewed in the light of arguments made by different authors who described programme evaluation as the effort to determine whether programme objectives have been reached and to record the gathering of information to assess the efficiency of a programme (Musal, Taskiran, Gursel, Ozan, Timbil, & Velipasaoglu, 2008).

The researcher organised a focus group discussion for the registered nurses in order to gain information regarding the implementation of the developed programme. The participants were invited on basis of their participation in the previous implementation and training workshop of the reflective practice programme.

### **6.3.2 Purpose of evaluation**

The purpose of evaluation was to determine whether reflection by practitioners has improved during implementation of an educational programme of reflective practice to determine the effectiveness of the programme.

### **6.3.3 Evaluation process**

The evaluation of the programme was carried out 18 weeks (about four months) after its implementation. The registered nurses were given a period of twelve weeks within which they should implement the programme before it was evaluated.

After twelve weeks (three months) the participants were invited to attend a half-day workshop in order to evaluate effectiveness of the developed programme. The date of the evaluation was meant to be 10 May 2012. Due to some limitations, the initial workshop for evaluation did not materialised as it was planned. Consequently, the evaluation was rescheduled and took place on 14 June 2012, where it commenced with a focus group discussion which attended by five participants.

The follow-up evaluation was participated, in by a total of nine registered nurses out of fifteen (15) who attended the training workshop. The initial number could not be retained due to the unforeseen circumstances beyond the researcher's control. Not all nine registered nurses participated in the focus group discussion. However, the researcher however managed to bring together five (5) registered nurses who attended the focus group discussion of 14 June 2012. The focus group discussion lasted about 90 minutes. This was succeeded by individual interviews with four registered nurses which were conducted on 19 and 21 June 2012. It was not easy to bring the participants together. The researcher who also served as the moderator had to obtain the verbal/telephonic consent through their supervisors in their respective units/wards for the participants to attend the evaluation process.

In spite of the hindrances described above, the evaluation process was conducted. The venue for the focus group discussion was comfortable and conducive to discussions and free from outside distractions and noise. The researcher, who acted as moderator

requested two colleagues to serve as co-moderators. All the participants, the moderator and co-moderators sat around a table which enabled them to see and hear one another well.

The moderator (researcher) welcomed the participants to the focus group discussion, after which she introduced herself and the co-moderators and also asked the participants to introduce themselves. The moderator (researcher) gave a brief overview of the topic to be discussed including the purpose and objectives of the evaluation, as well as the intended duration of the discussion. The moderator explained how the discussion was to be recorded—for example, the use of note taking and tape-recording. Permission for tape-recording was sought from the participants and granted. The researcher explained further to the participants that all contributions or views were valued and would be kept confidential and anonymous. The researcher further assured the participants that they were regarded as knowledgeable and experienced on certain nursing situations and patient needs about which she and co-moderators hoped to learn and therefore would value the participants' opinions. The researcher further indicated that it was important for them to hear every participant's ideas and opinions. She also pointed out that there were no right or wrong answers to questions. All ideas, experiences and opinions were valuable.

#### **6.3.4 Method of evaluation**

The evaluation was done through the focus group discussion method. A focus group discussion is a method of discussion designed for small groups. The focus group is described as a group which include participants with a shared experience or concern identified in advance by a researcher (Forneris & Peden-McAlpine, 2006). Again, according to the literature's description, a focus group can be of particular assistance in identifying factors of importance (Bengtsson & Ohlsson, 2010). Although Bengtsson and Ohlsson (2010) clarified that a disadvantage of the focus group is that some participants may feel uncomfortable to express themselves in front of a group of people, in this study, however, all participants in the group were already familiar with each other.

The focus group is a method of group discussion in which the interaction between the moderator and the group, as well as the interaction between group members, serves to elicit information and insights in response to carefully designed questions.

Focus group discussion was described as a research methodology in which a small group of participants gather to discuss a specified topic or an issue to generate data. The main characteristic of a focus group is the integration between the moderator and the group, as well as the interaction between group members. It was further explained that instead of just the moderator asking questions, the group members are encouraged to communicate with one another, exchanging ideas and comments on each other's

experiences or points of view. The purpose of the focus group discussion was to gain knowledge and learn perspectives of participants on the implementation of reflective practice programme (Wong, 2008).

To facilitate the focus group discussion, the researcher developed a guide consisting of questions on the effectiveness and applicability of the developed programme. The purpose of the discussion guide in a focus group discussion was to provide a framework for the moderator to ask probing questions (Wong, 2008). The probing questions in the discussion were designed to stimulate further discussion. The researcher acted as the facilitator and explained the objectives of the interview and how the focus group could contribute to the data collection. The researcher used the coding statements of individual participants in order to investigate similarities and differences. Each participant was allocated a number in order for the moderator to be able to compare the participants' statements. The focus group employed two co-moderators who took careful notes of the participants' statements.

The focus group discussion was guided by open-ended questions. Key questions were carefully guided to get to the point of the desired information. The technique used to collect information from the focus group discussion was a combination of note taking and an audio tape recorder to capture essential information.

The researcher (moderator) served as the leader of the discussion during the focus group discussion. In leading the discussion the researcher kept the conversation flowing. She took some notes of the comments made by the participants to use as references, and also operated the tape recorder at the same time. The researcher (moderator) constantly followed the facilitation guide she had developed beforehand. The moderator's role was also to look after the group dynamics and made sure that all participants joined in the discussions. The researcher (moderator) used probes such as:

- Would you explain further?
- Can you please describe what you mean?
- Did anyone have a different experience?

The moderator and the co-moderators captured and recorded the important information that was expressed by the participants.

All participants had the opportunity to discuss their experiences of learning in practice. Careful facilitation was maintained in order to ensure that individual participants did not dominate the group. During the focus group discussion the moderator demonstrated the listening skills. This was important for the participants to know that the researcher (moderator) paid attention to what they were sharing. This approach allowed the researcher to probe effectively at the appropriate points during the discussion.

The participants' responses were discussed. The focus group discussion proceeded until it reached saturation level where there was repetition of views and no new information

was shared. After the end of the focus group discussion a short summary of the discussion was presented and the participants were asked to indicate if the summary was an accurate representation of their views. The participants were asked to summarise their positions and to look for any information which might have been omitted.

During the focus group discussion an audio-tape was also used with the participants' permission. The researcher controlled the tape recording, monitored the time periodically to make sure that the discussion progressed appropriately, and ensured that all registered nurses who participated took part in the discussion. The audio-recorded discussion and interviews were later transcribed and analysed. The moderator thanked the participants for their time and participation and assured them that the information they had shared was valuable.

### **6.3.5 Data analysis**

Analysis of the focus group data was carried out. Transcribing of data was done and compared with the handwritten notes taken by the co-moderators and the moderator to fill in all the gaps. This involved sorting out the information and assigning it according to categories. Coding was followed according to the numbers allocated to each participant in order to categorise the information easily. The researcher (moderator) decided to use the interpretive level of analysis whereby she created connections between perspectives.

### **6.3.6 Discussions of findings**

Participants were requested to highlight their experiences of the reflective practice programme, elaborating on the positive and negative aspects of the developed programme. They were also afforded the opportunity to raise questions and to make recommendations. Exploring the introduction of reflective practice to registered nurses in the training hospitals, the researcher observed that the registered nurses perceived it as a new approach to which they needed to adapt, as it was different from their prior educational and practical experience.

The evaluation was guided by the following main question which was accompanied by probing questions to elicit responses:

#### ***Main question***

**How did reflective practice programme assist you in improving your daily practice?**

On the above question the respondents replied as follows:

- “It assisted me in setting priorities and assigning tasks to other colleagues.”
- “It helped me to bring improvement to my colleagues in keeping proper records.”
- “I have managed to look at things in a positive way even in a critical moment.”

- “I learnt to teach others to reflect back and use knowledge they have acquired during their clinical practice.”
- “It gave me the direction to look at the patients holistically, for example when doing the audit I have to see whether the report has been written in a problem-oriented way, according to the diagnosis or problem the patient has been admitted with.”
- “It also has helped me to guide/encourage the ward staff on the importance of proper record keeping and how they can improve.”
- “Reflective practice updated my knowledge and made me realise my shortcomings.”
- “It taught me that patients change daily and I need the application of reflective practice to manage it.”
- “Firstly I would like to say that my colleagues in OPD (registered nurses) even after the feedback was given to them felt that this programme is concerned with the registered nurses in the clinical wards only and not necessarily the outpatients ‘staff, so they responded negatively to it. Though on a daily basis they are practicing it, as it is heard in their daily patient problem discussion they encounter and the approach they decided to take as well as the evaluation and action taken toward this.”
- “One needs to further discuss and educate them on this and emphasise its importance though they do it unknowingly it should be acknowledged, learnt and put in general practice for all registered nurses.”

