

Learning from practice: the value of story  
in nurse education

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## Abstract

The central contention of this thesis is that story as an aid to learning, particularly student nurses' own stories of practice, is not being used to its full potential in nurse education. The dominant tendencies in nurse education are briefly outlined; the first, a 'top-down', managerialist approach, which is theory-focused, and where 'reflection-on-action' from an essentially theoretical perspective, with assessment strategies related to extrinsic criteria, is predominant; and the second, a 'bottom-up' approach, focused on practice itself as a resource for learning, with 'reflection-in-action' (moment-to-moment decision-making) as its major pedagogic strategy. This thesis argues that these approaches are too often treated in isolation from one another, but that for nurse education to be effective, professional practice must unite the two, and that story is an imaginative and stimulating method by which this can be achieved.

The thesis outlines the ways in which story has been explored in the literature, but the emphasis is on the 'humanness' of stories and the varied and diverse roles they could play in the development of nurse education. This discussion of the unique contribution that story can make to nurse education is placed in the context of two major theories of learning: constructivist and social constructivist, with particular emphasis on the seminal work of Schon.

The research methodology adopted is that of narrative, and data were provided by student nurses' written stories and learning accounts of practice, and notes taken during focus groups. The data were supplemented by the use of my own stories of experience of clinical practice. In all, 55 students' written stories and learning accounts were collected, and then analysed using a three stage approach: first, reading the stories and learning accounts; second, a two-part analysis using content analysis and analysis of form; and third, a structured presentation of findings.

Therefore, whilst accepting that direct learning from story is difficult to demonstrate, the evidence presented in this thesis illustrates the different ways in which stories can be an aid to student learning from practice, particularly by encouraging students to differentiate and structure clinical experiences that might otherwise remain undifferentiated and unstructured, and acknowledge and identify the tacit nature of their learning in practice and develop strategies for making it explicit. The evidence presented in this thesis supports the contention that inclusion in the curriculum of students' stories of clinical practice can contribute towards the transformation of nurse education.

## Chapter 1

### The current position of nurse education

*This story begins with the current state of nurse education in higher education (HE). In my experience as a nurse educator, I find that the curriculum undervalues the notion that learning can result directly from practice and instead is dominated by the assumption that learning from practice is only possible in an indirect way through theory. In this chapter I explain how nurse education has been driven by the model or approach to professional practice labelled technical rationality. This approach to learning and teaching is appropriate to the basic sciences dominated by medicine but not to nursing. For example, it has led to an undue stress on outcomes and formal assessment criteria. I explain the impact of technical rationality on the organisation of learning and teaching in current nurse education and suggest that, despite many criticisms to which it has been subjected in recent years, its hold is still strong.*

*I view the current organisation of nurse education as essentially managerialist. Many decisions, such as those regarding how modular learning outcomes should be written and utilised, are undertaken by management teams, controlled by outside agencies, and the emphasis is invariably on the scrutiny of audit data from departments serving to reinforce the power of management. It is suggested here that practice learning can be conceived in a manner different from that underpinned by technical rationality and that nurses can learn directly from practice, particularly through the medium of story, although the extent of such learning can be difficult to measure definitively. This is not to create a binary approach in which nurse education is seen either in a theory-centred or a person-centred way but rather to present nurse education as a vehicle for integrating the two, issuing exciting new challenges regarding teaching methods, assessment strategies and the contribution that students can make to their own education.*

## **1.1 Technical rationality, nursing practice and professional practice in nurse education**

For the most part, nursing practice has developed within a positivist paradigm (Diekelmann and Ironside, 2002). Much of the theory used in nurse education is borrowed from fields such as medicine, pharmacology, microbiology, immunology and psychology, rather than being developed from within nursing practice itself. Such theory is often generated from research carried out using a scientific methodology that relies mostly on quantitative research tools. It is often pitched at a rather abstract and academic level and can seem to have few, if any, clear links to actual practice.

Schon (1983) argues that this type of theory results from a general approach to professional practice known as 'technical rationality', whereby scientific methods of generating knowledge underpin the activities of practitioners. According to Schon (1983, 1987), technical rationality is a product of the positivist philosophical paradigm which assumes that problem-solving using scientific theory, methods and techniques can resolve the main problems professionals meet in their work. Schon possibly overstates this position, failing to see how a profession such as nursing combines theory-based and constructivist approaches. However, he is right to caution that, even though often invaluable to nursing, knowledge gained primarily from scientific, medically-based research to develop professional practice can understate the importance of professional learning taken directly from practice (see Marks-Marano and Rose, 1999). To understand how nurse education came to be dominated by technical rationality, with insufficient regard given to learning from practice, I explore in the next section the historical context of nursing and nurse education.

### **1.1.1 The historical context: the emergence of technical rationality in nursing**

The early dominance of the borrowed theory used in the medical systems model of viewing illness has its roots in the way nurse training was organised by Florence Nightingale in the early 1860s (Davies, 1986), which essentially

followed a practical 'training', 'task- orientated', 'medical-led' pathway. This was compounded in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries by medical discoveries, the development of new technologies and the way hospital medicine became the dominant practice (White, 1985). This early dominance of a medical systems approach resulted from a focus on specific areas of medicine centring on particular organs of the body e.g. neurology (brain), nephrology (kidney), cardiac (heart) and respiratory (lungs). This focus was needed to assess and document medical treatments and interventions. However, the development of nurse education *per se* in the early 20<sup>th</sup> century was limited due to the powerful advance of medical science and its associated technologies. This resulted in issues concerning the professional development of nurse education being badly neglected.

This medical-led approach to nurse training was dominant into the 1980s, partly as a result of political and professional pressures. Political influences had ensured the maintenance of the medical-style training in the 1950s and 1960s, as nursing recruits were needed quickly and cheaply to staff the emerging National Health Service hospitals (White, 1985). In the professional arena, many nurses opposed proposals for better-educated recruits (Wood, 1947; Platt, 1964), as they feared these might undermine the senior nurses' authority (Davies, 1986). At the same time, many nurses recognised the shortcomings of their training and sought to gain what they saw as a superior 'education' in terms of improving patient care rather than being dictated to by a medical-based 'training' (White, 1985).

To some degree, the dominant role of the medical model began to weaken in the 1960s due to changes in general education and within society at large (Worsley, 1987), fuelling the debate for a better-educated nursing workforce. During this period, the opening up of more opportunities for women and greater access to higher education (Altschul, 1987) led to a movement that saw nursing developing as a profession in its own right, with its own sphere of activity, skills-based knowledge and expertise.

While this resulted in nurses becoming aware of the limited knowledge base used to support their practice (Davies, 1986), it also left them unhappy with the borrowed medical system of delivering care. They began to look beyond the dominance of the medical model (Webb, 1981) and to develop their own theories for defining approaches to nursing care. Arguably, the first such theory was a systematic approach to nursing known as 'the nursing process', which strongly encouraged the adoption of a problem-solving approach as described by Meleis (1991).

The development of the nursing process has been accompanied by the development of ever more sophisticated tools to predict, measure and quantify the outcomes of care. Examples of nurses developing such theory can be seen in areas such as the prevention of pressure sores, including the Norton *et al.* (1962) pressure area risk assessment score, and other sophisticated tools developed by Waterlow (1985) and Bergstrom *et al.* (1987). The publication of the national clinical guidelines, developed using scientific processes (Dealey, 1996), also illustrates how nurses themselves have developed nursing theory.

Nurses have adopted and further developed tools originating in medicine such as the Glasgow coma scale (Teasdale and Jennett, 1974), which has been developed into the Neurological Assessment Instrument (Way and Segatore, 1994). Using such tools, assessment data are collected and analysed to generate theory based on empirical findings. However, despite these advances in nursing practice achieved by nurses themselves, a great deal of research remains to be done before nursing comes anywhere near to developing a theoretical base for supporting nursing practice (see Webb, 1981).

It was not until the 1980s that nursing was offered the possibility of enhanced education status with the Project 2000 proposals put forward by the old nursing governing body, the United Kingdom Central Council (UKCC, 1990). At the same time, the implementation of Project 2000 and the moving of nurse education from hospitals into higher education led many nursing theorists to



embrace further the language of positivism (Parker, 1997) and retreat from recognising how nursing practice might have its own issues and needs, requiring a different approach (Vaughan, 1992).

Whilst the technical approach to the development of nursing theory has much to offer, it can be too easily assumed to be superior to, and independent of, other approaches (Reed and Proctor 1993). I am reminded of a story from early in my teaching career:

#### My story 1

I had just written a chapter in a book relating to holism (Edwards, 2000). My head of department's secretary was having difficulty finding some posters to go on display at an in-house conference. I admitted to just presenting a poster relating to my published chapter and I would be glad to display it at the conference. On the day many people came around to view my poster but what was interesting is that they criticised it as not being valuable because it was not research, it was a theory or philosophy about what holism encompasses. For this chapter (Edwards, 2000) I had rigorously searched for research / literature on holism, looking for ideas, clues that would help me define it for nurses, I read so much I thought my head would burst. I challenged, questioned and thought about these words for a long time and decided that what I had produced in this chapter could be 'research'.

To contextualise, my experience as a nurse educator in higher education has been that a top-down approach dominates, and does so partly because the academic credibility of nurse education depends on the nurse curricula having a strong academic and theoretical basis (Rolfe, 2000). This is supported by the belief that nursing is more likely to be acknowledged as a profession by the prominent inclusion of scientifically-based theory in its educational courses, rather than by knowledge generated from within practice and by practitioners.

The view of nursing as an application of medical science restricts the development of professional practice, as it suggests that nurse education should be driven by the advancement of medicine and other disciplines and not by identified needs arising from nursing practice itself. Currently, there is a move to adjust the balance between theory and practice and for the

adoption of a more practical approach to the development of professional practice, drawn from clinical experience, and story has the potential to play an important part in this adjustment.

### 1.1.2 Technical rationality used to inform professional practice: some developments

This over-reliance on a scientific paradigm may be weakening as new technologies (such as parenteral nutrition, peritoneal dialysis, central venous pressure and pulmonary artery pressure monitoring) generate unintentional side-effects. More generally, quantitative research does not seem capable of dealing successfully with the problems and issues intrinsic to the professional practice of nursing that Schon especially has highlighted (1983: further discussed below).

Writers such as Rolfe (2000) and Marks-Maran and Rose (1999) adapt some of Schon's (1983) ideas concerning technical rationality to the discourse of nursing, and suggest that nurses should develop an attitude of scepticism towards the perceived infallibility of the scientific method. Marks-Maran and Rose (1999) argue that only if nursing science is conceptualised and pursued as an essentially practical endeavour will professional nursing practice advance, as successful nursing cannot be measured in the same way as physical, pharmacological, medical and psychological sciences. This idea of refocusing our attention away from the medical model's scientific approach towards a direct and unrelenting focus on practice as a resource in its own right for nurses' professional development resonates with my own recollections as a sister:

#### My story 2

As a newly appointed sister in critical care I wanted to involve relatives in the care of adult patients in intensive care. Yet involvement of relatives is not accomplished by haphazardly instructing the relatives to 'go and get on with it'. The relatives' involvement in care occurred when I carefully planned how the relatives may be involved, at what time, and in what circumstances. The ideas of how the relatives

could become involved existed in my mind as I worked in intensive care and perceived where relatives might help with care of a ventilated patient.

The idea of using my own professional practice as a learning resource, i.e. as a way of advancing my understanding, has been a consistent feature throughout my career as a nurse, and story 2 encapsulates the day-to-day process by which this has occurred. Unfortunately, because this pragmatic, individualised process is not easily justified by scientific research, it is often effectively minimised or silenced. This conclusion does not, of course, entail a wholesale rejection of the dominant paradigm, but rather a questioning of the view that scientifically-based research is necessarily superior to that arising from practice itself.

Positivism and the appliance of scientific research methodologies, which were supposed to professionalise nursing, may only have served to suppress what makes nurses' professionalism special – its grounding in the experiences of clinical practice. Lindsay (1990) suggests that thinking practitioners welcome scrutiny and will adapt their own practice in the light of theory developed from an awareness of current practice. The problem is that comparatively little recent 'scientific' research seems to offer very much to the nurse in the workplace.

Finally, Radcliffe (1995) suggests that the current approach does not have the ability to validate progressive or new ideas and argues that many aspects of nursing are spontaneous, being created by, and arising directly from, experience. Schon (1983) argues that many of the practical processes underlying professional work may be unconscious or tacit, and occur unpredictably in the day-to-day work of a practitioner. Story 2, taken from my own experience, illustrates the kind of unanticipated experience which can occur in the working life of a nurse.

### 1.1.3 A humanist paradigm

The alternative to the positivist paradigm in nurse education is a humanistic approach to the study and organisation of people in the workplace. This approach (see Boud *et al.*, 2006) takes for granted that human beings are social creatures and are unlike other phenomena in the world in having minds, emotions and values. As a result, it is suggested, people can and should participate in their own education. We create our own perspectives on the world, and, to understand people, it is necessary to understand their particular constructions of the world. Schon's (1983) model of reflective practice is one such humanistic alternative.

Another model that accepts that there is much benefit in a top-down way of educating people is a 'partnership' or 'co-constructive' approach, where sometimes teachers transmit and deliver but, at other times, learners are free to construct their own takes on what is on offer (Brundrett and Silcock, 2002). Adam (1987) suggests that the two models of nursing outlined above, the first based on scientific theory and the second more humanistic, located in day-to-day practice, should maintain their differences but share office within the discipline of nursing. Johnson (1994), like Adam (1987), calls for a similar pluralism for theory and practice, but doubts if applying theory directly to practice is feasible in nursing. But he does concede that some theory must illuminate the practice of nursing, allowing novices to see their own experiences in a broader context. Chinn and Kramer (1991) agree that many types of theory are essential in nursing, and that the richness of a wide range of perspectives can be integrated into practice.

Undoubtedly, a scientific approach does have its place, but this alone cannot adequately capture the creative, humanistic and expressive nature of nursing practice. Nurses' learning is more emotive and subjective than is assumed by a model built solely on scientific, medically-oriented research. Since trainee nurses spend over half their time in supervised practice, gaining clinical experience on hospital wards or in the community, caring for and interacting

with patients (Andrews and Roberts, 2003), the more creative, human dimension of their work is obviously of central importance.

In summary, there is a concern, shared by nursing writers such as Rolfe (2000), Mark-Maran and Rose (1999) and Watson (2000), that there has been a continuous erosion of the view of nursing as an essentially practice-based profession. I have written about this myself (Edwards, 2002) and others have presented relevant critiques, both within nurse education (e.g. Parse, 1992) and outside it (Packard and Polifroni, 1991). Researchers such as Watson (2000) propose that the caring, healing arts of nursing have themselves been in retreat, particularly since the 1980s. Correspondingly, there is a need to develop and expound the value of experience as a medium for learning in order to enhance the effectiveness and enrich the experience of nursing practice itself. In this dissertation, I am attempting to help achieve this repositioning of practice as essential to professional nursing and as a resource for professional development relative to scientifically-based theory.

#### 1.1.4 Using nursing practice to inform professional practice: a rebalancing

Nursing is above all a practice profession, immersed in practical experience. It involves engagement with people who are living with, and attempting to negotiate safe passage through, health, illness or disease. Novices often find themselves ill-prepared for the role of student nurse, as a consequence of the over-emphasis in the classroom on a medical model (Edwards, 2002).

Students quickly become aware that the theories learnt in class do not always inform the practical situations in which they find themselves in the workplace.

Unfortunately, not all attempts to re-balance theory and practice are successful. Characterising nursing practice as 'learning by doing' as Burnard (1988) does, hardly rebalances the theory/practice relationship since his approach involves an active, intentional learning process detached from context. Within his strategy, the learning of practical skills takes place in a skills laboratory far away from the context in which the skill might be practiced on a patient. So, even when nursing is admitted to be essentially practical,

theory-based reflection may focus a student on skills *qua* skills rather than placing them in real clinical situations. A reliance on theory-based reflection still divorces the nurse from the very situations s/he is familiar with, by-passing the nurse-patient interactions which are, perhaps, a nurse's most valuable resource for learning.

The point is this: a nurse's 'learning by doing' may evolve from decades of experience in clinical situations rather than solely from skills training. It certainly remains vital to the advancement and development of professional practice and, once this is fully recognised, the direct study of professional practices themselves might increasingly contribute to the knowledge base of the profession (Higgs and Titchen, 2001). For this to happen and a theory/practice rebalancing to occur, we need to ask a number of preliminary questions, foremost among which is how does learning occur from and within nursing practice?

Some of my recollections from practice may suggest some tentative answers. In the following extract, taken from my own nursing practice, the main content of the learning concerns patient (and nurse) sexuality.

#### My story 3

My first clinical ward as a student nurse was on orthopaedics. I had a very good charge nurse who was my guide. On one occasion I was bed bathing a young man of 18 who had been involved in a car accident. He was semi-conscious and really confused and disorientated. He had cerebral oedema. While doing the bed bath with the charge nurse the patient had an erection. I was only 18 myself and blushed when the charge nurse suggested that I hit his penis on the tip with a spoon.

#### My story 4

On another occasion, I was on a late shift until 10 p.m. I was just about to go into one of the side rooms to check up on a young male patient who was in traction and confined to bed. The charge nurse caught me and told me under *no* circumstances should I enter that room, his girlfriend was visiting.

Nurses often find it difficult to address the issue of patients' sexuality, as more acute life-threatening issues generally take precedence, even when the

patient's condition stabilises and improves. However, these two stories tell of me as a young woman of 18 stumbling through professional experiences of patient sexuality at a time when the freedom to express such concerns in hospital was often overlooked (Manley and Bellman, 2000). Nurses may also be embarrassed and afraid to acknowledge not only others' sexuality, but also their own (Plummer, 1995). Equally, in a later story from my career as a nursing sister, the sexuality of a patient's husband needed acknowledging:

#### My story 5

I was in charge of the unit where a young male patient who had been knocked off his motorbike was recovering from a head injury. He was not fully conscious and had weakness in all limbs but remained semi-conscious. He had a young wife; they had been married for just 6 months. One evening when I was in charge of the unit his wife came to ask me if she could draw the curtains and lie with him for 15 minutes.

In this second instance, my experience informed my decision-making and justified my decision to allow the wife to lie with her husband. The outcome of story 5 was influenced by my clinical experiences in stories 3 and 4. This use of stories over time hints at their potential as a valuable resource for informing future practice. However, inquiry into practice has been slow to evolve and develop (Chinn and Kramer, 1991), and there is a need for greater awareness of the possibilities of learning from nursing practice to inform professional practice.

#### 1.1.5 Theory and nursing practice: divergence and integration

This study advocates resetting the balance between theory and practice in nurse education, with story acting as a bridge between what is publicly or culturally demanded of nurses and their own unique preoccupations, personalities and needs. It would be absurd to argue that nurses should not be publicly accountable for their learning through methods geared to learning outcomes. But learning directly from practice, however that is measured, is equally important. Both theory and practice are essential resources, informing and nourishing each other (Peplau, 1988).

Johnson (1994) supports this position, arguing that, if theory is to support nursing practice and be relevant to its advancement, the two must remain connected. Fortunately, much work has already shown the importance of clinical learning as an educational resource in its own right. Field (2004), Andrews and Roberts (2003) and Papp *et al.* (2003) are among researchers pushing the profession in this direction. McCormick (1999) advocates examining practice in the light of all types of theory, but puts the study of theory first – possibly because nursing practice does not exhibit highly integrated abstract and systematic explanations associated with scientific, theory-dominated approaches.

In my own writings, I have attempted to build on an integrated knowledge for practice by relating some simple theoretical principles to areas of work, such as ethics (Edwards, 1997a), measuring temperature (Edwards, 1997b), blood pressure (Edwards, 1997c), and nutritional assessment (Edwards, 1998a). Nurses need to be able to integrate medical and technical theories to nursing practice but there is little in the existing literature that might help them to achieve this. My writing covered more complex areas of integration, which showed how theoretical principles relate to interventions and care in a number of important practice situations, such as high temperature (Edwards, 1998b), hypovolaemia (Edwards, 1998c), hypothermia (Edwards, 1999), electrolyte balance (Edwards, 2001a), and the Glasgow coma scale (Edwards, 2001b).

Writing, publishing and conference presentations support and develop my teaching, and keep me up to date with ever-changing research evidence and practices. They inform and enhance my teaching and (hopefully) maintain my credibility in the classroom. I wrote about issues within nursing that clarified the meaning of some skills and situations that are embodied in the practice. What happened (unexpectedly) as a result of my writing was an improvement in my relationship with my students and deeper insight into what students brought to the classroom. I valued and trusted them as individuals, they had something important to say about the care patients received in hospital, and they appreciated the contribution my writing made towards an improved level of understanding of their own experiences. In short, through my publications,



a bond seemed to develop between students and myself, as they associated me with an affirmed passion for, and understanding of, theory related to nursing practice. For me, this was a great inward achievement, a positive embrace given to me by students which I accepted without question.

Returning to the theory/practice relationship, its divergence is perhaps most obviously seen in the organisation of curricula where theoretical modules are separated from the practical, and are taught at different times with their own learning outcomes and assessments. To use a medical metaphor, if you view a human being as a collection of organs, all of which are learnt individually, you never learn or understand how they fit together. This format exacerbates the theory/practice gap in nursing already discussed.

One explanation for this separation of theoretical and practical modules in nursing curricula is that positivist theory valued by many nurse educationalists is not always seen as relevant by practising nurses themselves. Hampton (1994) suggests that clinical expertise is decided mainly by practical capability and not by theoretical understanding, a view shared by Derbyshire (1994), who believes theory is rarely reflected in the reality of clinical practice.

Most people accept that the theory/practice divergence is damaging and has to change. If practitioners themselves are taking seriously the role of education in their own development, nurse education can no longer be based on a rigid theory/practice separation. Perhaps, as a first priority, we need to identify the professional skills and knowledge nurses actually use to deal with clinical problems, as Higgs & Titchen (2001) advocate. Then, these skills and knowledge might be better understood and enhanced by backing them up with suitable theory. Johnson (1994) suggests that ultimately an understanding of nursing practice in itself will further an understanding of how excellent practice is best pursued. She hopes that, by exploring clinical practice specifically to identify its richness

and diversity, productive debate and analysis among nursing scholars can be facilitated.

Many authors (Cohen *et al.*, 2000; Burnard, 1988; Pearcey and Draper, 2007) have noted the significance of forms of learning other than the purely theoretical in nursing, such as the interventions nurses make in relation to patients, the cultural and social focus of their work, communication, teamwork, personal development and learning from mentors. Other studies (Nolan, 1998; Ogier, 1989; Davis, 1990; Spouse, 1998) highlight key attributes of learning, such as skills, attitudes and values, competencies and problem-solving. In my opinion, these can all be drawn from clinical practice experience, and there needs to be a way of situating theory in a clinical context as well as valuing learning from practice more highly.

#### 1.1.6 Managerialism in higher education

Managerialism, and its partner 'marketisation', have become dominant influences across many areas of the public sector over the past 25 years (Ball, 2003). Nurse education has been subject to these influences, leading to a public emphasis on 'performativity', which is described by Lyotard as 'a method of maximising efficiency through a culture of controlled outcomes and accountability' (Lyotard, 1984). These developments have been seen by some as heralding a crisis for professionalism, in which doctors themselves have been de-professionalised or proletarianised (Friedson, 2006).

The increasing influence of managerialism in higher education can be demonstrated in three clear ways. First, decisions around curricula are often taken by management teams with limited or no apparent consultation with those carrying out the teaching (Wright, 2001). Choices between real alternatives are not available for debate, discussion, questioning or challenge. An informed choice is absolutely not on the agenda (Edwards, 2008). Instead, in the control regime of management, nurse educators are regularly seen as a means to someone else's ends. They are rarely engaged in

significant consultation. Initiative is not required, merely skilful execution of tasks, and nurse educators are only to execute such tasks according to criteria set by others

Second, the move towards a learning outcome, assessment-led curriculum has shifted nurse education away from the theory and practice of curriculum design (Hussey and Smith, 2002), which is instead replaced by structures that constrain what, how and when nurse educators teach (Edwards, 2008). In the UK, central agencies such as the Quality Assurance Agency benchmarks and the Framework for Higher Education, Knowledge and Skills Framework, National Service Frameworks and Nursing and Midwifery Council set the models, which have to be adhered to. It appears that nurse education has to deploy new abstractions, such as generic skills, personal development planning, blended learning and work-based learning, all passed down by those from outside, and often with limited understanding of nursing's own well-established culture.

Third, there is an emphasis on ever more rigorous scrutiny of data from departments, which serves to reinforce and fortify the power of management (Edwards, 2008). For example, for management, the main (if sole) criterion is how many students actually secure pass grades for a module. If the number is high, the module is deemed a success. However, even in situations where management itself has set up a flawed module which students find very difficult to pass, it is the teacher who teaches the module, not the managers who constructed it, who receives the blame. This reminds me of a story from my own practice:

#### My story 6

I was given a module to run; I was not involved in the development of this module or the curriculum that it was a part of. The module has 6 learning outcomes (Table 1.1) and 3 elements of summative assessment (Box 1.1) in order to meet them; students have to pass them all to meet the learning outcomes. The practical assessment is an objective structured clinical examination (OSCE) which has 3 skills stations and students also have to pass all 3. Therefore, in effect students have to pass five assessments before they can move into the third and final year of the course. About half way through the 2<sup>nd</sup> year of running the module I was called in to see

management who informed me that too many students were failing the module. I clearly pointed out to them that students are rigorously prepared for the multiple assignments on this course and gave the many ways in which they were prepared. This is simply a very hard module to pass.

Managers insist on the use of learning outcomes and determine assessments to meet them, yet there is no guarantee these outcomes are understood in terms of the practices they represent. They may well have been misappropriated for managerial purposes (Hussey and Smith, 2002). In the managerialist environment, information can be taught to all in a guided, standardised manner and structured in order to pass a module but, as shown in story 6, this strategy may prove inflexible and can (unintentionally) be setting a student up to fail.

**Table 1.1 - Learning outcomes against the same module content**

	<b>Learning outcome</b>	<b>Indicative Content</b>
1.	Demonstrate how nursing knowledge and skills can be utilised to deliver safe and effective patient care.	Through the nursing seminars and practical sessions. Evidence based practice and journal club.
2.	Develop knowledge and skills that contribute to the assessment, planning, implementation and evaluation of patient care	Through care planning (nursing process) in nursing seminars.
3.	Apply knowledge of biological and pharmacological sciences to a range of clinical domains enabling them to practice safely and to develop clinical competence.	Biology, pathophysiology lecturers and integrated and nursing seminars.
4.	Show how relevant health policy informs the management of care.	All the pathophysiology and to some extent where relevant in the seminars and practicals pharmacology will be integrated.
5.	Identify and consider appropriate evidence that informs care interventions.	NSFs, KSF, Skills for health documents integrated in the seminars.
6.	Demonstrate the use of information skills, information technology, literacy and numeracy.	This will be examined in the practical sessions.

## 1.2 Organising nurse education: the key role of learning outcomes

The teaching of techniques and skills dictated by scientifically-based theories has led to the designing of current curricula as sets of modular content (Boxes 1.1 and 1.2), which in turn are linked to set modular learning outcomes (Table 1.1).

Within the academy, managers insist on the use of learning outcomes, generally in response to the demands of outside agencies, and such outcomes have consequently become the primary focus of higher education learning. Thus, they have been misappropriated for managerial purposes and this has led to their distortion (Hussey and Smith, 2002). This invariably results in a surface approach to learning, which is over-structured and rigorously follows guidelines that allow for little initiative on the part of students in their reactions to unanticipated situations.

### Box 1.1 – Assessment drawn for one module in a nursing curriculum

Assessment Regime:			
<b>Type:</b> (CW, Exam, TCA, Practical)	<b>Description:</b> (eg 3000 word essay on.../ 2 hour exam)	<b>Weighting: %</b>	<b>Due in Week No:</b> (indicative submission week)
<b>CW1 Assignment</b>	Scenario-based written assignment 1500 words	30%	8
<b>TCA1 Skills Station</b>	Practice-based demonstration of a range of identified clinical skills	30%	10-14
<b>EX1 Examination</b>	Seen Examination 2 hours	40%	15

**NB All elements must be passed in order to pass the module**

Quite possibly, the focus on intended learning outcomes has more to do with administrative and regulatory necessity than with education in the sense of students' deep engagement with the curriculum (Hussey and Smith, 2003). Generally speaking, nurse education has become outcome-orientated as a

consequence of the dominance of technical rationality as a context for professional practice. It is also a way of aligning nursing to other professions and outside agencies with standard criteria, such as the National Standard Framework (NSF) and the Knowledge Skills Framework (KSF). According to Hussey and Smith (2002), assessment-led curricula based on learning outcomes reveal a tick-box managerial mentality that prevails across many

#### **Box 1.2 – List of content from a module within current nurse curriculum**

##### **Working as a Professional**

- The need for appropriate knowledge and skills
- The use of evidence based practice and research skills
- The use of a problem solving approach to patient care
- Updated and current emergency skills
- Developing assessment skills
- Interprofessional working – roles within hospital setting
- Awareness of Code of Conduct and its application to practice

##### **Skills and Knowledge for Nursing**

- Mandatory sessions – CPR, V&A
- Pre and Post-operative care – risk assessment, interpretation of vital signs, acute pain assessment, management and drug calculations. Surgical wound assessment and management, healing by primary intention, blood clotting and homeostasis
- Tissue perfusion and pressure sore management - physiology, nursing care, risk assessment, chronic wound assessment and management, wound healing by secondary intention
- Temperature regulation – management of the hypothermic and hyperthermic patient
- Oxygenation of tissues – abnormal physiology i.e. chest infection, asthma, COPD, respiratory assessment and care, oxygen therapy, pharmacology and method of delivery of drugs, saturation recording, peak flow, suctioning, obtaining sputum specimen
- Nutrition – G I system, nutrition assessment, enteral feeding,
- Urinary system, renal physiology, micturition, catheter care, urinary incontinence, UTI
- Fluid and electrolyte balance, Intravenous infusion therapy, drug calculations
- Defaecation care of patient with constipation and diarrhoea, pharmacology relating to GI. tract
- The skeletal system – physiology bones and joints, joint replacement, osteoporosis, elderly person fractures
- Acute cancer care - breast, lung, colon, prostate

##### **Principles and concepts of care management and delivery**

- Use of nursing process to underpin holistic care
- Framework of care and care pathways
- Concepts and ethics of care
- Organisational skills
- Risk management
- Team working
- Health promotion

higher education institutions. Such a mentality is required to ensure learning can be controlled, pre-determined and managed so that all learning outcomes are met.

Certainly, learning outcomes have a legitimate use, and there is no doubt that learning outcome-driven measurement systems can provide critical information to educators on the effectiveness of the design, delivery and direction of an education programme. In addition, this approach can be more transparent from the point of view of students, as they know what they have to do and what is expected of them. But they also have severe limitations, in that they limit the extent and nature of learning in the nurse education curricula. A learning outcome itself indicates only the general nature of what is expected. The idea that learning outcomes can be framed in advance so as to specify *exactly* what is to be achieved in clinical practice is conceptually flawed because clinical practice is often unpredictable. Assuming it is predictable may be damaging to learning from practice insofar as it directs students away from their own relevant clinical experiences.

Generally speaking, the use of a learning outcome format fails to acknowledge that student nurses and other practice-based professionals need expertise beyond that identified by the course and module learning outcomes. Nursing students need to make their own decisions and come up with innovative and creative solutions for bringing about change (Edwards, 2003), and it is not always possible to catch these innovations in pre-determined learning outcomes. Indeed, students need to go beyond their modular, learning outcomes, assessment-led university experience if they are to become independent nurse practitioners of the future. To develop as independent practitioners, they must widen their knowledge and perspectives as learners and future nurses, at the same time enhancing clinical practice and patient satisfaction.

From the perspective of teaching methodology, the most fruitful and valuable features of higher education for learners themselves are often those where new ideas, skills and connections emerge, often unforeseen even by the

teacher (Hussey and Smith, 2002). The use of pre-determined and very specific outcomes inevitably restricts the emergence of the new and unforeseen. Entwistle *et al.* (2000) point out that, in practice, unplanned diversions from the intended focus of classroom activities account for over 60% of learning, and a good teacher should seize on such moments to ensure they are properly exploited for further learning.

But accepting the significant role of unplanned diversions does pose dilemmas for me as a teacher. After I have begun to engage students deeply and significantly with material and created conditions in which they can construct their own understandings, I often find that I must change the focus of classroom interactions away from student and student-led activities in order to meet learning outcomes. Student-responsive learning is seldom predictable and not easily planned (Hussey and Smith, 2003). In my own practice as a teacher, I have recognised that not all learning outcomes can be pre-specified and that some may emerge from activities within the classroom.

Finally, I am not denying the need for educators to indicate, or discuss with their students, what is to be covered in a teaching session or what they are expected to learn. Nor am I arguing that learning outcomes should be abandoned. I am claiming, however, that the way they are used can be, and often is, seriously flawed. I would contend that learning outcomes should normally be framed in sufficiently general terms that they can incorporate learning that emerges (often unanticipated) from the practical realities of teaching.

#### 1.2.1 Outcomes-led assessment, standardisation, and the use of competencies

Table 1.2 demonstrates how learning outcomes from a nurse curriculum module are often set alongside module assessments given in Box 1.1, to ensure each assessment meets each outcome, so that all are being met. As can be inferred from these tabulations, from a student perspective what matters is registering that they have met an outcome even if they have not



engaged with meaningful tasks. In my own experience, when confronted with learning not required by assessment, students become increasingly disinterested or even opt out (Wright, 2001). This instrumental attitude works against students engaging in learning for its own sake or simply because they are committed to nursing. As Moon (1999) points out, a pass/fail threshold for achieving learning outcomes can encourage students to aim only for minimum standards.

**Table 1.2 - Learning outcomes set alongside assessment**

	<b>Learning outcome</b>	<b>Assessment</b>
1.	Demonstrate how nursing knowledge and skills can be utilised to deliver safe and effective patient care.	Examination (S) Scenario based written assignment (S) OSCEs (S) Worksheets / quizzes (F)
2.	Develop knowledge and skills that contribute to the assessment, planning, implementation and evaluation of patient care	Examination (S) Scenario based written assignment (S)
3.	Apply knowledge of biological and pharmacological sciences to a range of clinical domains enabling them to practice safely and to develop clinical competence.	Examination (S) Scenario based written assignment (S) OSCEs (S) Worksheets / quizzes (F)
4.	Show how relevant health policy informs the management of care.	Examination (S) Scenario based written assignment (S) OSCEs (S) Worksheets / quizzes (F)
5.	Identify and consider appropriate evidence that informs care interventions.	Examination (S) Scenario based written assignment (S)
6.	Demonstrate the use of information skills, information technology, literacy and numeracy.	Examination (S) Scenario based written assignment (S)

Formative (F) / Summative (S) / Observed structured clinical examination (OSCE)

The use of learning outcomes for assessment purposes is partly the result of widening participation in higher education, which in effect dictates the need for standardised educational provision (Lyotard, 1984). An example of such standardisation is a generic marking system for Level 5 used in one higher education institute (Appendix 1). The advantage of such standardisation, it is argued, is that information can be taught to all in a guided and structured

manner (Hussey and Smith, 2002), and marked following standardised criteria. The majority of students will pass, thus achieving their diploma / degree at the lowest cost.