- “It helps me to reflect back on my daily practice/ action.”
- “With the reflection or thinking back to what you did will help you to improve what you did or to put more effort on what you are doing to get the solution to the problem.”
- “It helped me to make the correct decision/option.”
- “It will equip you with knowledge and skills regarding practice.”
- “It was an eye opener for me.”
- “It is kind of a scientific method.”
- “It is useful especially in nursing process.”
- “We learnt something that will help us in identifying our mistakes and make the improvement.”
- “I am not involved in actual daily practice. This is a process needed for us to practice professionally.”
- “People really do not know what reflection is all about they just practice a routine, no reflection.”
- “I made a plan of action—a programme to teach the staff whereby we started with assessment stage, reflecting back on previous knowledge and plan what action we will take. People do not attend “in-service training”, either registered nurses or enrolled nurses. This is a challenge.”
- “We had a meeting after the workshop to discuss on how we can implement this into our nursing practice. It seems that we need to do it in a scientific way. We have to ask ourselves on ‘what went wrong’. We learnt something from this that

we can apply to our practice. We plan to have official meeting with our staff in order to discuss this.”

- “It helped me on how to treat a person as a human being. To attend immediately to the patients’ calls.”
- “I learnt on how to tackle my patient’s needs.”
- “I got to know how to help my patients even if they do not ask for it I know what to do.”
- “This is effective and fruitful approach.”
- “I am now able to reassess my patients.”

### **Summary of findings on question one**

On question one nearly all the respondents indicated that the reflective practice programme was an eye-opener for them. They saw it as a kind of scientific method which is useful especially in the existing nursing process. They concluded that this is an effective and fruitful approach for all health providers, which is helping them to identify their mistakes and to reflect on their daily practice in order to make improvements. This approach assists them on how to set priorities and assign tasks to other colleagues to work as a team. Moreover this programme helped the registered nurses to know how to assist the patients even when they did not call for help and also to realize the need to attend to the patients’ calls immediately. This programme also drew the attention of the registered nurses to the necessity of treating patients as human beings. It was also pointed out that the reflective practice programme assisted the registered nurses to guide

and encourage the ward staff to realize the importance of proper record keeping and how they can improve. The participants further indicated that they learned to teach others to reflect back and use knowledge they have acquired during their clinical practice.

*In the second step, the following question was asked.*

**What did you like most about the reflective practice programme?**

On this question, the following are the responses from the respondents:

- “What I like from this process is to review my work where I can do changes and teach others to improve.”
- “The fact that you look back.”
- “Reflective practice is a reminder to look back to the client/patient’s condition.”
- “It is a very good programme to keep the nurses on alert. We can make the diagnosis correctly and handle situations. Situations that reminded me what to do and how I effectively managed it.”
- “It is very beneficial on health situations.”
- “Reflective practice helped me / reinforced me to do something correctly.”
- “I like reflection because this is showing me what I should do.”
- “During in-service training I have to make sure that nurses understand and learn something from me. If they do not understand I have to see what I can do so that they can understand better.”

- “I like the way that this will benefit the nursing profession if we will apply it in our daily practice.”
- “We want to start with reflective practice in our daily practice, because this is even important to apply at our homes in our family.”
- “It helped my colleagues to provide spot teaching on clients.”
- “I like Kolb’s experiential learning and Rolfe’s reflective framework and I want to apply into practice.”
- “Reflective practice programme gave me positive thoughts.”
- “I got to think back on how to nurse the patient and how to reflect back.”
- “I like the revision of assessment, planning and evaluation.”

#### **Summary of findings on the above question or item**

The responses here indicated that they like the reflective practice programme because it gave them some positive thoughts on how to nurse the patient and reflect back. The registered nurses pointed out that Kolb’s experiential learning and Rolfe’s reflective practice framework helped them to understand how to apply reflective practice into practice. It was concluded that reflective practice will benefit the nursing profession if the health providers will apply it in their daily practice. Some of the registered nurses expressed that what they like about this programme is the fact that it a very good approach that keeps the nurses alert and reminds them to look back to the patients’ conditions as well as to review their work and see where they can improve or where they need to teach others to improve.

*In the third step the following question was asked:*

**What do you believe should be changed and why do you think it is necessary?**

In answering the above question the respondents stated as follows:

- “Reflective practice is very important and informative.”
- “Many registered nurses should attend. All nurses need the information.”
- “Enrolled nurses should also be taught on how to apply reflective practice in order to improve quality care for the patients.”
- “In-service training should be directed to change the attitudes of nurses toward practice and learning.”
- “In-service training should be introduced to mitigate the negative attitudes of the nurses.”
- “Getting use to do it. Encourage nurses to attend.”
- “They should go with changes. Adapt to changes and have open-minded attitudes, for example to ask yourself why do you do BP; assessing the wound. You can do a lot of things if you have the brain.”
- “All registered nurses need to be updated to apply reflective practice in their practice.”
- “Emphasise reflective practice in basic training of nurses.”
- “Set reflective practice as a required standard for the practice of nursing to improve the standard of nursing care.”
- “In-service training to be emphasized to update nurses.”

- “Clinical nursing managers to demand the application of reflective practice by nurses and by them (managers) to observe bedside practice and improve it.”
- “Nurses should be open to share their expertise with others and see how it can improve the community.”
- “Proper bedside nursing should be revived.”
- “Nurses should be encouraged and motivated by telling them that they have various gifts whereby they can provide care to the patients.”
- “There is a need for consistency in supervision of nurses in the wards by the supervisors in order to make sure that nurses are applying reflective practice or practice quality care.”
- “The enrolled nurses should also be included in this programme because they are always at patients’ bedsides.”
- “The nurse as an advocate for the patient has to reflect on patients’ progress when giving a feedback to others.”
- “Nurses should also apply the reflective practice in their patient-nurse relationship and in health education to the patients for example interpreting patients’ diagnoses, treatment and their side effects.”
- “In-service training of all nurses in reflective practice is important and necessary.”
- “Reducing of the bureaucratic approach that inhibits improvement of quality of care because bureaucracy can inhibit the clinical manager to initiate the improvement of care.”

- “Discussions should be held between stakeholders and Ministry of Health and Social Services (MOHSS) for example training institutions about the improvement of care at state hospitals.”
- “The mind-set of registered nurses should be changed. Move from the thoughts of not regarding, this as not important.”
- “We need to be trained and be positive and apply and evaluate ourselves.”
- “Those who attended the training workshop should share information.”
- “More workshops are needed for each and every nurse to be trained.”
- “Involve all the nurses even the doctors so that all of us should have knowledge on reflective practice.”
- “Nurses need to be educated not to do practice as routine but to change people’s minds.”
- “I did not notice any changes.”

### **Summary of findings on the above question or item**

The respondents revealed that some changes need to be made regarding the application of reflective practice programme, such as teaching all health providers not to do things simply as a routine, but to improve on what they used to do. It was also mentioned that even the doctors should have knowledge of reflective practice.

A request was made for increasing the number of workshops so that each and every nurse can be trained, and those who attended the workshops should share the

information with colleagues. It was also mentioned that since the nurses are the advocating agents for the patients they have to reflect on patients' progress when giving feedback to others. Nurses should also apply reflective practice in their patient-nurse relationships and in health education to the patients for example to interpret patients' diagnoses, treatment and their side effects. The point was also made that in-service training in reflective practice for all nurses is important and needed.

There is a need for reduction of a bureaucratic approach that inhibits improvement of quality of care, in order to initiate and enhance the improvement of care. Continuous discussions between all stakeholders and the Ministry of Health and Social Services should be encouraged regarding the improvement of care in state hospitals. There is a need to have reflective practice as a required standard for the practice of nursing to improve the standard of nursing care. Clinical nursing managers should demand the application of reflective practice by nurses and by themselves to observe and improve bedside practice.

The atmosphere during the feedback session, the findings of which have been summarized above, was relaxed. The participants were open to tell their experiences and to share their views with others. The above comments of the participants correspond with what has been stated by Cirocco (2007), who indicated that important

domains for examining proficiency in nursing practice include: effective management of rapidly changing situations, monitoring and ensuring the quality of healthcare practices.

#### **6.4 SUMMARY OF THE CHAPTER**

This chapter delved into the implementation and evaluation of the reflective practice programme. It focused on the presentation of the philosophical elements and educational ideas pursued in this study. Relevant educational and teaching approaches opted for this study have been deliberated on. The researcher also considered the implementation strategies of the developed programme. It is assumed that reflective practice as the preparedness of registered nurses to think critically and to engage in reflection upon professional practice activities leads to the improvement of their performance.

The registered nurses who participated in the training and evaluation of the programme were deeply committed to the discussions. They have been motivated and were aware of their own responsibility for the improvement of their practice with regard to the application of reflective practice.

The purpose of the implementation was to equip the registered nurses with knowledge and skills of reflective practice to facilitate the development of reflection in registered

nurses. The developed programme was presented through the constructed sessions during which the content was explained. Active participation which leads to professional growth among registered nurses was encouraged during the implementation of the programme.

The participants of the workshop on the implementation of the reflective practice programme were required to evaluate the proceedings. They concurred that the objectives of the workshop were clear and its content was relevant to the nursing practice. They described the clinical scenario which was used as one of the teaching methods that expanded their knowledge and skills on reflective practice and made the nursing process to be clear and understandable and as such it helped them to gain knowledge which enabled them to apply reflection in their daily patient care. The evaluation of the programme on reflective practice was dealt with through focus group discussion and face-to-face interviews.

## **CHAPTER 7**

# **CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY**

### **7.1 INTRODUCTION**

In the previous chapter the educational programme was evaluated, and responses of the participants were analysed and discussed. The technique used was the focus group discussion and face-to-face interviews.