The most obvious weakness of this approach is that what happens in the classroom, in the minds of students and teachers, is dominated not by issues of learning but by the demands of assessment. All too frequently nurse education courses are using a standardised framework of this sort. Benner (1984) applies the Dreyfus and Dreyfus (1980) novice-to-expert skill acquisition model to nurses, identifying five levels of competence: novice, advanced beginner, competent, proficient and expert. Steinaker and Bell (1979) apply different levels of proficiency to learning a skill, those of observation, participation, identification, internalisation and dissemination. Yet, like many other similar theoretical frameworks used to determine clinical progression, what is left unclear is how nurses are expected to move from one level to another (Glaserfield, 1991).

One remedy for this problem of progression has been to add competencies to nurse curricula. Assessment, it is thought, can be determined by the use of competencies either set alongside a theoretical framework or as a list of skills to be achieved. Benner (1984) identified nursing competencies in her model describing the development of nursing expertise, and the Nursing Midwifery Council (NMC) has written a list of practice competencies that nurses need to achieve in clinical practice for educationalists to take away for interpretation, referred to currently in nurse education as the clinical skills cluster. This involves skills such as taking a blood pressure and pulse, infection control and many more (Diekelmann and Smythe, 2004). However, these competencies serve as a list of nursing skills that have to be demonstrated successfully by students (an excerpt from this can be viewed in Table 1.3) whilst, at the same time, the guidelines may be open to different interpretations by different institutions.

Many, if not all, of the competencies (see e.g. Table 1.3) are essential, but if students fail to get one such competency signed off, not because they could

not do it but because they never came across this competency in their placement(s), they fail the placement. This is generally the situation across the country as all nurse education institutes have to abide by the NMC guidelines.

**Table 1.3 - Excerpt from NMC clinical skills cluster**

These represent a sample of student nurses competencies, interpreted from the NMC skills cluster, and **must all** be achieved while in clinical practice

Skill	I have practiced / demonstrated	Sign and date competence		Evidence / comments / code
		Achieved	Not achieved	
Contributes to the assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk factors by identifying, recording, sharing and responding to clear indicators and signs				
Accurately undertakes and records a baseline assessment of weight, height, temperature, pulse, respiration and blood pressure.				
Contributes to the planning of safe and effective care by recording and sharing information based on the assessment.				
Where relevant, applies knowledge of age and condition-related anatomy, physiology and development when interacting with patients / clients				
Monitors vital signs under supervision and responds appropriately to findings outside the normal range.				
When faced with sudden deterioration in patients' physical or psychological condition or emergency situations (e.g. abnormal vital signs, patient collapse, cardiac arrest, self harm, extremely challenging behaviour, attempted suicide) respond appropriately by seeking assistance from a senior colleague.				
Performs routine, diagnostic tests (e.g. urinalysis) under supervision as part of assessment process.				
Collects and interprets data, under supervision, related to the assessment and planning of care from a variety of sources.				

Safeguards to prevent students failing for reasons beyond their control are difficult; if the NMC has determined that a particular competency is 'essential', the student has to be able to do it successfully to gain professional registration. Moreover, practitioners assessing the competencies often fail to

identify additional expertise. For example, a student can have feedback from practice staff that says 'the student engages with the patient' or 'the student has a high standard of patient care' but additional comments such as 'the student is a part of the team' or 'the student contributes to decision-making' count for nothing as such learning is not required as a competency.

Benner and Wrubel (1981) suggest that practical competencies are often acquired without conscious theoretical understanding, though this has been questioned by Field (2004), who doubted if students just learn to do a skill without understanding the principles involved and the theoretical underpinning which helps set priorities (McCormick, 1999) or informs decision-making (Spouse, 2001). Although Kelley (2002) includes the development of ability through thinking processes as necessary to maximise the enrichment of nursing practice, the competency-based approach, as reflected in the list laid down by the NMC and used to assess practical skills acquisition, clearly discourages independent thinking. By its nature, it also restricts attempts to explore learning from experiences of clinical practice, as it simply lists skills a student needs to become a nurse (illustrated in Ironside *et al.*, 2005).

The continued use of competencies for the development of nursing practice, and how they translate into nurse curricula, needs to be clarified by the NMC and other advocates. Students focus on achieving their competencies rather than on learning, listening to patients, considering how they actually provide care in practice situations or developing their understanding – in other words, the very things they come into nursing for.

In summary, learning outcomes accompanied by competencies do have legitimate uses as they focus an institution's assessment efforts to determine student learning in a systematic manner. But they encourage a surface approach to learning given that they reflect a model meant to ensure curricular transmission following strict guidelines. Universities control the conditions of success, which puts pressure on students to conform to the guidelines without questioning them. Under such a system, it is difficult to ensure that students come to clinical understanding via a process that involves synthesis, critical

thinking and imagination, and without devaluing creativity and invention, which such systems encourage (Lyotard, 1984; Hussey and Smith, 2002, 2010).

At best, learning outcomes can only be statements about what topic or fragment of the syllabus is to be covered by a teaching session, and what kinds of skills and capacities students will be expected to display in response (Hussey and Smith, 2010). Some degree of specificity is necessary and desirable, but learning outcomes should not be the sole focus of attention, particularly if students are to be able to construct their own learning. Bringing together the need to meet pre-determined learning outcomes and assessment with learning that arises spontaneously and unpredictably within the classroom and with student learning in and from clinical practice should be a central part of curricular management. However, the managerialist approach that accompanies the current assessment-led system seems to stand in the way of any such fusion.

*Traditionally, nurse education has followed the positivist, scientific paradigm drawn from the medical model in an attempt to give nurses' work status within the academy. However, the notion that this model has the ability to embrace fully the complexity of nurse education is unrealistic and reductionist, as many aspects of nursing are spontaneous and unpredictable, arising from nursing practice experiences. There is much to be gained from both theory and nursing practice experience but the potential of learning from the latter has not been realised. The very characteristics that underpin the uniqueness of nursing have been undervalued and even ignored.*

*The limitations of learning outcomes as a means of identifying learning in nurse education have been explored above. The use of learning outcomes as the basis for learning has failed to allow for individual expression, demonstration of emotion or the different impacts from the context of learning. Both my own and the work of others suggest that we have been misguided in how we encourage and define student learning in a managerialist environment.*

*The learning from nursing practice is currently not derived directly from practice itself, but from the modular system geared to students responding satisfactorily to assessments and this system is predominantly assessment-led. McCormick (1999) suggests that practice learning could be improved if it was itself the focus within Higher Education Institutions (HEI), rather than students concentrating on completing academic assignments, examinations and competencies, although a number of the set assignments are practical and involve written reflections generally using a prescribed model of reflection.*

*The challenges to the present state of nurse education described above have given rise to the need to explore new approaches to professional learning, and reflective practice has been encouraged to promote learning through clinical practice experience. However, even reflection is seen as something to be controlled and measured (Saltiel, 2010), as will be discussed in the next chapter.*

## **Chapter 2**

### **Reflective practice and nurse education**

*The previous chapter suggested that, as currently constituted, much of nurse education is dominated by a technical rationality paradigm that fails to acknowledge adequately the importance of practice in nurse education. Such criticisms are not new, and have been the subject of debate within the profession from at least the 1980s onwards. One important outcome of these debates has been the interest shown in how reflection might impact on nurse education, particularly in regard to the divorce between theory and practice that characterises much of the current education received by nurses.*

*This chapter examines Schon's (1983) role in highlighting the use of the technical rationality approach and emphasises the central role played by reflection-in-action in the work of professionals such as nurses, and in particular the pursuit of what he terms 'an epistemology of practice' (Schon, 1983, p.viii). Whilst taken as given that reflection, however approached, must enhance to some degree the practice of any professional, and indeed should be at the centre of what it means to be 'professional', the chapter will discuss some of the challenges facing both teacher and student in establishing an effective model of reflection. It differentiates especially between those issues that have arisen from the way in which reflection has been incorporated into practice, and those that result from the sometimes confusing ways it has been conceptualised.*

#### **2.1 The changing nature of professionalism**

Frost has identified 4 major ways over the past 30 years in which the space where professionals reflect has been transformed, all of which pose some interesting challenges to the use of reflection in nurse education and, in particular, to the idealist approach that still dominates most practice (Frost, 2010, p.15).

The first such challenge he labels 'informationalism', which has impacted on professional life in two main ways, both adversely (Frost, 2010, p.16-17). First, the mountains of new information via government policy documents, white papers, and research articles etc., have undermined the self-perception of many professionals as possessing, and mastering, expert knowledge, essential to the successful prosecution of their roles. This is evidenced in advanced practice in nursing where the Nursing and Midwifery Council (NMC) are finding it difficult to determine what constitutes an advanced practitioner. Second, and developing some of the ideas first presented by Schon (1983), the Internet has given access to expert knowledge to the patient, who may know as much – and sometimes more – about particular conditions than the professional. The result is to threaten to undermine the self-esteem of the professional.

The second challenge is what Frost calls 'globalisation', by which professionals find themselves no longer in control of their local environments but often see themselves as 'victims' of changes taking place in all parts of the globe. Hence, what happens in, say, an African country has as much, if not more, impact on the professional space than anything that goes on 'in the head of the practitioner'. Third, he calls attention to what he describes as the 'network society', by which the reality of work is now often collaborative and cooperative, dependent upon networks and partnerships. Such changes are often antithetical to the notion of reflection as an idealistic enterprise.

Finally, Frost stresses the emergence of managerialism and what he calls 'the risk society', by which professional values are felt (by the practitioner) to be subordinate to inspection and audit, with professionals being left with the perception that they are less trusted and have less autonomy than was the case 'before' (Frost, 2010, p.15-21). The extensive spread of a managerialist culture into most aspects of academic life has also presented serious challenges regarding how reflective practice can be taught. This is not to criticise reflection *per se*, but rather to acknowledge that a top-down approach, such as most managerialist regimes insist upon, determines the nature of the reflective practice that any programme or individual teacher can



pursue. At the same time, managerialism seems to pose a threat both to teachers' esteem as professionals as well as to their very jobs and occupational prospects.

Any sense of self-regulation or autonomy is rapidly being eroded. The deference that was once paid to professionals appears to have withered away, with notions such as seniority becoming pejorative terms rather than symbols of status. In other words, the material reality of most professionals has changed dramatically with the individual controlling less effectively the space(s) in which s/he operates, with the implication that change and development are not always within the power of the individual to bring about, however much s/he might wish to do so.

## **2.2 Schon and professional learning**

Schon's role in the counter-drive to meet the challenges Frost identifies is seminal. The starting point for Schon's discussion is:

'...the question of the relationship between the kinds of knowledge honoured in academia and the kinds of competence valued in professional practice' (Schon, 1983, p.vii)

and the recognition that skilled practitioners often cannot describe effectively what it is that they do to bring about successful outcomes, and instead exhibit a '...knowing-in-practice' which engages the tacit knowledge the practitioner is often unable to distinguish or define. Schon (1983) was interested in analysing the distinctive structure of what he called 'reflection-in-action', and identifying the implications of such reflection for professional practice. The context for his research was what he identified as the crisis of confidence in professional knowledge (Schon, 1983, ch.1), by which he meant that the former esteem that professionals had enjoyed, at least up to the 1960s, had been seriously undermined. The result was a loss of confidence regarding the claims to the expert knowledge that was the basis of their status. As he argues, from the 1960s to the 1980s:

‘...both professional and laymen have suffered through public events which have undermined belief in the competence of expertise and brought the legitimacy of the professions into serious question’ (Schon, 1983, p.9).

In Schon’s (1983) view, these years witnessed the failure of experts to solve society’s problems, to live up to their own ethical values and norms, and to have little to offer society more generally. In other words, the type of knowledge to which the professions claim a monopoly was no longer relevant to the demands of a world in which complexity, uncertainty, instability, uniqueness and value conflicts had become the characteristic demands of professional practice. Problems as such, in the former sense of being manageable by the professional and capable of clear-cut solutions, do not exist and instead, quoting Russell Ackoff, professionals ‘... manage messes’, which do not have solutions (Schon, 1983, p.16). If ‘85 per cent of the problems a doctor sees in his office are not in the book’ (Schon, 1983), then how does the professional react? Such problems cannot be solved by the model of professional knowledge that the practitioner has relied upon and on which his / her status as a professional is based. As Schon sums up:

‘Complexity, instability, and uncertainty are not removed or resolved by applying specialised knowledge to well-defined tasks’ (Schon, 1983, p.19).

Instead, professionals in practice rely upon ‘artful’ ways of dealing with indeterminacies and value conflicts, but as such methods or approaches do not fit in with the models that professionals have been brought up on and take for granted, they are often unable to make sense of them. Hence, as Schon puts it:

‘We are bound to an epistemology of practice which leaves us at a loss to explain, or even to describe, the competencies to which we now give overriding importance’ (Schon, 1983, p.20).

What Schon (1983) is criticising here is the model of technical rationality discussed in chapter 1, and the degree to which this model exercises such a dominant influence on the hierarchy of knowledge claims and status. He includes in his definition of technical rationality the way in which professional

activity consists in instrumental problem-solving made *rigorous* by the application of scientific theory and technique (Schon, 1983, p.21). The converse of this position may be that other forms of knowledge are less rigorous, if rigorous at all – and knowledge lacking a theoretical base has little claim to the very name. In the grand scheme of things, ‘general principles’ are at the top of the ladder and ‘concrete problem-solving’ is at the bottom.

The consequence of such a hierarchy is that research can be institutionally independent of practice, with practitioners merely putting into practice what the findings of research suggest. In other words, researchers deal with knowledge but practitioners exercise skills, which lack a knowledge base. This polarisation permeates the English educational system, as the perennial arguments over the academic-vocational divide illustrate. As Edward Shils argues (cited in Schon, 1983):

‘There was general agreement that knowledge could be accepted as knowledge only if it rested on empirical evidence, rigorously criticised and rationally analysed...’ (p.35)

From the perspective of technical rationality, professional practice is in essence a process of problem-solving. The difficulty with this is that it ignores the process by which the decision is made, what Schon (1983) calls the ‘setting’. Problems do not exist as such; instead they are defined and, in this sense, created by the practitioner in an attempt to make sense of them. What is included – and excluded – within the definition of the ‘problem’ is set by the practitioner, who thereby imposes limits and coherence on what is an infinity of potential characteristics. Schon (1983, p.40) argues that the process of selection, whereby the practitioner ‘frames’ the context in which the problem will be tackled, is subjective and not determined by research or models of action.

This process of selection is seen most clearly in the classroom where there is rarely one correct way of dealing with a problem (Silcock, 1999, p.88). Schon (1983) draws attention to the way teachers are constantly ‘conversing with situations’ in an attempt to explore what these demand of them – and are as

likely to come up with 'incorrect' answers to questions as 'correct' ones. Of course, for virtually all practitioners, there is no either/or choice between using theory to solve problems and dealing with them pragmatically. Some practical situations can indeed be tackled – and tackled successfully – by the application of theory, although such problems tend, in Schon's view, to be of rather less importance to successful practice than those that he describes as 'messes', which are incapable of technical solution (Schon, 1983, p.42).

As Russell (1988, p.13-14) indicates, Schon is at pains to emphasise that there may be an entire range of issues and assumptions relevant to learning the practical knowledge of a profession that remain unnoticed and neglected without the reflection-in-action perspective. However, this emphasis on reflection-in-action presents both the teacher and the student with certain dilemmas, not least that neither can always know what relevant knowledge they possess nor how precisely they can use such knowledge in any given situation. As Schon writes, in his day-to-day practice the practitioner makes:

'... innumerable judgments of quality for which he cannot state adequate criteria, and he displays skills for which he cannot state the rules and procedures. Even when he makes conscious use of research-based theories and techniques, he is dependent on tacit recognitions, judgments and skilful performances' (Schon, 1983, p.50).

The rest of this chapter will draw out the implications of Schon's conclusions for nurse education, and examine how other writers have responded to Schon's views.

### **2.3 The value of Schon's analysis**

Schon's analysis has helped us recognise that professional practice is not just a set of low level practical skills, but can be dignified as a form of practical wisdom or intelligence (Carr, 1995) i.e. as a sophisticated form of professional artistry incorporating subtle and skilled moment-to-moment cognitions. Boud (2010) points out that reflective practice seems to be particularly appropriate for professional courses such as nursing (and teaching, generally) with their emphasis on the personal interaction between professional and client, where

practice consists of more than just the exercising of technical skills and knowledge. For this reason, some of the main ways in which Schon's analysis can enrich nursing practice are worth detailing individually.

### 2.3.1 Recognition that professional practice is more than a set of practical skills

As a so-called semi-profession, and perhaps intimidated by the superior status of medicine, nursing could see the adoption of Schon's notion of reflective practice as a means of improving clinical practice itself as well as enhancing its professionalism generally at a time when the nature of professionalism was being publicly questioned. Therefore, it is hardly surprising that nurse education was possibly the first profession really to take up reflective practice in a serious way. For example, in 1990, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), as part of its framework for post-registration education and practice (PREP), stipulated that all nurses were to engage in some form of reflective activity and to provide written accounts within a personal professional profile (PPP). When the UKCC outlined steps to build the PPP, reflection became crucial in the second stage, termed 'self-appraisal' (Burton, 2000, p.1009). The increasing prominence of reflective practice could also be seen in publications such as 'Making a Difference' (DH, 1999) and 'The Capable Practitioner' (The Salisbury Centre, 2000), which had a major effect in highlighting the benefits of reflective practice to the point where it became increasingly unquestioned and hegemonic.

The knock-on effect of these developments may be seen in the educational programmes for professionals such as nurses, social workers and teachers, where reflective practice became a core skill (Gilbert, 2001). This is particularly evident in continuing professional development (CPD) programmes established by professional bodies, as seen in the CPD frameworks of the Royal Pharmaceutical Society of Great Britain (2008), the Royal College of General Practitioners (2008) and the Nursing and Midwifery Council (2008) (Appendix 2), all of whom insist that professionals must reflect

on the way in which learning informs and influences their work (Bradbury *et al.*, 2010, p.81). In this sense, reflective practice has certainly helped raise the status of nursing as a profession, due in no small part to Schon's innovative thinking. However, for that very reason, it is in danger of becoming a dogma and, as Clouder and Sellars conclude:

'...it is clear that reflective practice and clinical supervision have been embedded in and pervade policy documents at all levels and, therefore, are unlikely to be displaced in the immediate future' (Clouder and Sellars, 2004, p.264).

Central to Schon's (1983) analysis is his argument that professions such as medicine and law have undergone – and are still undergoing – a crisis of professional knowledge, and this applies also to so-called semi-professions like nursing, with consequences for how nurse educators approach the question of reflection. For example, in an age of increasing teamwork in the professional workplace, nurses are expected to work within the multi-disciplinary team (MDT) in care, sharing and receiving information from members about procedures, interventions and treatments. A broad range of healthcare professionals (HCPs) all work together to ensure the patient is comfortable. However, nurses often feel inferior to other professionals owing to the dynamics of the MDT, and this may disrupt teamwork, make nurses less likely to contribute, and exacerbate the on-going and rarely acknowledged power struggle between doctors and nurses.

This power struggle is compounded by Government proposals to strengthen the autonomy of nurses and the current change to an all-graduate profession within nurse education. In addition, there is a move towards the creation of advanced nursing roles and specific skills such as nurse-prescribing. This has resulted in nurses taking on roles that have traditionally been fulfilled by doctors (Bradley and Nolan, 2007), thus intensifying further the power struggle between nurses and doctors. It remains the case that some doctors are still reluctant to accept non-medical prescribing (Wilhelmsson and Foldevi, 2003), despite evidence, such as that provided by Latter *et al.* (2004), that nurse prescribers are able to provide safe, effective prescribing care that is both popular with service users and has a positive impact on patient care.

Jones and Jones (2006) insist that when nurses assume roles that have traditionally been the prerogative of the doctor, a complementary approach to partnership is required if these new roles are to be implemented successfully. To establish cohesive teams of professionals, collaboration between nursing and medical teams is essential. Yet, for nurses, it is not about gaining more authority, autonomy or power, nor should their enhanced role be viewed by doctors as threatening to their own position. Instead, it should be about health care professionals utilising reflective practice to ensure positive working relationships, and to bridge nursing and medical knowledge.

### 2.3.2 Spotlight on context-based experiential learning

Practical wisdom and intelligence are, or should be, of equal value to theoretical knowledge in team-building and Schon (1983) has helped practitioners to understand this. He has placed a spotlight on context-based, experiential learning and helped practitioners see that their work is not just about technical skills learned through training. Linking the work of Dewey, with his distinction between 'routine action' and 'reflective action' (Dewey, 1934, reprinted in 2005), Schon separates 'reflection-in-action' from 'reflection-on-action' (Schon, 1983). Following on from this (see also Kolb (1984) with his notion of the learning cycle), there has been much discussion regarding the nature of experiential learning, especially the nature of knowledge in the workplace, and its relationship to the techno-rational mode of knowledge generated by theory. Indeed, the earliest proponents of reflective practice argued that the latter was privileged over the former and that workplace knowledge, or tacit knowledge, was by definition very difficult to identify and pin down, both by the practitioner doing the reflecting and by the mentor / teacher doing the listening.

Since Schon's seminal work, the three main aims of reflective practice have been to find a means whereby tacit knowledge and knowledge based on theory can be fruitfully combined, to develop strategies for uncovering how the tacit knowledge of the practitioner has been built up and consolidated, and to

work out how a practitioner can be led to identify, and therefore revise and develop, this knowledge. This latter task is a formidable one for any teacher, for as Clouder and Sellars conclude:

‘...qualified practitioners who have developed expertise operate at such a tacit level that their capacity to analyse their interventions and, perhaps more importantly, discuss their conclusions and teach colleagues might be impeded’ (Clouder and Sellars, 2004, p.267)

Certainly experiential knowledge has moved from the margins to the mainstream, at least in terms of the focus of research, where there is a deeper understanding that skilled actions can attain very sophisticated levels without being consciously articulated (Silcock, 1994, p.279). But, with the implementation of reflective practice into teaching programmes, some of the issues around tacit knowledge have been ignored or played down, and, in an attempt to find a place for theory, the emphasis on it has become dominant. As the role played by reflection in assessment has become more prominent, (see below), the greater has been the temptation for teachers to treat tacit knowledge as instinct or intuition – precisely what Dewey set out to challenge. Reflective practice could have emancipated nurses but, in the event, this has rarely been the case and what has emerged is a hybrid using reflective models, guided reflection and theory-based intellectualised ‘navel gazing’.

### 2.3.3 Innovative development from Schon’s analysis

Schon’s (1983) analysis has been built on to develop practice, and discussion of such issues in the research literature has produced some interesting suggestions as to how reflection might be conceptualised differently in the future. For example, Boud (2010, pp.32-33) has developed the notion of ‘productive reflection’, which explores ways of considering reflection in workplaces (probably the majority) that are not focused on the independent individual learner. Instead, the focus is on organisational intent, involving multiple stakeholders and connecting players. With its generative rather than instrumental focus, productive reflection is ‘open, unpredictable, dynamic and changing’ (Boud, 2010, p.32).



Boud (2010, p.34) recognises that, within such trans-disciplinarity, there will be different notions of good practice and even different understandings of what constitutes evidence, with different assumptions and standards being brought to bear. Indeed, on account of differences in power positions inherent in this sort of co-production, reflection might not be feasible in some contexts, while in others considerable planning might be needed. Billet and Newton (2010) developed a new model termed 'learning practice' to consider professional learning that occurs throughout a professional's working life. It focuses on learning in practice, rather than learning which takes place separately from practice. Their concept of learning practice suggests that it is not sufficient to rely upon individual personal reflection or professional support for guidance. In this model, the two main concepts identified by Schon (1983), reflection-on-action and reflection-in-action, are harnessed to ensure individuals reflect and contemplate future possibilities. Billet and Newton (2010) claim this new model of 'learning practice' goes further than individual learning efforts to embrace ongoing professional learning.

## **2.4 Problems with applying Schon's analysis**

Two of the main problems with applying Schon's analysis are how to integrate theory and the difficulty of teaching reflection-in-action

### **2.4.1 Integrating theory into Schon's ideas**

Central to Schon's analysis is a denial that practical expertise derives from an inductive process of *analysing* and *theorising* an 'experience and practical activity' (Saltiel, 2010, p.131-132), rather than a reliance upon un-theorised, so-called common sense or intuition. The central role of tacit or embedded knowledge in so much professional practice is recognised, as is the problem that:

'...it is not consciously perceived as guiding one's actions i.e. it works below a subjective threshold' (Herbig *et al.*, 2001 p.688)

with the result that, even for the most conscientious or self-aware of practitioners:

‘...the incident-based acquisition of tacit knowledge is accompanied by a lack of reflection’ (Herbig *et al.*, 2001).

Indeed, the more experienced and successful the practitioner, the less incentive there might be even to acknowledge the need to analyse / theorise practice itself, particularly when, in a managerialist environment, there are so many seemingly more pressing demands on the practitioner's time. This means that trainee nurses could well be mentored or taught by experienced professionals who themselves cannot articulate – or even, in some cases, understand – what it was about their practice that made it successful, and hence what it was that they were trying to convey to the trainees.

#### 2.4.2 The difficulty of teaching reflection-in-action

Following on from this is the difficulty of teaching reflection-in-action which, by its nature, is located in real contexts and is not accessed outside these. In regard to the professional knowledge of the teacher, it is essential that those leading reflective practice sessions are fully aware of the different theoretical objections regarding how reflective practice is both understood and implemented. Fejes quotes one teacher supervisor commenting on her role:

‘The important thing is to be neutral in the discussions, at the same time as being active...Then it is not about my opinions and beliefs but about others' beliefs and opinions...’ (Fejes, 2011, p.805)

On the face of it, teachers should receive training in how to ‘teach’ or to ‘supervise’ reflective practice. In practice, and through no fault of their own, many adopt the commonsense, empirical approach that dominates so much of the official documentation. It is perfectly understandable that some are too overwhelmed by the demands of managerialist working contexts to want to challenge what appears *ipso facto* to be straight-forward, particularly when reflection has become so central to models of assessment on virtually all

professional courses. Many would perhaps be unable to define with any precision what is meant by the term 'reflective practice' – subscribing to the view that, whatever it is, there are only two forms, reflection-in-action and reflection-on-action.

It is hardly surprising, as Boud points out, that professional education has many examples of poor practice under the guise and rhetoric of reflection (Boud and Walker, 1998, p.192), and that the concept of 'reflective practice' has come to mean many things to many people.

## **2.5 Current approaches: some further issues**

From both a theoretical and an empirical perspective, hybrid models have developed as an attempt to tie reflection-in-action to reflection-on-action. For example, in teaching, it is sometimes assumed that, if students go into the classroom and reflect-on-action, they will be able to reflect-in-action when they are in practice and improve their ability to care for patients. That is, it is assumed that reflection-in-action can be developed by theory-based reflection-on-action, that one aids the other. However, it is unclear whether such strategies actually work and Schon (1983) seemingly denies it. This, and the fact that much professional preparation has to occur in academic rather than clinical environments, has led to reflection reverting to the process Schon (1983) most criticises – individualistic, cognitive, detached from practical settings, and guided by others who are themselves guided by theoretical accounts, assessment-led target setting and managerialism.

Schon's (1983) original work has been the subject of considerable critical scrutiny, particularly in regard to the role of theory. Does reflection-in-action rest upon more than intuition and what Schon calls 'knowing in practice' (Schon, 1983)? Some researchers have pointed to the relatively sparse nature of the empirical evidence on which claims for reflection have been based.

### 2.5.1 Reflective practice remains poorly defined

Whilst all nurses are now expected to reflect, not least because professional progression depends on being able to demonstrate that such reflection has indeed taken place, it is not clear either that patient care has improved as a consequence or that theory is being generated (Burton, 2000, p.1013). There is some danger that any teaching that includes reference to reflective practice must be 'good', irrespective of whether it is clear why students are being asked to reflect, how teaching of reflection is planned and structured, and whether any 'learning' takes place as a result (Silcock, 1994, p.283). As Cotton claims, reflective practice is often:

'...poorly defined, uncritically presented and yet is enthusiastically accepted as good for nursing and nurses' (Cotton, 2001, p.512).

Many of the difficulties around reflective practice pinpointed above centre on the lack of clarity over what it actually is. Indeed, the framing of the problem in this way begs the question of whether reflective practice is singular or whether there are not a number of different forms lumped together under one banner without any attempt to differentiate between them (Cotton, 2001, p.273). For example, for many professionals – and presumably, therefore, for many trainees – reflective practice is interchangeable with critical thinking, in that both seem to share many of the same cognitive features. In fact, in much of the literature – and presumably in much of the practice – it remains unclear whether reflection is in any way fundamentally different from merely thinking, nor is there much agreement as to whether reflection has to be critical or not. As Saltiel (2010) concludes, there is as much debate and uncertainty about the nature of *critical* reflection as there is about reflection itself.

It would seem that different meanings are given to the notion of reflective practice according to the different disciplinary and workplace traditions practitioners come from (Boud, 1998, p.192). Indeed, as practice becomes increasingly specialised, it becomes less likely that there still exists a shared ideology of caring or even commonsense understandings of what constitutes

'good' nursing practice, and, even within specific professional traditions, different and even conflicting understandings can prevail side by side.

This very conceptual messiness has allowed reflective practice to be all things to all people, which may explain how it has gained such a hegemonic presence in nurse education (Cotton, 2001, p.513). For example, it is even suggested that the focus of reflective practice is not so much cognitive knowledge about practice as spiritual knowledge about self – a difference of understanding that, if adopted, would have serious implications for reflective practice in the classroom (Rolfe and Gardner, 2006, p.594).

### 2.5.2 The individualistic orientation of reflective accounts

One important question that has often been at the centre of current debate is how an essentially individualistic model such as reflective practice can be accommodated within the realities of the workplace. Schon (1983) stresses the importance of context, which individualist orientations play down, but the discourse around reflective practice is heavily weighted towards notions of the 'individual', and the individual's thoughts and actions.

Kilminster *et al.* (2010) argue that the focus on the individual fails to consider the situated understanding of practice and shows insufficient recognition of the context of nursing practice. There are, as argued earlier, power dynamics between doctors and nurses alongside ideological challenges presented to professional practitioners when resources are being reduced and quality of care undermined. Current thinking and practice around reflection generally pay insufficient attention to the power dynamics within the workplace.

Arguably, more attention has to be given to differing practices and cultures as well as to the changing nature of professional work itself. The individualistic approach needs juxtaposing with a world of work characterised by team-working and cross-professional collaboration, and reflection that ignores or minimises the importance of the context of the workplace – and this context could be a local or global one – grossly overstates the power of the individual to control their own world. As Boud argues:

‘...context is perhaps the single most important influence on reflection and learning, concluding that the main problems of reflection result from context rather than being problems of reflection *per se*’ (Boud, 1998, p.196).

Developing this position, he stresses the problematic nature of context, pointing to its constructivist and subjective nature and contending that it has a greater impact on how practitioners develop than anything that is peculiar to them as individuals. If this is indeed the case, then perhaps the chronology of reflection could be modified, with teacher and student reflecting in advance of the learning event and not merely during (reflection-in- practice) or after it (reflection-on-practice).

### 2.5.3 The realities of reflective practice in the classroom

If it can be sustained that reflective practice does not ‘tell it as it actually was’, but in fact needs to be interpreted through some sort of discourse analysis, then this raises some interesting challenges for both the teacher and the student. On purely pragmatic grounds, reflection can – indeed, should – challenge the traditionally didactic role of the teacher as the expert whose opinion and judgement should, in the last resort, prevail. It may be the case, as Johns argues, that:

‘...reflection always needs to be guided because it is profoundly difficult to see beyond self, to see how their own self-distortions and limited horizons and those forces embedded within practice... have limited their ability to know and achieve desirable work’ (Johns, 1997, p.198 cited in Cotton, 2001, p.516)

but the danger here is that this decisively augments the power of the teacher in a situation where power relationships already are heavily weighted against the student, without the teacher even being aware that such inequalities exist. This has serious implications for what the student is prepared to discuss or ‘confess’, and on how the teacher (or ‘confessor’) hears – and interprets – what is being said, or what is allowed to be said. As Cotton contends:

‘...because of the power differentials between reflective practitioner and guide, the guide’s view of reflection and nursing may be decisive in what will be evaluated as

valuable nursing practice and reflection, subjugating other views, including those of the practitioner' (Cotton, 2001, p.516).

Again, this is not to criticise reflection as a learning or teaching tool *per se* but instead to stress how important it is that teachers are fully aware of such potential pitfalls and are prepared to modify their approach accordingly.

It is probably true, as Carroll *et al.* (2001) argue, that the potential of reflection cannot be fully realised unless it is identified as a process that requires professional support both clinically and academically, as it is not an easy task for a student to do alone. It is important to recognise that reflection *can* help to develop inner personal learning and self-awareness of the student's own values or beliefs, moral views, and influences from their own cultural backgrounds, provided that they receive the appropriate mentor support.

One of the criticisms levelled at the different notions of reflective practice concerns the validity of so-called 'true accounts' that are produced in reflection, and which, it is suggested, do not take into account sufficiently the constructed and subjective nature of narratives. According to Mattingley (1998), reflective accounts of practice are generally taken as giving unmediated access to the objective world of the practitioner; they are treated as merely 'after-the-fact' accounts of experience that make practice accessible to the reader / listener (Mattingley, 1998), without any critical consideration of the truth claim embodied in the account. In this sense, reflective accounts tell us:

'... as much about how professionals construct their identities and the contexts within which this happens, as what is 'really happening' (Saltiel, 2010, p.135).

To see such accounts as reflecting 'what really happened' over-emphasises the space available for free choice and agency, as well as assuming that any such reality is ever accessible.

If reflective practice presents severe challenges to teachers, the same can be said of its impact on students. On one level, it could be argued that students

are presented with the situation where the philosophical underpinnings of reflection are in conflict with the increasingly market-oriented approaches that are prominent in most other aspects of their training. In other words, if reflection is to be a student-centred, bottom-up process, it conflicts with the managerialist ethos of the programme generally, with the result that reflection itself becomes a top-down process, with emphasis on assessment, generic skills and tick boxes.

At the same time, given the focus of reflective practice on the role of the individual as well as the in-built assumptions concerning the power of the individual to make decisive change for the good if s/he were so determined, there is a danger of overstressing the negative side of reflection, encouraging practitioners to see themselves as 'not good enough' (Hargreaves, 1997, p.6-7). Ixer (1999) has argued that the potential of reflection to generate learning from practice in nursing is limited as it relies too much on such negativity, with the focus on self-criticism (what a nurse did not do well) rather than on self-praise (what a nurse did well). Again, this is far from inevitable and, in the hands of a skilled teacher, can be avoided. But the potential for playing down the achievements of a student, and to stress only what 'improvements' are required, is a very present one.

#### 2.5.4 The impact of reflective practice on assessment

If reflection does become part of a managerialist approach, then this is implemented most effectively by means of the assessment strategies that students are subjected to, and ultimately controlled by. As chapter 1 indicates, the nursing curriculum has become increasingly dominated by managerialist concerns, and nowhere is this more glaring than in the way in which radical thinking behind reflective practice has been supplanted by the need to make it fit into a top-down, measurable part of an accountability system, dominated by pre-determined learning outcomes, to the point where it can often assume a formulaic and constraining structure that encourages only conformity and even cynicism on the part of the practitioner rather than the autonomy and originality that is claimed for it.



The prioritisation of assessment presents genuine dilemmas for those teaching – and learning – reflective practice. On one hand, what exactly is being assessed – the skills of reflection or standard academic writing conventions? If it is the former (as all courses would presumably claim), what precisely are these skills and how can they actually be assessed? On the other hand, if reflection is not assessed, will practitioners take it seriously, by making time and resources available for it in the case of management, or bothering to do any more than go through the motions when completing assignments or participating in classroom discussion on the part of students? Students are highly unlikely to reflect openly on situations where their practice may well have been below the standards established by the profession (in other words, regarding those situations where it is most necessary for them to reflect) if such accounts are to place them in a situation where they might be failed. Instead, they are far more likely to ‘write what the examiners want’. This applies particularly to reflective journals, in situations where such writings are seen and used for assessment purposes by an authority figure. Hargreaves has pointed out that in such cases:

‘...reflections which were intended to be confidential and personal may take on the nature of ‘evidence’ (Hargreaves, 1997, p.225).

Students will be quick to sense what the ‘answer’ should be and write to this end, irrespective of whether the content of their accounts mirrors the realities they have experienced during their practice. As Cotton sums up:

‘...the literature on reflection shows that not all interpretations and interpreters are viewed as having the same legitimacy or importance, with meanings appearing to be largely legitimated by institutional truth rather than aesthetic truth and constituted by normative judgements rather than dynamic fusion of horizons or true consensus, (Cotton, 2001, p.516)

or, to put it more succinctly:

‘...any attempt to predetermine the mode of reflection risks subverting the very act we wish to promote’ (Silcock, 1994, p.281).

As part of their practice assessment within higher education, student nurses are expected to make academic commentary on events in practice using a cognitive model of reflection which often omits space for the expression of genuine emotions. What is expected is a cogent account of what may be learned from the experience in the cosy and comforting language of nursing discourse. Indeed, reflective frameworks can actually restrict the deeper exploration of practice and suppress creativity and thinking (Nicholl and Higgins, 2004), especially if the nurse is a novice, or is faced with incidents which exceed the scope of the questions posed within the framework (Hilliard, 2006).

## **2.6 Reflective practice within my own practice**

The personal and professional concerns concerning the use of reflective practice present me with a dilemma when I am required to include reflection as a method of assessing students' clinical practice learning. For educational purposes, students are expected to learn from such assignments to help them in the future (Boud, 2010). Such an approach advocates the use of some sort of guide to reflection, which is given as a list of stages a nurse has to go through in an assignment to ensure this happens. There are a number of cognitive models of reflection available, for example, Gibb's (1985) reflective cycle and Johns' (1995) structured process of reflection. These guides do not, however, accurately verbalise or articulate the complex activity of learning from practice. In my own experience, this use of reflection for assessment serves to erode students' willingness to express their true feelings.

The reflective assignment has to be written using the vehicles of expression which the student has played no part in choosing (Saltiel, 2010), for example, the language of academia required to fit the reflective account into a model using a set number of cue questions (Box 2.1). This use of cue questions for reflection undervalues nursing care, as the reflections themselves become procedural, as if the student is compliantly following a recipe. As each cue question has been dealt with, the student moves onto the next, rather than questioning and challenging the experiences they are describing. Learning

through reflection can be a laborious and formulaic process (Palmer *et al.*, 1994) and can become just another tool of technical rationality (Rolfe, 2001; Rolfe and Gardener, 2006).

#### **Box 2.1 – Example of a practice assignment using reflective cue questions**

***Write a reflective account of your experience of carrying out an aspect of a health, social and/or risk assessment for a service-user with whom you have had involvement.***

You are advised to discuss your proposal for the reflective account with your mentor before embarking on the written account. This piece of work should be **1000 words**, and be referenced appropriately in accordance with Faculty guidelines. This is a Level 2 piece of work. As a guide, the descriptive element should be limited to 15% of the overall word limit. As this is a reflective piece of work you are required to write your account in the first person (use of 'I').

You need to consider the following in order to identify significant issues within the situation/event/patient scenario you have identified and been involved in. The following cue questions are provided to assist you to write your reflective account.

**Please ensure that you address all of the cue-questions. These are provided to assist you to write your account.**

In negotiation with your practice mentor (and with agreement from the client), identify a service-user (from your placement) that you will carry out an assessment on. It is advisable to identify an aspect or specific area of need to assess. For example, you may choose to carry out an assessment of the patient's willingness to take medication or an assessment related to the moving and handling of a client.

1. You will need to carry out the chosen assessment using either a local assessment tool or a standardised assessment tool sourced from a reliable academic source.
2. What barriers and challenges did you face in carrying out the assessment? Particular emphasis should be paid to noted limitations with the assessment tool and issues relating to engaging the service-user with the assessment process.
3. What were the findings from the assessment process? What are the likely nursing responses to highlighted need?
4. How did you feel you performed within the assessment?
5. What have you learnt from this experience? Consider your new understanding of undertaking a risk assessment.
6. What are the broader issues arising from this?

Through reflective diaries, students are expected to become aware of their learning and how it is occurring, although Nairn (2004) suggests that these tend to be merely accounts of medical knowledge and are largely descriptive. In addition, it is the responsibility of students to keep their own journal, and tension often arises over whether teachers should have access to journal entries or only be allowed to read them with student consent. Again, the ethics of this practice are rarely considered or discussed.

Whilst reflection can be used to relate theory to practice and practice to theory, much student reflection remains superficial (Field, 2004). I can see this in my own practice as a teacher:

My story 7

Students are shown how to do a blood pressure and they perform this skill with various degrees of dexterity and coordination. However, when asked to explain the theoretical underpinning of blood pressure or its relationship to other clinical measures e.g. heart rate, temperature and respiratory rate they are unable to do so.

Students understand how to do a blood pressure on a superficial rather than applied level, but it is the more connected, conceptual level of knowledge which makes a difference, as it allows the student to respond to the patient's change in condition and the thought processes that go with it. This will lead to a nurse taking responsibility for his/her actions in situations where a patient deteriorates and interventions are required. However, students who reflect-in-action might solve the immediate problem but too often fail to draw significant meaning in any depth or detail from it.

*In summary, despite some reservations regarding the practice of reflection, it remains the case that, at least in principle, reflective practice has the potential to raise the professional status and morale of practitioners. It can also give insight into what a professional's tacit knowledge consists of and how it might be articulated and effectively passed on from teacher to student. For example, Silcock (1994) has argued that the adoption of reflective practice as a dominant model of teaching can result in:*

*'...the elevation of teachers as persons capable of ultimately managing and directing events through knowledge and expertise (Silcock, 1994, p.283).*

*However, and assuming that the teacher has a choice, the issue is about which model of reflective practice most effectively works with students, and what 'work' means in this context? It goes without saying that reflective students are better than unreflective ones, but being reflective does not make a student necessarily a more effective nurse.*

*The reason we have difficulties with reflective practice is that nurse professionalism has to combine reflection-on-action (theory-based) with reflection-in-action (practice-based), and this is challenging. On the surface it appears straightforward, but making this link raises all the difficulties that I have identified in this chapter, particularly as all reflective practice approaches have to meet institutional demands, whilst at the same time satisfying the needs of the individual student.*

*All reflective practice is rooted in the tacit knowledge that practitioners develop almost without being conscious of doing so, but how is that knowledge to be articulated and organised, and given a 'frame', without some association with theory? The kind of reflection that will be adopted will depend on factors specific to an institution or workplace. The problem for nursing is that Schon's analysis has not been fully assimilated for the reasons stated in this chapter, and the 'top-down', theoretically-oriented model has come to predominate. What we can usefully take forward is the need to take seriously Schon's work and look for ways for developing, accessing, and understanding the world of practice he writes about, exploiting more extensively practice itself as a teaching resource. The next chapter will examine the peculiar claims of story to resolve some of these dilemmas.*

## **Chapter 3**

### **Learning and story**

*As I have demonstrated in the previous two chapters, there are two major approaches to nurse education. One is a top-down, theory-driven managerialist approach, utilising reflection-on-action from a theoretical perspective with extrinsically-set assessment criteria dominating. The other is a bottom-up approach focussed on practice itself as a resource for learning, recommending reflection-in-action that is difficult to assess and teach. To be effective, professional practice must unite the two in some way. Where professional education courses attempt to do so, the insights of theorists such as Schon are often lost simply because it is easier to assess theoretical understanding and technical skills than 'practical wisdom'.*

*With this in mind, I want to move outside reflective practice as the main pedagogic strategy, and explore ways that practice itself can aid professional learning. Nurse education draws on practice, but generally, when using reflective practice, applies some sort of method or guide to direct student learning. This approach fails to recognise that much learning arises from individual students' own practices.*

*This chapter explores the value of using story in nurse education as a way of facilitating learning from practice. In my experience of nursing and as a nurse educator, stories are widely employed for a range of purposes, and I examine the literature on story in nurse education. I argue that restricting stories to curriculum content does not realise their full potential, and instead demonstrate the value of story within the dominant paradigms of learning and development, taken largely from developmental psychology and cultural psychology. Finally, the research questions for this study are stated.*

### **3.1 The nature of story**

Stories often affect us directly as human beings and exploit our humanness. They have to be put together or constructed, and often this very process reflects the need of individuals to express an experience in a way which makes sense to them, particularly if the experience has a strong emotional resonance, with an individual being changed or seriously affected by the emotionally charged circumstances of the story. When stories grow and take shape, they can bring important experiences alive.

#### **3.1.1 The characteristics and qualities of story**

Different types of story can be attributed to different genres, each with their own frameworks and approaches, which are used to structure events and experiences so that they are meaningful and easily communicated (Elliott, 2006). Riessman (1991) helpfully suggests that the concept of genre can be applied to film, where, for example, there are horror, war, action or science fiction films, with their own heroes and villains. This typology can be applied to stories in nursing whereby the hero is the student and the villain the teacher, manager, mentor or doctor. Often nurses' stories are horror stories in themselves, with 'war' being depicted in the power struggles between health care professionals. Action stories emerge as the student experiences emergency care, and the use of invasive technology in patient care can be seen as science fiction.

Classifications of story can be applied to literature (Riessman, 1991) and can also be used when describing nursing stories. For example, the passion nurses have for their role can be seen as romance; stories from nursing practice can be funny, and thus be viewed as comedy; stories can be likened to a tragedy seen in the suffering and pain, and maybe death, of a patient; the story might even be a detective story whereby a patient's condition is unknown and has to be investigated. This way of looking at stories, using the concepts

of type and genre, is helpful in identifying what participants encounter in clinical practice.

For Bruner (2002), a story has to have a plot, characters, allies, connections, moods, obstacles and consistency, and tell about the past. Elliott (2006) suggests that a story has to have a plot, generally with a beginning, middle and an end. Leiblich *et al.* (1998) describe the plots of stories as developing gradually over a period of time, as does Elliott (2006), who uses the terms regressive, stable or progressive. If regressive, the story refers to some deterioration or decline and is seen as negative in tone. A progressive story gives an account of advancement, achievement or success, and is deemed to be positive. A stable story is one which demonstrates no evidence of decline or progression. Using this framework, stories can be conceptualised as a series of chapters, characterised by the direction of a plot.

Fairbairn and Carson (2002) propose that a story does not have to conform to a pre-ordained structure. For example, a story can chronicle events and may even have coherence but may not be a story if its lack of structure, plot, and style of presentation or content are the main focus. What may be described by others as just an account of event(s) can still, according to Fairbairn and Carson (2002), be called a story by the story-teller or writer. In other words, what matters is if the story has purpose, meaning and value for the person who wrote it. In this study I adopt this latter interpretation. The two most general features of story accepted here are, first, that story encapsulates something important in an individual's experiences and, second, that it connects us to our sense of being human – often by way of our emotions.

### 3.1.2 The humanness of stories

Stories are a way by which humans make sense of their experiences (Squire, 2009) as well as enabling us to connect with ourselves as human beings. Bruner (1990) suggests that humans have an inborn tendency to tell and understand stories. Denzin (1989) asserts that humans are social beings and



stories constitute and maintain sociality, in that they involve tellers and listeners. Unfortunately, such approaches addressing the relationship between humanness and story have had a limited impact in the development of nurse education.

Van Der Post (1972, p.1) argues that 'if you lose your stories you die' and implies that, without our stories, we are not human. Stories impact on students in ways respecting what it really means to be human – possibly essential to the person-centred roles of teaching and nursing. Therefore, story is important in representing nursing as a characteristically human, and humane, activity.

### 3.1.3 The emotional aspect of stories

Christiansen and Jensen (2008) draw attention to the impact of the emotional aspect of stories, and argue that emotional learning from stories is powerful, and can give rise to learning that is both transferable and reflective. This point has a particular resonance for writers such as Boud *et al.* (1993) who are concerned about the omission of feelings and emotions in higher education contexts where teaching and learning strategies tend to focus solely on intellectual development. As Moon puts it:

'.....story can capture the holistic and lived experience of the subject being taught, it can tap into imagination, emotions and form new and meaningful connections between existing areas of knowledge' (Moon, 2008, p.232)

From this perspective, stories can be a means to explore difficult emotional experiences through an examination of the physicality of injury (Nairn, 2004), although such stories need not be dramatic or tragic (Cramer, 1997). Even stories that do not represent an aspect of nursing especially well may still be compelling when used in the classroom to illustrate aspects of care. As professionals, nurses are expected to display emotions such as concern, empathy and even anger, so long as these are controlled expressions. Uncovering these feelings is difficult but, by allowing students to explore their own stories, some aspects can be opened up. Stories can provide a space for

the expression of genuine frustration in a way that the language of academic discourse prohibits.

Students' stories also provide insight into what nurses are thinking and feeling about the practice situations in which they engage day-to-day. Yet this use of stories can still be at odds with the current nurse education curriculum and the professionalisation project of nursing, its current health care environment and evidence-based practice. Yanay and Shahar (1998) point out that nurse education is required to allocate time to assist students to recognise and cope with their emotions, and with constraints on their 'appropriate' use. But, too often, emotional learning is ignored or under-stressed, with seemingly more important issues, such as meeting learning outcomes and coping with modular content, taking precedence.

### **3.2 The current use of stories in nurse education**

Story has long been used both in nurse education and the education of other professionals. This is partly because stories are easy to learn and store in the memory through a holistic or picture vocabulary, and, as Moon (2004) suggests, they can be a vehicle to facilitate learning rather than merely impart knowledge. Most prominently in nurse education, stories are employed to meet a set learning outcome or as a way of exploring curriculum content such as ethics, culture, or communication (Orland-Barak and Wilhelem, 2005) or exemplifying a link between theory and practice. For these purposes, the stories of teachers, other nurses and patients, as well as students' own stories, may be of value.

#### **3.2.1 To meet a particular learning outcome**

One learning outcome often met using story is the understanding and application of ethics, where stories can crystallise issues concerning ethical dilemmas. Davidhizar (2003) believes that the learning of ethics is enhanced if students can relate their own experiences, values and morals to a particular

scenario. With today's advanced technology, more complicated ethical topics, such as organ transplantation, euthanasia and 'do not resuscitate' orders, are part of daily nursing care. Davidhizar (2003) further suggests that story can be used beneficially to improve students' knowledge of diverse cultures, helping them to become culturally sensitive and raising their awareness of cultural characteristics and stereotypes.

### 3.2.2 To deliver specific subject content of a curriculum

Educators can use stories to target learning related to many areas of content, including research into health problems and chronic illness (Bury, 2001), emergency care (Nairn, 2004), intensive care and palliative care. Stories can facilitate the understanding of key concepts, such as empathy (DesGupta, 2004) and suffering (Schmidt Bunkers, 2001). Robinson Wolf (1997) use story to illustrate the relevance of skills such as bathing a patient for the first time, and Midgley (2006) demonstrates that stories can be used to improve nursing practice. By contrast, theories of learning are usually discussed outside of any context (Field, 2004) rather than being targeted at particular needs and experiences.

As well as exemplifying curriculum content, story is commonly used as a method of communication between nurses, providing critical information on diagnosis, treatment and prognosis of a patient's condition. Orland-Barak and Wilhelem (2005) used students' written stories of clinical practice to illustrate frequent references to procedural and medical learning.

In much of the literature, stories are used to support curriculum learning outcomes and content rather than because they arise directly out of students' learning. When story is used in this way, it easily gives rise to a learning environment that is controlled and planned by the teacher, and which ignores the possibility of generating learning environments suited to the individual student's needs and experiences.

To explain why this is important, four types of stories arising directly from clinical experience are discussed. These are: stories told by teachers, those told by other nurses, those told by patients and those of the individual students themselves.

### 3.2.3 Stories used to meet learning outcomes and teach curricula content

First, the stories of teachers may be used to meet a specific learning outcome, illustrating an area of curriculum content based in lived, clinical experience. I began using stories in the classroom after writing my own personal narrative (see chapter 4), my own story of how I came to research and writing through dissatisfaction with my professional context (as discussed in chapter 1). My personal narrative (written in the early stages of my doctoral work) included my stories of clinical practice and I drew on these as a teaching tool. I told stories of my experiences of clinical practice through which I learned to become a nurse (see chapter 4), which were subsequently shared in the classroom.

Having recognised the value of my own stories, I sought out other nurses' stories of clinical practice, intending, if appropriate, to use these stories in my teaching. One such story, told at a conference by a nursing sister who had been on duty in A&E the day of the London bombings in 2007, stands out above all others:

#### Nurse's story 1

I worked on duty, it was quite early on, but that changed the moment the call came to inform the department a number of bombs had gone off on the London underground. The accident and emergency (A&E) department put in place the emergency management protocol and people were transferred to other areas as soon as possible. Many injured arrived, some dead, others suffering severe blast injuries. One particular woman, whose identity was not known, apart from sustaining multiple blast wounds had lost both feet, one just above the ankle and the other half way up her calf. She was triaged and sent to intensive care, still with no name or relative knowing where she was or if she was still alive. On the following morning when I arrived on duty everything had seemed calmer somehow. I noticed as I walked into the reception area two middle aged women looking for their sister. I spoke to them and they showed me a picture of their sister. Of course I did not recognise her as the woman from last

night, but I had my suspicions so I asked them if their sister had any distinguishing features. They both looked at each other and replied; 'Yes she had very distinctive ankles.'

This story details horrific injuries, with such descriptions being common in the broader literature (Tangherlini, 1998), and has real value in illustrating realistically (rather than in some contrived way) those areas of curricular content dealing with such situations.

The purpose of the next type of story, that of patients' own stories conveyed to health care professionals, is threefold. First, a nurse can help the patient to tell their illness story in an environment in which they feel free to do so. Through this process, nurses re-construct a story of patients' past lives that may help determine current treatments and nurse interventions. Such stories help students gain important information for the structuring of a plan of care. Second, an important aspect of using patients' own stories is that stories require a special way of listening. Coles (1989) describes how patients bring their stories to health care professionals to listen to, and Sorrell (2000) suggests that listening to stories helps students understand the illness as experienced through the patients' own eyes. Listening is an important, if undervalued, skill for students, and story can help develop this. Third, students can explore with patients what it is like to live with a particular disease, helping them to picture a patient's situation from a human rather than a clinical perspective. Patients can tell their stories in a way that helps nurses understand their lived experiences.

Two short excerpts from my own stories of clinical practice are significant here, whereby a relative, whose husband of over 60 years had died, informed me what this felt like:

'It is like a physical amputation; like I have just had my right arm cut off, and I would give it willingly if it would bring him back to me'.

In another instance, a patient told me what it was like to have chronic obstructive pulmonary disease (COPD):

'It is like being suffocated over a period of 30 years'.

These excerpts helped me to develop empathy, and I was sensitised to what it was like for someone to suffer the loss of their lifelong partner, or to have been plagued by a chronic illness over so many years. Sharing the personal experiences of patients and relatives helps nurses to negotiate their way through a mixture of emotional, moral and practical issues as well as helping them make better sense of the cultural context within which nursing takes place.

Articles making use of patients' stories include memories of treatment of breast cancer (Thomas-MacLean, 2004) and lung cancer care (Bell, 2003), experiences of cancer patients (Fincham *et al.*, 2005), palliative care (Shuster, 2001), patient's experiences of having a chronic wound (Beitz, 2005), the lived experiences of prolonged mechanical ventilation (Arsianian-Engoren and Scott, 2003), experiences of older people (Kirkpatrick and Brown, 2004) and of psychiatric hospital admission (Gilbert *et al.*, 2008). Such stories give nurses an insight into the experiences of patients and relatives, and much can be learned by engaging with them.

Finally, students' own stories can be used to meet learning outcomes and curricula content. Strategies for using such stories include writing stories in a diary or journal. Nairn (2004) advocates the use of diary stories, but these often tend to be narrative descriptions of medical knowledge and are largely academic in style, and it is difficult to see what students are learning from these sorts of exercises. They may also be framed within abstract nursing theories, such as reflection, when this is seen as an imposed theory-led process. Also, it is the responsibility of students to keep their own journal, and tension arises over whether teachers should have access to journal entries or only be allowed to read them if the student gives consent.

In my faculty, students do not have to submit their diaries, but can choose to quote or append excerpts when writing assignments. They write an assignment on the learning from their diary. When reading such excerpts, students can become aware of how learning is being facilitated through writing and responding to their own stories of clinical practice. The incorporation of story-telling activities in the classroom, whereby students can demonstrate listening and hearing skills, and find meaning through reflection and critical thinking, as well as sharing ideas, thereby ensuring their views are valued, can also facilitate learning. McDrury and Alterio (2002) detail exercises helping students begin to 'find' their stories, prompted by a trigger, such as a picture from the Internet of patients with cancer or a wound.

Encouraging students to read, and then discuss their stories with peers in the classroom, is a valuable teaching method. Sorrell (2000) asked students to write two stories during a semester, having given them specific guidelines for writing an effective story. These students observed that the most effective stories were often the 'never again' stories – ones that stand out in a person's mind because they illustrate an experience that is extremely important to that individual, demonstrating the value of story in emotional development (McDrury and Alterio, 2002), something which is explored in this work.

Story-telling in groups is another way to incorporate students' own stories (Sorrell, 2000), a method I have used in my own teaching sessions:

#### My story 8

I asked one group of students to write down a story on the topic of moving and handling and, once the story was written down, to work in groups of two or three and tell each other the story. Following this, students were asked to share some of the issues raised by their stories and brief notes were documented on a flip chart by me. The students were then asked to write in their groups on a separate flip chart some themes that arose from the notes displayed.

As would be expected, issues that were displayed on the individual group flip charts highlighted the emerging complexity of moving and handling practice. More significantly, the students found the actual process therapeutic, as when they heard

other students' stories of moving and handling, it gave them reassurance and a feeling they were not alone; other students were going through similar emotions and frustrations at some of the poor practice observed in this area.

Without prompting, students attempt through their stories to find solutions to the complexities of moving and handling practice. Relevant here is the influence of the teacher, for I did not just ask the students to write a story and let them 'get on with it', but instead had a central role in creating an environment in which the students felt safe to tell their stories in an atmosphere where they could give depth and emotion to their stories. (This notion of a democratic but unequal relationship or 'partnership' between student and teacher is discussed more fully below).

Students' own stories are repeatedly being used as data in educational research, such as in Bowman's (1995) work where students tell their own stories in order to better understand influences on their decision-making and patient outcomes. Bailey *et al.* (2004) look at nurses' stories of caring for individuals suffering from shortness of breath. Using stories involving ethics, which present particularly sensitive issues, Pagono (1991) provides a safe context in which nurses (novice and experienced) can tell the stories of ethical dilemmas they face in practice. Masson (2005) uses nurses' stories to illuminate ethical situations commonly occurring within clinical practice. Stories can be used in this way to draw the students into meaningful dialogue about ethical decision-making. They can analyse dilemmas and discuss issues, which may lead them to ask further questions about policies, practices and standards of ethical behaviour.

Sorrell (2000) stresses the importance of setting time aside for students to read their stories aloud in class. However, within the current curriculum, time is precluded for such engagement with students' own stories, due to the demands of academic assignments and specified practice competencies. As a result, stories of practice can be gradually forgotten or overlooked. If we are to improve learning from practice in nurse education, we need to focus on



individual student learning first, and then seek a collective direction towards which nurse education can work.

### 3.2.4 Reflective practice using story

As discussed earlier, reflection has frequently been employed to promote professional learning and the processes of reflection can be applied to story, as seen in the work of McDrury and Alterio (2002), who explain how reflective activities together with story can contribute to professional learning. Certainly, there is a relationship to be drawn between reflection and story in that a story can be an aid to, or focus for, reflective thinking. As Moon (2004) puts it:

‘.....story is a valuable tool for the enhancement of reflective learning’

However, used in this way, story can become no more than an aid to reflective exercises (e.g. reflection-on-action) rather than a medium for students’ own experiences and emotions. The danger is that what has happened to reflective practice could easily happen to story, in that it might become used primarily for assessment purposes and forced into the same straitjacket.

Students have often described to me events they have experienced in accident and emergency (A & E):

#### Student story 1

I was caring for two patients as part of my management 3<sup>rd</sup> year module. The first patient was a man in his 50s who had presented in A&E with rib pain. This condition could have been for a number of reasons e.g. pneumothorax, MI, pleurisy, cancer or chest infection. The second patient presented in A&E with an asthma attack, difficulty in breathing, anxious, which was exacerbating the situation. The patient needed oxygen and a nebuliser prescribed ASAP to help with her breathing. So, I had to decide which patient to care for first, but both were potentially life threatening.

#### Student story 2

I was caring for a young patient in A&E, I knew something was wrong, but I could not put it into words eloquently. The patient’s blood pressure was high and their heart rate felt a little, peculiar and not normal. The patient had cardiomyopathy. I knew this, but

did not know what it was. I went to inform the staff nurse of my concerns and suspicions about the patient, and I was told that he would be there in a minute. I remained concerned, and the patient's sister who stated she had never seen him this bad before supported this. With this in mind I undertook a 12 lead ECG. I took the ECG straight to the doctor, as the charge nurse had not taken me seriously. The doctor immediately saw this patient was in atrial fibrillation and the patient was transferred immediately into the resuscitation room.

After telling these stories, students often ask how they can write them up for their reflection assignment. I suggest they write their stories down in their practice diary, and just tell the story as they told it to me, without any professional or academic commentary about how they could manage these situations differently in the future. This is not to deny the value of story as illustrating key practices but to insist that its value is not merely illustrative. The emotional side of nursing practice is important in itself (Lalor *et al.*, 2006) and this is not always revealed in forms of reflective exercises or activity.

Thinking emotionally in current nurse curricula is easily by-passed during the high pressure life of clinical practice, and its key role in nursing needs to be exposed. Nairn (2004) points out that the constant use of reflection-on-action as the only way to learn from practice situations ignores other language-based ways of learning, including story-telling. I feel the writing down of the story has as much legitimacy for practice-based learning as using a story specifically designed to illustrate some set objective or aspect of curricular content.

In short, it is not being suggested that story be a replacement for the reflective practice used in nurse education but instead should be viewed as an aid to such practice. Saltiel (2010) argues that a story can be just as artfully constructed as any other use of language, and story can certainly be used more artfully than is currently the case. The following example (my story 9) is meant to illustrate how a story can be used to make the reflective learning process more meaningful:

### My story 9

I was working on ITU with a staff nurse who was caring for a patient. I was going through the renal system with her as she was undertaking a post graduate intensive care nursing course and wanted a better understanding of this body system. The patient deteriorated and became disorientated, confused and her blood pressure dropped to lower than her normal reading. Immediately the nurse acted, intervened by giving the patient a fluid challenge to increase the patient's blood pressure and increased the inotropic support. This worked, and the patient came round, but more fluids were needed to replace circulating volume to maintain stability. I wanted to use the situation and link it to the renal system integrating theory into the nurse's practice. I said to the nurse that what had occurred in front of my eyes was amazing and showed expert clinical practice at work. I asked her 'How did you do it?' The nurse could not answer me, 'I do not know, I will reflect on it later', was her answer.

As this story demonstrates, the nurse wanted to engage reflectively with the situation but at the time was unable to do so. She had difficulty explaining to others the learning gained through her on-the-spot reflection. If she had recounted the above instance as a story, it would have aided reflection and enabled her to share her expert practice. Story can facilitate the sharing of professional practice in a way that reflection alone cannot. Bowman (1995) concludes that story can give students an opportunity to create lively discussion to develop others' understanding of professional practice in a supportive environment.

Chan (2005) proposes that, instead of turning to this kind of reflection, we should begin by sharing stories, as a basis for understanding caring in nursing. This is to acknowledge that, in telling stories, students are interpreting, and reinterpreting, what they have experienced, just as those listening are interpreting and reinterpreting what they are hearing through the prism of their own experience. This is what Moon (2008) means when she talks about 'known' stories, where stories are told informally or formally among people who share experiences in a profession or workplace.

The inclusion of story recognises the value of having an 'open' view of learning, resembling the productive reflection described by Boud *et al.* (2006)

and the ideas of Billet and Newton (2010), who embrace a more ongoing form of learning throughout a professional's working life. The latter stress the significance of individuals' unique experiences as learning resources and the importance of their interactions with other experienced practitioners.

Generally speaking, although stories have been employed as learning tools in nurse education, I would argue that using them as merely an aid to *overt* reflection fails to exploit their full potential. While stories mostly focus on exemplifying the curriculum content and ignore story ownership (i.e. the question of who is telling the story is treated as irrelevant), their use as a teaching tool may not achieve much beyond surface learning. To explain better what this means, consider my story 10:

#### My story 10

In the curriculum students have to learn how to perform a blood pressure, and stories from students' own practice can be used to emphasise the issues with regard to its meaning, accuracy and significance for the patient's health. This superficial learning is valuable but it concentrates only on the blood pressure itself rather than a more insightful understanding of it in relation to other measures such as heart rate, respiratory rate, temperature and urine output, which when added to blood pressure, a greater understanding of a patient's condition is gleaned.

As revealed here, students are shown the skill of measuring blood pressure but do not connect it to other haemodynamic measures, failing thereby to gain a more applied or fuller understanding. Insofar as learning which transcends a surface level is that which connects relevant experiences and understandings meaningfully, this may be achieved through pedagogy aided by story.

#### My story 11

I was in the skills laboratories and the students were undertaking the skill of pain assessment, a complex interaction between the patient and the nurse. The students understood the pain scale from 1-10, 1 being the least pain and 10 being the most severe. They recognised the different types of analgesia available for the relief of mild, moderate and severe pain, identified by the pain ladder. However, what some students could not grasp was how the different causes of pain link to the administration of analgesic drugs, as some analgesic drugs have been developed for

special types of pain e.g. non steroidal anti-inflammatory (NSAIDS) for inflammation. Therefore, even if the patient said their pain was severe e.g. a 10 score, but the cause was due to inflammation e.g. a fracture (broken bone), an NSAID drug, according to the pain ladder, for moderate pain, may be more appropriate as it is specific to the cause of the pain.

Again, in my story 11, students appear to have some learning and insight into pain, but do not properly understand it, in the sense that they do not appear to integrate the new learning with other learning by building on what they already know about pain. Often what occurs in skills work is that students learn the words and actions of a skill superficially without integrating it with their existing knowledge. As a nurse educator, I have seen the value of using student-generated stories in the classroom and their potential for mediating the connected, meaningful learning desired.

This conclusion is important, and because it implies some theoretical issues regarding the possible differences between surface and more meaningful learning, these issues are explored next by examining standard development theories of learning.

### **3.3 Standard developmental theories of learning**

Some insight into the role stories might play as aids for learning can be derived from examining briefly the two dominant traditions currently explaining human learning and development, the socio-cultural theory based on the writings primarily of Vygotsky (1978) and Bruner (1986), and the cognitive development tradition rooted in the writings of Piaget (1962). These are discussed briefly in the following sections, with special emphasis on the two complementary perspectives they bring to learning, suggesting two complementary roles for story.

Although these developmental traditions are often set against each other, Silcock and Brundrett (2002) have rejected '...the poverty of an analysis which asserts the need for an 'either-or' position on the Piaget-Vygotsky debate'.

What is stressed are the senses in which the two theories together give a fuller account of the complexity of human learning than they do separately (Daniels, 2001). Despite differences, both theories see learning as a form of 'construction' in that the learner is involved in a process of invention or interpretation to give meaning to experiences. This is a process that nurses go through when recounting their stories, in that they are 'constructing' or 'socially constructing' experiences in a narrative form that makes such experiences accessible to them. Without this process, the learning that students have gained may well remain beyond reach or realisation, and the mediating role that story plays is therefore vital.

### 3.3.1 Vygotsky: the socio-cultural dimension to learning

Vygotsky has argued that social (or cultural) context shapes many of our attitudes, ideas, and behaviors in ways individual cognitive capabilities for learning alone cannot. Humans construct their world through interaction and collaboration with others (Mercer, 2008), and learning and development are mediated processes, in which tools, such as speech, are of crucial importance in shaping possibilities for thought and action and, in turn, being shaped by them (Daniels, 2005, p.6). Particularly important is the role of 'talk', as distinct from the notion of 'language' often attributed to Vygotsky (Mercer, 2008, p.92). Other researchers have analysed what they have labeled as 'dialogic teaching' (Alexander, 2008), 'collaborative reasoning' (Kim *et al.*, 2007), and 'exploratory talk' (Barnes, 1976) to support the view that:

'.....reasoning is fundamentally dialogical and, hence, the development of reasoning is best nurtured in supportive dialogical settings such as group discussions' (Rheznitskaya *et al.*, 2001, p.155).