The purpose of this chapter was to justify the study in terms of its aim and objectives, as well as to evaluate the developed programme of reflective practice in terms of its positive contribution to the body of scientific knowledge.

In this chapter the recommendations, conclusions and limitations of the study are discussed to ensure the application of the educational programme and to improve the quality of care rendered to patients in clinical settings. The researcher discusses about further research to be done and makes a final concluding remark on the study.

## **7.2 CONCLUSIONS AND RECOMMENDATIONS**

The most influential elements in enabling the development of reflection and reflective practice are a supportive environment, intellectual and emotional accommodation of individual differences, group discussion, respect between professionals, and time for reflection. Opportunities to meet with other registered nurses in small groups for reflection are an essential aspect to set aside for reflection. The support from supervisors before and after certain caring interventions is important. Training and support of students as well as in-service training of all staff in the clinical setting is needed. Thus the use of reflection needs to be developed and applied to different situations.

Since reflection offers an opportunity to consider one's strengths and weaknesses and to determine learning needs, it is important to have a professional and theoretical background for one's actions to be able to give reasons for why one acts as one does and to know what can happen if one does not act, in that way. The participants described how their individual experiences, capabilities and involvement in changing and complex work situations influence knowledge use.

This was done based on the following objectives as set by the researcher:

**Objective 1: To explore and describe reflection practiced by registered nurses.**

It was concluded that the data obtained from the registered nurses showed a restricted understanding of reflective practice, because the content of their responses was based mainly on their daily routine work without paying attention to reflection-in-action and reflection-on-action as it is stipulated in literature on Kolb's experiential learning, Rolfe's reflective practice framework and the nursing process, as well as the integration of Rolfe's reflective practice framework in the nursing process (see chapter 5 and 6).

Participants did not always understand their responsibility concerning their roles and functions. It was found out that:

- their observations were not done properly;
- many registered nurses used shortcuts as a way of completing procedures;
- intervals of giving medication were not adhered to;
- clinical teaching was ineffective; and
- uncompleted tasks were observed in daily practice.

**Recommendations:****Nursing guidelines and clinical teaching**

Regarding the above concerns, the researcher made the following recommendations:

- Nurse educators should use scenarios during clinical simulations to prepare students in practice-based professions so that this becomes an important educational strategy to facilitate learning.
- Nurse educators need to use various strategies to facilitate the development of students into reflective practitioners.
- The staff development unit in training hospitals needs to introduce a variety of methods to help registered nurses to apply reflective practice in clinical practice.
- It is important that senior registered nurses or supervisors in the clinical setting should prepare clear guidelines and appropriate rosters to assist new staff and students to develop the requisite knowledge and practices to ensure good patient care outcomes.
- Reflective diaries are also important. Registered nurses should be encouraged to keep reflective diaries. These can be used to evaluate events in their daily practice, to describe the events in their practice, to reflect on what may become routine and to develop and evaluate the action taken.
- Hospital management and training institutions should set up standards for practice to improve the nursing situation and to address the shortage of staff in the units/wards.

**Objective 2: To develop the conceptual framework.**

It was concluded that the recipients (the registered nurses) need to be assisted by an agent (researcher) to understand the concept of reflective practice in order for them to be able to apply it in their daily practice for quality care of patients.

With reference to Objective 2 the researcher recommended the following:

- Training institutions should make reflective practice part of the continuous education of nurses in order to improve the nursing standards.
- The hospital management should develop a good leadership approach and create an environment to support registered nurses to improve in their daily practice.
- A reflective type of training is important for nurses; thus nurse educators should make sure that it is included in their education and reinforced.
- Nurse educators should value the necessity of providing education to new nurses in whose minds reflective practice can be easily instilled.
- Nurse educators must pursue the teaching and learning of the reflective process at the undergraduate level of nursing education. Teaching, according to Walsh (2011), should focus on interpreting the experiences of people and exploring their shared meaning and understandings.
- Adoption of reflective processes in clinical supervision in nursing need to be ensured to enable nurses to become self-reflective in their work in order to

enhance their professional knowledge, skills and humanity when relating to people in their care, as well as their families, communities, other members of the health care team and themselves.

- Nurse educators and clinical supervisors need to use reflective models, theories and methods as research approaches in order to encourage levels of analysis and interpretation of nursing issues related to practice and clinical development, clinical supervision, education and leadership.
- Training institutions and nurse managers should organise workshops which include many people at operational level so that everyone becomes knowledgeable on how to reflect back.
- Relevant stakeholders should assure that all nurses are included in the training of reflective practice not only registered nurses in order to achieve our goal.

**Objective 3: To develop and implement an educational programme of reflective practice.**

It is concluded that an educational programme of reflective practice was developed, implemented and evaluated. A group of 15 registered nurses participated in the implementation of the programme as well as in its subsequent evaluation. Positive suggestions were made concerning the implementation of the programme, especially that the duration of the training workshop needed to be extended to more than two days.

The following recommendations were made based on the abovementioned objective:

- Nurse educators should incorporate the reflective activities in the undergraduate and post-graduate levels of professional education, including continuing programmes to promote reflection.
- Nurse managers should encourage registered nurses to keep reflective diaries which will help them to report their feelings and opinions about personal feelings in regard to events experienced.
- Nurse educators and nurse managers should encourage registered nurses and other staff members to use reflective models, theories, and methods to guide and enhance education, practice and development of self-reflective nursing leaders who can act as stabilizers and agents of change in the dynamic context of nursing and health.
- Training institutions and nurse managers should organise regular reflective workshops in order to assist registered nurses and other staff members in clinical practice.
- Training institutions need to ensure that nursing education includes reflective models, theories, and all methods in the training of nurses so that nurses may be able to utilize and integrate reflective practice in their practice and practice development, clinical supervision, education, research and leadership.

- Nursing education in Namibia must make reflective practice a compulsory competency of registered nurses and should adopt the notion of reflection as an essential part of learning.

<p><b>Objective 4: To evaluate an educational programme of reflective practice</b></p>
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It is concluded that the programme was evaluated and changes were made accordingly.

**Recommendations:**

Based on the above objective the following recommendations were made:

- Training institutions and nurse managers should see to it that more workshops are organised for every nurse to be trained.
- The value of reflective practice must be recognised and supported by people in management in order to motivate the supervisors and nurses to value the practice.
- Further research on the relationship between reflective practice and nursing expertise development should be envisaged by future researchers in the field.

### **7.3 LIMITATIONS OF THE STUDY**

The limitations of the study were in the evaluation of the educational programme. The researcher did not manage to have the full quota of 15 registered nurses attend the

training workshop for feedback. The focus group for evaluation of the programme was postponed twice due to some excuses from the registered nurses who had attended the training workshop. This was mainly prompted by the work-related circumstances such as busy wards, off-duty times and night duties, as well as staff annual leave. Some indicated a lack of interest in the programme. Therefore it was difficult for the researcher to assemble all the participants for one focus group discussion.

#### **7.4 CONTRIBUTION OF THE STUDY TO EXISTING KNOWLEDGE**

It should be claimed that the study made a contribution to existing knowledge for the following reasons:

- This study explores the registered nurses' experiences in the clinical area in terms of reflective practice, an aspect which has not previously been studied in Namibia. This addressed a gap in the knowledge.
- A conceptual framework was developed to serve as a guide to develop an educational programme of reflective practice.
- The educational programme of reflective practice which was designed demonstrates the relationship between the nursing process and Kolb's experiential cycle and how Rolfe's reflective practice framework can be integrated in the nursing process.

- Another notable area, in which the study makes a unique contribution to existing knowledge is the development of understanding of the application of reflective practice.

## **7.5 CONCLUDING REMARKS**

The reflective practice programme provided a guide for the registered nurses and other health care providers to reflect in clinical practice. Reflective practice can be regarded as a tool for change and improvements in order to see clinical effectiveness and quality care. Thus reflection is an essential aspect of the nurses' daily practice. Through reflection, nurses in Namibia will become reflective practitioners who provide quality care to the patients effectively. Thus institutions of nursing education in Namibia should realise that a most important and advanced step in the provision of nursing education is the teaching of reflective practice in order to produce reflective practitioners. The researcher is of the opinion that being in a dynamic world, the development of reflective practice is of great importance to facilitate reflection among nurses in Namibia.

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## **APPENDIX A    The permission letters**

Mrs L. N. Nelumbu  
Faculty of Medical and Health Science  
University of Namibia  
27 May 2009

The Permanent Secretary  
Ministry of Health and Social Services  
P/ Bag 13198  
Windhoek

Dear Sir

Re: Request for permission for study information

I am a lecturer at the University of Namibia in the Faculty of Medical and Health Sciences. I would like to embark on a study on Reflective Practice (Nursing Practice) among registered nurses, the proposal of which has been already approved by the post-graduate committee of the University of Namibia on May 11, 2009.

I am hereby requesting permission to conduct research on the above-mentioned subject among registered nurses in the state hospitals in Windhoek. The copy of my proposal is here attached.