Slavin (1980) has stressed that such collaborative learning not only increases the learner's academic achievement but also boosts their self-esteem and motivation. Hence, nurses join with others, whether teachers, fellow-nurses, other members of multi-disciplinary teams in which they participate or patients,

to form learning communities, and thus what they learn is, to an important extent, shaped by others as well as by themselves.

This notion of situated learning, of learning being a shared activity, has been developed by Lave and Wenger (1991), with their concept of legitimate peripheral participation, in which learners become participants in communities of practice and learn a way to speak about the activities, identities, artifacts and so on of that community.

Therefore, although Vygotsky was at one with Piaget in arguing that mind mediates between the external world and individual experience, he was far more concerned with the process of how mind endows experience with socially-situated meaning, and how making meaning involves not only language but a grasp of the cultural context in which language is actually used. As Bruner puts it:

'...mental development consists in mastering higher order, culturally embodied symbolic structures ' (Bruner, 1997, p.68).

Stories are important ways in which we share experience and are, therefore, influential in the way in which learning is mediated between individuals, with learning being 'grounded' in the social environment in which it is learned, with the learner interacting with others and then 'internalising' that which has been learnt.

In many ways, story can act as a mediator for the learning that takes place between individuals. Nursing has its own culture of telling and using stories, which is essentially an oral culture, but a more written culture of stories might help preserve and detail what nursing is and what nurses do. Even though my research does not centrally engage with the development of a written culture, stories bring with them a language generated through the process of writing and need to be recorded if they are not to be lost.

At the same time, there are clear socio-cultural arguments favouring the increased use of story. As already pointed out, there is a danger that story could be excluded from the discourse of health care by too much focus on the formal dimensions of nurse education, and insufficient stress given to crystallising and transmitting the embodied knowledge nurses need in order to perform their professional practices effectively.

Stories can be used for communication between nurses on the ward or with other health care professionals. Plummer (1995) details how, in some instances, the social context can be hidden in the interactions between nurses as they tell their stories in their local contexts. Stories can be a product of nurses' culture, encapsulating some important elements of that culture, illustrating the potential of the socio-cultural approach for understanding and developing learning.

### 3.3.2 The cognitive-developmental (Piagetian) tradition

Although both Vygotsky and Piaget see learning as a form of construction, with their theories being seen as complementary, it is important to identify some of the differences between them. As Bruner puts it:

'Piaget's genius was to recognise the fundamental role of logic-like operations in human mental activity. Vygotsky's was to recognise that individual human intellectual power depended upon our capacity to appropriate human culture and history as tools of mind' (Bruner, 1997, p.65).

Piaget focuses on individual cognitive resources, whereby humans are born able to learn and construct their own worlds through their own actions. Piaget concentrates on exploring how very young children learn to learn, and stresses age-related stages of development, beginning with simple sensory motor skills, and progressing through an egocentric and tangible understanding of the world to forms of abstract reasoning, allowing the child to generalize from a particular experience or to understand the world from another's perspective.



Individuals construct their own sense of what the world is about, but in conjunction, and through interaction, with other individuals, via what Piaget called 'assimilation' and 'accommodation', by which the individual, through experience, adds new elements of learning to existing knowledge. When looked at from this perspective, learning happens when learners face some challenge or problem, experience a mental 'dissonance' or 'disequilibrium' and adapt to these circumstances by learning. Hence, what is crucial is how effectively assimilation and accommodation can be facilitated by learners regaining some balanced position when faced by challenges, problems or difficulties.

The role of the teacher is to find ways of enabling learners to make sense of new experiences by placing them in the context of existing knowledge, and encouraging them to make connections between different schemas of learning. Many learners may not know what they know, their knowledge being tacit, or may see their experiences as merely one-off events relevant only to themselves. Crucial to learning are the connections the learner makes between what is to be learned and existing experience.

For nursing, the cognitive developmental tradition clarifies some simple criteria for meaningful learning. For example, students can know how to carry out a nursing skill (competency), but not fully understand what it means (see my stories 10 and 11), in that they cannot generalise from it nor see their existing learning in a new perspective. Students learn the surface features of skills and concepts without properly understanding them. The contrast between superficial and more meaningful learning is the difference between being able to do a skill without understanding it in all its complexity and relating it to other skills learned, thereby transforming previous learning. Piaget described this connectivity in learning as 'schematic', a stage in the conceptualizing of knowledge. My story 11 illustrates this:

My story 11 continued

Students could see the significance of knowing the different causes of pain and the need to understand them, but they did not yet know what the distinct causes of pain

are (inflammation, lack of blood supply, chemicals, spasms, stretching, irritation). However, they knew they were relevant to their understanding of pain and they knew they needed to know about them.

Most of the literature on how professionals acquire knowledge is based either (and largely) within the socio-cultural tradition, or (and to a lesser extent) in the cognitive-developmental tradition. However, for the most effective learning, there is no need to see the two traditions as alternatives, but rather as complementary means of understanding the processes by which nurses learn, and this is explored in the next section.

### 3.3.3 The two traditions and story

In regard to story, both developmental traditions have much to offer, precisely because each approaches learning from a different starting point. Both throw an important light on the type of learning that takes place within nursing, but from different perspectives. Each has different criteria for what constitutes effective learning, but these do not conflict and there have been successful attempts to combine them. In principle, there is no reason why both traditions should not be exploited to exemplify the role of story in learning.

The following illustrates how both traditions can be of value to the learning that takes place in nursing:

#### My story 12

I was visiting one of my clinical areas to see some students in their clinical placement. The unit was very busy as a 32 year old 23 week pregnant woman had been admitted early that morning. I put on a set of scrubs and went in and helped. She had collapsed in A&E, with one fixed and sluggish to light pupil reaction, showing there was some severe brain injury. The neurological team was uncertain why this had happened. She needed to go for a CT scan of the brain. She had had one already, but it had been inconclusive of the cause, as the swelling of the brain was so great. She was having multiple infusions of drugs to maintain stability; she was fully ventilated, being fed by a tube involving the multiple use of technology, which needed to be converted into a source that would enable the patient to be monitored during transport to CT scan. I helped, took instructions from the qualified nurse organising all

of this. No book or any amount of skills laboratories could have helped the nurse do this, her instructions to me were clear and concise, she knew exactly what she was doing, it was planned and internalised in her mind (moment-to-moment decision making), and it was pure artistry happening before my eyes. However, all the time, she was watching the monitors to ensure at any time the patient's blood pressure, heart rate, oxygen levels were not compromised, if so the patient could have died. Her understanding on a more sharply applied level was outstanding.

In this story, the nurse is working from a practical model constructed in her mind, using her skill and dexterity in organising and preparing the patient for CT. This model can reasonably be described as a 'schema' in that, although it conforms to standard practice, it was fully 'internalised' in the nurse's expanded professional repertoire. At the same time, her skills had almost certainly developed in collaboration with other nurses, during training and afterwards i.e. socio-culturally. That is, the internal models used in nursing will usually be both personal and have socio-cultural resonance. Which perspective is most useful from which to grasp the value of story will depend on particular instances. Of course, the nurse's interaction with other members of the MDT, to undertake tasks in the context of the nursing environment, shows a degree of socio-cultural skill acquired over a long period.

To summarise, story has a particularly important role to play in nurse education because it can represent and exploit the wide range of experiences that nurses live through in their professional work. Nurses daily encounter shared culturally-based experiences as well as uniquely personal ones, and story has the potential to make effective use of both. In most educational contexts, story is mainly used when material is to be shared or used with others, but this is not to deny that individuals spend most of their time thinking *as individuals*, constructing stories to justify or support how they behave or what they believe.

### **3.4 The potential of stories in nurse education**

Benner (1983) points out that, if the meaningful use of story is left undeveloped, education and practice may be deprived of the uniqueness and

richness of the knowledge embedded in clinical experience. In this sense, by giving access to learning that would otherwise remain hidden, even to the nurse him/herself, story assists in creating that learning. Andrews (2009) adds that story provides a valuable tool in the search for meaning derived from practice, and, in my experience, to be involved in the process of finding meaning from your own stories is both empowering and motivating.

#### 3.4.1 Representing experience through stories

The developmental traditions provide insight into the use of stories in learning. However, on a simpler, day-to-day level, stories can be seen as a way to help represent and understand experience, particularly stories of difficult days in practice and tragic moments in the life of patients. Smith (1992), Street (1992), Sutton *et al.* (1996), Fowler (2008) and Henderson (1994) all write about the value of experience, but many nurses are unaware of the powerful learning that can be generated through story (Winter, 1995). Nursing has failed to tell its own story, a story of practice experience, which may appear superficial but when told over and over, each time with more depth, meaning and insight, can result in more meaningful learning. Through stories, nurses share with one another their experiences, a process which is not unproblematic (Aranda and Street, 2001; Frid *et al.*, 2000) but one through which they can find meaning in their stories, expanding and deepening their understanding of practice.

These stories of experience emerge as a language expressing the everyday life of a student nurse. The mutual exchange of stories and interpretations can derive meaning from, or give meaning to, experience (as 'constructivists' claim), and so become a fruitful way of exploring complex, integrated and interrelated professional issues. Real life student experiences told in a story can demonstrate to them, and to others, the complexity and unpredictability of the environment in which they work.

### 3.4.2 The temporal element of stories

Stories fix events in time, and the temporal element of stories can help us look backwards from the story to examine the present, as well as look forward to the future, in order to bring about change or transformation in practice. Bruner (1986) claims that stories are 'timeless miracles of experience', helping us to locate the experience in time to inform present and future practices. Clandinin and Connelly (2000) assert that our experiences are called upon temporally over a period of years or even a lifetime. The need for continuity in experience, first discussed by Dewey (1938, reprinted 1997), presents a view of continuity as the ability to take temporal perspectives on experience – to look backwards into the past, fix the present moment and look forward into the future. Because they fix events in time, stories can give continuity to experiences which might otherwise be temporally fragmented and disconnected.

Conle (1997) and Squire (2009) point out that it is possible to undergo personal change and growth as well as gain understanding through story. A story may show change or transformation in an individual due to its temporal form. Not only can stories help bring about such change in individual practice and understanding through time, they can also contribute to initiation of policy changes and improvements in the system. For example, the publication of Koch's (1998) work, employing story as a research method, led to a change in the dehumanised, objectified care referred to in the elderly patients' stories. The changes effected by the research not only resulted in nurses listening to what a patient had to say, but influenced policies allowing patients to make their own judgements based on adequate information, participation and self-direction in their care. In addition, there was allocated an increase in material resources, registered nursing staffing levels and amenities.

Edwards (2002) proposed that learning to be a nurse can be viewed as a collection of different experiences of professional practice, and evolves from decades of clinical experience. Rolfe (2000) and Parker (1997) add that this

type of learning remains vital to the development of nursing practice. In this study, I explore the idea that stories connect separated or fragmented experiences in time, helping us look back to the past, stand in the present and look forward into the future. That is, students may, by telling a story in the present, look backwards to other stories and forward to their own development. Using the term derived from Piagetian psychology, stories 'schematize' temporally disparate events and so make them usable mentally.

### 3.4.3 To give voice

Story has an important role, given the current emphasis in higher education on student voice. Ironside *et al.* (2005) suggest that, if educators are serious about listening to the student voice, they should pay attention to students' stories. Students' accounts of practice help teachers to be mindful of the wide range of learning that occurs in practice settings (Ironside *et al.*, 2005). Through their stories, students are telling teachers what they are learning rather than the teacher determining what they think the student has learned through written analysis. Ironside *et al.* suggest that:

'It is timely to explore what students are obtaining from their clinical experiences and what these experiences mean to students as they learn nursing practice' (Ironside, *et al.*, 2005, p.50).

In relating the different stories of patients, the students' own style and expression needs to come to the fore and this can be achieved through story.

Stories are a way of assisting communication (Calman, 2000) between health care professionals, as seen through my own practice experience:

My story 13

When I was a staff nurse in charge of a general medical ward I had in the course of the afternoon noticed a patient's condition was deteriorating. I called the doctor as I was worried; I felt the patient needed to be reassessed. I got the doctor on the phone and he promptly asked me 'What is the patient's blood pressure?' I went to look at the patient's chart, got the results and returned to the phone to inform the doctor. Once

completed I was asked another question and each time I went back and forth to the charts or patients notes to find out the answer to each question in turn. My inability to tell the full story to the doctor about the patient's worsening condition failed to get the doctor's same level of concern, consequently the doctor did not come.

Belenky *et al.* (1986) claim that students do not have a voice, and this may be true in clinical practice because of the more powerful voices of doctors, qualified nursing staff and other health care professionals, such as physiotherapists, radiographers and occupational therapists. Although nurses can use stories to give themselves a stronger voice in clinical practice, Bowman (1985) argues that, for students to achieve a truly audible voice, teachers must relinquish some of the control to which they have become accustomed. The voice of a student may be eroded or even erased by the professional language of detachment and objectivity which is often the dominant discourse of academia. The stories written by students give them the opportunity to speak in their own words, the language of practice.

#### 3.4.4 Teacher and student: partners in the learning process

Story can help provide a learning environment where teachers and students are partners in the learning process (Nehls, 1995; Heinrich, 1992), encouraging both to challenge and rethink the nature of learning and teaching (Ironsides *et al.*, 2005). Vygotsky stresses the non-deterministic nature of learning, emphasising the active role of individuals in their own cognitive and emotional creation, making the teacher-learner interaction much more than a simple transmission of prescribed knowledge and skills. This underlines the role that the teacher plays in partnership with the student, a partnership that is democratic though not equal. Story allows nurses to contribute to the creation of knowledge, and is one of the most successful methods by which such 'new' knowledge can be internalised. In this way, the partnership of teacher and student creates, through story, a social-cultural artifact, but one which acknowledges the personal contribution of the experience of the nurse.

These interpretations of the teacher / student relationship closely represent how I experience the bond with students, as seen in an excerpt from my personal narrative:

'The boundaries between us became permeable and continued to evolve throughout the semesters. I noticed an enthusiasm from them to attend all of the seminars and I do not think this was just merely their relationship with me, but more about our individual understandings of a collective nursing identity and a willingness to learn together. The seminars and the ongoing relationship provided a space for engagement with ideas, a space whereby a new relationship was evolving in the classroom domain.'

Using story involves working in an alternative paradigm from that set by a traditional teacher-led, outcomes-led curriculum, and instead relates to a student-led focus, in ways often associated with the Piagetian tradition of learner-centred pedagogy. Students and teachers become co-investigators in dialogue regarding problems often significant to both (a form of learning recommended also by the Vygotskian tradition). When stories are shared between teachers and students, it creates a unique and more democratic pedagogical partnership between the two.

Van Manen (1990) characterises the concept of pedagogy as one that involves human interpersonal and caring processes of education:

'It is a process that draws us caringly toward those whom we teach' (Van Manen, 1990, p.31).

As we listen to someone else's story, we are drawn into the unique reality of that individual, which is often so personal and intimate that the stories may pour forth with unexpected tears from both story-teller and listener.

Geanellos (1997) concurs that it is important to recognise that the telling of stories creates an intimacy in the classroom that can sometimes be upsetting. The sharing of stories between myself and my students necessitates a safe learning environment where both students and teacher feel secure in



disclosing personal feelings and information. Creating such an environment is challenging, but the role of the teacher is to ensure that this occurs.

To sum up, in terms of the development of student nurses' learning, story can play an extremely productive role. Once students have committed their experiences to paper, it admittedly becomes very difficult to identify definitively the nature of their learning. Are stories the means through which learning that has already taken place is being recorded - although in the very act of recording, such learning will be reconstructed and learnt differently by the student? Or is story itself the means by which students learn and understand (perhaps for the first time) the meaning(s) of their experiences? Even students themselves would be unable to pinpoint the precise nature of their learning from story.

What does seem clear, and what the data presented later in this thesis support, is that, *as an aid to learning*, story has an important role to play. Through the written dialogue between the student and their story, a dialogue expressed in the language of the nurse, not of the academic, students can develop a clearer insight into their learning, grapple with issues concerning ethics and values that are too often excluded from formal consideration, and begin the challenging task of making explicit and transferable learning that has until then been implicit and often unacknowledged. If learning concerns making sense of our experiences, and then building upon this understanding to bring about change in our practice, then story fulfils this mediating role for the student nurse in his/her quest to become a professional.

### **3.5 Research questions**

Given my concern with the mode of learning and teaching in nurse education and my personal experience of learning through the use of stories, the questions being asked in this study are as follows:

1. How does story help illuminate the lived world of the nurse?
2. How far does story crystallise the personal pre-occupations of a nurse and help resolve personal issues s/he may have?
3. How might story aid nurse education, especially taking into account relevant theoretical perspectives?
4. Overall, therefore, does story have a useful role to play in nurse education, and how might this role be better realised?

*In this section I explored the literature on story in nurse education. The nature of story has been described, with particular emphasis on the humanness of stories and how they can be used to express emotions. The stories of teachers, nurses, patients and students demonstrate the variety of stories that contribute to learning. However, these can be of limited value if deployed only to explore topics within the curriculum content.*

*The two traditions of learning were considered to help understand the role story might have relative to constructivist and social-constructivist or socio-cultural theory. In general, it is proposed that story is not being used to its full potential. It can help novice professionals find meaning in their own day-to-day experiences, and create a more democratic teacher-student relationship. Story can utilise the temporal dimensions of experience and give voice to those who do not usually have a voice.*

*Learning from practice is the essence of nursing, but due to its complexity and the way practice is often given a peripheral position in the curriculum, it does not easily lend itself to research activity. In the next chapter I explore how my own interest in story developed and describe the personal process of learning connected with my stories.*

## Chapter 4

### My own story: a journey of learning through story

*In the first chapter, I attempted to shed light on the current approach to nurse education and explain how this became the trigger for my work. In chapter 2, I explored reflective practice, and in chapter 3 I considered the literature on story and how it is currently used in nurse education, exploring how it can aid learning and help to focus and illuminate practice in a way theoretical study alone cannot. I concluded that such possibilities are not currently being fully realised, referring to two developmental traditions of learning to reinforce my case.*

*This chapter sets out a distinctive approach to the potential use of story which will underpin my position by examining how I came to write my own personal narrative and develop my own learning from professional practice. I set out to explore how story has influenced my own learning, and present a personal account of such learning in general and my own stories of clinical practice experiences in particular.*

*My learning was enhanced by the literature on story, but, at the same time, my own stories provided insights that the literature did not wholly touch upon. It is my view that framing elements of my practice experience as stories made the learning special and, by becoming attuned to my own stories, I developed a deeper understanding of my own practice and of nurse education generally.*

*Links between my stories and learning are made by looking back at my personal narrative written as part of earlier work carried out for this doctorate. I draw on stories from my many years of practice written as a smaller part of a longer personal narrative. Story is not only about illuminating curriculum content, but also can be used as an aid to pedagogy – giving additional focus and meaning to nurses' own experiences in practice. It has taken me a long time to be able to identify how I have benefited from story as part of my own*

*professional development, and exploring how this has happened might prove of value to the field of nurse education generally.*

#### **4.1 Writing a personal narrative**

Personal narrative is a form of autobiographical story-telling that gives shape to experience (Gaydos, 2003), with 'narrative' being regarded here as a substantial big picture and 'story' as a smaller part of it, as suggested by Fairbairn and Carson (2002). Personal narratives are important in nursing, as determining a person's self-story is often a way of fixing a starting point for their struggle towards personal growth. An example of this is the way I came to research and writing through dissatisfaction with my professional context, and I began by writing my own personal narrative (in the early stages of my doctorate), which included stories of my clinical practice.

I used my own personal narrative in the way identified by Maguire (1998), who argues that narratives can restore feelings otherwise lost and provide direct contact with lives we formerly led or now lead. They can help clarify the important ways in which we are individuals in our own right with unique identities. This view resonated with me, as my childhood in the East End had become lost, and only when I became a higher education professional did it somehow seem significant. By engaging with my personal narrative, I was able to delve into my early life and, through this process, I started to appreciate its role in shaping the person I had now become.

Bruner (2002) demonstrates how unsettling narratives of life can be for all of us. However, the purpose of writing my personal narrative using a collection of my own stories was to make sense of my own life, and though this was sometimes disturbing, I persevered in order to understand the origins of the ideas for my research. The personal narrative that emerged has brought my nursing and teaching life to the surface and given me an appreciation of the value of my own stories of clinical practice.

In Bruner's (2002) book 'Making stories', he refers to the 'creation of self', in which he implies that self is in some way external to, and separate from, the stories we make. He suggests that narrative only gives the briefest look at ourselves. Yet, in part, the purpose of personal narrative must be to reveal ourselves to ourselves. Indeed, self-awareness may not always focus on our personal concerns, but can also involve a commitment to others. Personal narratives reveal a form of self-awareness that expresses or reveals one's commitments and responsibilities (Bruner, 2002). This way of looking at self-awareness is one I find most useful as a nurse.

## **4.2 The beginning**

One Christmas, when I was 12 or 13, I was taken by my parents to the accident and emergency department of a very large London hospital suffering from a headache and sensitivity to light. I was admitted with query bacterial meningitis, but, as it turned out, I only had viral meningitis or bacterial encephalitis, which are not as serious as the former. I cannot remember which diagnosis was eventually given, and my mum and dad could not say either, but it did not really matter that much to them anyway, as long as I was all right.

While in hospital over the Christmas period, I enjoyed watching the festivities on the ward and realised that I wanted to become a nurse. I wrote as part of my personal narrative in 2006:

Making the decision to be a nurse was only the beginning of things. When I made the decision I had no idea of the great dive I would make into a strong current that was to carry me to places I had never dreamed of when I first made it. I never gave up on it, I had made my decision. I knew I would get to do it and I managed to just get into my nurse training with the minimum of five 'O' Levels.

I started as a student nurse in 1977, and worked as a staff nurse and sister until 1991. Yet I did not appreciate the significance and value of these years of clinical experience until after I became a nurse educator in 1992. Teaching helped me to make my practice explicit, and I began to look back to my

practice years and view them as stories worth relating in the classroom. A timeline for this is given in Table 4.1.

**Table 4.1 – A timeline of how I came to story**

<b>Date</b>	<b>Timeline</b>	<b>Identification of stories</b>
1971	12 years old in hospital and decided to be a nurse	
1977	Start training as a nurse	Stories generated from experiences in a variety of clinical practice areas.
1981	Qualify as a nurse (SRN), started first staff nurses job on a medical ward at my training hospital.	
1983	Begin a post graduate work-based cardio-thoracic course in nursing, specialising in patients with respiratory and cardiac conditions	
1985	Begin my career in intensive care nursing in London, only stayed for 6 months as I had the opportunity to go to Australia.	
1985	Work in Northern Territory and Victoria, Australia	
1987	Return to England and continue my career in intensive care nursing	
1992	Begin my career in education, in a college of health studies (before nurse education went into higher education)	
1996	I begin to develop an interest in stories and their potential for use in nurse education	Look back into my clinical practice experiences and present them as stories in my teaching.
2001	My interest in story grows	I use stories in a more structured way, wrote them down and they appeared in my teaching materials.
2005	Begin my EdD and my research journal	
2005	Research begins for this thesis	
2006	Write my personal narrative	Includes my stories from clinical practice

### **4.3 Developing as a nurse educator**

Gaydos (2003) proposes that people writing their personal narratives begin in many different places, usually starting with memories that are emotionally

intense and important to self-definition. I started when I was a nurse educator, and drew on my own stories of clinical practice as a teaching tool.

Since becoming a nurse educator in 1992, I have gone through a succession of phases, similar to those identified in the conceptual ordering of career phases by Phillips (1982). Using Belenky *et al's* (1986) five ways of knowing, I can also better understand features of my life history, and I incorporate some elements of their work in my account. However, Hubermann and Neufield's (1983) account of the lives of teachers has most similarities to my own. The story of these phases, and how they impact on my professional development and research journey, follows.

#### 4.3.1 Career entry into nurse education

The first phase of the life cycle of a teacher is career entry (Hubermann and Neufield, 1983). Within two or three years of becoming a nurse educator, I realised the limited opportunity to develop my creativity, share my ideas and explore issues related to higher education with other like-minded academics, or develop roles other than that of lecturer. When I entered nurse education, I hoped to contribute to curricula design and to the construction of educational theory, but found myself having to conform to the routine of teaching, with no voice in such matters.

Nevertheless, I asked myself questions about my practice as a teacher: 'How can I share my ideas and views with others?' 'How can I progress and have my voice heard?' and 'What were the students really learning?' As a novice educator, I could not answer these questions, being unable to articulate the extent and range of my ideas, nor did I have the language to represent my views to other professionals.

#### 4.3.2 Stabilisation phase

In the next phase, the 'stabilisation phase' (Hubermann and Neufield, 1983) circa. 1995, I felt I was in a period of transition from novice to master. I found

myself asking different questions about how I teach students, and became more focused on student learning than on teaching. A greater equity developed between the students and myself, which proved of considerable value. The emergence of a balanced relationship between student and teacher is, according to Lightfoot (1985), what allows both to be a whole person in the classroom, with neither having to show dominance over the other. Diekelmann (2005) argues that teachers should use learning strategies that encourage engagement in learning, and make a course interesting and compelling to students. Belenky *et al.* (1986) invoke the metaphor of 'teacher as midwife', whereby the teacher helps the student draw out, and give birth to, their own ideas.

However, such a relationship between student and teacher remained elusive, as I found I was not a genuine partner of the students. Despite the equity I aspired towards in the classroom, there continued to be a dichotomy between students interacting with me as a person, and me as the teacher, writing the marking criteria and rating their performance. This was one of the living contradictions I experienced which sat uncomfortably with me as I struggled to be more collegiate with students and responsive to their needs.

The stabilisation phase (Hubermann and Neufield, 1983) related to independence and autonomy in the classroom, and by 1997 I had become more spontaneous, more confident and better prepared in regard to teaching resources. I felt free to pursue my own ideas, one of which meant sharing experiences of my clinical practice with students.

I first recognised the power of sharing stories of my experiences when I lectured to a group of 150 students. Half-an-hour into the session I noticed the whispers, and over the next 5 minutes, as more students joined in, they became louder and louder, so much so that some students could not hear what I was saying. I stopped speaking and remained silent for a while. Then I introduced a story from my practice that related to the topic of the lecture. There was silence in the room and all 300 eyes were focused on me in anticipation of my story.



As I told such stories, new possibilities for teaching emerged, and I began to realise the extent to which my own experiences impacted on how I taught and facilitated students' learning. I used stories particularly to help students value their own experiences. Since then, I have paid a great deal more attention to my mode of delivery and how best to use such stories. It might be that everyone just loves a good story, but students seemed to relate to the stories and, for example, after lectures often asked me questions about the patients who figured in them. Through such experiences, I recognised the potential significance of stories in my educational work and the value they had for students, and my continuing excitement about using stories in nurse education came about through these lived experiences.

#### 4.3.3 Reassessment phase

The next phase of Hubermann & Neufield's (1993) framework is 'reassessment', and I have been experiencing this in some form since circa. 2002. I have come to ask a number of questions about my future career path, aided by a consciousness of the constricting nature of ever more routine official texts and regulations to which I have to adhere. I felt my individuality as a teacher had become overshadowed by the restrictions of everyday teaching in an environment that stifled my creativity and innovation. As I point out in Edwards (2008), management styles were becoming excessively bureaucratic and I was expected to be subservient to the agenda of others. It was these ideas that motivated me to advance my professional development through doctorate level study, rather than seek promotion to higher education management.

#### 4.3.4 Serenity, compliance, conservatism and disengagement

In the serenity phase (Hubermann and Neufield, 1983), I find myself as a teacher who is at ease in the classroom. I can anticipate most situations and answer most questions that come my way. My ambition for promotion has declined, and I am more inclined to invest in my own professional development. Sadly, in the final phases of compliance, conservatism and

disengagement, which usually occur at the end of a teacher's career, the teacher often is content to carry out the instructions of others. There is a gradual withdrawal from professional duties, disenchantment with the teaching role, disinterest in professional development and detachment from the educational organisation as a whole. I am determined to avoid this process, as evidenced by my decision to take on doctoral level work.

The Doctorate in Education (EdD) encourages me to engage in reflexivity rather than remaining baffled and frustrated. It has given me greater insight into myself and what my values are, and presented an opportunity to understand their significance to my research and, indeed, my life.

#### **4.4 A life in practice**

The EdD led me to reflect on my career as a nurse educator, and I began to look more closely at my own stories and how they might enhance my learning.. As I returned to my stories and read the literature for this study, I began to identify the phases of my own learning and the particular aspects that stood out. I articulated my personal account of how story had enhanced my learning through a number of stages, which have been labelled as the pre-narrative stage, stages of remembering, writing and sharing, and, finally, a stage of learning from stories. Each of these stages is explored, explaining how they emerged and how they relate to the literature.

Vygotsky and the socio-culturalist tradition recognise the importance of social aids or tools to signal the relevance of some aspects of teaching, and crystallise it in terms of individual experience. An aid such as story accesses the cultural lives of individuals, making sense of undifferentiated or bare experience. The Piagetian tradition also asserts that the lived experience has to be narrated or 'constructed' to teach anything, and students' first need is to make sense of their clinical experience. Put another way, it is the perspectives we take on experience and the use we make of it that matter. In the two developmental traditions, cultural tools, cognitive theories and models

help us grasp how we need perspectives on experience in order to learn from it.

Stories can be regarded as tools. They have a message and communicate an idea, and possess a meaning for the teller and the reader. Uncovering the message is often the purpose of the story (Bruner, 2002), although it may be so well concealed that even the teller is not aware of it. Stories have an implicit message, or messages, but we can be blind to them. Models of learning such as those proposed by Moon (1999) and McDrury and Alterio (2002) help clarify what it is that stories are seemingly concealing. These writers suggest maps (Moon, 1999) or models of learning from practice (McDrury and Alterio, 2002), detailing how learning from story can happen. The work of Moon (1999) and McDrury and Alterio (2002) especially helped to expand my ideas concerning story, although Bruner (2002) posed the pertinent question of what kind of models stories actually are stories.

The model suggested by Moon (1999) identifies a map of learning and includes the phases of noticing, making sense, making meaning, working with meaning and transformative learning. McDrury and Alterio (2002) modify Moon's (1999) work and develop learning from story as having five stages – story-finding, story-telling, story-expanding, story-processing and story-reconstructing. Mason (2002) suggests that the practice of 'noticing' involves six stages, the first of which is the notion of embodied learning, although this could be referred to as 'not-noticing', with the other stages being ordinary noticing, marking, recording, accounting of and accounting for. This model is embedded in the field of psychology, addressing processes of noticing and reflection, but it can be applied to story and has the potential of helping us better grasp how people learn from story.

#### 4.4.1 The pre-narrative (the representation of experience)

As discussed above, experiences alone do not teach – it is the perspectives we take on experiences, how these are assimilated and how we make use of them that matters. One starting point for any discussion of learning through

story is the notion of embodied learning (Boud, 2010) incorporating, as Bruner (1986) calls it, a 'taken-for-granted phase' – a 'presupposition' i.e. what exists prior to interpretation, cognitive or social construction. Mason (2002) recognises that practice is embodied but refers to it as not-noticing, in that it can exist apart from any meanings the individual gives to it. Van Manen (1990) also points to the pre-narrative, which for him is the world as the nurse immediately experiences it rather than how s/he conceptualises, categorises or understands it.

Models of learning from story make explicit the shift from the taken-for-granted pre-narrative to the recognition of the experiences embedded in practice. Another way of putting this, from the socio-cultural perspective (also from that of reflective practice), is that this particular stage indicates what is tacit or implicit in practice, waiting to be made explicit or conscious. Stories evidently have a role in this 'constructive', interpretive or meaning-making process needed to give sense to practical experience.

Regarding my own narrative, I began to look back at my learning through engaging with my stories and became aware of a period before remembering, a period when I walked through the wards day and night, encountering practice as a 'pre-linguistic realm of experience', involving images, noises, sensations, smells, feelings, grief, happiness, caring, and loving, in the stream of my own consciousness. This was a time when I did not express what I was experiencing or indeed learning about, but I was at one with the world of clinical practice. I was conscious only of patients that I cared for and interacted with, and I took it all for granted, not thinking about it, reflecting upon it or analysing it. I refer to this as my pre-narrative stage.

Thinking back to my own development as a nurse, I can identify a time when I did not notice my experiences of practice and was ignorant of their value and potential for learning. However, I would not say that it passed me by. This world of immediate everyday experience, the world that I inhabited as a nurse, was always there as an inalienable presence, and it is this that I use as the starting point for my research.

#### 4.4.2 Remembering stories about practice

For a story to be remembered, it has to have some sort of impact and (practice) value (Dewey, 1938, reprinted 1997), perhaps involving emotion or feelings. Bruner (2002) argues that a story begins with some breach in the expected state of things, usually something going awry, otherwise there is no story to tell. The story has to be of a certain quality, and individuals can filter stories that are worth remembering and those that are not. Mason (2002) stresses the importance of filtering as our attention is highly selective. Individuals undoubtedly need to sift through their stories to find the ones that are worth telling, as there is often too much to notice in any practical situation and we could not cope with all the possible interpretations.

The notion of remembering is represented in the models of learning through story – i.e. as making sense (Moon, 1999), story finding (McDrury and Alterio, 2002) and ordinary noticing or marking (Mason, 2002). Mason (2002) points out that noticing is about how we perceive what is around us and is something we do all of the time. As professional nurses, we are sensitised to notice certain things, particularly the patients we care for. In my own narrative, when I began to attend to, and make overt, certain features in my stream of consciousness that were my clinical practice experiences, this constituted a form of 'noticing'. Indeed, as I probed my own clinical practice experience and isolated certain images, stories began to emerge. McDrury and Alterio (2002) refer to this stage as finding the stories that urgently need to be told. An example is given below:

##### My story 14

As a first year nurse I was on night duty. In the morning at around 6 a.m. the staff and I would circulate the ward and change and wash any patient who had been incontinent, sit them up or out of bed for a cup of tea. In the end bay were 4 elderly ladies whom the staff nurse and I set about sitting up for their cup of tea. One of the ladies was persistent in her request for a cup of tea, 'I need a nice cup of tea, get me a cup of tea' she repeated over and over in her high pitched tone, that was reminiscent of this particular patient. I explained that we had nearly finished and we were now going to distribute tea to all patients. When I got to her bedside with her cup of tea, she had died.

When situations such as this touched my personal sense of empathy, core values, feelings or emotions, the story easily came to the surface.