Sincerely yours

---

Lucia N. Nelumbu

9 - 0:0001



**REPUBLIC OF NAMIBIA**

**Ministry of Health and Social Services**

Private Bag 13198  
Windhoek  
Namibia  
Enquiries: A. Muheua

Ministerial Building  
Harvey Street  
Windhoek  
Ref.: 17/1/1

Tel: (061) 2032125  
Fax: (061) 272286  
E-mail: amuheua@mhss.gov.na  
Date: 15 July 2009

**OFFICE OF THE PERMANENT SECRETARY**

Ms. N. Nelumbu  
University of Namibia  
Windhoek

Dear Ms. Nelumbu

**Re: Study - A program to enhance reflective practice for registered nurses in training hospitals in Windhoek**

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to of great importance.
3. Kindly be informed that approval has been granted under the following conditions:
  - 3.1. The data collected is only to be used for academic purposes;
  - 3.2. A quarterly progress report is to be submitted to the Ministry's Research Unit;
  - 3.3. Preliminary findings are to be submitted to the Ministry before the final report;
  - 3.4. Final report to be submitted upon completion of the study;
  - 3.5. Separate permission to be sought from the Ministry for the publication of the findings.

Wishing you success with your project.

Yours sincerely,

*N. Kahure*  
MR. K. KAHURE  
PERMANENT SECRETARY



*"Health for All"*

## **APPENDIX B INTERVIEW RESULTS**

### **1. The first respondent's answers**

- “I try to reflect on what I have done except for much work.”
- “There are some challenges, for example the shortage of staff and many patients that cause me to cover half of the work. I just use shortcuts in order to complete the tasks, for example when giving medicines the intervals are not adhered to. Some patients receive their medicines early and some late which affects patients negatively.”
- “I tried to prioritise the conditions, with the understanding that serious patients should receive treatment and nursing care first.”
- “I always try to improve the situation, for example to provide the quality patient care and to teach students.”
- “I believe that when I give medicine to any patient I must make sure that the right dosage of the right medication is given at the right time to the right patient.”
- “I try to provide nursing care to my patients, for example feeding, as I believe that nutrition supplements the effect of medicine and enhances speed recovery.”
- “Maintenance of the hygiene of my patients is one of my priorities.”
- “After I assured that the patients have received their treatment I spend the remaining time teaching the students.”
- “When I am off duty and recall an uncompleted task meant for any patient I immediately call my colleagues who are on duty and ask them to complete it.”
- “I love my work and I wish to see my patients go back home being happy.”

### **2. The second respondent's answers**

- “When a doctor prescribed a wrong dosage, I take an initiative to double-check and change it in order to give the right dosage to the patient and inform a doctor about this as I believe that this will save the patient's life and also protect me from guilt feelings and blame for negligence.”
- “I also try to act during emergencies to give oxygen, for example when I see that a patient is experiencing difficulty in breathing before I call a doctor.”
- “When I administer medicine to a patient I always make sure that the right medicine is used, also checking its expiry date thoroughly.”

- “When administering the medicine, I try to observe the patient’s condition before and after giving him the medicine in order to detect any side effects.”
- “When a patient is complaining about pain at the site of the drip, for example, I check carefully if that site is not swollen and if the patient is still complaining I take the initiative to stop the drip and inform the doctor.”
- “When I see the improvement of my patient I always feel good.”
- “When there is a conflict among us as colleagues I always try to talk to my colleagues so that we can understand each other and work as a team.”

### 3. **The third respondent’s answers**

- “I cannot act immediately on some of the prescribed treatment because of many patients.”
- “I first look at urgent conditions, meaning I always prioritise patients who need immediate attention.”
- “I try to provide teaching to students, trying to do it in the right way in order to prevent negative consequences.”

### 4. **The fourth respondent’s answers**

- “Because of the shortage of staff and many patients, procedures are not followed in the correct way as they are supposed to be.”
- “I just use short cuts in order to complete the procedures.”
- “I tried to maintain good relationship among staff members.”

### 5. **The fifth respondent’s answers**

- “I tried to do what I supposed to do.”
- “When the ward is full the procedures are also slow—for example, administration of medicine which sometimes prevents me to reflect properly on what I did or should do.”
- “When I am off-duty and remember something which was to be done I call my colleagues at work to complete it.”

**6. The sixth respondent's answers**

- “I love what I am doing–I love working with patients.”
- “When I am off duty I still feel “guilty” if did not complete everything for the patient because of the time.”
- “When I have finished my work I always feel good because I completed what I was supposed to do.”
- “I expect the patients to be happy about my activities and this encourages me to do and love my work.”
- “When I am giving treatment to the patient I always ask myself if the treatment I am giving will help him or not.”
- “I believe that the cure of a patient is mainly based on the loving care.”

**7. The seventh respondent's answers**

- “Currently I work with difficulty because of the shortage of staff, patients are too many and diseases are now complicated.”
- “I want to work the way it is supposed to, but the work is too much.”
- “I try to support the patient, but I often just do it in a quick way in order to finish the task.”
- “Shortage of staff contributed to the poor delivery of service for example I do not do observations properly because of many patients.”
- “I am always stressed because of too much work, the intention is to help every patient, but I cannot do it properly.”
- “I always tried to prioritise the very sick patient to get the attention first.”
- “I feel bad when I did not do what I was supposed to do, for example when I observed that the patient looks pale it means that I need to do the haemoglobin test instantly but because of an overload I may do it later.”
- “I wish to attend to all the patients but the shortage of staff is disturbing.”
- “I feel guilty if I do not perform the procedure according to the prescribed time because I know that the medicine can only work perfectly within the prescribed intervals.”
- “I feel good when I have completed my duties, because I believe that this will help the patient to become well and go home being happy.”

8. **The eighth respondent's answers**

- “When I am doing something I make sure that I do it in the correct way.”
- “I always have to make sure that the medicine I give to the patient is the correct one.”
- “Some doctors are helpful especially when the prescribed medicine is new. They explain well.”
- “When the ward is busy sometimes I just try to finish under stress.”
- “When I am off duties I always ask myself about what I have done, even after I have given the report to the other colleagues.”

9. **The ninth respondent's answers**

- “I try to do the procedures the correct way.”
- “I am sometimes faced by the challenges of inadequate materials such as drip plasters, gloves, electrocardiogram (ECG), machine parts that are missing or even the machine itself which is not available.”
- “I administer medicines according to the doctor's prescriptions.”
- “Whenever the medicine has been prescribed by an intern doctor I assure that the dosage is correct; if not I inform him/her about it.”
- “The main problem in the wards is shortage of staff. I was called to come and work when I was off duty, which I did as I believe that the patients will suffer a lot when there are not enough nurses.”

10. **The tenth respondent's answers**

- “I do the procedures according to the doctors' prescriptions.”
- “I can do most of the nursing care procedures, for example putting up a drip and even checking haemoglobin; when it is low I inform the doctor. When the patient is complaining of headache I give him Panado and do observation after 2 hours. If the condition is not improving I call for doctor's opinion.”
- “When the wound is sore and is bleeding I have to examine its condition. If it is infected I have to inform the doctor.”
- “Nursing care is important in any emergency case. I always try to attend to patients in order to provide nursing care.”
- “I try to maintain good relationship among the staff.”

### 11. The eleventh respondent's answers

- “As a registered nurse I do reflect, the problem is the shortage of staff and insufficient time.”
- “I must know the work and how I can cope with the work load.”
- “I try to make sure that quality nursing care is provided to patients.”
- “I must make sure that the needs of the patients are met and patients are satisfied.”
- “I always think about the patient’s social, physical and psychological wellbeing, and after they are discharged I want to see them going home being well and satisfied.”
- “I feel happy when the patients are satisfied with my work.”
- “I always try to solve problems by myself and where I cannot I seek help from my supervisor or colleagues.”
- “My focus is to be a role model, acting in a polite way and respecting the patients and colleagues.”
- “I try to be responsible for each activity in the ward, teaching and advising my colleagues in order to develop their knowledge and skills and also to learn in turn.”
- “I try to supervise the colleagues who work under my supervision.”
- “I also have a responsibility to advise the intern doctors because they are still learning.”
- “I also take care of cleanliness of the environment where I nurse the patients in order to prevent infections.”
- “My focus is to be friendly and feel empathy towards the patients and colleagues.”
- “I always ask myself about the treatment which I gave to the patient if it is the right dose given at the right time while looking forward to the improvement of the patient.”
- “I try to keep the record of all the activities.”

### 12. The twelfth respondent's answers

- “I tried to give advice to the doctor concerning the patient who was suffering from cardiac problem. I asked the doctor whether that specific cardiac patient should continue with intravenous infusion as I know that it may cause problems

for the heart. The doctor did not accept my advice at that time, but he realised later that I was right and took off the drip. I was thrilled to see the patient getting the right treatment.”

- “When I am administering intravenous injection I always make sure not to enforce the medicine because it can damage the patient’s vein. When I am done I observe the condition of the patient and keep the record.”
- “When I see that the child is vomiting after getting the medicine I insert a nasogastric tube in the child’s nose so that it can get the right dose.”
- “I try to maintain the culture of respect towards my colleagues, being calm and understanding.”
- “I try to be a role model for my colleagues and I wish them to do the same.”
- “I like to keep good communication with my colleagues.”
- “I always try to complete what was prescribed. When I am off-duty and remember something that I am supposed to have done I phone my colleagues to do it.”