#### 4.4.3 Writing the stories down

According to Mason (2002), the making-sense phase identified by Moon (1999) is aided by writing the story down, which he refers to as recording. Writing down stories can be very useful but is not enough, and Mason (2002) contends that, if writing down the story is the extent to which (narrative) accounts go, this limits the potential for influencing and informing the future.

As a nurse on the ward, stories helped me value those experiences, and I began to uncover the potential for using stories for learning and teaching. As my ideas concerning the use of stories became more structured, I incorporated them into my lectures and teaching materials as well as my published articles and conference papers. The desire to write them down was not only about the need to record them, but also about my own willingness to share my learning through writing and publishing, and this led to a number of published articles and a book. By writing down my stories, I was doing what Moon (1999) refers to as 'making sense', a process which provides an opening for organisation and explanation.

#### 4.4.4 Sharing stories

Another element in the models of learning, and in my own, is the sharing of stories, a process regarded as significant by *inter alia* Heinrich (1992) and Moon (1999). McDrury and Alterio (2002) also value sharing and advocate this in their learning-from-story model, referring to relevant features of sharing as story expanding and story processing. Josselson (1995) points to stories as a way of ordering the material and putting ideas together for learning to take place. One of the first stories I organised and shared in the classroom concerned my experiences as a nurse in critical care:

### My story 15

A patient had returned from cardiac surgery and while recovering from the anaesthetic he became very violent towards the nurse caring for him, swearing and using very strong language. He was thrashing out at nurses kicking, hitting and swearing. This was affecting his blood pressure and heart rate, which could put too much pressure on his newly grafted cardiac / coronary arteries so it was decided to ventilate and sedate him for longer. The next 2 days weaning from the ventilator (breathing machine) was attempted but he again became violent toward nurses / staff and even his relatives; this worsened on suctioning down his breathing tube (endotracheal tube, ETT).

His relatives were distraught as he was generally a very well mannered man, kind and caring, they could not understand his behaviour. It was decided that this behaviour could be the result of his major operation and that he had undergone a personality change, which has been documented in the literature following surgery of this nature. On the 3<sup>rd</sup> day it was decided to wake him up as his physical condition no longer warranted further invasive ventilation and treatments. His drugs were reversed and in a matter of hours he was extubated (ETT removed). When he woke he explained to us that he thought the Irish Republic Army (IRA) was torturing him: he had been in the army and had served in Northern Ireland during the worst of the trouble there.

When I recounted this story, my students listened, questioned, and urged me to say more, trying to understand what had happened and identify the knowledge and skill involved in caring for such a patient.

The stories I shared of clinical practice were real to students. They enabled them (and me) to think about and reflect upon what may have been happening, and promoted understanding and learning. Through my sharing of stories with students in an open way, allowing them to express emotions freely and offer opinions, and see the various tensions and different choices, a deeper understanding of my story began to develop. Through the sharing process, I was able to locate alternative insights, responses and interpretations. Sharing stories also encourages others to remember their own stories.

An unexpected consequence of using my stories in the classroom was an improvement in the relationship with my students and a sharper insight into what they bring with them. My written stories seemed to speak to students; they were a common language of practice in our endeavour to create a learning relationship. As a result, the students became active participants in the story-telling process, and meaning and learning began to emerge.

#### 4.4.5 Learning and story: some personal illustrations

McDrury and Alterio (2002) suggest that learning occurs by expanding and processing the story, due to listening, questioning, reflection and expansion, so that learning does not happen until the end. I would suggest that learning is facilitated by stories throughout their shaping and telling. After all, each time I tell one of my stories it is different. I have learned something new from, and about, it. Here I present an analysis of how my stories of clinical practice have impacted on learning, which may well be occurring during any stage of the shaping and telling of a story. I propose that the shaping, telling, listening to or sharing of a story can have diverse features that are themselves aids to learning. The analysis below identifies some of these main features as aids to emotional learning (including the role of humour), the understanding of ethics in nursing practice, the role of intuition, the 'personalising' of some practice, the connecting of theory to practice and the structuring of practice experience through time. Each of these is discussed in turn.

##### *4.4.5a Stories and emotional learning*

Nursing involves listening to patients telling their stories, which can be an emotional experience. Calman (2000) contends that hearing a real person tell a story can have a very powerful impact, passing on much about the human condition and the emotions and feelings we all have. In my experience, learning often takes place during or after powerfully emotional events, for example:



#### My story 16

A young man was on the ITU and was brain stem dead, his family had been asked to donate his organs, the family agreed. The transplant co-ordinator was contacted and everything was in place for the patient to go to theatre for organ retrieval. His family went with him to theatre and said goodbye. A few hours later the ITU had been informed that a liver had become available locally and in 5 hours time we would receive the patient from theatre. The liver of the young man transferred to theatre one hour ago had been offered to a local patient. The operation was taking place in the hospital straight away. The nurses said goodbye to the patient who we had cared for some time, to receive another patient from theatre who had been donated his liver.

#### My story 17

A woman who was 36 years old and who had primary liver failure (generally the cause is unknown and not due to alcohol abuse) had a liver transplant. Her recovery was uneventful and she was transferred to the ward. She returned home. It was a wonderful feeling when 6 months later she visited the ITU. She looked so different; her skin was no longer yellow (jaundiced). She wanted to thank us all for her life back, which had changed so much. She had got married and was now 3 months pregnant.

These are what can be referred to as 'strange events' in my practice years, and one made me feel absolutely wretched, the other quite happy.

Nevertheless, they gave me an insight into nursing and a realisation that it is sometimes full of bizarre and extraordinarily special emotional moments. My response to such events also tells me something about myself and my emotions and feelings. If I had known beforehand the emotional chaos I was to encounter in some situations, I may well have avoided them and thus lost valuable learning opportunities.

Humour can also be viewed as a way of helping nurses to cope emotionally. Humour took me to new places, gave me new thoughts and removed me, in the short term, from the routine of clinical practice:

#### My story 18

I was admitting a male patient one day, who had a prosthetic leg. He had lost it during the war and he was admitted for a hernia repair. I politely asked the patient if his leg was clearly labelled with his name. The patient asked me why. I replied very

sincerely that, because things have a habit of walking on the ward. At first I did not realise what I had said but we both laughed at my unintentional wit.

I can recall many instances where laughter helped me to deal with difficult and embarrassing situations, and Penson *et al.* (2005) agree that laughter can be the best medicine in such circumstances.

#### *4.4.5b Learning ethics in my nursing practice*

Ethical decision-making is about judgement as to what is right and wrong. Carper (1978) points out that it requires an understanding of various philosophical positions, and Tschudin (1986) draws attention specifically to ethics in nursing, which focus on matters of rights, responsibilities and obligation. While Taylor and White (2000) allude to the moral dimensions of practice in health care, Chin and Kramer (1991) consider ethics more as creative processes and distinguish between clarifying situations, valuing the patient and advocating for the patient. These processes all appear relevant when nurses serve as advocate for the rights and responsibilities of others, as well as for themselves, although there may be no right or wrong answer to an ethical dilemma, only alternative perspectives as to what constitutes an appropriate response.

Ethics include issues such as when to withdraw treatment, whether to resuscitate a patient, or whether to allow relatives to be present during resuscitation. MacLeod (1994), McKinnon (2005), and Marks-Maran and Rose (1999) all support the view that ethics in practice are not always about life and death situations, but can be about everyday clinical practice issues and decisions. For example:

##### *My story 19*

I was working on a ward as a student nurse. The ward was full, but one patient, who was in renal failure, could go home if their blood results were within reasonable limits. The bed manager arrived desperately needing a bed for a new patient in accident and emergency (A&E). The bed manager suggested that the patient waiting for their blood results could wait for them in the discharge lounge. It was difficult to get the bed manager (not a nurse or health care professional) to understand that if the

patient's blood results were not within normal range the patient would continue to require the bed for further investigations and possible treatment.

In this story, it is everyday professional practice that I am concerned with, involving issues related to ethics. I benefited through this and other stories of similar experiences as I acquired a broader understanding of the meaning of ethics for my practice. I also gained more differentiated knowledge and awareness of the professional and ethical codes ([www.nmc-uk.org](http://www.nmc-uk.org)). In an article (Edwards, 2007a), I drew attention to how I used such stories to work towards ensuring decisions were informed and unbiased and that all viewpoints (those of the patient, relatives and work colleagues) were included, with the aim of avoiding purely emotional judgements that lacked the necessary impartiality.

Stories have helped me gain a valuable insight into what constitutes ethical behaviour in nursing and how professionals (administrators, managers and doctors) approach things differently, as demonstrated by the following:

#### My story 20

I was caring for a young child of 4 years old, who had been involved in a road traffic accident (RTA); his condition was serious. His mother had been very protective of him since he was born and they rarely went out of the house while the husband was at work. The husband had begun to encourage his wife to take their son out more and on the occasion that she did, the boy not been taught how to behave close to a road, ran out and was knocked down by a car. There was not much the medical staff could do, except keep the young child comfortable. The child was intubated and ventilated, his brain severely swollen and damaged. I was in the room with the child's mother and father and the anaesthetist when the child's condition deteriorated; he was going to die. The doctor wanted to do something, to intervene, but there was nothing that could be done, it would only be distressing to the parents. I said to the doctor 'Let the parents hold the child, while he dies'. The doctor found it very difficult to let go and do nothing.

When discussing the event afterwards with the doctor it transpired he had felt helpless, as he could not perform his role, which was to save the child's life. He found it difficult to discuss what happened with his medical colleagues, as doctors are charged by their training to do everything in their power to defeat death. The situation however, is very different in nursing as the nurses' role is to ensure that

when death ultimately comes it is respected for the parents to help them grieve in the face of the death of their child.

In the above case, the nurses involved talked through the events afterwards and expressed their feelings of disappointment and grief. The doctor who was in the room with me at the time was invited but never came. Gilbert and Mulkey (1984) suggest that, when things are revealed in such a way, 'the facts are discovered'. Taylor and White (2000) point out that nursing is not simply an individualised action, but is a collective act of an occupational group. I had learned, through 'storying' my practice, about the value of a group sharing emotional experiences rather than reading about such matters in a book.

#### *4.4.5c Developing intuition in clinical practice*

Although nursing has used theory as its model for education and knowledge generation for many years, several writers (e.g. Benner, 1984; Pyles and Stern, 1983) recognise both the need for intuition to be accepted as legitimate and for intuitive judgement to be better understood. What seems clear is that intuition is a way in which we can learn through experience, even if it bypasses our normal reliance on logic and linear thought processes. As King and Appleton (1997, p.198) point out:

'A nurse may sense that there is something wrong with a patient who appears perfectly stable. However, the nurse cannot communicate what is wrong in words and finds it difficult to articulate what is occurring with the use of standard knowing techniques; it is a 'gut feeling'.

Intuition somehow becomes more acute the more that is known about the patient and the more meaningful the interactions that have occurred between nurse and patient. In my own experience, the use of intuition was a normal occurrence, as my story 21 reveals:

My story 21

I was with relatives when a patient died; it had not been a lengthy illness and was very unexpected indeed. I allowed the relatives to stay in the room with the patient

and when they were ready I guided them to a room so the nurses could do last offices before he was transferred to the mortuary. In the room I offered them a cup of tea; I made this and returned with it to the room where I had placed them. I sat with them for quite a while, I expected lots of questions, why did he die, what was wrong with him, but none came. I sat for quite a while afterwards with them saying very little. When I left the room and all through the rest of the evening and later that night I had felt inadequate with the family, I had not said anything, I had been incompetent. When I returned to work the next morning the family all arrived and wanted to speak to me. They gave me a bunch of flowers thanking me for my kindness and empathy yesterday evening.

Putting the above events into story form reveals the important role of intuition that a theoretical account does not. That is, I learned from this story that sometimes it is good to fall silent and sense intuitively the feelings in the air or from within, and through this experience I began to understand intuitively and value a language without words – the universal language of silence.

The telling of this story revealed more about my tacit assumptions and cherished notions than could have been achieved through theory alone. The idea of dying is about one's progression through life, and I needed to recognise it from within. As a nurse, I could not stand with the relatives at the bedside without being deeply moved. I could not be an impartial authority without showing tenderness and reverence in the presence of death. In this practical experience, I was intimately involved, something not possible when engaging with theory.

#### *4.4.5d Personal learning and story*

Personal learning is fundamental to a practice discipline based on interpersonal relationships. Smith (1992) asserts that personal learning includes gaining inner personal meaning from life experiences, and in my own writing (Edwards, 2002), I have argued that personal learning can arise from nurses' experiences, such as having a baby, bereavement or a close family member spending a period of time in hospital. Only through self-knowledge can the nurse know and understand others. The following story relates to gaining greater personal insight:

## My story 22

In 1977 I went from the East End to the West End of London to do my nurse training. I was shy and protected mainly due to my upbringing in a safe and sheltered environment. I had a self-perception of myself as uninteresting as I had not travelled, seen or done very much outside my own lived world. Working as a student nurse I had to earn respect from my patients who often laughed at my Cockney accent. I had a passion for nursing and a caring nature with a desire to succeed but felt I had to work 50% harder due to my humble East End background, to prove that I was worthy to be trained as a nurse. While on practice my East End accent was continuously mentioned by patients and colleagues. It is probably not an exaggeration to say the continuous mention of my accent while in clinical practice grated on me.

This story, drawn from my own personal narrative, suggests that patients and colleagues did not seem to have a shared understanding about my competency as a nurse due to my East End accent. I could not properly communicate in these circumstances. The insight provided by this personal experience emphasised the importance of paying attention to what would lead me being viewed as a competent nurse, and writing it down as a story served to reinforce my learning. This learning from my own practice is supported by Taylor and White (2000), who point out that demonstrating an identity of competence can be about being able to communicate clearly and authoritatively.

The processes of learning from this personal experience taught me that how I presented myself verbally instilled trust regarding my ability as a nurse in my patients and other staff members. Carper (1978) draws attention to personal learning as a requirement for 'therapeutic use of self', and therapeutic self-development can be furthered by employing the story of one's personal experiences. Such self-development enables the nurse to establish a relationship with his / her patients rather than viewing them as passive recipients of care. The nurse engages in a relationship rather than remaining detached. Amongst nurses there is now considerable support for the idea that the quality of inter-personal relationships influences the incidence of illness, coping mechanisms and recovery.

Personal learning can be gained through interaction with others through listening (Calman, 2000) and much of nursing is about listening to patients telling their stories. Calman (2000) asserts that personal learning and the therapeutic use of self are ways that may assist communication, which is at the heart of clinical practice. However, it is worth stressing that, as previously argued, learning of any sort has to be crystallised, shaped, and given form ('constructed') via some medium, in this case, story. The following relates to my own development regarding my ability to communicate:

#### My story 23

As a student nurse I cared for Elsie (pseudonym) a 62-year-old lady admitted to the ward with unstable angina. Her blood pressure was high and she complained of chest pain. Elsie was given sublingual GTN, which relieved the pain. She was very anxious which I knew would certainly increase her blood pressure, heart rate and consumption of oxygen. I interviewed Elsie about her social needs and life style. It appeared that Elsie was not particularly concerned about her condition at all but her cat at home. She needed to inform her neighbour quickly so that 'Misty' the cat could be fed while she was in hospital.

I always thought that my primary sense as a nurse was sight, particularly the power of observation to notice when a patient was anxious, but writing this story helped me to understand that seeing does not always equate with knowing nor would it, in isolation, help me to understand my patient's anxiety. To do this, I needed to interview Elsie and learn to know when and how to speak, what to say, and how to say it. Most of all, I needed to listen.

To summarise, the capacity to care goes hand in hand with constructing a discourse of learning from written stories of practice that include not only the exploration of practice and theory, but also the learning from emotion, intuition, and personal experience. Learning from experience is multifaceted. It can occur in many different ways – sometimes independently, sometimes interdependently – but always experiences have to be mediated, often by some kind of narrative.

#### *4.4.5e The way story has helped me to connect experiences*

What I gained from stories contributed to my emotional development, ethical insight, intuition, and personal learning. I learned a great deal that could not be easily separated into parts, for each part was a connected piece of a whole. Bruner (1986) would explain this as my ability to sense possible connections before being able to grasp them in any formal way. I had come to recognise a kind of connected learning in my stories, as seen in story 24:

##### *My story 24*

Jack was a retired gentleman in his 60's; he lived alone, as his wife had died about two years ago in a car accident in which he was the driver. Jack had started to drink heavily. He had a history of alcohol abuse, for which he had a previous admission, including occasions for bleeding oesophageal varices. Jack was admitted to intensive care following an oesophagectomy and had breathing problems following surgery, which required ventilation. Jack had been on the intensive care unit for over a month and due to his lengthy ventilation period he had a tracheostomy. His condition continued to improve; however, there were problems with maintaining his nutritional requirements. Jack could eat if he wanted, but he was taking a minimal calorie and fluid intake orally, and was being supplemented with total parenteral nutrition. One particular day, Jack expressed his wish for a Guinness.

Theoretical understanding is represented by the ethical principles of non-maleficence (do no harm), beneficence (what is good or bad for a person), veracity (to tell the truth and not lie to or deceive others) and autonomy (self-determination, the right to make own decisions), as well as the normative ethical philosophies of deontology (moral obligation and commitment) and consequentialism (what makes an action right is if it produces the best possible outcomes), which were applied to practice.

The practical emphasis involves the complexities of caring for such a patient with a tracheostomy and parenteral nutrition. That said, there are elements of emotion in a story that can be sad and touching. There is evidence of my personal learning gained through the interaction with Jack, and it is through intuition that I considered the decision not to give Jack a Guinness, because he was an alcoholic, to be unjust. Many separate skills and bodies of



knowledge are detailed in the story of Jack, but what is interesting is how they are working together and connect through the story.

Moon (1999) suggests that, if students are making meaningful connections, there is a shift from superficial to more differentiated learning, and this shift can be aided by story. Standard developmental theories also suggest that learning which transforms us culturally (Vygotsky) or cognitively (Piaget) is learning which becomes 'part of us' – i.e. is significant to us as members of cultures and as unique individuals with particular values, attitudes and perspectives on life. As argued above, stories can be regarded as useful aids in mediating experiences, as they are seen as both culturally and personally significant, connecting diverse experiences in significant ways.

The story of Jack is a good example of how a story brings many important dimensions of nursing together in potentially transformative ways. This story was originally part of my pre-narrative. I remembered it because it is special to me, and I told it to my students to emphasise the use of ethical principles and philosophies in the classroom. This was only a superficial use of the story, and I was not aware of the more differentiated meaning and understanding within it. Although I wrote down the story and used it as a basis for an article (Edwards, 1997a), it was not until I started to share the story with students that I realised its full potential for developing learning.

In discussions with students, I began to appreciate how they were establishing links between the ethical principles and philosophies in their practice situations, and what it meant for them to be a patient advocate. In addition, I recognised the sense of conflict the students had with regard to the decision. Autonomy is one of the most powerful ethical principles and I think Jack should have had a Guinness. A small number of students challenged this decision. I had always thought giving Jack a Guinness was best, but as the students' reasons for challenging the verdict unfolded, the complexity of the issue became clearer.

Students had always been encouraged to acknowledge health education / promotion principles, but there was conflict between, on the one hand, advocating to Jack that he should stop drinking, and, on the other, allowing him to have a Guinness. In this particular story, there was not only a connection between skills and bodies of knowledge but also a conflict between health education / promotion and ethics. In turn, I could see the students' critical thinking skills brought into play as they counter-argued the premise that health education at this stage in Jack's care was inappropriate as he was still recovering from a serious illness. Only when he was fully recovered should the issue of stopping drinking be prioritised.

In summary, theory, practice, emotion, ethics, intuition and personal development are all related, but when they are in conflict (as in this case), very different opinions can be held as to what constitutes 'best' care. However, the story of Jack suggests that nursing is a synthesis of skills and bodies of knowledge, intuition, emotion and personal learning that should be integrated as the basis of patient care. They all played some role in caring for Jack, and the story can, potentially at least, be considered as a way of reinforcing and crystallising the interconnectedness that learning needs to make it transformative.

#### *4.4.5f The way story connected my learning through time*

According to Hochschild (1983), learning which is not interconnected or linked to other learning is likely to be surface learning. It is when students link experiences together in ways important to them ('schematically' in Piaget's psychology) that learning ceases to be superficial. Christiansen and Jenson (2008) build on this idea and identify 'deep' learning as that which engages our emotions. It can be that which provokes empathy and compassionate concern. It can be learning that leads to action following a critique of practice, a change of practice or review of ideas about practice. It is proposed that students' story writing helps them engage with clinical experiences, make connections between the experiences and respond to them meaningfully.

That is, it helps move a student from superficial to more professionally transformative or meaningful learning.

Drawing again on the story of Jack (story 24), I attempted to demonstrate how my learning from it moved on and developed through time. I used this story many times in the classroom, and, in the ensuing discussions with the students, my understanding of the story has itself become much deeper.

Usually students understand the need to give Jack his Guinness, as autonomy was the most powerful ethical principle related to this story. Yet over time, with different groups of students, this decision created some tension between health promotion principles and the ethical principle of advocacy. I have tried to show how, by studying and retelling the story of Jack, I have come to understand it in ever richer and more meaningful ways over many years.

These experiences as crystallised by story could be interpreted collectively and contextualised within a longer-term historical story, given meaning in terms of the larger context of nursing which changes as time passes. This potentially allows the past to be connected to, and have continuity with, the future. The significant point here was that, returning to story 23 and, having understood Elsie's anxiety, I was prompted to consider how in future I needed to attend differently in such a situation, so I could use my intuition more effectively.

Finally, I have had many clinical experiences during my years in practice, and it was the learning drawn from these that informed my future nursing practice. By examining this process of self-learning, I developed a conceptual framework depicting the process of learning, which I have described above. The connections between my stories and learning have been made by looking back over many years of practice and by using them in the classroom, which in turn led to further development and learning. The dimensions of learning drawn from my stories (ethical, personal learning, intuition, emotional

learning, connectivity and learning through time) highlight the value of story for learning in nurse education.

However, I am in a different position from that of my students. Stories that have proved significant for me may not be significant for them, but, by using their own stories, students may be able to progress more quickly with their learning. The way story can mediate experience, crystallising what is important and helping a learner make connections s/he might not otherwise make in focused ways useful for clinical practice, has certainly informed my own professional story. It is my view that such an approach has the potential to make a valuable contribution to nurse education.

*In this chapter I detailed how I came to value the use of story and how I developed a strategy for learning through examining my own learning in practice. As a nurse educator in higher education, I felt early in my career that my creativity was being stifled and my voice was not being heard. In an attempt to bring practice alive for students, I looked back to my days in practice and started to tell them stories from it. I developed a trusting relationship with students and encouraged them to expand their learning through stories.*

*The stories depicted a life in practice and led to the development of my own ideas of how students might also learn from story. I found it useful to divide learning from story into five stages – a pre-narrative, remembering, writing of stories, sharing stories and finally the identification of individual learning that emerged from them. By such strategies, I identified the individual learning which opened up my understanding of, for example, ethical principles, emotional learning, intuitive insight, and practical interactions with patients.*

*The storied experiences that had accumulated from my clinical practice years and the inclusion of these experiences in the classroom began to be unscrambled, assessed, considered and used as a platform for further scrutiny. Since stories have been so valuable for enhancing my learning in practice, perhaps their use could be developed to bring about a similar*

*learning experience for others. This possibility is the main stimulus for my research. The individual learning from my stories forms the basis for recreating the key elements of the process for exploring students' learning from their written stories of clinical practice. I propose that students' written stories about practice, and the exploration of them, can enhance students' learning. In the next chapter, I outline the research strategy employed to explore how students' learning can be developed through their own stories of experience in practice.*

## **Chapter 5**

### **Research methodology**

*The challenge in chapter 5 was to develop an appropriate methodology to uncover the nature of learning that is stimulated by story, for which purpose I reviewed a number of qualitative methodologies. The research approach chosen was narrative methodology, and the procedures used to collect data were developed for application with student nurses' written stories, to explore story as a potential aid to learning from clinical practice.*

*The research methodology chosen includes the use of students as participant researchers, whereby the students examine how they believe they have learned from a written story. Focus groups were also part of the research. Students who contributed their stories and learning accounts were invited to participate in focus groups to confirm a student interpretation of their learning. This method placed the researcher in a less commanding and controlling role in the process of data gathering, a view that was consistent with the democratic thrust of my research.*

*Because story played a significant role in my own professional learning and I wanted to explore its use as an aid to learning for student nurses, I applied the approach I used with my own learning outlined in chapter 4. A number of student nurses were asked to remember a story from their clinical practice, write it down, identify their own perceived learning from it and share it with me. This process was meant to help focus participants' thoughts on a recent experience that occurred in their clinical practice, their perceived learning from it and the benefits this may have had in developing insight into their clinical practice and themselves as nurses. In this chapter I also explained my own role in organising and presenting findings relative to the theories introduced earlier while seeking to answer the research questions.*

## 5.1 Selection of a methodology

In research into nurse education, a significant number of studies employ the use of patients' or nurses' stories (see chapter 3). Often researchers use stories as a way of targeting specific curriculum content (see chapter 3), and I use my own stories and those of others from my teaching (see chapter 4) for this purpose. Stories are, in fact, used as a research tool in many ways. For example, as part of an investigation, they can make nursing practice – such as care – visible in such a way as to make a difference to patients, perhaps disclosing that which is sub-standard. Many studies employ qualitative research strategies, taking a perspective on story from ethnography (e.g. Bailey and Tilley, 2002), grounded theory (Lalor *et al.*, 2006) or phenomenology (Koch, 1998).

### 5.1.1 Qualitative research strategies

Denzin and Lincoln (1998, 2000) established one of the guiding principles of qualitative research, which is to enhance knowledge by investigating it in its relevant context. Thus, Higgs and Titchen (2001) use a qualitative strategy to reveal how students find encounters with patients in clinical practice helpful, with such encounters serving as a means for students to gain clinical expertise. Increasingly, nurse educators are acknowledging qualitative research to be the most appropriate for discovering what students are learning from their courses, and a qualitative approach places emphasis on student-centred, holistic and human aspects of care. Pope and Mays (2006) believe that qualitative research provides a structured path reaching parts (i.e. achieving aims or answering questions) that other methods cannot reach. An emphasis on interpreting and understanding learning from students' written experiences of clinical practice as promised by qualitative research captures something of the essence of this study.

### 5.1.2 Qualitative methodologies

There are diverse qualitative methodologies, including those based in ethnography, grounded theory and phenomenology. Each was briefly considered for its potential in exploring the nature of learning from students' written stories of clinical practice.

Hammersley and Atkinson (2007) define ethnography as a methodology in which researchers describe and interpret holistically the patterns of behaviours, values, beliefs and language of a defined cultural group. Pallet (2003) stresses that ethnography is a quest to learn about and understand human cultures as these develop over time. He places cultural behaviours and attitudes into conceptual frameworks to facilitate investigation. Stories have long been used for purposes of data collection within ethnographic research as shown by the work of Bailey and Tilley (2002), which involves the examination of participant stories contained in interview data.

Central to the ethnographic approach using story (Bailey, 2001) is the reliance on interviews to elicit the story to be analysed. Researchers themselves analyse story data in order to convey to a supposed listener the meaning participants intend. In other words, they do not let the story speak for itself. McCance *et al.* (2001, p.351) confirm that the interview is the method chosen most frequently for ethnographic research using narratives. However, since this study is not primarily an enquiry into the culture of the student nurse group (though this is not ignored), interview-based ethnography was not chosen as its research approach.

Grounded theory (Glaser and Strauss, 1967; Charmaz, 1990) is another methodology for investigating learning from nurses' written stories of practice. As the name implies, it concerns substantive theory development through a recursive process of data collection and analysis, to provide comprehensive explanations of a phenomenon or phenomena (Polit and Beck, 2008). A recurrent data collection process requiring repeat researcher-participant contact is a reason this methodology is judged unsuitable since participants



(student nurses) are usually subject to busy routines in their respective clinical areas. That said, grounded theory can be used to generate research-based knowledge of behavioural patterns from any form of data (Glaser, 2001) as shown in Lalor *et al's* (2006) study.

Also, grounded theory implies a form of theory development where the concept is brought closer to the reality experienced than other approaches achieve (Strauss and Corbin, 1993; Creswell, 2007). As I am attempting to look at the reality for nurses' clinical practice experience of using story, this might recommend a grounded theory approach. However, my remit is more closely tied up with the claims for learning from stories than with investigating experienced reality, so a grounded theory methodology was not chosen.

Phenomenology may be the most suitable methodology for exploring how students learn from their own written stories of practice. Somekh and Lewin (2005) explain how phenomenology is geared to understanding and interpreting individuals' lived experiences, such experiences being communicated to others who have had similar or equivalent experiences. Put another way, phenomenology seeks to find or mimic the internal logic of a perspective or lived experience by, as far as possible, entering into the world of participants (Gray and Malins, 2004). Hence, this approach could enrich the researcher's insight into participants' meanings as these are embedded in their written stories of clinical practice.

The quest for interpreting and understanding individuals' own constructions or meanings of phenomena has resulted in the development of a number of variants of phenomenology, which can be grouped within two philosophical frameworks, descriptive and interpretive (see Polit and Beck, 2008).

Descriptive phenomenology, developed initially by Husserl (1965), mainly focuses on providing 'pure descriptions' of human experiences. This links directly to my study in that students are asked to write a story describing their human experience as nurses. Creswell (2007) emphasises that, in order to provide pure descriptions, researchers should set aside their own experiences as much as possible, allowing fresh perspectives on any phenomena under

investigation. However, the use of story without additional analysis has been found to be limiting, as seen in studies by Koch (1998), Orland-Barak and Wilhelem (2005) and Maivorsdotter and Lundvall (2009). The single use of 'the story' fails to bring to the fore the interpretation of any embedded meaning, and to draw out such meaning some interpretation is required.

Providing interpretations of lived experiences is a core principle of interpretative phenomenology or hermeneutics, a theoretical framework founded and developed by Heidegger (1962). Parahoo (2006) confirms that this type of phenomenology goes beyond pure description, focusing on interpretation of human experiences. He points out that such focusing is more likely to lead to well-differentiated levels of knowledge and understanding. Linked to Parahoo's view is Heidegger's (1962) assertion of the interpretative nature of human existence. He claims that humans are constantly interpreting the world in which they live, and argues that its meaning can only be known through interpretation.

Interpretive phenomenology is an interactive and dynamic process linking the lived experiences of participants to the interpretative act of researchers (Denzin, 1983). Polit and Beck (2008) argue that, while the findings of interpretative phenomenology cannot be generalised, they can provide deeper understanding of specific situations or events. It is for this reason that this study could have adopted an interpretative phenomenological approach, as I am looking at students interpreting their own learning from their written stories. Researchers such as Davidson (2004) use the hermeneutic phenomenological approach to explore the use of storytelling in the classroom. His research reveals the different ways students learn through using story – such as learning with others in a safe environment – and, when applied to story, the interpretative phenomenological approach does seem to advocate a deeper search for meaning or significance than other approaches. Other interpretive phenomenology research includes that by Baille and Curzio (2009), who use a survey to obtain students' experiences of learning to take a blood pressure. Allcock and Standen (2001) interview student nurses to determine their experiences of caring for patients in pain. Cornish and Jones

(2010) employ focus groups to glean students' views and experiences of moving and handling policies. The interpretive phenomenology is combined with a variety of data collection methods to determine nurses' real experiences, but what is most striking is that the interpretation and analysis are undertaken by the researcher(s) alone – i.e. rather than by, or in collaboration with, nurses themselves

Crist and Tanner (2003) note that data analysis solely by the researcher(s) is a common practice in phenomenology. But it is the meanings for the investigator and interpretive team which seem important, rather than the participants' experiences, although Alderson (1998) claims that participants' involvement is a significant underlying precept of qualitative approaches.

In this study, without denying my ultimate responsibility for the investigation, I use participants as researchers to elicit their own learning from their stories and take research beyond the researcher's sole analysis of text. I thereby adopt a more collaborative approach than that commonly used in interpretative phenomenology.

Looking at a wide range of qualitative methodologies has been a valuable process in understanding my own work. Thinking about the methodologies which turned out not to be appropriate has allowed me to reach this point. Perhaps I was looking in the wrong place for a methodology which incorporates aspects of my own practice. As much research now undertaken employs the use of story within a stand-alone narrative methodology e.g. Aranda and Street (2000), I decided to develop my own approach within this now standard research framework.

## **5.2 Developing my own narrative research methodology**

Narrative research is a new approach that is plausible, flexible and open-ended, encouraging a researcher to search for novel insights. As such, it fits well with the purpose of nursing education research (Carson and Fairbairn, 2002) that seeks ultimately to make the classroom and practice environment

places where students are more likely to learn. Interestingly, there is a strong moral dimension to narrative research. Holloway and Freshwater (2007) point out that a methodology which involves the sharing of stories achieves a relationship where the balance of power between participants is less unequal than in other approaches. The researcher can include participants, without taking full control, and so develop a bond which might allow more insightful outcomes to emerge from the data.

Through narrative research, nurses can describe the world from their perspective and in their own language. They can show 'nursing as it really is', or, at least, as the individual nurse understands it. Nursing is about practice, and I am concerned with the potential for students to learn from their clinical experiences of practice. More exactly, I am exploring students' learning from their experiences represented as stories of clinical practice situations. Carson and Fairbairn (2002) point out that narrative enquiry can take real account of what nurses actually do. Narrative begins with practice and ends with practice, so it presents many fruitful possibilities for my own research.

Holloway and Freshwater (2007) suggest there is more than one approach to the study of narrative. Narrative research can be interpreted in many different ways and qualitative researchers can build their own 'narrative methodology'. Story-telling may well be an integral part and a key element of narrative enquiry, and, from some perspectives, story-telling itself can be regarded as narrative research. However, Frid *et al.* (2000, p.695) suggest that 'narrative' and 'story-telling' do have different meanings. A narrative is an account of events experienced by the narrator, while story-telling is the repeated telling or reading of a story by persons other than the narrator. Nevertheless, in nursing research, 'narrative' and 'story' can be used interchangeably and that is how they are employed here.

In another sense, narrative and story can be related hierarchically, with narrative presenting a substantive or 'big' picture, while story provides 'smaller' elements of the overarching narrative. This view is taken in chapter 4, where story is seen as a smaller part of my narrative. Yet, according to

Fairbairn and Carson (2002), narrative and story both recount human actions and emotions, and need not be regarded as different, as the same or even as having a hierarchical relationship. Instead, they can be put together in a coherent way which makes sense for a researcher.

Whatever conclusions we reach about their relationships, narrative and story can legitimately be put together. Here, 'story' is the term adopted for the practical experiences students write down and designate as 'stories', in that they represent clinical practice experiences of nurses who are at the forefront of caring for patients.