### 13. **The thirteenth respondent’s answers**

- “What comes to my mind first is that the prescription should guide me before I go to the patient in terms of the correct dose, time and how to give the particular medicine.”
- “I always ask the patients whether they are allergic to some medications before I administer any medicine and I tell them to report any reaction occurrence.”
- “I also try to observe the effect of the medicine on the patients, for example when I see that the patient has been on the treatment for five days without an improvement I consult the doctor.”
- “I try to counsel the patients, for example when they are going for an operation. I always try to explain everything to the patients in order to make them feel comfortable and be ready for the operation.”
- “When a patient fell from a bed, I immediately asked myself about what has happened and examined the patient carefully for any pain or sore.”
- “I try to identify the cause of an incident and rectify it, for example by providing the bed with a side trellis.”
- “I always ask myself if I have satisfied the patient and I wish my colleagues to do the same.”

- “When I completed my shift at the end of the day I want to leave the patients being happy.”
- “I always try to be at the bed side of the patient to assist him when something happens with him such as vomiting, for example.”

14. **The fourteenth respondent’s answers**

- “I think I reflect on what I have done because when I do observation I try to do it in the right way.”
- “Before I give medicine I have to check the prescription carefully to see if the right treatment is given to the right patient and make sure that the patient swallows his medicine.”
- “When I finish treating the patient I always go back and check if I have recorded all the activities in the patient’s file.”
- “I look forward to the patient’s recovery and I am pleased to see the patient recovered and going home being happy.”

15. **The fifteenth respondent’s answers**

- “I do reflect on what I do. If I happened to be in the full and busy ward I sometimes find myself moving from one patient to another without washing my hands in between. I am however conscious of this, for example when I gave an injection without having my hands washed I blame myself afterwards as I know that what I did may cause the spread of infection between patients. I resolve not to do it again.”
- “Another example is when I was in a busy situation where I felt tired and could not turn the patient. When I went back home I was feeling guilty because I did not do my job. Later on I decided not to leave the patient unturned again in order to prevent him developing bedsores.”
- “When I am off duty and could not give medicine to the specific patient at the prescribed time I always call my colleagues to do it. I want to render the quality nursing care but I have too much workload.”
- “I tried to teach new staff even though the time is against me because I believe that this is part of my responsibility.”

## APPENDIX C Themes and sub- themes

Themes and sub- themes are analysed as follows:

### Theme 1: Participants reflect on their daily practices and experienced concerns and attributes of caring

#### Concerns:

#### Participants' responses

Observations are not done properly:

-As a registered nurse I do reflect but I do not do observations properly because of many patients.

- When the ward is full the procedures are also slow for example the administration of medicine which sometimes prevents me to reflect properly on what I did or should do.

Shortcuts

I just use shortcuts in order to finish the asks, for example if I happened to be in a full and busy ward I sometimes find myself moving from one patient to another without washing my hands in between.

- I try to support the patient, but I often do it in a quick way in order to finish the task because of the many patients in the ward and the shortage of staff.

Intervals of administering medicines are not adhered to:

- I do reflect that sometimes some patients for example receive their medicines earlier or later than the prescribed time because of the many patients who are being attended to. This can have negative effects to the patients.

**Ineffective teaching:**

- After I assured that the patients have received their treatment I spend the remaining time teaching the students, trying to do it properly in order to prevent negative consequences.

- I strive to be responsible for each activity in the ward, teaching and advising my colleagues in order to develop their knowledge and skills and also to learn in turn.

- I make an effort to teach new staff even though the time is not always sufficient because I believe that this is part of my responsibility.

**Attributes:****Determination of the needs of patients:**

- Maintenance of the hygiene of my patient is one of my priorities.

-I seek to provide nursing care to my patients, for example feeding them as I believe that nutrition supplements the effect of medicine and enhances speed recovery.

- I usually make sure that the needs of the patients are met and patients are satisfied.

- I always reflect on the patient's social, physical and psychological well being, and

would like to see them going back home being well and satisfied after they are discharged.

- I also take care of cleanliness of the environment where I nurse the patients in order to prevent infections.

Prioritising of nursing care:

- I first look at urgent conditions; meaning that I always prioritise patients who need immediate attention.

Record keeping and report giving: activities.

- I try to keep the record of all the

- When I finished treating the patient I always go back and check if I have recorded all the activities in the patient's file which is important for my colleagues to know about the patients' progress and activities performed and to be done.

Maintaining of proper communication:

- I strive to maintain a good relationship among the staff.

- I like to keep good communication with my colleagues.

- I try to counsel the patients, for example when they are going for an operation.

- I try to maintain the culture of respect towards my colleagues being calm and understanding.

- Serving as a role model: - My focus is to be a role model, acting in a polite way and respecting the patients and colleagues.
- Clinical supervision: - I try to supervise the colleagues who work under my supervision.
- Advice: - I also have a responsibility to advise the intern doctors because they are still learning.
- I tried to give advice to the doctor concerning the patient who was suffering from cardiac problem.
- Whenever the medicine has been prescribed by an intern doctor I assure that the dosage is correct if not I inform him/her about it.
- Acting during emergency cases: - I also try to act during emergencies to give O<sub>2</sub>, for example when I see that a patient is experiencing difficulty in breathing before I call a doctor.

**Theme 2: Participants experience different emotions during reflection and expressed their meaning**

**Sub- themes:**

**Participants' responses**

**Positive emotions:**

Feeling happy or good and motivated

- I expect the patients to be happy about my activities and this motivates me to do and love my work.

- I feel good when I have completed my duties, because I believe that this will help

the patient to become well and go home being happy.

- I feel happy when the patients are satisfied with my work.

- I look forward to the patient's recovery and I am pleased to see the patient recovered and going home being happy.

Provision of loving care:

- I believe that the cure of a patient is mainly based on the loving care.

- I love what I am doing, I love working with patients.

- My focus is to be friendly and feel empathy towards the patients and colleagues.

**Negative emotions:**

Guilty/ bad feeling:

- When I am off-duty I still feel guilty if did not complete everything for the patient because of the time.

- I feel bad when I did not do what I am supposed to have done for example when I observed that the patient looks pale meaning that I need to do the haemoglobin test immediately but because of an overload I may do it later.

- I feel guilty if I do not perform the procedure according to the prescribed time because I know that the medicine can only work perfectly within the prescribed intervals.

- Another example is when I was in a busy situation where I felt tired and could not turn the patient. When I went back home I was feeling guilty because I did not do my job.
- Encountering conflict:
- When there is a conflict among us as colleagues I always try to talk to my colleagues so that we can understand each other and work as a team.
- Work-related stress:
- I am always stressed because of too much work the intention is to help every patient, but I cannot do it properly.
  - When the ward is busy sometimes I just try to finish under stress without reflecting on what I did.

### **THEME 3 Participants reflect on resolutions to challenges and internalization of values in their daily practice**

#### **Sub- themes:**

#### **Participants' responses**

Provision of nursing care according to patients' conditions:

- I always try to improve the situation, for example to provide the quality patient care.
- When the patient is complaining about pain at the site of the drip, for example, I check carefully if that site is not swollen and if the patient is still complaining I take the initiative to stop the drip and inform the doctor.

- I can do most of the nursing care procedures, for example putting up a drip and even checking haemoglobin when it is low I inform the doctor.

- When the patient fell from a bed, I immediately asked myself about what has happened and examined the patient carefully for any pain or sore.

- I always try to be at the bedside of the patient to assist him when something happens with him such as vomiting, for example.

- I think I reflect on what I have done because when I do observation I try to do it in the right way.

Checking procedures of  
administering of medicine:

- I believe that when I give medicine to any patient I must make sure that the right dosage of the right medication is given at the right time to the right patient.

- When a doctor prescribes a wrong dosage, I take an initiative to double-check and change it in order to give the right dosage to the patient.

- When I administer medicine to a patient I always make sure that the right medicine is used, also checking its expiry date thoroughly.

- When administering the medicine, I try to observe the patient's condition before and

after giving him the medicine in order to detect any side effects.

- When the wound is sore and is bleeding I have to examine its condition. If it is infected I have to inform the doctor.

- When the patient is complaining of headache I give him Panado and do observation after 2 hours. If the condition is not improving I call for doctor's opinion.

- When I am giving treatment to the patient I always ask myself if the treatment I am giving will help him or not.

- Whenever the medicine has been prescribed by an intern doctor I assure that the dosage is correct. If not I inform him/her about it.

- I always ask myself about the treatment which I gave to the patient if it is the right dose given at the right time while looking forward to the improvement of the patient.

- When I am administering intravenous injection I always make sure not to enforce the medicine because it can damage the patient's vein. When I am done I observe the condition of the patient and keep the record.

- What comes to my mind first is that the prescription should guide me before I go to the patient in terms of the correct dose, time and how to give the particular medicine.

- I always ask the patients whether they are allergic to some medications before I administer any medicine and I tell them to report any reaction occurrence.

- I also try to observe the effect of the medicine on the patients, for example when I see that the patient has been on the treatment for five days without an improvement I consult the doctor.

- Before I give medicine I have to check the prescription carefully to see if the right treatment is given to the right patient and make sure that the patient swallows his medicine.