More detail about the particular narrative approach taken is discussed next. These are headed in the text below as follows: the use of written stories as a research endeavour, the role of participants and focus groups, and, finally, the organisation of findings to reveal the ubiquitous role stories can play in nurses' learning in relation to the research questions asked.

### 5.2.1 Story as a research endeavour

It can no longer be accepted that our stories of clinical practice should remain as an oral social activity and, once told, are very quickly forgotten. They are too valuable and important and we need to understand them better. Fairbairn and Carson (2002) view new qualitative methodologies, such as narrative enquiry, to be as much about developing new educational attitudes and values as about allowing story to be accepted as a legitimate research endeavour. Similarly, although Tilley (1995) prefers to label stories as 'case studies' or 'accounts', both are generally 'made up' for teaching purposes. The use of real life stories, according to Fairbairn and Carson (2002), has much to offer as a way of understanding how people actually do interpret their lives. Koch (1998) argues that examining understanding through story is a legitimate research endeavour whereby readers can decide for themselves what is interesting or significant. I agree with Fairbairn and Carson (2002), that story can offer a better understanding of nursing, and with Koch (1998),

that story can be at the heart of a legitimate research endeavour, leading ultimately to improved professional action.

### 5.2.2 Written stories

To develop a comprehensive picture of helping students learn through story, I needed to adopt an approach that was appropriate for such a task. The approach selected is the exploration of students' written stories, interrogated by means of an array of analytical tools developed for exploring my own stories and the learning that developed from them, combined with ideas gleaned from wider theoretical studies. Interviewing is probably the most frequently used method chosen for narrative approaches, and, for example, McCance *et al.* (2001) and Reissman (1993) interview participants using several broad questions to elicit oral stories.

Such narrative researchers may well assume interviewing can be a more effective way of representing students' views as students themselves interpret the verbal interaction of a story as representing their experiences. Writing something down could set up barriers to 'truthful' representation, as students have time to think about, and possibly fabricate, the content of a story. However, Koch (1998) used written stories to bring about change in elderly care, implying such stories can have a 'real life' impact in themselves.

Orland-Barak and Wilhelm (2005) also use written stories though they do not incorporate the potential of learning from stories into their study, while Attard (2012) used written stories as an aid to improving professional practice. As I have stressed in this study, I want to encourage students to write down their stories rather than elicit these from interviews. For one thing, my research attempts to move away from a nursing culture that values only telling stories (i.e. confirming an oral culture) towards developing a written culture. Such a culture could establish a resource of stories recording what nursing is and what nurses do, something theory alone can never achieve. The world created through story is not in the first instance a secure world. It only lasts as long as the story. Writing it down makes the story more permanent and,

therefore, powerful. If we as nurses value the stories we tell, they need to be put into a written form, otherwise they could be lost.

More practically, and in line with the view of Attard (2012) that written stories can help aid professional practice, I suggest that these can influence a profession with developing its own practice-based knowledge, enabling it to be in a stronger position to chart its own path to the future. Koch (1998) supports the idea of nurses writing down their stories, suggesting that writing may be a means towards developing new forms of story-telling. The use of written stories is especially relevant to teaching practice-based professions and for research (Frid *et al.*, 2000). Documenting and recording nurses' stories in writing makes nursing practice visible (Mason, 2002), and goes some way towards what Winter (1995) called the 'organisation of our experience into meaning'.

Bruner (2002) believes it is possible to find meaning in stories that goes beyond the story content itself. Like Glaser'sfield (1991), he asserts there is a reality which can only be identified and known by ourselves as individuals. Conceivably, story can give access to such reality. Writers such as Hampton (1994), Henderson (1994), Mason (2002) and Attard (2012) advocate the use of written stories as a way of gaining self-awareness. In their studies, they detail accounts of the inner experiences related to practice stories. Stories may also be useful aids for teachers working in classrooms.

Rolfe (2000) suggests that written stories can develop our understanding of the world we know, while, as Koch (1998) concluded, they can have huge emotional significance – essential for the development of nursing. Written stories may also show the complexity and unpredictability of the environments in which nurses work. They help to crystallise the meaning of lived and shared experiences which otherwise might remain tacit. Obviously, student stories will never be identical to lived experiences themselves. As van Manen (1990) argued, all recollections of experiences and identification of learning from them are transformations of those experiences, as the experience captured in writing is already transformed at the moment it is written. The

story can never be taken as an immediate representation of experience, only as a meaningful record. What I hope to achieve through written stories is to gain access to the meanings embedded in nursing practice that might otherwise be hidden.

### 5.2.3 Participants as researchers

I asked students to provide their written stories as primary data, but also requested them to report what they considered they had learnt from writing their stories. That is, I invited them to participate in the research analysis, a strategy proposed by Reason (1994). In this way, I hoped to gain the best representations of the students' own ideas about what they had learned. Very few studies explore how students can use stories as an aid to learning, i.e. using students as research participants in the way proposed here. Carson and Fairbairn (2002) believe knowledge derived from a study can be maximised by researchers developing relationships with their study participants, and claim that such relationships can aid the eliciting of personal and professional experiences. Certainly, when researchers interact closely with participants, they give the latter opportunities to talk freely about the totality of their experiences. I made every attempt to achieve this kind of fruitful relationship with my focus groups (discussed below).

Kim (1999) insists that, as a practice discipline, nursing needs to develop a method of inquiry that involves practitioners directly in the inquiry and, as Squire (2009) insists, narrative research can incorporate and engage practitioners in the research process. There is no reason why this should not also apply to the use of story. An interpretative approach to research allows the voice of those whose views are usually silent or ignored to be heard. This matters, since the voice of students is perhaps the most valuable in deciding what to preserve and what to replace as we create a new student-centred, practice-based nurse education.

Nevertheless, Gilbert (2008) warns that, while active participant involvement is considered by qualitative inquirers to be an ingredient for success, study



results are often biased towards researchers' perceptions. De Poy and Gitlin (2010) add that in such circumstances the participants can be inhibited and their disclosure of personal information over-shadowed by the researchers' interpretations. However, participant involvement is a good starting point for exploring a situation in instances where very little is known about whatever is being studied. As the way nurses learn from stories of clinical practice falls into this category, this study adopts active researcher involvement as part of its holistic exploration.

Faulkner and Thomas (2002) go further, indicating that qualitative methods, increasingly utilised by educational researchers, can only be complete when they include the subjective experiences of students. Some qualitative researchers, such as Burns and Grove (2003), Casebeer and Verhoef (1997) and Aranda and Street (2000), believe that researcher-participant interaction is the best way to develop a deeper understanding of human experiences as these appear to the individuals affected.

However, as discussed above, there is the issue of the lecturer-student power relationship to take into account (Holloway and Freshwater, 2007). This relationship is rarely one of partnership, and could allow the researcher undue influence over the behaviour of participants. Martin (2002) points out that, within higher education, students are sometimes excluded from research activity as researchers, on the grounds that they do not know enough about the topics under investigation. By such means, academia maintains power over students. An excerpt from my personal narrative relates to this issue:

#### My story 25

I am reminded of a time when I was in an exam for a statistics module for my masters in nursing. The exam paper and formula were given out and we were told we could start. I turned over the page and immediately knew the formula given for the statistics paper was incorrect. I put up my hand and informed the lecturer present that this was not the correct formula required to answer the exam questions but she said yes it was. It was of course realised the incorrect formula had been given, the exam was stopped while the correct one was found and the exam resumed. The delay need not have been so long, if the lecturer had taken notice of what I had said.

Holloway and Freshwater (2007) draw attention to the importance of the researcher not assuming a superior position over participants. They discuss the desired relationship as one of 'congruence', a reciprocal partnership helping to ensure genuineness, authenticity and transparency, defining 'congruence' as the researcher not assuming the role of the expert superior to the participant. The empowerment of participants also creates what Holloway and Freshwater (2007) call tactical authenticity – i.e. it respects student voice. More generally, Reason (1994, p.11) proposes that a participative methodology involves research being conducted *with* people rather than *on* people, becoming an inquiry into experience and practice together.

Finally, inviting students to become participants as researchers allows my teaching practices and research ethics together to inform the investigation, conforming overall to my ethical stance as a researcher. By including students as researchers, I am able to empathise with and, hopefully, respect them. I can listen to their stories and give them a voice, not suppressing what is significant and relevant to them as students. The use of focus groups reinforces this general aim of respecting and valuing students' own interpretations of their stories.

#### 5.2.4 Focus groups

The use of focus groups, as suggested by Vaughn *et al.* (1996), is employed as a means of checking the category analysis drawn from the stories and learning accounts for accuracy and relevance. In addition, focus groups were used to identify further the meanings of the complex layers of learning from the students' written stories. Clarke (1999) suggests that using focus groups allows the researcher to get close to participants and explore their views and concerns, and Vaughn *et al.* (1996) propose that a focus group is 'focused' in the sense that members consider and debate a given issue or topic. According to Krueger and Casey (2000), the inclusion of focus groups places the researcher in a less commanding and controlling role in the process of information gathering, a view that is consistent with my research intentions discussed above.

Through focus groups I offered students a way of sharing their understanding of learning from their stories. I adopted a minimal role in group interactions, as suggested by McLafferty (2004), and encouraged students to discuss openly their experience of writing down their stories and analysing their learning from them as well as explaining how they felt about the process as an approach to learning from clinical practice.

I was hoping that, through the use of these ideas, as supported by Clarke (1999), Vaughn *et al.* (1996), Krueger and Casey (2000) and McLafferty (2004), students would influence each other with their comments, form opinions after considering the views of others and come up with some consensus as a group about the learning that can take place when story is used. Having written a narrative and having used stories myself, I knew that different views of the same experience can exist. I attempted to encourage students to become more engaged with their stories of practice and more aware of the broad range of perspectives that guide their learning. Inviting students who contributed their stories to be a part of a focus group would hopefully give me more detailed information on participants' priorities, as well as opinions and ideas.

I also wanted to include focus groups to give back to the students something other than just participating in my research. It was hoped that they would continue to value their stories as a way of learning in the years following this research and view that learning as part of a life-long process to improve their practice as nurses.

#### 5.2.5 Organising and presenting findings: my role

Nurses do not have at their disposal my experience as a researcher, nor the professional and theoretical knowledge needed to evaluate evidence for the ways stories aid learning or report findings in as convincing a way as possible. Because this is important, it is discussed as a stage of data analysis below.

### 5.3 Ethical issues

Ethics were not only dealt with when I completed the forms for the University approval panel but have been respected throughout this work, including with regard to my own personal account, the use of participants as researchers and in the research design process. Before beginning the research, I needed to obtain ethical approval both at the University at which I was taking the Doctorate in Education (EdD), and in the work place where the research would be situated. Permission was granted from both institutions to solicit stories, and the learning they had gained from them, from student nurses in a suburban London university. I did not approach participants until I had been granted ethics approval from both institutions.

Holloway and Freshwater (2007) suggest that, before undertaking research, informed consent from all participants should be obtained, and this was granted to all students who volunteered to take part (see Appendix 3). The issue of anonymity in research also needed to be considered (Williams and Keady, 2008) and, under the ethical guidelines for human subjects at both universities, this was guaranteed for all participants. Students were not required to put any form of identification on their story, and all the information sheets and consent forms were numbered. Students were told to keep the information sheet with the number displayed in the top right-hand corner of the page and return to me the consent form, which had the same number in the top right-hand corner.

When I typed up the stories and learning accounts, I listed separately the number related to them and, if any student, at any time, wanted to remove their story from the research, the contact details were given on the information sheet. They could email, telephone or text me their story number and I would remove their story from the project. In this way, no students' names were identified from the outset and stories are referred to as numbers only. The full research account is a transformation by the researcher of what I have received from the participants and focuses directly on the phenomena under study i.e. learning from experiences of clinical practice using written stories.

## 5.4 Research design: researching how story aids learning

The research design for this study included the selection of the participants, which involved collecting students' written stories following a number of stages linked to my own account of learning from stories outlined in chapter 4.

### 5.4.1 Selection of the participants: collecting students' written stories

The participants were all student nurses from a suburban London university, either undertaking an undergraduate Diploma in Nursing (pre-registration) in their second or third year or a post-graduate course at Degree or Masters level but with a number of years experience as a qualified nurse. I asked both pre- and post-registration nurses to volunteer to take part in the research. They were invited to write down a story of their practice and identify their learning from it following the process given in Table 5.1. To recruit the participants I:

- Placed a notice on Blackboard for second- and third-year students to access;
- Handed out photocopied information to second- and third-year students in the classes I was teaching;
- Asked two colleagues to circulate this information to their groups of students.

The 55 participating students submitted a total of 55 written stories and learning accounts. The second-year adult branch student nurses' stories are depicted as 2A; a third-year story is 3 and broken down into the following branches of adult (3A), child (3C) and mental health (3MH); post-graduate students stories are shown as PG (the numbers can be used to cross-reference stories and learning accounts to the appropriate analysis given in the Appendices). There are:

- 19 second-year (2) Adult branch (A) undergraduate students (2A 1, 2, 9, 10, 12-16, 18, 21, 23, 26, 27, 33, 36, 44, 50, 54)

- 25 third-year (3) undergraduate students which are broken down into:
  - 17 Adult branch (3A 17, 21, 23, 30, 32-40, 44, 48, 51, 52)
  - 4 Child branch (3C 1-4)
  - 4 Mental health branch (3MH 1-4)
- 11 Post-graduate (PG) students (PG 1-6, 7-8, 12-14)

Individual contributions consisted of one story and learning account from each student, which ranged from 1- 4 typed or written pages. Although the students were undertaking their nurse qualification in a suburban university, there are stories that recount experiences in London hospitals where they gained their clinical practice experience.

#### 5.4.2 The stages of data collection

For this study, I followed my own account of learning from stories outlined in chapter 4, by asking the research participants (student nurses) to follow the same process i.e. remember a story drawing on their own practice experience, write it down, identify their own learning from it and share it with me. All participants who volunteered to take part were given an information letter (Appendix 4) about my research, asking them to share a story about a memorable or meaningful moment in their clinical practice experience. The letter explained that the stories could be in the form of informal anecdotes, as described by Nelson (1993). The students who agreed to participate wrote their stories and learning accounts independently, outside of the classroom. In addition, students were also given a consent form (Appendix 3) and six cues to writing a story (Appendix 5). The participants were given the option as to whether they used the cues, and some of my own stories were given as examples (see Appendix 5). The circulation of information to stimulate the remembering of a story was the first stage of data collection and no analysis took place at this stage.

In stage two, students were asked to write down a chosen story, which could either be one they had previously written or a new story as they remembered

it. This follows procedures I have developed in my faculty where students are encouraged to keep a practice journal of clinical practice experiences and their learning arising from it. It is the responsibility of students to keep their own journal. For the one story submitted by students, I was not concerned about grammar or writing style and there were no hard or fast rules. I felt strongly about this, and my view is supported by Shor and Freire (1987, p.20):

‘... these writers were not pre-occupied in following grammar! What they searched for in their writings was an aesthetic (practical) moment’,

and students were assured that the grammar and writing style were not being judged.

Stage three involved students expressing their own ideas in writing about what learning they considered had occurred from writing their story i.e. an analysis of their perceived learning from that story. I called the students' first analysis of their own learning 'learning accounts'. I subscribe to the views of Koch (1998), who claims that, although story can convey so much, change only comes about through working directly with research participants. I did not want the students to feel that my interpretation of their learning was more valid than their own, and even though the students' perceptions of their learning initially appeared to portray just a collection of bald statements (see Appendix 6), learning could nonetheless be drawn from them.

I realised that the learning accounts were a key aspect of my research approach, and therefore the information given to students contained no information about learning theories or styles, or examples of the type of learning that might emerge from their stories. My choice not to include such guidance allowed maximum freedom, as I did not want to predetermine the students towards any particular view of learning. Instead, I allowed students to advance their own interpretation and understanding of learning from their story. Stage four involved the students sharing the written story and their learning account with me as the principle researcher, which they returned to me by post in the envelope provided or by email.

The final stage involved the use of focus groups for students who had participated in the research. Davidson (2004) suggests that focus groups may elicit a multiplicity of views and emotional processes around understanding of stories within a group context. In addition, group interaction might widen the potential contribution of story by activating forgotten details of the experiences shared. This data collection technique also enabled me to explore any consensual views that emerged, informing my own category analysis and ultimately my presentation of findings. Dates for the focus groups were posted on Blackboard, as stipulated in the research information (see Appendix 4), and I split them into second-year undergraduate, third-year undergraduate and post-graduate students, thus establishing three separate groups. All meetings took place in a small seminar room with 21 third-year students attending the first (split into 6 groups, a-f), 14 second-year students attending the second (split into 3 groups, a-c) and 12 post-graduate students attending the third (split into 3 groups, a-c).

For the first part of the focus group, students were placed into self-selected groups of between 3-5 people. These groups were asked to debate and discuss the process of learning from story as they saw it, the learning that emerged and any comments they wanted to add about the potential for using story in the context of clinical practice. This all took place without interruption from me, during which time I took notes. At the end of the 20-minute discussion, I invited students to document the parts of their dialogue that took place in their groups, and write what they were willing to share in a mind map on a flip chart. It was important that group members were given the opportunity to share only those aspects of their stories and learning that they felt comfortable to expose. Mind maps (Buzan and Buzan, 1996) were utilised to help maintain consistency with what was written down. The stages of the research I outlined relative to my own account in chapter 4 can be followed in Table 5.1.



**Table 5.1 – The stages of learning related to the process of data collection**

<b>Stages of the personal learning process</b>	<b>Process of data collection</b>	<b>Data generated</b>
1. Remembering	Giving out the research information to help students recall a story of a patient's journey or an aspect of clinical practice	
2. Writing	Write down the story	Student stories
3. Identification of learning	Identify their own interpretation / perception of what they learned from their story i.e. the learning evident in the story.	Learning accounts from 55 participants
4. Sharing of the story and learning	Submit the story and learning account to the researcher.	Written stories and learning accounts from 55 participants
5. Focus groups	Take part in a focus group (1 of 3): 1. Discussion on: <ul style="list-style-type: none"> <li>• Understanding of stories</li> <li>• Contribution to learning</li> <li>• Possibility of using process in the future.</li> </ul> 2. Write down what you want to share in a mind map	Mind maps from student discussions. Researcher's notes from discussion

## **5.5 Data analysis procedures**

Elliott (2006) points out there is no standard approach or list of procedures that is generally recognised as representing a narrative method for analysis, and Freeman (2003) considers that narrative researchers generally use a multitude of different approaches. The main analytic strategies I used were those linked to narrative analysis given by Lieblich *et al.* (1998), holistic content analysis and holistic analysis of form, leading to a final qualitative exploration of the diverse and varied role story can play in nurses' learning. The final stage of analysis structured the presentation of findings.

Lieblich *et al.* (1998) do not give a clear definition of what they mean by holistic analysis of narratives, but they assume that the whole story should be analysed and not cut up into pieces and assigned to themes. Consideration is taken of interpretations of narrative analysis by theorists such as Elliott (2006), Squire (2009), Bruner (1990) and Riessman (1993), and by other researchers including Clandinin and Connelly (2000), Nelson (1993), Maivorsdotter and

Lundvall (2009), Labov and Waletzky (1967) and Koch (1998). A summary of the procedures used in analysis here is given in Table 5.2. It is useful to divide these procedures into three stages.

**Table 5.2 – A summary of the approaches to analysis**

Stages of analysis	Analysis type	Results generated	Literature employed
1	Reading student nurses' stories and learning accounts as they were presented	General overview of data	Koch (1998), Maivorsdotter and Lundvall (2009), Elliott (2006), Riessman (1989)
2(i)	Holistic content analysis	Categories arising from stories	Elliott (2006), Lieblich <i>et al</i> (1998)
		Searching for patterns and connections in the category analysis	Lieblich <i>et al</i> (1998), Elliott (2006)
2(ii)	Holistic analysis of form	Individual learning arising from the story process	Riessman (1991). Elliott (2006), Lieblich <i>et al.</i> (1998), Bruner (1990), Squire (2009)
		Evidence of learning through time	Elliott (2006), Dewey (1938, reprinted 1997), Clandinin and Connelly (2000), Squire (2009)
		The process of learning analysis: searching for structure	Drawing on Labov and Waletzky (1967), Elliott (2006)
3	Organising and presenting findings: the role of story in professional learning	Reviewing all evidence collected, from the content analysis and analysis of form,	Lieblich <i>et al.</i> (1998). Koch (1998)

### 5.5.1 Stage 1: reading student nurses' stories

My analysis began with reading the participants' stories, and I started by presenting them as descriptions of past events in the students' lives. The purpose of reading the stories as they were presented was to get a feel for them as they were told and to gain a sense of their narrative power. This general approach is adopted by Koch (1998) and Maivorsdotter and Lundvall (2009), who do not even analyse the story material gathered during their research but still reach significant findings that, ultimately, brought about change in the areas they investigated. For example, the stories presented by

Koch (1998) are referred to as 'good' human stories (Squire, 2009, p.46) and, once the stories were made public, relevant action resulted.

Similarly, Orland-Barak and Wilhelem (2005) illustrate how nurses' stories, without any layer of interpretation, can help with the practice of nursing. For the present research, I carefully read the participants' stories and learning accounts (an example is given in Box 5.1). I refer the reader to Appendix 6 to view the stories and learning accounts in their entirety and, for a general overview of the stories, Appendix 7 should be consulted. Together (i.e. stories which shaped the students' learning accounts) these are analysed as objectively as possible, using holistic content analysis.

#### 5.5.2 Stage 2(i): holistic content analysis

The second phase of analysis was to find meaning in the participants' stories and learning accounts. I approached this, first, through holistic content analysis, identifying categories and searching for related patterns to determine, for example, if students themselves were connecting the different categories in any way.

##### *5.5.2a Identifying categories arising from stories*

Sorting the content of stories into categories, aided by learning accounts, was necessary to determine the possibly significant connections between what the students could be learning (a later part of the content analysis). Even though the stories were self-selected in response to an open invitation, the differences, and sometimes similarities, among them invited categorisation. Using Lieblich *et al's* (1998) ideas on categorical content analysis, I highlighted appropriate sections of the text, extracted these sections and placed them within the categories. The final categories were arrived at by developing category descriptors (Appendix 8), as Koch does (1998). Linde (1993) acknowledges the difficulty of removing the experiences of the reader from the text, and I used my own experiences and knowledge of nursing and nurse education to assign story content into categories.

## Box 5.1 – Story 2A1: Participant story and learning account – example

### Story 1 – 2<sup>nd</sup> year student

This clinical experience will be focused on an 85-year-old man who lives in a residential home. I was involved with his care whilst on my district nursing placement. He had a stroke and he is also a diabetic patient. The purpose of the district nurse's visit is to draw up his insulin for him to self-administer. One day we arrived to draw up his insulin, and it was not there, so we had to go back to the surgery, to collect the insulin from the pharmacy. This affected the patient because he had to wait for us to get back before he could eat. This could have been prevented, if the nurse who visited the patient on the previous day had mentioned this in the hand over. This therefore, shows, without effective communication the holistic care of a patient is compromised.

#### *Story 1 – Learning account*

- What diabetes mellitus is the two types, treatment and complications
- What a stroke is, the blood vessels involved and what happens to them to cause a stroke
- The care this type of patient requires
- The influence of mentors on the student learning and if they are not consistent throughout the impact this can have on student learning
- The use of experienced staff to support student nurses is fundamental to professional socialisation and skilful role models can enable students to discover knowledge embedded in clinical practice.
- The role model observing mentors enables students through the process of reflection, to internalise their mentor's behaviour and build on previous knowledge and experience.
  - An imitation and observational form of learning whereby students simply absorb their role model's qualities and skills
  - Students are responsible for their own learning needs and must be actively involved in the modelling process to glean the knowledge the expert takes for granted.
  - Opportunity to work with experienced and knowledgeable practitioners and observe them providing care.
  - Enthusiasm for professional development unparalleled by any other learning experience.
- If the quality of the hand over by the nurses who visited the patient the day before had been better the situation could have been prevented, if effective hand over prepares and enables nurses to take over the care of patients and continue to deliver high-quality care.
- Failure to communicate effectively with someone and cause them concern, especially if they are vulnerable through illness, the effects of poor communication can result in more than minor irritation
- Good communication e.g. listening, guiding, thinking, engaging, making sense of knowledge and information and sharing – associated with life-long learning and required improving patient care.
- Communicating well with colleagues and others is about seamless care – a continuum where patient care is delivered smoothly.
- The NMC give guidelines for professional practice, recognises the vital role good communication plays in delivering patient focused care
- The importance of MDT care and communication as the key to successful health care provision
- Nursing hand over that is accurately documented information promotes effective time management and quality of continuing nursing care.
- The link between application of nursing care and communication to ensure nurses focus on the fundamentals of care and uphold the principles of clinical governance
- Hand over needs to be practised, structured and effective, reinforcing the professional status of nurses in modern health care provision.

Largely, the categories were not imposed on the story and learning accounts but were suggested by the texts themselves. Final judgements about the

categories were bolstered by the focus group data that added to the credibility of the category descriptors used. The key categories resulting from this stage two analysis are listed below, with the main areas emerging from the data clustered under thirteen key headings:

1. Issues of theory and practice
2. Emotional learning
3. Ethical understanding
4. Development of intuition
5. Communication
6. Cultural awareness
7. Engaging with reflection / personal learning
8. Teamwork
9. Learning from and with others
10. Professional development / critical thinking
11. Management
12. Educating patients
13. Hospital and community

The same categories were used for the analysis of all stories and learning accounts, and I examined each learning account and mind map for words related to that of the descriptions given in Appendix 8. Sometimes I included partial or complete sentences, and I added all the repetitions of the same expression when developing the categories to determine the learning of importance to students. I constructed a table of categories, which varied for each individual story and learning account. An example of this is given for story 2A1 in Table 5.3, and the remainder can be viewed in Appendix 9.

**Table 5.3 - Story 2A1: Categories that emerge from the student story and learning account**

<b>Practice</b>	<b>Communication</b>	<b>Learning from and with others</b>
The care of stroke and DM Improving patient care Delivering patient focused care Record keeping / documentation Quality of continuing nursing care Nurses' focus on the fundamentals of care Modern health care provision Must be actively involved to glean the knowledge the expert takes for granted.	If the quality of the hand over by the nurses who visited the patient the day before had been better the situation could have been prevented. Effective hand over prepares and enables nurse to take over the care of patients and continue to deliver high quality care. Communicating well with colleagues and others The vital role of communication Importance of communication to successful care Application of communication Hand over needs to be practised, structured and effective Communication depends on the nurse, client and other team members	The influence of mentors on student learning if not consistent throughout can impact on student learning Skilful role models help discover knowledge embedded in clinical practice Imitation and observational form of learning – absorb their role model's qualities and skills Opportunity to work with experienced and knowledgeable practitioners and observe them providing care
<b>Educating patients</b>	<b>Cultural awareness</b>	<b>Emotional</b>
Information sharing	The use of experienced staff to support students' fundamental to professional socialisation.	Failure to communicate effectively with someone can cause him or her concern, especially if vulnerable through illness.
<b>Team work</b>	<b>Political</b>	<b>Management</b>
The importance of MDT care	Clinical governance	Effective time management
<b>Reflection / personal learning</b>	<b>Theory</b>	<b>Professional development / critical thinking</b>
The role model observing mentors' enables students through the process of reflection, to internalise their mentor's behaviour and build on previous knowledge and experience	DM – two types, treatment, complications Stroke – blood vessels involved, what happens to cause a stroke What is involved in good communication – listening, guiding, thinking, engaging, making sense of knowledge and information sharing	NMC gives guidelines for professional practice Reinforces the professional status of the nurse Lifelong learning Student responsible for their own learning needs and must be actively involved

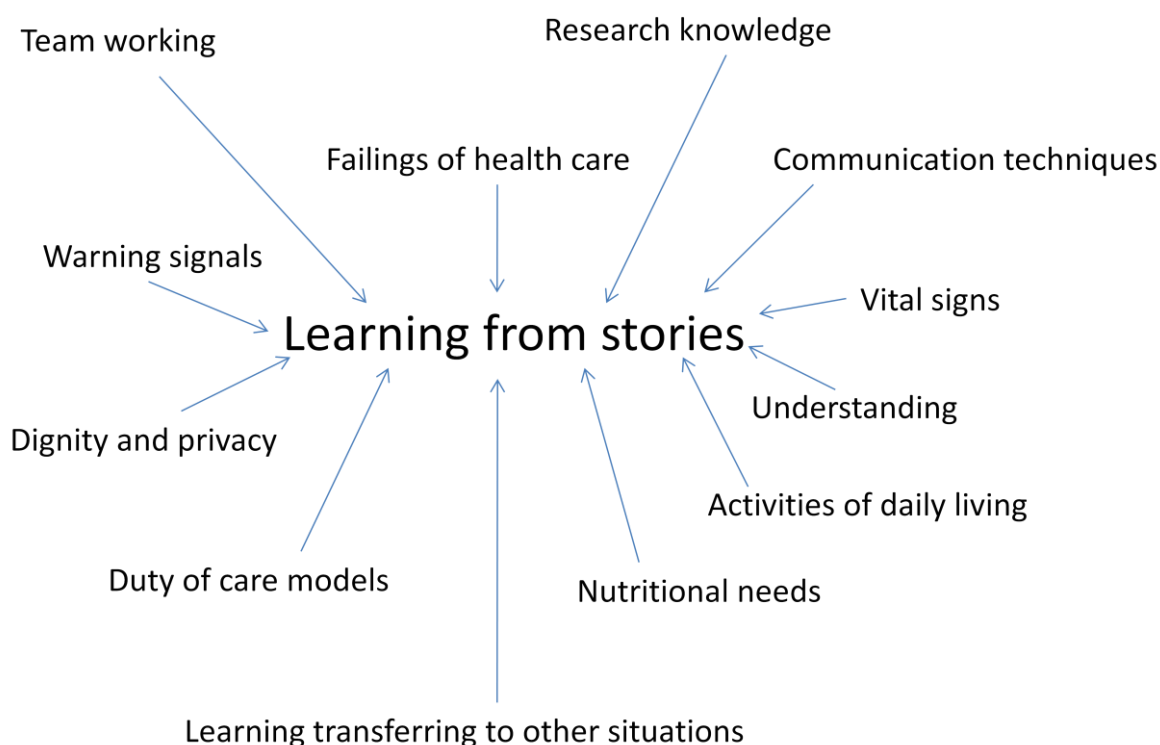
An example of a focus group mind map can be viewed in Figure 5.1, with all other focus group mind maps placed in Appendix 10.

Lieblich *et al.* also stressed the importance of paying special attention to individual sentences and paragraphs which might help to illustrate sub-categories emerging within the broader frameworks. Therefore, what was considered along with the category analysis data was evidence for sub-categories, labelled further dimensions drawn from within each category (an example using the category of intuition given from all stories collectively is given in Table 5.4, with all the further dimensions for each category included in Appendix 11). The objective behind creating further dimensions was to

discover whether there might be additional elements of learning when story was applied that may not show up through a first study of content.

**Figure 5.1 – Mind map drawn from focus groups**

**Focus group 2a: 2<sup>nd</sup> year Adult student nurses**



*5.5.2b Identifying patterns in and connections between the categories*

This analysis looked to uncover patterns within and between the category data (Lieblich *et al.*, 1998; Elliott, 2006) and I used Lieblich *et al.*'s (1998) idea of looking for patterns in the data as described in the holistic-content approach to analysing stories. They suggested reading the material several times, until patterns significant for nursing practice emerge e.g. links between theory and practice, which might help to clarify what students are learning from their stories (The patterns identified from story 2A1 are given in Table 5.5 and, for all other patterns, see Appendix 12). Lieblich *et al.* (1998) also suggest the researcher needs to believe in his/her own ability to detect meaning from the text; it will then 'speak to you'.

**Table 5.4 – Differing dimensions for the category of intuition**

Differing dimensions	Excerpt from students story and learning account
Engagement with intuition	Was able to spot something that was bothering patient. Just knowing when things need to be told and shared with mentor or more senior members of the team, so further action can be taken. (2A15)
Unaware of how they came to know or understand	Felt something was wrong but could not put it into words. Not being afraid to develop intuition and use it in practice, if situation not understood but know something is not right. (2A18)
Lacked confidence to use it	My intuition had told me to get an interpreter. On a previous occasion I had been advised that interpreters were only to be used in emergency situations due to the financial cost which had made me apprehensive regarding instructing one. (3C3)
Struggling to articulate feelings of unease	Instead of ignoring and put aside my own feelings and emotions about this situation I persisted with voicing my concerns and this led to the patient receiving the appropriate treatment. (3A39)
Putting information together	Took all of the information and put it together, just knew something was wrong. (2A18)
Acting on intuition	Knew something was wrong and had to take action so took a non-invasive intervention 12 Lead ECG. (2A18) Interpreting non-verbal communication e.g. facial expressions. Taking cues from patient and moving to a quieter area. (2A26) Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family, I respected this. (3A34)

Sometimes there are few, or no, clear patterns emerging within stories and learning accounts, and, at others, connections are made by students themselves related to their clinical experiences of, for example, caring for a patient. In Piagetian psychology, the term ‘schema’ is used for the linking of otherwise disconnected ideas into a coherent whole. In the example given in Table 5.5, a learner makes connections between ideas that have become associated during a professional activity, i.e. caring for a patient.

In an attempt to acknowledge connections between the categories, I noted especially when students mentioned two or more connected categories or related issues in one or two sentences or paragraphs. I placed these under the joint headings of the participants’ learning, in the words written by the student (Table 5.5).



**Table 5.5 – Story 2A1: The identification of possible connections between the categories**

The categories presented as patterns	Student excerpt related to the pattern
Learning from and with others / practice	Opportunity to <i>work with experienced and knowledgeable practitioners</i> and observe them providing care. (A1)
Communication / practice	<i>Effective hand over</i> prepares and enables nurse to <i>take over the care of patients</i> and continue to deliver high quality care (A1)
Communication / emotional learning / theory	<i>Failure to communicate effectively</i> with someone can cause him or her <i>concern</i> , especially if <i>vulnerable</i> through <i>illness</i> . (A1)
Communication / practical	<i>Communicating well with colleagues</i> and others is about seamless care – a continuum where <i>patient care</i> is delivered smoothly (A1)
Professional learning / communication / practical	<i>NMC give guidelines for professional practice</i> ; recognise the <i>vital role of communication</i> in delivering <i>patient focused care</i> . (A1)
Teamwork / communication / practice	The <i>importance of the MDT care and communications</i> as the key to successful <i>health care provision</i> (A1)
Communication / practice / professional development / management	<i>Nursing hand over</i> that is <i>accurately documented</i> information promotes effective <i>time management</i> and <i>quality of continuing nursing care</i> (A1)
Communication / practice / learning to be a professional	<i>Hand over</i> needs to be <i>practised</i> , structured and effective that reinforces the <i>professional status</i> of the <i>nurse</i> in modern <i>health care provision</i> (A1)

### 5.5.3 Stage 2(ii): holistic analysis of form

I approached the second part of stage 2 analysis through holistic analysis of form. Riessman (1993) argues that researchers need to avoid simply looking for content, and instead advocates the examination of individual narratives to interrogate their subjective dimension. This can be done through holistic analysis of form outlined by Lieblich *et al.* (1998). In this stage, I looked for differences in the ordering of events in stories (their structure) and the way connections between them are made in order to identify what might be judged important features of individual learning, learning through time and the way stories can be mapped against the learning stages identified earlier.