- When I see that the child is vomiting after getting the medicine I insert a nasogastric tube so that the child can get the right dosage.

Follow-up of uncompleted task:

- As a registered nurse I reflect on uncompleted tasks meant for any patient, even when I am off duty.

- As a registered nurse I do reflect. When I am off duty and recall an uncompleted task meant for any patient I immediately call my colleagues who are on duty and ask them to complete it.

## APPENDIX D The schedule for programme implementation

Day 1- Thursday, 16 February 2012

### The Teaching and Learning Workshop on Reflective Practice

Place: WINDHOEK CENTRAL HOSPITAL (ROOM 13)

Time	Session	Activity	Facilitator
8h30- 9h30	1	Welcoming, Rules, Purpose and Narratives	
9h00- 9h30	2	Explanation of the concept, Reflection	
9h30- 10h00	3	Reflective theories, Experiential learning cycle	
10h- 10h30	<b>Tea</b>	<b>Tea</b>	<b>Tea</b>
10h30- 13h00		Reflective practice	
13h00- 14h30	<b>Lunch</b>	<b>Lunch</b>	<b>Lunch</b>
14h30- 15h30	4	Nursing process	

15h30-16h30	5	Recap of all sessions	
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**Day 2- Friday, 17 February 2012**

<b>Time</b>	<b>Session</b>	<b>Activity</b>	<b>Facilitator</b>
8h30 – 9h30	1	Integration: Nursing process and Rolfe’s reflective practice framework	
9h30- 10h00		Questions and Discussion	
10h00-10h30	<b>Tea</b>	<b>Tea</b>	<b>Tea</b>
10h30-11h30	2	Case scenario	
11h30-12h30		Case presentation	
12h30-13h00	3	Recap of integration sessions and the evaluation of the workshop	

# **EDUCATIONAL PROGRAMME TO FACILITATE REFLECTIVE PRACTICE AMONG REGISTERED NURSES**

## **1. Introduction**

The researcher was convinced that the development of a programme is the good idea that will enhance the proper application of reflective practice in clinical settings for nurses not simply to perform daily routine activities without paying attention to reflection.

## **2. The purpose of the programme**

The purpose of the programme is to offer knowledge and skills to effectively address the clinical challenges which the registered nurses may encounter in terms of reflection, and to encourage them to develop reflection in order to deliver quality patient and nursing care.

## **3. Objectives of the programme**

- Define the concept of reflection.
- Interpret the meaning of Kolb's experiential learning cycle.
- Describe the experiential learning cycle content.
- Interpret Rolfe's reflective practice framework.
- Discuss the content of Rolfe's framework.
- Define the nursing process.
- Discuss the levels of nursing process.

- Interpret the importance of integration of Rolfe's framework in the nursing process.
- Apply the integrated framework into practice.

## **4. The content of the programme**

### **4.1 Reflection**

Reflection is defined as a process of reviewing one's repertoire of clinical experience and knowledge to invent novel approaches to complex clinical problems. Reflection also provides data for self-evaluation and increases learning from experience. It is further defined as a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice (Bulman & Schutz, 2004); Bulman & Schutz, 2008).

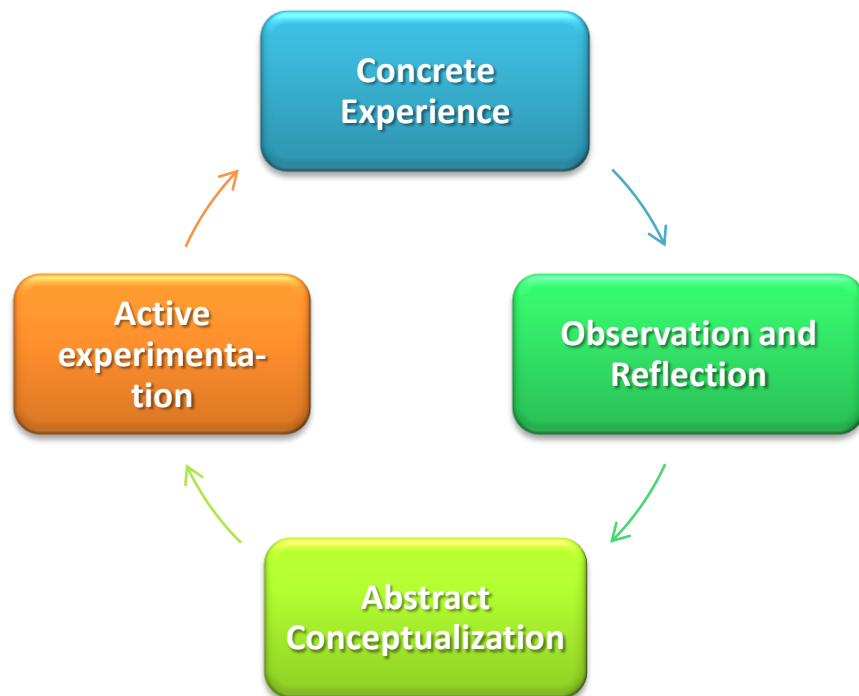
Reflection can also be seen as an integral part of practice to which registered nurses need to have a commitment in order to develop such important skills. To do this, registered nurses should think of an experience at the moment and go through it so that they can get insight into ways in providing solutions to different situations.

### **ROLE PLAY on reflection**

*An example can be used from the clinical environment.*

## 4.2 Experiential learning cycle

Experiential learning is defined by Quinn and Hughes (2007, p. 33) as “learning by doing, rather than by listening to other people or reading about it.”



**Fig 1. Kolb's Reflective practice: An experiential learning cycle**

### 4.2.1 Objectives

**After this session the participants will be able to:**

- interpret the meaning of Kolb's experiential learning cycle;
- describe the experiential learning cycle content;
- interpret Rolfe's reflective practice framework;
- discuss the content of Rolfe's framework.

#### **4.2.2. Concrete experience**

This level is based on an inquiry concerning something which happened.

It focuses on the identification of the problems of practice. At this level registered nurses are experiencing personal challenges and are involved deeply in thoughts about the specific challenges. The registered nurses should also be concerned about something or an activity she/ he has done.

Smith (2001) argued that the use of concrete experience refers to the testing of ideas and the use of feedback to change practice and theories.

#### **4.2.3. Reflection**

Reflection exists to provide guidance and help registered nurses to look back over challenges or events which happened, to review them and change them into learning experiences.

#### **4.2.4. Conceptualisation**

This level provides that learners such as registered nurses should make an appropriate decision by using the concepts so that they can make a conclusion from past and present experience. This involves the ability to construct a plan of action to address the problems. According to Kolb (1984), learners (registered nurses) should be able to develop concepts that enable them to integrate their observations into useful theories.

#### **4.2.5. Experimentation**

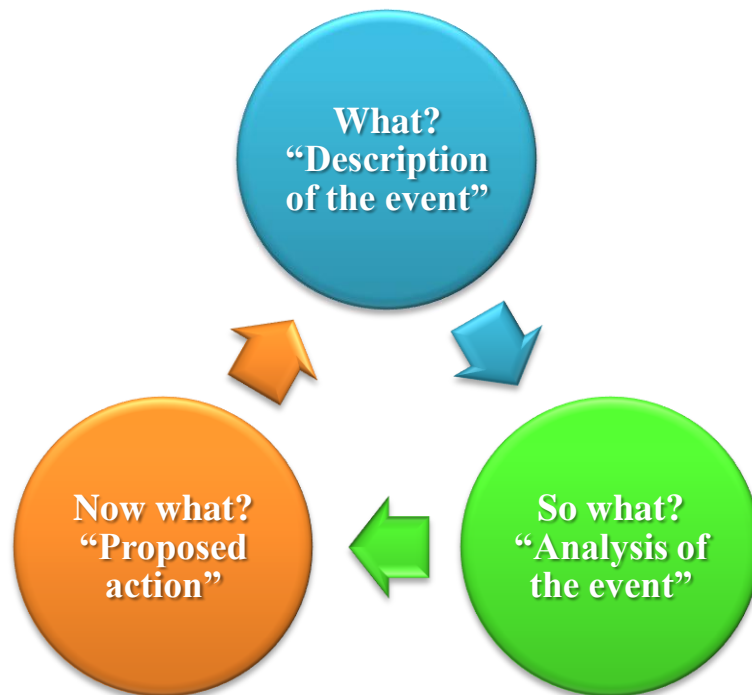
Registered nurses are now at the stage where they can plan, and apply the new learning from the previous experiences. Registered nurses might also try and record an event where they are aware of reflecting in action, then also apply retrospective reflection to the same events.

Smith (2001) explained that experimentation is well understood because it is based on application through action in a new circumstance within a range of generalisation. This means that action is taking place in a different set of circumstances and the learner is now able to anticipate the possible effects of the action.

## 5. Rolfe's model of reflective practice

### 5.1. Definition

Reflective practice is understood as a process of learning and development through examining one's own practice, including experiences, thoughts, feelings, actions and knowledge (Mezirow, 1981; Brockbank & McGill, 1998; Kim, 1999; Bolton, 2005, cited in Bulman & Schutz, (2008).



**Fig 2. Rolfe's reflective practice cycle**

### 5.2 Rolfe's model of reflective practice

**What**—A description of the event; led by the following trigger questions:

- What happened?
- What did I see/do?
- What did the other people do who were involved in this?