#### 5.5.3a Individual learning

Elliott (2006) insists that it is important to obtain a story that reflects the interpretations and values of the individual. On this basis, I selected seven students' stories and learning accounts and analysed them in detail. An example is given in Box 5.2, with the other six shown in Appendix 13.

## Box 5.2 – Story 3A37: The individual analysis of a student story and learning account

Here I integrate an excerpt from a student's story, their learning account (given in full in Appendix 4 and 9 with the researcher's commentary) from it and give a commentary on the potential links between the categories identified.

One student recalled learning from an incident related to the delivery of the nursing care provided for one patient. The medical condition of the patient called 'Wendy' was very complex, yet despite this, the student connected with her in a way that shows the possibilities of how the student developed individual learning. The student writes:

### Story 37 excerpt

Wendy is a female patient in her mid 80's with left buttock sciatic pain and degenerative lumbar stenosis. Lumbar spinal stenosis is a narrowing of the vertebral canal that compresses spinal nerves. When I first nursed Wendy, she was reluctant to leave her bed, and although had good physiotherapy input, lacked confidence in walking. The pain in her left buttock exacerbated the situation. Wendy felt hesitant to move from lying fairly immobile on her back (defined as a "comfortable position") to either side ("painful positions"). The pain in her buttock had also led to a loss of appetite.

When I entered Wendy's room, I noticed she was quite upset. I introduced myself and talked to her to find out why she was upset. Over the shift, working with my mentor we spoke briefly to the physiotherapist and worked out how Wendy could benefit from altering the times of therapy and being exhausted by everything being done in the morning, as by 10 a.m. she had had a bath, breakfast, physiotherapy and walked to the toilet and stairs, a doctor visit. This was all too overwhelming for her. So her schedule was changed and some of these activities were moved to the afternoon. In the afternoon Wendy felt more rested after a sleep and so was more willing to leave her bed with minimal assistance, practising the safe transfer in and out of bed. I was also able to encourage Wendy to transfer to and from the lavatory with a stick. Encouraging Wendy to sit in her chair also enabled her to feel more inclined to eat and drink.

Through the practice of such 'basic' nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, mobilised to and back from the bathroom, improved her confidence in walking with a stick, and had regained some of her appetite. From the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice.

### Learning account excerpt

- A brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided to my patient, over a whole shift.
- I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients.
- The situation encompasses how I used the nurse-patient therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist. The patient will be named 'Wendy' to ensure that confidentiality is maintained.
- When I first nursed Wendy, she was reluctant to leave her bed and lacked confidence in transferring from bed to chair. Wendy felt hesitant to move from lying fairly immobile on her back (a 'comfortable' position) to either side ('painful positions'). The pain in her buttock exasperated her loss of appetite; pain can reduce a patient's desire to eat.
- I am aware of the importance of team-working. I am also aware of tendency, of healthcare professionals to remain within the safety of their own specialist area.
- It is critically important for Wendy to increase her mobility and sit up to eat.
- Along with mobility, a nutritionally sound diet will play an essential component in improving and maintaining Wendy's recovery.
- I am pleased that I worked closely with the physiotherapist to encourage Wendy to get out of bed and transfer safely to the chair.
- I am also pleased that I adequately communicated to the physiotherapist that I wanted to work with her to see how she assisted Wendy in safe mobility.
- I now view team-working as more than just a theoretical concept that should be applied to nursing practice; rather it is an essential nursing skill that can lead to enhanced quality of care.
- I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing.

### Researcher commentary

By working as a team and negotiating with other health care practitioners team-working really influenced the delivery of care for Wendy. The brief and unplanned team-working session with a physiotherapist made all the difference to the care provided to this patient, over a whole shift. In her learning the student had recognised the skills of other healthcare professionals to assist her in the management and delivery of the best care for Wendy. The student had incorporated elements of communication, the development of a therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist. In addition, the student had made reference to theory, was guided by her own professional status as a student nurse and all the time critically thinking about what could be done about it.

*For example*, the student began her account by describing the patient's condition and giving some brief insight into what this condition entailed using *theory*. She continued to *interact* with the patient recognising Wendy's non verbal language as the student noticed she was upset, she listened to Wendy's account of her hospitalisation, while at the same time *critically thinking* about the meaning and significance. By being open to Wendy's account the nurse interprets Wendy's concerns and realises that some of her problems could be handled by negotiating with the physiotherapist to *work together as a team* to change her care. The use of other HCP is recognised by nursing *professional body* (NMC). This culminated in the student nurse using her *practical skills* to assist Wendy's transfer in and out of bed and to walk to and from the lavatory with a stick. But more importantly Wendy was no longer upset, and the student had gained *personal* insight into herself as a nurse. This visible symbol of caring is what should be celebrated as the difference we can make as nurses.

Selection was on the basis of the richness of the data they provided and the sense in which they seemed 'unique' accounts. These students' accounts of learning were uniquely detailed and to scrutinise them as such might, I believed, provide a more differentiated understanding of what the students were actually learning. Part of what I hoped to achieve was the preservation of the story and learning accounts in their entirety so that I could understand each one as a complete entity. A story is more than the sum of its parts. This process helped me become attuned to participants' stories and learning accounts as the genuine products of 'individual' learners.

### *5.5.3b Learning through time*

Time is not mentioned in the holistic analysis of form given by Leiblich *et al.* (1998, p.88), but reference is made to the 'individual's personal construction of evolving life experiences'. This emphasises that some form of learning through time is an important element in the analysis of stories. Squire (2009, p.44) uses the term 'reconstruction of story across time and place', and others refer to the nature of story as temporal (Elliott, 2006). Elliott (2006), Dewey (1938, reprinted 1997), and Clandinin and Connelly (2000) use the concept of continuity to denote the passage of time, linking past, present and future. Clandinin and Connelly (2000) discuss looking backwards into the past, looking in the present and looking forward into the future, and I use Clandinin and Connelly's (2000) terms to search for temporal patterns in the data to represent these (relevant terms are given in Appendix 14). An example of this kind of analysis is given in Table 5.6, with the remainder in Appendix 15, focusing on what the stories and learning accounts may be revealing about students learning to become nurses over time – perhaps as part of a lifelong learning process.

**Table 5.6 – Story 2A1: Identifying learning through time**

<b>Time</b>	<b>Student learning account excerpt</b>
Looking backward	The role model observing mentors enables students through the process of reflection, to internalise their mentor's behaviour and build on previous knowledge and experience.
In the present	<p>He had a stroke and is also a diabetic patient. One day we arrived to draw up his insulin, and it was not there, so we had to go back to the surgery, to collect the insulin from the pharmacy. This affected the patient because he had to wait for us to get back before he could eat.</p> <p>What diabetes mellitus is - the two types, treatment and complications?</p> <p>What a stroke is, the blood vessels involved and what happens to them to cause a stroke</p> <p>The care this type of patient requires</p> <p>Opportunity to work with experienced and knowledgeable practitioners and observe them providing care.</p> <p>Enthusiasm for professional development unparalleled by any other learning experience.</p> <p>Communicating well with colleagues and others is about seamless care – a continuum where patient care is delivered smoothly.</p>
Looking forward	<p>This could have been prevented, if the nurse who visited the patient on the previous day had mentioned this in the hand over.</p> <p>The influence of mentors on the student learning and if they are not consistent throughout the impact this can have on student learning.</p> <p>The use of experienced staff to support student nurses is fundamental to professional socialisation and skilful role models can enable students to discover knowledge embedded in clinical practice.</p> <p>If the quality of the hand over by the nurses who visited the patient the day before had been better the situation could have been prevented</p> <p>Good communication is associated with life-long learning and required improving patient care.</p>

### *5.5.3c Mapping the process of learning: searching for structure*

This aspect of analysis extends the process of looking at actual events in the stories and learning accounts, in that I explored the features and characteristics of learning from story defined earlier as a process – i.e. using the terms pre-narrative, remembering, writing, sharing and learning. I used the descriptors defined in Appendix 16, setting them alongside the stages identified. An example is given using story 2A1 in Table 5.7, with the others available in Appendix 17. Placing individual stories and learning accounts relative to a sequenced or staged account provides a practical tool for what Labov and Waletzky (1967) term a chronological structure which may help with understanding the wider process of learning from story.

**Table 5.7 – Story 2A1: The process of learning analysis**

The process of learning from story	Student learning account
Pre-narrative	This clinical experience will be focused on an 85-year-old man who lives in a residential home. I was involved with his care whilst on my district nursing placement. He had a stroke and is also a diabetic patient.
Remembering	Failure to communicate effectively with someone.
Writing / recording	The NMC give guidelines for professional practice. Nursing hand over that is accurately documented. Hand over needs to be practised, structured and effective that reinforces the professional status of nurses in modern health care provision.
Sharing	Good communication e.g. listening, guiding, thinking, engaging, making sense of knowledge and information and sharing – associated with life-long learning and required improving patient care. Communicating well with colleagues and others is about seamless care – a continuum where patient care is delivered smoothly. The link between application of nursing care and communication to ensure nurses focus on the fundamentals of care and uphold the principles of clinical governance.
Learning from story	Students are responsible for their own learning needs and must be actively involved in the modelling process to glean the knowledge the expert takes for granted. Opportunity to work with experienced and knowledgeable practitioners and observe them providing care. Enthusiasm for professional development unparalleled by any other learning experience. The importance of MDT care and communication as the key to successful health care provision

#### 5.5.4 Stage 3: Organising and presenting findings: the role of story in professional learning

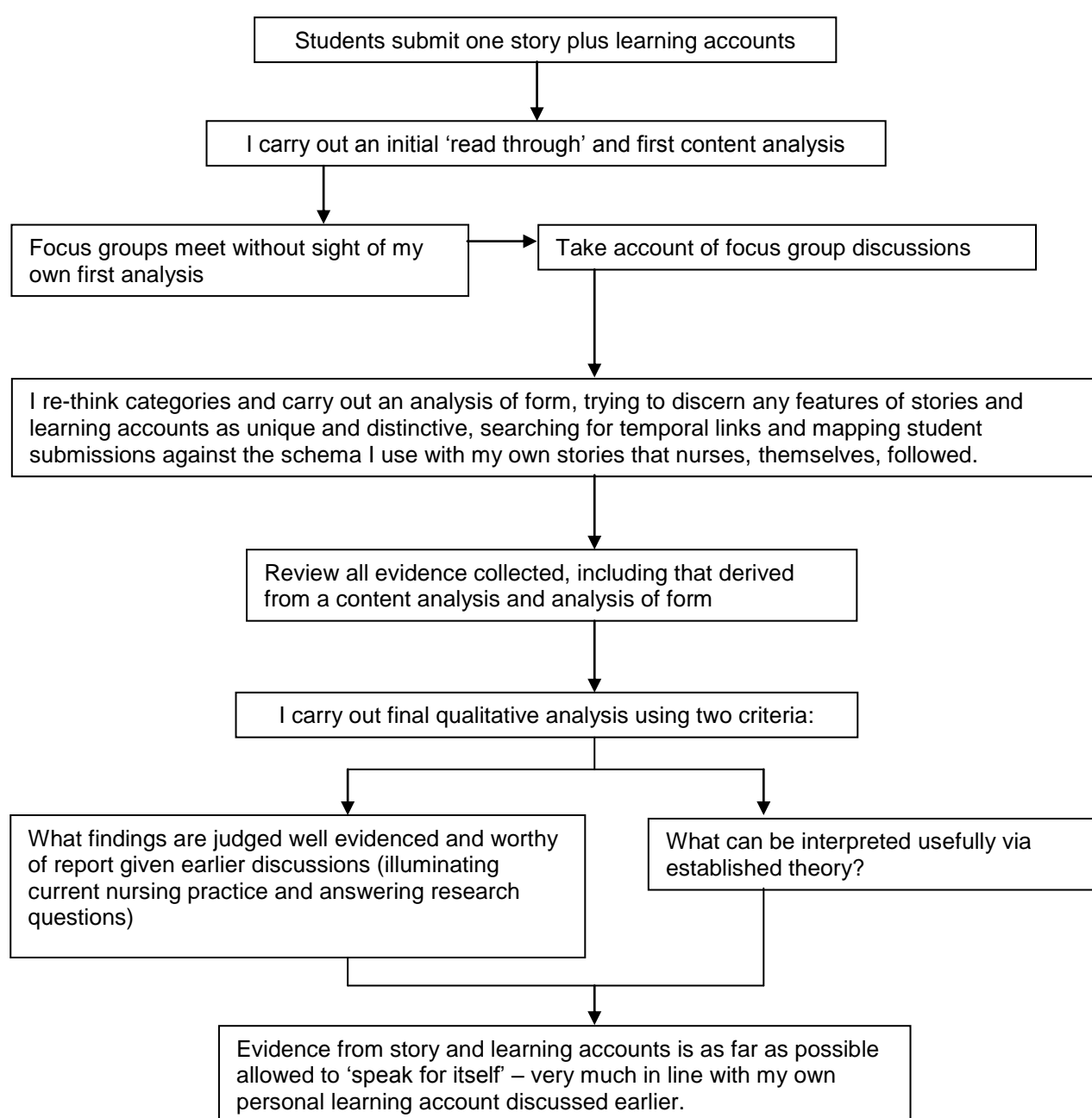
Stage 3 draws together strands of earlier analyses. However, it does not just report results from these earlier stages as this would not have fully revealed the richly varied and diverse potential of the nurses’ stories as resources for learning. A final qualitative analysis with interpretative comment (given in chapter 6) incorporates student judgments and is informed by the analyses of content and form, yet it also allows me to meet my research aims and answer research questions in a way that, as far as possible, lets the stories and learning accounts ‘speak for themselves’. This strategy keeps faith with my view that stories can be aids to learning in their own right. A flow chart summarising the data gathering and analytic procedures is shown below in Figure 5.2.

Two guiding criteria for the final discussion are: what evidence derived from analyses and from the final review itself is judged most likely to illuminate nursing practice (answering the research questions listed in chapter 3), and

what evidence can be linked usefully to key theoretical rationales – to help persuade of their validity? Three headings were used merely as convenient ways of grouping the final discussion:

1. The revelatory role of stories
2. Their exploratory role
3. Stories as direct aids to learning

**Figure 5.2 - Flow chart giving a summary of the data gathering and analytic procedures**



*In this chapter, I described my struggle to find an appropriate methodology for my study. I evaluated a number of qualitative research methodologies, including ethnography, grounded theory and phenomenology. None of these was entirely appropriate as a methodology on which to base my research exploring students' own learning from their stories of clinical practice situations, but nevertheless they helped me to understand more clearly what I needed. In the end, I chose a narrative methodology developed from my own stories, a conceptual framework which I used to explore stories of practice elicited from students.*

*In this study, stories refer to stories written by students. Since student voice is a key element within this work, I have not only asked students to provide their written stories as primary data but have also included them as participants in the research analysis, to represent better their clinical experience. The use of focus groups was also employed as a research method, to confirm the main learning categories, and to encourage students to speak openly and freely about their story and learning, and experience of using the staged learning process I have described. In the exploration for an appropriate methodology, I detailed how I gained access to students as well as outlining the ethical issues that relate to the use of story. Data analysis takes a number of forms, leading to a qualitative analysis with interpretative comment to demonstrate the varied and diverse roles story can play as an aid to clinical learning. This final report is given in chapter 6.*

## Chapter 6

### The potential impact of story on students' learning

*The starting point for the research design outlined in chapter 5 is my personal account of learning from stories outlined in chapter 4. Research participants (student nurses) are asked to follow the same process i.e. remember a story, draw on their own practice experience, write it down, identify how they understand their own learning to have been affected by it, and share this understanding with me. Students express their own ideas in writing about what learning has occurred from their story which I call 'learning accounts'. Even though the students' perceptions of their own learning may at first appear to portray just a collection of statements relating to the story, learning can be drawn from them as they depict a collection of insights to be explored and harnessed. The 55 participating student nurses submitted a total of 55 written stories and learning accounts. Most of the learning discussed comes directly from the nurses themselves.*

*In this chapter, I present a final qualitative analysis of the stories and learning accounts submitted by the participants in an attempt to develop the idea of story as an aid to learning beyond its current use in nurse education. I explore this data as illustrating the various ways stories can, for example, focus undifferentiated experiences, make explicit what might otherwise be tacit, and crystallise the meaning of lived and shared experiences, thereby giving students a voice. The stories reveal features of students' shared lives, detailing something of themselves and their lived experiences in ways fruitfully informing my own role as a teacher.*

*The stories also express the personal lives of nurses relative to clinical practice and how they can help students resolve contradictions, meet challenges and cope with complex emotional situations. As interpretations of the students' lived experiences, stories help nurses reflect on their concerns, difficulties and ways of coping, and can be a medium for sharing reflections with others as another aid towards improving professional practice.*



*The clinical setting is a complex and often difficult place for novice nurses who are expected to learn from, and develop professionally within, it. Although stories are a medium through which students report what they have already learnt, they never just report experience but 'reconstruct' it in potentially significant ways, whilst at the same time helping nurses explore and become better able to understand their professional lives and development. Findings are presented below in such a way as to illuminate these processes, looking at the potentially revelatory role of stories, their exploratory powers and their significance as direct aids to diverse kinds of learning.*

## **6.1 Opening statement**

The structure of this final qualitative analysis, comprising a presentation of findings, is merely a convenient way of exploring the role of story in student nurses' learning. The richness of the data collected, and my own contact with student nurses on a daily basis, both in the clinical context as well as in the classroom, would have allowed me to approach the analysis from other, and equally insightful, perspectives. Even a revelatory and purely exploratory role for stories does more than just reveal and explore what is happening in the clinical situation, but adds to clinical experiences in ways that are of central importance to nurses' learning, as will be discussed below. Both the classroom and the hospital ward are contexts in which so much is happening and inevitably much of this is lost under the pressure and demands of professional practice. So much is unknown and uncertain, and story is one means by which such lost uncertainties might be regained, and learned from.

From my own extensive experience in practice and as a nurse educator, it is clear that students learning can be furthered through story. Given the highly dynamic and fast-moving nature of the professional context, the challenge in the data is to explain how they perform, and to attempt to differentiate between learning that results directly from story and learning that is made explicit by means of story. In the end, it may be impossible to *prove* in any definitive way the precise nature and extent of the learning that results directly from story, but hopefully the analysis below will be persuasive in giving validity

to my contention regarding the potential of story in the development of nurse education.

## **6.2 Story content: its revelatory role**

Story has an important revelatory role which clarifies often hidden aspects of what is happening in the clinical setting. This is revealed in the content analysis in chapter 5 which defined 13 categories drawn from the data i.e. students' stories and learning accounts. Putting learning into story form adds to these categories by identifying the dimensions that may not be apparent in the raw experience. The story in this section reports what can be learned experientially and gives form to what might otherwise be formless, although before the experiences have been reported as stories, many are likely to have been thought about or reflected on.

### **6.2.1 Stories as a group**

The categories drawn from the content analysis can be further broken down into their differing dimensions (Appendix 11). From a research viewpoint, gathering experiences in story form brings together a diversity of examples of experiential learning that would be hard to accomplish in another way. For the individual nurse, bringing clinical experiences together in a coherent narrative makes such experiences accessible for learning purposes.

To start the analysis, in the category 'intuition', there is evidence that students are using an intuitive approach in their nursing practice. For example, one student states:

'Just knowing when things need to be told and shared with mentor or more senior members of the team, so further action can be taken.' (2A15)

However, it appears that students can recognise different dimensions of intuition, such as how they may be unaware of how they come to 'know' or understand a situation (intuitively) while somehow not understanding it:

'Not being afraid to develop intuition and use it in practice, if situation not understood but know something is not right' (2A18)

Although some students seem to understand the value of intuition, their stories reveal how confidence is an important element in being prepared to act on it, as other influences are often perceived to be more powerful:

'My intuition had told me to get an interpreter. On a previous occasion I had been advised that interpreters were only to be used in emergency situations due to the financial cost which had made me apprehensive regarding instructing one' (3C3)

McKinnon (2005) and Effken (2001) propose that intuition needs to be handled with care as 'just to know' is not always right, as well as being difficult to learn from in the future. Appleton and Cowley (2003) point to a lack of consensus as to what the term really means, and Paley (1996) likens intuition to prejudice, habit, extra-sensory perception and whim. McKinnon (2005) strengthens the argument for intuition by examining the contribution of neuroscience and cognitive imaging technology. However, despite the evidence for the existence of intuition, nurses continue to struggle to articulate the powerful feelings of unease which often informs their practice:

'Something felt wrong but could not put it into words' (2A18)

If nurses cannot supply concrete data to substantiate their disquiet, confidence in their own intuition is constantly struggling against the demands of evidence-based practice. Story helps them express such disquiet and is arguably a step towards dealing with it. McKinnon (2005) claims that intuitive knowledge can be learned and shared through the use of story and that, in some instances, students' learning shows them connecting information or evidence about a situation together with intuition to show, for example, where something is wrong.

There is an indication of some connection between the learning categories of intuition and emotions, with students' lack of self-belief in using intuition shown in excerpts that relate to emotional learning whereby they felt

'inadequate', 'not knowing enough' and 'apprehensive', which may explain why nurses tend to stay silent if they 'just feel' concern about a patient. For example:

'I remained apprehensive' (3MH2)

'Feelings of inadequacy, inferior, foolish' (2A9)

'I was excited, but also apprehensive about the task' (3A35)

One student attempts to link evidence with intuition to show something was wrong, but does not seem to know what it meant or explain what was bothering the patient, and so an intuitive explanation emerges:

'All of the information put it together, told me something was wrong' (2A18)

But students still struggle to make sense of that situation. Some stories reveal how they show bravery in acting upon their intuitive judgements. For example:

'Something was wrong so took a non-invasive intervention a 12 Lead ECG' (2A18)

'Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family, I respected this' (3A44)

This analysis picks out differing dimensions of intuition and the way it is used in nursing (Appendix 11, section 11.13). Learning to pay attention to intuition in this way – through story – may ensure its role in clinical practice is better understood. Correspondingly, such improved understanding might, for example, encourage closer observation of a particular patient. More generally, story can explore the key role of intuition in nursing, showing how it harnesses an evidential basis for feelings to inform and support actions. It can reveal nurses' intuitive expertise in a way that has proven difficult in the past. A more sharply applied engagement with intuition, maybe connecting it with emotional learning, can be demonstrated through the interpretations of students' stories.

Ethics is a key category in the stories and learning accounts, covering aspects such as accountability, responsibility and confidentiality toward patients (Appendix 11, section 11.3). Grasping the role of ethics in practice is important, as nurses have the patients' lives in their hands:

'Responsibility for the patient, advocate, especially in end of life issues, so the patient's wishes are facilitated' (2A18)

'As a nurse, my responsibilities included close monitoring of the patient's condition, on this occasion I allowed my attention to be diverted, my reactions had been quick and effective' (3A38).

'The need to consider the other patients that I had responsibility for' (3C3)

'It is acknowledged when a registered nurse delegates tasks, the accountability remains with the nurse' (3A34)

'Maintaining patient confidentiality, but telling when things cannot be kept confidential and need to be shared, asking permission to do this from wife of patient' (2A15)

The data show other aspects of ethics playing a part in nursing practice, such as advocacy, autonomy and being non-judgemental toward patients. For example:

'The need to work in partnership with the mother to identify goals and needs and act as an advocate in assisting the family' (3C3)

'The patient's wishes, discussing these with HCP and relatives – facilitating this role' (2A15)

'When action is based on desirable practice, it has the potential to empower both the practitioner and the patient' (3A38)

'Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind' (3A33)

These aspects of ethics within the formal curriculum tend to concentrate on the de-contextualised elements of a situation and do not enable nurses to

evaluate key issues in practice and make reasoned decisions. In this study, through story, students have identified those aspects of ethics particularly challenging in practice, stretching the student beyond the familiar curricula content that relates to ethical issues. For example:

'In this regard there is both an ethical and moral obligation on nurses to ensure that they gain consent for all decisions involving treatment, ensuring that the principle of patient autonomy is respected' (3A37)

'Students are taught the importance of establishing a caring relationship with the patient, and the need to respond with genuineness and empathy to promote trust and rapport' (3A35)

'Nurses should be emphatic, responsible and respect the dignity, wishes and emotions of their patients even though sometimes, some of the wishes are impossible to be granted' (3A21)

Nurse education not only needs to introduce students to the traditional ethical principles and theories, but also to develop a more sharply applied understanding. Because they engage with real-life situations from practice, students' stories may well be a useful tool in reaching this fuller understanding.

A significant category in student learning is communication, and students detail the many facets of communication that appear to figure in their practice (Appendix 11, section 11.8). These include the use of verbal (language, talking, interactions, and tone of voice), non-verbal (eye contact, listening, facial expressions, and body language) and written communication.

'Documentation as a vital source of communication' (2A10)

'Read patients notes to help understand the patient's condition' (2A10)

'Eye contact, communicating interest, silence, body language, displaying active listening skills' (2A12)

'The uses of voice e.g. tone and using simple language, making emphasis on relevant aspects of the circumstances to facilitate absorption and understanding.'  
(2A15)

Here, students are showing understanding of both the inexpressible and expressible in conversations with patients. In a similar way, nurses highlight in their stories another kind of communication, that which occurs with other health care professionals, and students learn how to improve their communication skills through the interpersonal relationships that develop between the nurse and other professionals, patients and relatives. For example:

'Communicating well with colleagues and others' (2A1)

'Communication depends on the nurse, client and other team member's relationship'  
(2A2)

'Calling the doctor to come to see patient informing of the patient's condition' (2A10)

'Observing the non-verbal expressions of the family and them saying they had never seen him this bad before' (2A18)

'Allowing the patient time to reveal concerns' (2A15)

How nurses learn to develop communication skills is a basic issue for nurse education, and a great deal of work is currently going on in this area. In my experience, it is in practice where these valuable skills are most effectively learned, and story has the potential for developing such skills and their use.

Further dimensions include the barriers to communication faced by students, and how these can impact on outcomes and delay treatment. Such barriers include nurses not always being listened to, avoiding eye contact, lacking in confidence or not being able to present themselves as confident – which often leads to anxiety.

Some students have a problem with getting themselves heard or being assertive when they feel the patients' needs are not being met, as shown by the following excerpts:

'Not listening to what I was actually saying' (2A9)

'Not being able to hear conversations that go on and missing some important points' (2A12)

'Not listening to me as only a student. How to get someone to listen to you' (2A9)

Belenky *et al.* (1986) illustrate how students often lack a voice when contrasted with the more powerful voices of doctors and qualified nursing staff. Stories can help students get heard more effectively and develop a stronger voice. As Calman (2000) asserts, telling a good story to others about a patient may ensure the story is listened to.

Further, Calman (2000) suggests that communication can be used in a therapeutic way to encourage a patient to talk or to disclose feelings and concerns, and for the nurse to allay patients' anxiety. This can be illustrated by the following:

'Communication as a therapeutic skill, which is deep' (2A14)

'Trying to get the patient to express feelings can help identify accept and work through feelings even if these are difficult' (3MH3)

Students need to develop the appropriate skills to be able to use communication to full effect. For example, they may need such skills to elicit a patient history or journey, which is fundamental to understanding the nature of the patient's disease and the necessary treatments required. (An account of the difficulties of gaining information from a patient and how it can be fraught with complexities is detailed in Appendix 6, student story 3A21). Because nurses communicate with others through stories, demonstrating their skills as communicators can gain them respect. As already discussed,



incidents revealing nurses' communication skills are evidenced in the student data:

'I had managed to get her to open up to the doctors in telling her name and address, and that she was truly grateful for my help and even wrote me a letter of thanks.'  
(3A23)

If patients cannot understand what is being said, they may not view the student as competent, something I found in my own practice as I struggled with my East End accent (chapter 4, my story 22). Students need to show they are competent nurses through their communication skills and thereby gain the respect of patients and other professionals.

A further dimension of communication revealed in the data is that of interaction. For example:

'Eileen enjoyed having her nails painted, and as we spoke she would recall her family. She told me about her husband John and how he had passed away shortly after they married, she seemed happiest at these times talking about her past, and she mentioned her son but he lived abroad and rarely rang to see how his mother was let alone visit her' (2A50).

Here, the student's learning account illustrates how s/he communicated with others while, at the same time, being involved in multiple interactions. Christiansen and Jenson (2008) propose that interaction is a 'connected' form of communication, in that interaction involves events taking place at the same time or one event occurring as a consequence of another. Interaction may involve the nurse talking and listening to a patient, while at the same time interpreting what the patient is saying and giving answers. Nurse education could use students' own stories as a way to identify and nurture their more sharply applied understanding of interactions rather than concentrate too exclusively on traditional communication skills.

Story also reveals the central role of culture, and Sargent *et al.* (2005) claim cultural competence is essential to effective health care. Cultural competence

requires individuals to become sensitive to the values, beliefs, and practices in a patient's culture. As one student points out:

'People communicate in different ways' (2A2)

and others raise the issue of how communication varies between cultures (Appendix 11, section 11.4). For example, in some cultures, eye contact is not recognised as a legitimate or valued form of communication, with the result that:

'People's mannerisms may come across as rude or arrogant' (2A2)

'Conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures.' (3MH2)

Cultural awareness is, nonetheless, highlighted as a separate category with additional dimensions (Appendix 11, section 11.4). One such dimension is meeting the patient's religious needs while in hospital and offering this support:

'I made sure that the son knew the chaplaincy team, who had access to a member of their faith, would be available to talk with him and spend time with his father, however, they declined' (3A44).

Issues surrounding dying and how cultural needs in this area differ from patient to patient, and from nurse to nurse, can arise as part of cultural awareness:

'Cultural issues related to the dying patient, facilitating this in clinical practice' (2A15)

'Issues related to death and dying that are cultural and discussing these with the patient' (2A14)

In cases such as this, stories put into context sensitive or 'difficult' issues by presenting them as lived situations relevant to nurses' own experiences. It is particularly important when faced with caring for a patient who has died that nurses understand the patient's individual requirements relating both to

religion and death, such as who should be present, and what relatives might need afterwards. A story account of a lived situation clarifies the need for this culturally sensitive understanding. Attitudes towards death and dying include the students' own beliefs as well as any difficulties they might have with communicating with, for example, non-English speaking relatives and patients, as the following illustrate:

'A realisation that some attitudes and stereotypes are ingrained and may pose a challenge to my career as a professional nurse' (2A12)

'Husband translating for patient, did not notice the area was not private and carried on interpreting' (2A26)

'Polish patients, and difficulties with speaking and understanding English, unable to explain mechanisms of injury' (3A32)

Some learning accounts highlight the sometimes differing cultural values of health care professionals themselves:

'Differing cultural values of nurses and doctors divide the medical and nursing profession' (2A12)

A perceived aspect of the hierarchical culture of nursing was impacting on the behaviour of one participant:

'Fear of speaking out due to status (determined through the culture of nursing, perpetuated in clinical practice, and through education)' (2A12)

To challenge others is difficult when students find themselves at the bottom of a hierarchy of clinical practice which includes doctors, physiotherapists, radiographers, occupational therapists, nurses and health care assistants.

One student stated:

'It is debated whether dominant cultural practices within a hospital .....consider it of limited value to the nurse who they believe has restricted power within the organisation' (3A35)

The hierarchy embedded in a hospital's culture may make it difficult for students to challenge and influence change, or act as a barrier to developing the focused learning and understanding from which nurses might profit. However, it is possible for students to learn to break through this when they use story as an aid, by pinpointing key issues at stake. For example, one student comments:

'Ignoring the hierarchy determined by the culture of health care – break into the inner circle for the benefit of my patient' (2A12)

Adopting such a position via a story can influence the students' learning about when it is appropriate to 'break free', with story providing a way not only of advocating cultural awareness as it relates to a patient, a traditional view in current nurse curriculum, but also of making plain the hierarchy within health care. Despite having limited experience in this aspect of practice, management is another category that students identify in their stories (Appendix 11, section 11.5). For example:

'It is vital to be aware that planning ahead, prioritising, delegating and good time management help to maintain effective management of nursing care' (3A21).

Students seem to be aware that management experience is valuable to their development as nurses:

'Realised how important it is to acquire experience to manage these situations satisfactorily' (2A15)

and one dimension that the students' learning seems to be mainly concerned with is managing the care of their allocated patient or group of patients:

'Enthusiastic and confident that could manage patient's care' (2A10)

'I have found that I can adequately manage the nursing care of a patient' (3A37)

'I was allocated to manage the care of a dying paediatric patient' (3C1)

Another dimension concerns issues relating to knowing when to seek help, prioritise or delegate:

'Knowing when to seek help when necessary' (2A9)

'Would have helped if I had called others to assist me' (3A36)

'Priority setting is also an important skill in nursing, I was unsure of how to delegate' (3A40)

'I gained experience in delegating duties to healthcare assistants, student nurses, and to ask for assistance from staff nurses when necessary' (3A33)

'I had to ask a recovery nurse to prepare everything for the dressing change. This made me feel uneasy' (3A40)

Another perspective on management is learning to cope with the busyness of the ward and to deal with students' own ability to manage their time effectively:

'There were so many things to do within specified periods of time and this put my time management skills to the test' (2A10).

'The reason was that the time allocated for personal hygiene and that of the dispensing and administration of drugs nearly overlapped. By planning and prioritising this way, I was able to manage the time efficiently' (3A21)

'Time management and prioritisation are essential skills within nursing for successful, efficient and effective patient care' (3A34)

Students appear to engage further with management issues when they find themselves not only dealing with general tasks, such as organising the care of their patient(s), seeking help, time management, delegating and prioritising, but also having to manage within a managerial hierarchy:

'Assumption about position in the hierarchy of other health care professionals e.g. behind the sister' (2A12)

'This managerial duty made me nervous because the consultants, doctors, physiotherapist, occupational therapist and dietician came to me regarding the management of those patients' (3A33).