**So what**—An analysis of the event, led by the following trigger questions:

- How did I feel at the time of the event?
- Do I feel troubled? If so, in which way?
- What positive aspects now emerge for me from the event that happened in practice?
- What observations does any person helping me to reflect on my practice make of the way I acted at the time?

**Now what**—Proposed actions following the event described and analysed, led by trigger questions:

- What are the implications for me and others in clinical practice, based on what I have?
- Where can I get more information to face a similar situation again?
- How could I modify my practice if similar situation were to happen again?
- What help do I need to help me “action” the results of my reflections?

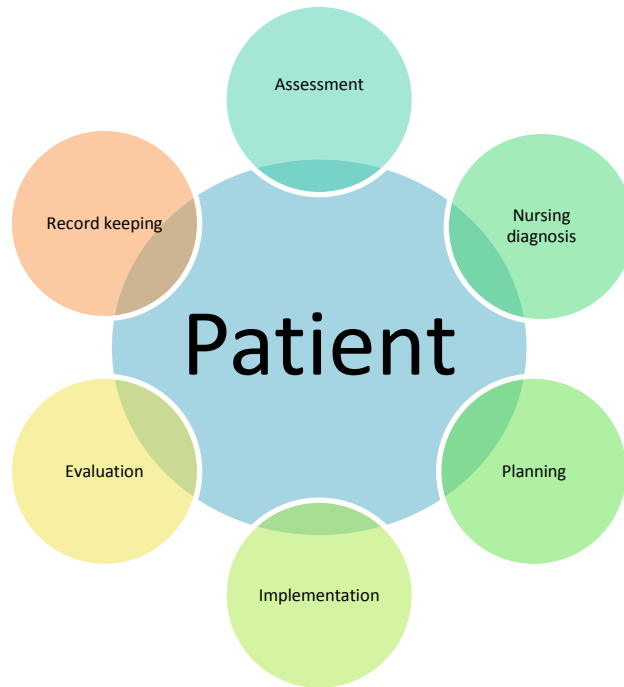
- Which aspect should be tackled first?
- How would I notice that I am any different in clinical practice?
- What is the main learning I take from reflecting on my practice in this way?

## **6. Nursing process**

### **6.1 Definition**

The nursing process refers to the relationship or interaction between a patient and a nurse.

The nursing process consists of the following five components: assessment, planning, implementation, evaluation and record keeping.



**Fig. 3. The Nursing Process diagram**

## **6.2 Objectives**

**After this session the participants will be able to:**

- define nursing process and
- discuss the levels of nursing process.

### **6.3 Assessment**

**Assessment comprises the following aspects:**

- The identification of different needs of patients.
- Identification of patients' behaviour associated with unexpressed needs.
- Assessment of the presence of a need and its effects on the patient.
- Recording of patients' needs.

### **6.4 Planning**

**Planning should focus on the following:**

- prioritising of the patient's needs, deciding which needs urgent attention;
- assessing the presence of a need and its effects on the patient and
- planning to meet the need which is the highest on the priority list.

### **6.5 Implementation**

Implementation should indicate how the knowledge and skills are applied to solve problems. This is the implementation of the plan.

## 6.6 Evaluation

**Evaluation involves an in-depth analysis of the plan concentrating on the following:**

- evaluation of the success or failure of the plan and
- strategies of re-planning in case of the failure of the original planning.

## 6.7 Record keeping

Records and recording are essential elements of reflective practice. Registered nurses should decide what to keep. These records should reflect the quality of their clinical role.

**Table 1. The relationship of the content of the programme: Nursing Process, Kolb's cycle and Rolfe's framework.**

NURSING PROCESS	KOLB'S CYCLE	ROLFE'S FRAMEWORK
Assessment of a patient; history taking, physical examination	Concrete experience: focus on identification of problems	What happened? What do I see?
Nursing diagnosis	Observation and reflection: consolidation	How is my relationship to the patient? How to resolve the situation?

Planning: planning of nursing care	Ability to construct a plan of action: nursing care plan	What action do I take?
Implementation	Transformation of the developed concepts, actions in new situations	What did I base my actions on? What other knowledge to solve the problem?
Evaluation	Evaluate whether the actions were successful	Possible consequences. What could I have done better?
Record keeping	Record keeping	Record keeping

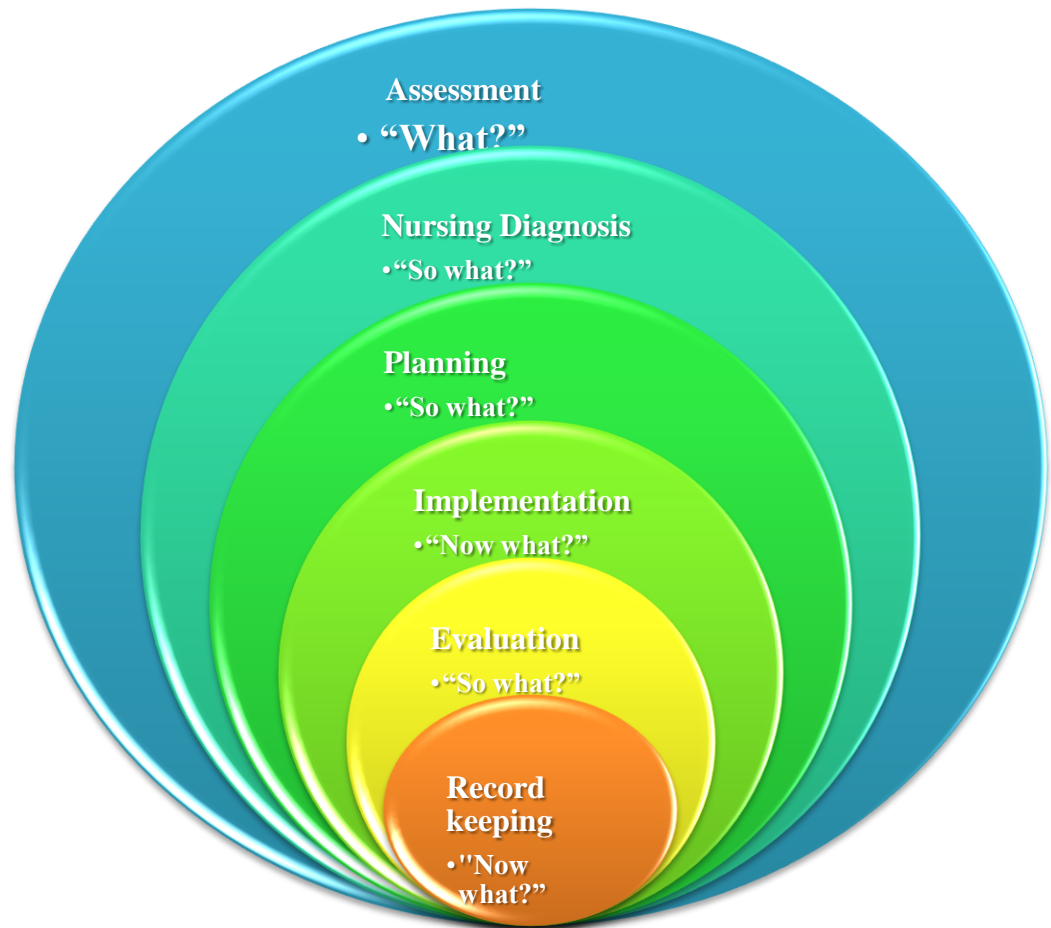
## 7. Integration of reflective practice into nursing process

### 7.1 Introduction

The nursing process, as described previously, can be improved when integrated with Rolfe's framework of reflective practice. The researcher noticed that it is appropriate to integrate Rolfe's framework in the existing nursing process in order to enhance reflection among registered nurses. This integrated process consists of six stages which are guided by Rolfe's trigger questions of reflection: "What?", "So what?", and "Now what?"

## 7.2 Objectives

- Importance of integration of Rolfe’s framework in nursing process
- Applying the integrated framework into practice



**Fig 4.** Nursing process and Rolfe’s reflective practice framework

**Table 2** Integration of Rolfe’s reflective practice framework in the Nursing Process

Nursing process:	Rolfe's reflective practice framework:
Assessment:	What?
An example from practice: 52-year-old man suffering from stress. On day two, observation shows BP of 150/120.	Ask yourself about the experience. What happened? What are factors contributing to this problem (physiological and other, for example, psychological or social)?
Nursing Diagnosis:	So what?
Stress due to psychological problems	What would be my role as a registered nurse concerning the meaning of this experience? Do I have adequate knowledge about this experience? What kind of care is my patient looking for?
Planning:	So what?
Explain the problem to the patient. Develop the nursing care plan. Involve the doctor. Have the prescription in place according to the doctor's order. Prepare the environment—for example, a quiet and relaxing warm room.	Whom else do I have to involve? What have I learnt about this experience? What else I can think of as a solution to this problem? What action, based on my patient's and the family's feelings and needs? If I act in this way what would happen to my patient?
Implementation:	Now what?
Do observation: Blood pressure should be monitored 6 hourly. Position of the patient and position of the cuff. Accurate readings. Medication should be given as prescribed. Proper counselling	What else could I do? What do I need to do in order to improve my patient's care? What might be the outcome of my action?
Evaluation:	So what?
Does the treatment work or not? Is the problem addressed and improved?	What have I learned about this experience? What knowledge and skills have I gained? What more do I need to know about this?
Record keeping:	Now what?
Recording of the activities performed	What do I need to do after my actions? What do I need to change for next time?

### **7.3 Scenario**

Mrs. Black visits the casualty department with her 6-month old baby girl. The baby looks very ill and tired. The baby's weight is 5 kg and is suffering from diarrhea. The weight taken 3 months back was 4.5 kg. The last immunization (DPT & Polio) was given after ten (10) weeks.

#### **Objectives**

After this session the participants will be able to:

- analyse the given scenario accordingly and reflectively and
- demonstrate knowledge in the application of reflective practice in their daily practice.

#### **Instructions:**

- Analyse the scenario in light of the integrated framework of Rolfe in nursing process. Indicate how you would apply the result of your analysis to a similar situation in your daily practice.

This was an example for a teaching moment during the workshop. The participants were advised to use any example from their respective clinical environment for application.

**APPENDIX E**

**Implementation evaluation**

Dear participant

You have attended a two-day workshop of teaching and learning on reflective practice. You are requested to complete the evaluation form below.

**Part 1 Feedback on programme presentation**

- 1. Was the number of days appropriate for the content presented?

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- 2. Were the objectives of the sessions clearly set?

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- 3. Was the content relevant to nursing practice?

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- 4. Was the content relevant to the participants?

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- 5. How was the summary of sessions presented?

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6. Were the participants encouraged to participate in the discussions?

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7. Did the participants have the opportunity to raise questions?

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**Part 2 Feedback on the case scenario**

1. Studying the clinical scenario assisted me to apply reflection to the nursing process.

Yes	No
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**Any comment**

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2. The clinical scenario based on reflective practice improved my ability to analyse the patient case.

Yes	No
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**Any comment**

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3. The group discussion on clinical scenario expanded my knowledge and skills of reflective practice.

Yes	No
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**Any comment**

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**The feedback on implementation evaluation**

**Part 1 Feedback on programme presentation**

1. Was the number of days appropriate for the content presented?

Participant 1: Yes–very nice short; Participant 2 : No–suppose will be a 5-days workshop therof–every participant has to set and present her own Scenario to see whether everyone understand; Participant 3: Yes we do with enough time to elaborate on the content; Participant 4: Two days were not enough, at least 3 days so that participant can have a clear picture and listen attentively; Participant 5: Yes, the days were appropriate; Participant 6: Yes; Participant 7: No- more days (3 to 4 days) could have been appropriate because we had a lot to discuss and learn from each other; Participant 8: For the future we can make 3 days in order to get time for elaboration; Participant 9: It was enough; Participant 10: Yes; Participant 11: Yes it was appropriate for the presentation; Participant 12: Yes; Participant 13: Yes; Participant 14: Yes -----

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2. Were the objectives of the sessions clearly set?

Participant 1: Yes–stipulated nicely, Participant 2: Yes it was clearly set; Participant 3: =Yes very clear; Participant 4: Excellent clear but one should pay attention to understand the Kolb’s and Rolfe’s reflective practice, that’s why 3 days will be more appropriate; Participant 5: Yes objectives were clearly set out;

Participant 6: Yes stipulated clearly; Participant 7: Yes- the objectives were clear and concise; Participant 8: Yes—it was clearly set up; Participant 9: Yes objectives were clear; Participant 10: Yes; Participant 11: Yes; Participant 12: Yes; Participant 13: Yes; Participant 14: Yes -----  
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3. Was the content relevant to nursing practice?

Participant 1: Yes—Integrated to our nursing process; Participant 2: Yes—it is; Participant 3: Very much relevant; Participant 4: Yes; Participant 5: Very much relevant; Participant 6: Yes; Participant 7: Definitely; Participant 8: The content was very much relevant to nursing practice; Participant 9: Yes; Participant 10: Yes; Participant 11: Definitely it was relevant to nursing practice; Participant 12: Excellent; Participant 13: Yes; Participant 14: Yes-----  
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4. Was the content relevant to the participants?

Participant 1: Yes—sort of revision; Participant 2: Yes—it is; Participant 3: Yes; Participant 4: Yes; Participant 5: Personally I say yes; Participant 6: Yes; Participant 7: Yes we learned a lot; Participant 8: Very much relevant; Participant 9: Yes; Participant 10: Yes; Participant 11: Very relevant; Participant 12: Yes; Participant 13: Yes; Participant 14: Yes -----  
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5. How was the summary of sessions presented?

Participant 1: Well presented short—to the point; Participant 2: Clearly presented; Participant 3: After every session; Participant 4: Very good; Participant 5: Very clear and understandable; Participant 6: Well presented; Participant 7: Perfectly summarized, and understandable; Participant 8: It was clear and understood; Participant 9: Yes; Participant 10: Very clear and understandable; Participant 11: Was presented in a clear session whereby all participants gave inputs on

practical situation; Participant 12: It was very nice; Participant 13: Yes;  
Participant 14: Well and clear-----  
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6. Were the participants encouraged to participate in the discussions?

Participant 1: Yes- case presentation done, role play, reflection of our ideas;  
Participant 2: All the participants encouraged; Participant 3: Participants was  
more than ever encourage to participate actively; Participant 4: Yes; Participant  
5: Yes- there was good group participation; Participant 6: Yes eg. group  
discussion which was carried out appropriately; Participant 7: Yes; Participant 8:  
The participants were all actively participated; Participant 9: When the lecturer  
show that the person it out or not understand, tried to draw attention by mention  
by name; Participant 10: Yes from the 1st day which makes it more interesting;  
Participant 11: Yes; Participant 12: Yes we need more workshop; Participant 13:  
Yes; Participant 14 No participants were actively participating on their own ----  
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7. Did the participants have the opportunity to raise questions?

Participant 1: Yes—questions were asked, when were not clear; Participant 2:  
Yes; Participant 3: Yes; Participant 4: Yes; Participant 5: Yes everyone could  
interact and ask questions and given answers; Participant 6: Yes after each topic  
discussed; Participant 7: Yes; Participant 8: Yes participants got opportunity for  
question and contribution; Participant 9: Yes very often; Participant 10: Yes;  
Participant 11: Yes the floor for questions was provided to participants to air  
their questions and views; Participant 12: Yes; Participant 13: Yes; Participant  
14: Yes-----  
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**Part 2 Feedback on the case scenario**

8. Studying the clinical scenario assisted me to apply reflection to the nursing process.

Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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**Any comment**

Participant 1: Continuation of workshop will be needed for us to review and new skills that we experience; Participant 2: Yes because I now know how to apply the nursing process and Rolfe's role in the nursing process; Participant 3: Yes; Participant 4: Yes; Participant 5: It makes even the nursing process clearly understandable; Participant 6: I hope it must be done continuously and follow up to see whether participants are productive; Participant 7: Clinical scenario helped me to gain knowledge and be able to apply reflection in my daily patient care; Participant 8: Yes; Participant 9: It helped me to understand the relationship between nursing process and Rolfe's reflective practice; Participant 10: Yes; Participant 11: Yes; Participant 12: It was very good and interesting; Participant 13: Very well conducted and presented; Participant 14: Yes-----

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9. The clinical scenario based on reflective practice improved my ability to analyse the patient case.

Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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**Any comment**

Participant 1: Hope to get more scenario; Participant 2: I will be able to apply it because now I know what about reflection, nursing process, Rolfe's reflective practice and know how to interact them together; Participant 3: I am now able to use reflective practice in my nursing process; Participant 4: Yes; Participant 5: Very much to use critical thinking; Participant 6: It must be done as holistic by all health professionals on their daily activities; Participant 7: Now, I will be able to analyse and my critical thinking is improved; Participant 8: Yes; Participant 9: Yes because according to what questions I applied the nursing process; Participant 10: Yes; Participant 11: Yes; Participant 12: Yes; Participant 13: Good presentation done; Participant 14: It refreshed my mind to do

what is right-----  
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10. The group discussion on clinical scenario expanded my knowledge and skills of reflective practice.

Yes✓	No
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**Any comment**

Participant 1: Hope the clinical instructor will also involve other staff/ update their skills and knowledge; Participant 2: As I gain more on what I never know; Participant 3: Yes; Participant 4: I do appreciate this workshop because it has helped me to manage my time so that I can do the reflection to record all the relevant data even under pressure of workload; Participant 5: I strongly agree and hope to use the skills and knowledge gained in my daily nursing care practice; Participant 6: Same as above, No 1 and 2. Clinical instructor must follow it up with every department to see whether it is applied on daily basis; Participant 7: Yes; Participant 8: To continue in training; Participant 9: The discussion expanded my knowledge to recognize what I left out on my presentation; Participant 10: Because some of us have start forgetting the whole issue of reflective practice; Participant 11: Nursing process in reality is not being done by means of reflection but this clinical scenario enabled or expanded my knowledge on reflecting back, trying to dig more on what might be the cause of problem; Participant 12: Yes; Participant 13: Improved skills and knowledge on my nursing care; Participant 14: Important points which were excluded by some participants were highlighted and therefore was very educative.-----  
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