Students who may be engaging more with management issues are those who acknowledge the barriers to being a good manager:

'Economic burden of managing elderly patients with heart failure' (2A13)

'Insufficient information to carry out a comprehensive assessment' (2A14)

'Forgetting information can be due to the busyness of the ward during certain periods' (2A10)

The data suggest that students are becoming aware of the requirements of being an effective manager:

'The amazing communication, organisation, management and co-operation of all staff was very impressive' (2A27)

'The shift leader delegated staff accordingly taking into consideration appointments, escorts, psychiatric response, medication, ward security and other activities that were going to take place that day' (3MH4).

One student may already be feeling the weight of responsibility of the managerial role:

'Management skills are vital and necessary for nurses in order to fulfil responsibilities' (3A21).

Others may be showing a more differentiated insight into the role of the manager:

'I believe that I gave managerial and personal support, guidance and after-care to this vulnerable patient in a respectful therapeutic relationship' (3A33)

'I have been able to assess how I feel about my nursing delivery and management of care for a patient over a whole shift' (3A37)

'I had to manage communication between various professionals' 'time management for the care of this child and others on the ward whose care I was participating in' (3C1).

Some students are able to combine managerial skills in response to the managerial role:

'While caring for this patient I utilised management skills such as prioritisation, time management and delegation' (3C2)

Through their stories, students can recognise early in their professional development the differing dimensions and relevance of management to their future role as nurses.

In summary, in a revelatory role, story can help students organise, highlight or bring together important features of what they are engaging with in practice. The categories derived from a content analysis focus on complex curriculum content issues linked to learning outcomes the students have to achieve, as predetermined by the curriculum. Through story, the students seem to differentiate and structure what previously may have been undifferentiated, and possibly unstructured, in ways that enable them to meet these learning outcomes. Stories can break down an experience into categories and dimensions accessible to analysis in ways not usually possible in a complex social setting, ordering or structuring them in ways that the experience itself would not do. In much of the data, students are using story as a means to express and record what they have already learnt through practice, but writing down that learning in the form of story clarifies and deepens it, giving it further meaning.

#### 6.2.2 Socially constructed and individual features of learning: interactions and differences

Relevant to this section are two standard approaches to learning identified as constructivism and social constructivism. Many of the above examples of the way stories bring together experiences indicate how these experiences are

being individually or socially constructed (or re-constructed) by nurses in order to give additional meaning to them. Here, I attempt to present examples of joint or group construction and interactions between these and the more unique or individual construction, pointing out how story can reveal group and individual features of learning which can be viewed as the same or similar. They may only differ slightly in the use of language but ultimately can be interpreted as meaning the same or differ in important ways.

### *6.2.2a Similar features of socially constructed and individual learning*

In the following excerpt one student maintains a respectful, non-judgemental and caring attitude:

'Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind.' (3A33)

This learning gives the student insight into her values and beliefs – she appears to be individually constructing her own distinctive take on how to deal respectfully with a patient. In the focus groups, students discuss moral and ethical values (Appendix 10, 2c), and the data suggest that, through stories, both individually and collectively students can learn about values and beliefs, their own and those of others.

There is also evidence of similarity between individual and group understanding of ethical considerations, as seen in the dimension of ethics relating to consent, which is given in the focus group (Appendix 10, 2c) and in the individual student learning accounts (Appendix 11, section 11.3):

'Sought consent for procedures, drew curtains for privacy and maintained dignity' (2A10)

'Verbal consent to undertake the non-invasive procedure' (2A13)

'Patient consent regarding records and obtaining information' (2A14)



As introduced above, students regard communication to be at the heart of clinical practice (Appendix 11, section 11.8), as demonstrated in the following:

'The vital role of communication' (2A1)

'Importance of communication to successful care' (2A2)

'Good communication also has a good impact on patient care' (A48)

'Considered as a yard stick in nursing practice' (3MH4)

'...the ability to communicate effectively is the most important area that requires expertise in order to manage patient care efficiently.' (3A34)

Yet communication also features strongly in the focus groups, helping to sharpen and underline key features (Appendix 10). When asked about learning from stories, participants stress:

'Facial expressions' (2b)

'Non-verbal communication' (2b)

'Listening' (2b)

'Reading body language' (2b)

Interesting in relation to the idea of individual and group features of learning are the ways nurses think about their work, with both groups and individual students using medical terminology in the same way. For example, this can be seen in the medical theory illustrated by the individual students' (Appendix 11, section 11.1) use of the following medical terminology:

'Diabetes mellitus – two types, treatment, complications, medication' (2A1)

'Stroke – blood vessels involved, what happens to cause a stroke, Dysphagia' (2A1)

'Heart disease, cardiomyopathy' (2A15)

'Cancer with liver metastasis' (2A15)

'End stage renal failure', 'Paralysis, Seizures', 'COPD, tuberculosis' (2A33)

'Respiratory failure' (3A35)

(see Glossary of medical and nursing terms in Appendix 18 for explanations used here and elsewhere in the thesis). In the focus group data (Appendix 10), students use the language in a similar way:

'Stroke' (2c)

'Respiratory failure' (3c)

'Renal failure' (1f, 3c)

'Cardiac failure' (3c)

'Diabetes' (3c)

Students mention a wide range of medical conditions in their stories and learning accounts. However, individual students are not only grappling with the medical terminology, but also revealing the difficulty they have in understanding the complex medical terminology and abbreviations. As one student notes:

'Understanding specific terminology that relates to care .....a CTPA scan and its value as an investigation to diagnose a PE' (2A12)

Many issues linked to the individual students relate to practice issues (Appendix 11, section 11.2):

'Monitoring vital signs and documentation' (2A10)

'Ensuring patient care and safety' (3A40)

'Administration of medication when they were due' (2A10)

'Nutritional needs when patient's not eating or drinking' (2A13)

'Wound dressings, aseptic technique' (2A13)

Attention is beamed on what the groups have written about their practice (Appendix 10):

'Vital signs' (2a)

'Protect patient from harm' (2b)

'Pharmacology', 'Drug interactions' (1d)

'Nutrition' (1d, 1f), 'Parenteral feeding and insertion of NGT' (1e), 'Nutritional needs' (2a), 'Malnutrition' (3c)

'Wound care (3a) 'Infections control' (1a, 2c)

Unsurprisingly, these examples illustrate the medical focus of students' work, and the stories themselves can help to promote learning by getting students to understand better the issues that are important to everyday work in practice.

This insight into the links between individual and socially constructed group learning is revealed in the stories. It stresses the importance of nurses sharing the same meanings in regard to issues such as values and beliefs and communication, because, when information is passed on about a patient to other nurses, this sharing process can create a supportive network that will work together for the benefit of patients. A consensual approach can develop a close relationship between teams and individuals enabling them to handle issues in an innovative and creative manner, as well as serving to benefit patients.

### *6.2.2b Similar features of socially constructed and individual learning with differing terminology*

In relation to the general use of the term 'advocacy', it is interesting that the focus groups refer to this as 'patient preference' (Appendix 10, 3a) or 'involving the patient', whereas individual students (Appendix 11, section 11.3) refer to the same thing as:

'The patient's wishes, discussing these with HCP and relatives – facilitating this role' (2A15)

'When action is based on desirable practice, it has the potential to empower both the practitioner and the patient' (3A38)

The issue of empathy is mentioned in the focus group data (Appendix 10, 2b) and is also raised in the individual student learning accounts (Appendix 11, section 11.3):

'The opportunity to understand what the patient was going through (empathy) and thereby improving the quality of care I could have given to the patients' (3A48)

It seems individual students (Appendix 11, section 11, 13b) take a broader perspective in their work than those in groups. For example, individual students state:

'One needs to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve lifelong learning' (3A33)

'Wanting to know, understanding is a typical desire of a nurse – a passion for nursing?' (2A12)

'Considered the areas of health promotion not only for my patient, but also for patients in the wider social context' (3A34)

The focus groups (Appendix 10) express these broader perspectives slightly differently. For example:

'Own personal issues' (1a)

'Ethical values' (2c)

'Looking back at evidence' (2c)

'Adding past experiences and literature and stuff' (3a)

'Research knowledge' (2a, 3a)

'Understanding' (2a)

'Learning transferring to other situations' (2b)

'Practical learning' (2c)

'Education issues' (1c)

'Better understanding of overall health consideration of my patient' (1e)

These slight differences in terminology used between socially constructed or group and individual learning can harmonise individual and group perspectives on important matters that impact on every-day nursing practice.

### *6.2.2c Differing features of socially constructed and individual learning*

Individual students represent their insights into practice in different ways (Appendix 11, section 11.2). For example:

'The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it.' (3A38)

'I believe that this experience has given me a practical insight' (3A36)

'This situation highlighted that in order to become more confident as a nurse I will need to actively seek out situations where I care for my own group of patients as a student.' (3C2)

'I have gained a new perspective on my practice.' (3A40)

'It was the application of this knowledge that leads me to suspect that there was something more.' (3A39)

Individual students give some detail about their insights into practice, whereas the group (Appendix 10) use short statements to explain what they do as nurses:

'Management interventions' (1b)

'Infection control' (1a)

'Post operative care' (2c)

'Cardiopulmonary resuscitation' (1c, 1f)

'Vital signs' (2a)

'Fluid management' (1c, 1e, 1f)

'CVP' (1f)

'Neurological observations' (1d)

Venepuncture and cannulation (1c, 1e)

'Practical learning e.g. ECG, wound care' (3a)

'Practical and theoretical' (3b)

The differing features of group and individual learning suggest that individuals are far more likely than groups to reflect upon, and to think critically about, their experiences.

Another issue between the social and individual constructions of practice is that of teamwork. Team-working especially involves sharing and receiving information from members about procedures, interventions and treatments, as evidenced in the individual student data (Appendix 11, section 11.9):

'A decision to seclude the patient was made by the nurse in charge in liaison with the nursing team and the ward doctor was informed of this decision' (3MH3)

'The restraining team demonstrated teamwork, inter-professional practice and record keeping as integral part of teamwork and helped with the violence management if the problem occurred again.' (3MH4)

Through engaging with, and telling their own stories, students can learn how to convey a good patient story to a doctor:

'I was impressed by how fast the doctor came to see my patient after I told him the situation, maybe there was urgency in my manner or voice?' (2A17)

However, this may not always be the case, as one student states:

'Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us' (3A52)

The group data make only a brief reference to teamwork (Appendix 10, 2a) through the engagement with stories. It could be argued that students were working together in the focus groups, sharing their stories and negotiating what to document in their mind map, but this is not well represented in the written data.

One other difference of importance to nurse educators resulting from the focus group accounts but not mentioned in the individual student data concerns research. The focus groups refer to the need for professionals of all disciplines to consider how they can change the way in which they put into practice the findings of research. More than ever nurses are under scrutiny, and more than ever they need to show that they are implementing the evidence-base which is either inaccessible or yet to be fully developed (Rolfe 2000). In other words, students are being required to produce evidence where little or none exists. This issue was referred to in the focus groups (Appendix 10), when students wrote:

'Research knowledge' (2a, 3a)

'Duty of care models' (2a)

'Activities of daily living' (2a)

However, they do not give much insight into the nature of research or models of care. In the related data, there is brief reference given to:

'The failings of health care' (2a)

The nurses' individual data neglect to detail the failures of health care. These aspects of research, models of care and the failings of practice may be overlooked in the individual data because students only identify with them when they are more experienced or have the confidence to speak out. These differences suggest that individual student nurses in practice may not be exposed to research evidence, models of care or the failings of health care, and they only come to light when stories are explored in groups.

As individuals, students can learn how to tell their stories better and how to get themselves heard. In the group, members not only shape their own story but help shape the stories of others. Therefore, applying theoretical ideas such as individual and group construction might enable nurses to become more equal and active partners in caring for patients, and may allow nurses' views to be heard in regard to the treatment they want for their patient. Given that members of groups identify research as a significant feature of nursing when individual students do not, this is significant and requires thinking about in terms of the way nurse education can contribute to a better understanding of the key role of research generally in nursing.

### **6.3 The exploratory role of stories**

As I have a fairly large group of stories, I have attempted to interpret as well as reveal what the priorities of nursing care are for this particular group and to identify what their main concerns might be. Although this aspect of story closely resembles that above, it stresses the interpretation of data rather than simply revealing what is embedded in it. For example, this discussion



uncovers what nurses appear most sensitive to, aware of, and find hard to cope with. In addition, story can help students to deal with problems that occur in practice, find insight into their preoccupations, identify ambitions for the future, and scrutinise the mental theories they use. This kind of information is worth having in its own right as well as being useful for future research into nursing practice and informing nurse education more directly.

### 6.3.1 The priorities of student nurses

Students appear to be prioritising their care (Appendix 11, section 11.5), and students' stories show they may be finding it hard to decide which patient to care for first:

'The need to prioritise my patient's care was of paramount importance nursing priorities change throughout the day as new events occur' (3A34).

'I made sure the most important tasks were highlighted and given greater priority' (3C2)

'Prioritising can create tensions for nurses because the needs of one patient compete with those of another in terms of urgency' (3C3)

Students gaining access to clinical skill development have many competencies to get signed off by their mentor to pass their clinical placements (Appendix 11, section 11.10). They have to undertake so many hours on night duty and often want to experience as many elements of practice as possible which will contribute to their learning. For example:

'I was up for the task and trusted to undertake this by my mentor.' (2A9)

'Observed by mentor, who was able to give the information I failed to give, this related to some prescribed medications (electrolytes) the patient had been prescribed' (2A10)

'Escorting a seriously ill patient with mentor, handing over the patient, directed to theatre a very useful learning opportunity was given to the student by the mentor' (2A27)

'Experiencing night duty with my mentor' (3A32)

The mentor has to ensure that the student is aware of what is taking place on the ward on any particular day to ensure their maximum exposure to a variety of clinical practice experiences:

'...attended the first weekly lecture on oncology' (2A33)

'Need mentor to expose me to relevant experiences' (2A16)

'Wanted to observe the scan' (2A10)

To achieve their competencies, students recognise that they need support and help, and cite situations where mentors were encouraging and supportive:

'She (the mentor) was supportive and encouraging and allowed me to learn through supervised practical experience.' (3A33)

'My mentor and the other members of staff made it clear to me that I could ask for their help and support at any time.' (3C1)

'Experience night duty with my mentor' (3A32)

'I reminded myself that I was not on my own and I could have full support from my mentor if I needed it.' (3A40)

'My mentor contributed to this experience with psychological support and minimal verbal guidance' (3A40)

'Support was available from my mentor as well as other members of staff'. (3C1)

'My mentor and the other members of staff made it clear to me that I could ask for their help and support at any time'. (3C1)

'I reminded myself that I was not on my own and I could have full support from my mentor if I needed it'. (3A40)

To be able to meet the practice competences, students prioritise working under supervision:

'I was also (under supervision from the nursing staff) encouraged to perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient.' (3A48)

'I carried out the above checks under the supervision and with the assistance of the charge nurse supervising me.' (3A44)

'I required supervision from my mentor with the administration of medications for my patients.' (3A21)

'Whilst on placement I was engaged in providing care under the direction supervision of a registered nurse to a group of post-surgery patients.' (3A39)

They constantly refer to reporting to their mentor as a priority, to ensure safe practice and to undertake tasks they are unable to perform alone:

'Shared with mentor or senior members of the team' (2A15)

'Informing the mentor of issues that relate directly to the patient's condition' (2A15)

'Regularly consulted with my mentor' (2A10)

Sometimes students felt frustrated in their student role as they had to wait for their mentor to undertake tasks they were not yet permitted to perform:

'My mentor allowed me to plan the patient's care, and was available for advice and assistance and to perform those tasks which I was unqualified to carry out myself (such as administering intravenous medication).' (3A38)

'There were limitations to my role that required input from my mentor' (MH4)

'My mentor was often busy with her own work load, I was required to find her and wait until she had finished the task she was currently completing' (3MH4)

'In order to maintain safe practice I had to delegate the administration of the patient medicines which she has through her femoral line to the registered nurse' (3C2)

However, as students become more confident, they rely less on their mentor and begin to work more autonomously:

'Learning to work independently with less support from my mentor' (2A16)

'I was allocated my own patients to manage with minimal supervision from my mentor. My mentor and the other members of staff made it clear to me that I could ask for their help and support at any time' (3C1)

'We agreed that I would work within my limitations as a student and seek her advice or direction as required' (3A44)

'My mentor was nearby to observe my nursing skills, communication skills and give me reassurance. I had relied upon some assistance from my mentor. My mentor contributed to this experience with psychological support and minimal verbal guidance' (3A40)

Another priority for students is to gain feedback from their mentor:

'My mentor was pleased with my work' (3A51)

'My mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality.' (3A51)

'Although the criterion highlighted by my mentor was my lack of speed, the greater and more important implication was the risk presented to the patient should the wound become infected and pathogens spread to and compromise bone tissue.' (3A51)

There is evidence in one student's story of struggling to find meaning in a feedback given by a mentor (Appendix 13, story 3A51). The nurse is told to do the dressing more quickly, and warned of the possible consequences:

'My learning is that if wounds are not dealt with in a timely manner infection can set in; therefore, I as a practitioner would fail in my duty of care to the patient. If a hospital acquired infection (HAI) sets in, such as MRSA, the patient may require an extended hospital stay. The infected patient becomes a source of infection to his carers and other patients if infection control policy is not adhered to. Should the infected limb require amputation, this too will necessitate prolonged hospital care and if mobility is compromised pressure wounds could set in compromising and distressing the patient further.

The patient's social, work and home life will be affected; specifically dependants of the patient who may be devastated if that infection resulted in the patient's death. If I as the nurse or the hospital were found to be negligent the patient or patient's family could take legal action and seek recompense. The increased financial burden for the extra care, materials etc. or defending legal action can seriously affect the trust's funds resulting in reduced or loss of services, staff or hospital closure.' (3A51)

The student struggles with the feedback when the mentor tells her/him to work more quickly. Interestingly, the mentor added a rationale as to why s/he needed to 'hurry up', which was an increased risk of bone infection if a hip replacement wound is left exposed for too long.

The unpredictable nature of feedback can cause stress and lead to a loss of concentration and poor performance, perpetuating further anxiety. Clynes (2004) notes that students often do not understand that concerns highlighted by the mentor are directed towards ensuring improved clinical performance and quality patient care. The question from the mentor, in this instance, was posed in a supportive manner, which eased any troubled feelings the student may have had. Due to the follow-up explanation by the mentor, the student learned to direct actions professionally and confidently, leading to improved quality of care. The mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality. The student states:

'I had given the patient adequate care and consideration to minimise distress and relieve pain during the dressing procedure, and was demonstrated in the patient's relaxed posture, gesture (a smile of trust and confidence in the student's knowledge and ability) and speech (asking questions).' (3A51)

Learning from feedback in a supportive and informed way, and the story told about it, might reasonably be considered a vehicle for enhancing such support and enlightenment. Such considerations may well decide whether students pass or fail a particular clinical placement:

### 6.3.2. The main concerns of student nurses

When using story as an aid to learning, the main concerns of nurses may be clearer than when using the raw experience.

#### *6.3.2a Student sensitivities*

Students seem to be sensitive to various types of emotions and feelings and these may be positive or negative (Appendix 11, section 11.11). Some students mention the unpleasantness of certain situations:

'How hard it is to deal with sudden loss' (3A44)

'Patients can be emotionally distressed by their experience in surgery' (3A48)

'Did not feel that I could be trusted' (2A18)

'I felt very nervous and a bit scared about these because the staff I was dealing with were much more experience and I felt my standard was poor compare to theirs.'  
(3A21)

'I was a bit hesitant at first as I do not have the knowledge of children's nursing'  
(3A23)

'Feelings of being out of depth, due to situation e.g. eye injury' (3A32)

'Feelings of nervousness about using medical terminology such as "ophthalmic" and sounding stupid if pronounced wrongly' (2A32)

'Failure to communicate effectively with someone can cause him or her concern, especially if vulnerable through illness.' (2A1)

'Feelings of inadequacy, inferior, foolish' (2A9)

'Concerns about not knowing enough, flustered, out of depth, frustrated and stressed.' (2A16)

'Panic, fear of missing information, frustration, isolation, loneliness, being an outcast from the group, undervalued' (2A12)

'At the time however, I feared that I may be criticised by the other nurses.' (3C2)

'At this point I was feeling very frustrated and disappointed.' (3C3)

'I felt I should have been advised of the language difficulties in handover that morning.' (3C3)

'The effort of attempting to communicate was such a slow, painstaking process I remained apprehensive' (3C3)

These excerpts illustrate the many clinical situations that give students negative feelings, with one student stating how recalling the situation had a negative effect on her coping with memories of, and concerns for, the death and suffering of patients. However, what is interesting are the good feelings that can still emerge from the students remembering (via story) the situations that at the time provoked negative feelings:

'I was able to support the patient by providing psychosocial needs and a supportive, encouraging and respectful therapeutic environment' (3A33)

'Led to my decision to head into palliative care in my nursing career' (3A44)

'I believe I got to see some of the best practices a nurse can offer a patient' (3A48)

'I felt honest and professional.' (3A21)

'I feel there is a lot more to be learnt.' (3A23)

'I feel she was under the best possible team.' (3A23)

'Felt pleased with a learning opportunity' (2A9)

'I was pleased that the patient felt more comfortable due to my care' (3A33)

'Feelings of empowerment due to acts of bravery' (2A12)

'I also felt that I had prioritised my care correctly' (3A39)

'I felt justified in involving the interpreter' (3C3)

'Kept calm and spoke to the mother clearly' (3C3)

What initially may appear as a story not contributing to students' sense of fulfilment can be converted into a positive experience. It is the turning around of feelings within a story that can be a cementing force for more sharply applied learning.

In addition, and related to the above discussion of mentoring, students are concerned about the influence of their mentor (Appendix 11, section 11.10). This may be positive:

'Positive feedback from mentor regarding performance' (2A10)

'Was able to understand due to the explanation given to me by my mentor the relationship between VT and electrolyte imbalance e.g. potassium' (2A10)

'After I had been to my first meeting with my clinical tutor and had attended my first weekly lecture on oncology I was able to consider these experiences in a more positive manner.' (2A33)

'She was supportive and encouraging and allowed me to learn through supervised practical experience.' (3A33)

'I performed on the day were carried out to the complete satisfaction of my mentor' (3A35)

or negative:

'Influence of mentors on student learning if not consistent throughout can impact on student learning' (2A1)

'Mentor taking over when necessary, when student knowledge can go no further' (2A10)

'She (mentor) did not confirm with other members of staff that I was managing this patient today. This invariably was leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice' (2A23)



In clinical practice situations, students seem sensitive as to who has the authority within health care:

'I was under the supervision of the other doctors and nurses there, and in the resuscitation room in an emergency the doctors mainly take over and the nurses do as the doctor's request' (3A23)

Students seem to be concerned that they work with experienced HCPs. While this links back to the importance of group sharing, it is worth reconsidering in the context of nursing priorities and sensitivities. For example, Calman (2000) proposes that learning from peers, colleagues and the groups with whom nurses associate contributes to personal and professional learning. Andrews and Roberts (2003) contend that senior staff should provide role models and support for juniors and, by example, show the relevance and importance of learning from others (Appendix 11, section 11.10). Vygotsky (1978), through his notion of the zone of proximate development (ZPD), has been influential in developing the view that students best realise their potential development level under guidance from more advanced individuals or in collaboration with others. Vygotsky's view echoes in the students' words:

'Opportunity to work with experienced and knowledgeable practitioners and observe them providing care' (2A1)

'Skilful role models help discover knowledge embedded in clinical practice' (2A1)

'When I noticed the change in Mrs Smith's Oxygen saturation and respiratory rate, I almost panicked and wanted to handover to my mentor, but she reassured me and told me to check the drug chart for prescribed medication.' (3A40)

Students are concerned about following hospital and government policies (Appendix 11, section 11.7):

'Our role was to ensure that patient care was managed according to clinical priority as opposed to waiting time' (3A32)

'Hospital infection control policy was maintained, wearing protective clothing to protect myself from any contact with bodily fluids or blood and to prevent cross infection to him and others.' (2A10)

'Adhering to strict hand washing techniques' (2A10)

'According to the A&E guidelines, any woman suffering from PV bleeding should be placed in a side room' (PG12)

This concern may relate to litigation, and students refer to this in their learning accounts:

'Legal cases referred to e.g. inquiry into David Bennett after prolonged restraint, and Munjaz court ruling of 2003 local health authorities had rights to formulate local policies that depart from the Mental Health act (1983) in the best interests of the patient. Additional rulings in 2005 further stated that the Code of Practice guidelines were not always legally binding' (3MH1)

'Documentation should include data about what was observed and must comply with professional standards and legal requirements' (2A10)

Students are aware that, if hospital policy is not followed and a mistake or error is made, the hospital will not take responsibility and the nurse will have to fend for her/himself.

### *6.3.2b Other concerns of students*

Students are aware of gaps in their knowledge (Appendix 11, section 11.12):

'Did not know what it all meant, process would help me to gain understanding and interpretation' (2A18)

'My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading.' (3A34)

'Patients with conditions that are not understood by myself will continue to be a part of the experience of being a nurse.' (3A36)

'I also recognise there are gaps in my knowledge of certain skills and theories, which are required when managing the care of patients. I believe I could have managed this patient's care better if I had more medical knowledge. The theory side of nursing knowledge is good but I need to be more aware of it and utilise it in practice situations.' (3C3)

and they stress the need to update their knowledge (Appendix 11, section 11.13):

'Increasing my empirical knowledge on guidelines and protocols before embarking on patient care will assist me in future clinical practice and will help me understand some of the problems that I may encounter' (3C3)

'I accept I should at least have the BNF with me. If this situation arises again I will check in the BNF to clarify doubts.' (3A21)

and to obtain additional knowledge (Appendix 11, section 11.13):

'After researching the disease processes, I now have a better understanding of the priorities for this type of patient care.' (3A36)

'This incident posed a greater challenge by extending my clinical practice contributing to my continued learning, a prerequisite for the provision of professional nursing. I can further expand my knowledge and skills base' (3A35)

Students are also aware of the importance of teamwork (Appendix 11, section 11.9):

'The importance of MDT care' (2A1)

'Depends on team work' (2A2)

'This incident demonstrated the merits of collaborative practice' (3A36)

'I am aware of the importance of team-working.' (3A37)

'The process of seclusion requires teamwork and adherence to local restraint and seclusion policies' (3MH1)

Students seem to be aware of certain aspects of care when story is used, and this helps to ensure that their knowledge and skills are up to date as well as recognising that learning about nursing is a lifelong process (Appendix 11, section 11.13).

Another area where students appear uncertain or unclear about their role concerns the delegating of tasks to other members of staff (Appendix 11, section 11.5):

'In all of this the other patient had been forgotten and his care could have been delegated to another.' (3A17)

'I felt unease in delegating to senior staff; I was democratic because I explained why I needed them to undertake the activity.' (3A21)

'I should have been more democratic in delegating tasks staff a chance to choose' (3MH3)

One issue that causes students considerable anxiety concerns the boundaries that need to exist between nurse and patient (Appendix 11, section 11.11). Becoming too involved emotionally with patients can put students in conflict with their theoretical training (Sorlie *et al.*, 2005) or the NMC code of conduct and other ethical guidelines laid down by the nursing profession (Hochschild, 1983). For example:

'I felt conflict between the person-centred care I wished to provide and the restrictions of operating within the contemporary health system' (3A38)

'Nurses cannot allow themselves to get too emotionally attached to the patients' (3A48)

The nursing profession is divided as to whether it is acceptable to express feelings and become emotionally close to patients. Students have to manage emotional attachment in a way that both promotes caring and compassion as well as resonating with their own identity as nurses, although one student seems to have no hesitation in becoming fond of a patient:

'The more time I spent with the patient the more attached I got to her and I felt a lot of empathy towards her mother' (3C2)

Advice such as 'don't get too attached to patients' needs to be handled with care, and students have to make their own judgement on the matter.

Students seem to be unclear about how well they face emotional challenges:

'I had mixed feelings when asked to assist in Sarah's care. I was excited, but also apprehensive about the task, not because it was outside my experience, but because of the environment in which it was being performed.' (3A35)

'While looking after this patient I sometimes felt overwhelmed as she required constant care and attention. At times I felt stressed and by the end of the shift I was physically tired.' (3C2)

'I felt nervous and was unsure if I could manage the patient's care myself. I was very nervous and panicked at the task, which has the potential to make other people nervous, as well.' (3A40)

'I was however nervous because we were all aware that the child was only on the ward for Tender Loving Care (TLC) and would therefore die on the ward, we did not however know how long before this happened.' (3C1)

'I believe I could have become more actively involved in reassuring the patients and letting them know they were in good hands and they were being taken care of. It can be very emotionally draining.' (3A48)

'I also felt nervous about the care of this patient because I didn't have a grasp of part of the patient's condition during the shift.' (3A36)

and unsure about how to respond to patients' emotional reactions:

'Concern for the patient's stress' (2A15)

'I did feel very scared for the patient as she was under 16 years old' (3A23)

'Sometimes patients can be emotionally distressed by their experience in surgery' (3A48)

'I found the fact that I could not seem to calm her hard to deal with' (2A50)

'The patient felt punished, and I felt it had damaged the therapeutic relationship with the patient.' (3MH4)

In some cases, the student was anxious about his/her own and the patient's feelings:

'Nurses are expected to cope with their emotions and their patient's emotions' (3MH1)

and others were not clear about when to seek help (Appendix 11, section 11.5):

'Knowing when to seek help when necessary' (2A9)

'Would have helped if I had called others to assist me. Better organisation of my actions' (3A36)

'I had to ask a recovery nurse to prepare everything for the dressing change. This made me feel uneasy.' (3A40)

If students are not clear about delegating work to other HCPs, combining emotional and professional practice and coping with their emotions, or do not have the confidence to speak out about the failings of health care, nurse education should be taking notice and ensuring that these areas are explored more systematically within nursing courses.

### *6.3.2c The most pressing concerns of students*

Students find it especially hard to cope with some concerns, particularly the daily pressures of clinical practice (Appendix 11, section 11.12):

'Nurses are under pressure.' (2A9)

'Rather than feeling empowered by successfully taking charge of patient care, I actually felt constantly worried, and nervous about how much I had to do. I should communicate when I don't feel able to cope with the level of care that has been assigned to me, because patient care is of primary importance. Once the hand over

was over and I was left alone, I mentally took a step back and realised that the patient had many aspects of care that needed to be considered.' (3A36)

'The demands of every day nursing can often prevent individualised care at a time when a person is most at risk of losing their independence.' (3A38)

They find it hard to cope when they are struggling to articulate feelings of unease (Appendix 11, section 11.11):

'Instead of ignoring and put aside my own feelings and emotions about this situation I persisted with voicing my concerns and this led to the patient receiving the appropriate treatment.' (3A39)

and often seem frustrated as they want to do more for their patients:

'Concerns about not knowing enough, and becoming flustered, out of my depth, frustrated and stressed' (2A16)

'Concerns about not knowing enough about the vast areas related to oncology and those who are severely ill because of it' (2A33)

'I feel there is a lot more to be learned' (3A23)

Students are showing concerns within their clinical practice and story can express these in a way the raw experience would not. The expression of these concerns can also enable nurse educators to support students and alleviate anxiety more effectively.

### *6.3.2d The concerns students feel about their mentors' limitations*

The role of mentors and mentoring recurs throughout student stories and has already been examined from other perspectives. Nonetheless, it is worth revisiting as stories indicate that the performance of the student's mentor can often be substandard (Appendix 11, section 11.10). Students wrote:

'My mentor's role to facilitate this process and she was not able to fully relinquish the charge of the patients to me and just supervise or be there for me when I needed her.

She did not confirm with other members of staff that I was managing this patient today. This invariably was leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice.' (2A23)

'There were limitations to my role that required input from my mentor. My mentor was often busy with her own work load, I was required to find her and wait until she had finished the task she was currently completing.' (3C4)

'Better supervision cannot do anything alone' (3MH2)

Facilitation of student learning requires a mentor who is supportive, can act as a good role model, teacher, guide, and assessor; and has the student's interests at heart. The processes of training staff to undertake the role of mentor are often complex and theory-laden and, as a result, some avoid assuming a mentor / facilitator role. The use of story could develop the mentor role, as stories are accessible and, with permission, could be incorporated in the Guides for Mentors made available on most courses.

Field (2004) states that, to move on in their careers, students need to acquire a high level of learning in nursing practice, which in turn requires stimulating dialogue with a mentor who has a good knowledge of theory and practice. The mentor should be accessible when the student feels unable to complete a task, and give the backup and guidance needed for future development. This is constantly stressed by students:

'Skilful role models help discover knowledge embedded in clinical practice' (2A1)

'Positive feedback from mentor regarding performance' (2A10)

and Field (2004) concludes that, while learning from a mentor can extend existing learning, an appropriate setting is not always provided. In practice, mentors vary in quality and commitment, and poor mentoring can lead to students failing to identify learning from their practice.



### 6.3.3 Coping with tensions that occur in practice

Story can help students become more attuned to tensions that occur in practice and help them deal with the challenging and demanding environment of current nursing. For example, a student story and learning account recognise the need for the patient, Frank, to maintain hygiene and independence while being severely ill (Appendix 13):

'Frank asked if he could wash and change his gown and I agreed to assist him. Because I wanted to encourage his independence, I prepared the washing items for him and allowed him to wash himself.' (3A38)

This learning account stresses the importance of students acknowledging conflicts in care, in this instance between the person-centred care the student wishes to provide and the demands of every-day nursing, which can work against individualised care:

'I felt conflict between the person-centred care I wished to provide and the restriction of operating within the contemporary health system. The demands of everyday nursing care can often prevent individualised care at a time when a person is most at risk of losing their independence' (3A38)

Tensions frequently occur in nursing practice, and story may be able to help students become attuned to such tensions and better able to identify how they can deal with them.

In the above case, it would have been easy for the student to focus solely on completing the prescribed interventions required of vital signs in the form of physiological measures and structured assessments and accumulating data related to this complex patient. Instead, to ensure the patient did not become dependent, the student made time to work with him and helped him to be involved in washing himself. The student could just have completed the task by doing the wash *for* the patient, and it might have been safer to have done so. The student's learning may have been influenced by these struggles when dealing with the complex care this patient needed.

One learning account deals with a situation whereby, in twelve and a half hours, a patient went from being intensively nursed and cared for with lots of medical interventions in a busy intensive care setting to being nursed in a palliative manner (Appendix 13):

'For me the shift highlighted how hard it is for both staff and families to see the change from active highly intensive treatment to palliative care.' (3A44)

In this story, intensive intervention measures were removed and the focus changed from life prolonging / saving to comfort-care measures, as in all likelihood the patient would die. Being told that a patient is going to die can deeply influence how nurses respond. Especially in critical care, it can be by distancing and non-engagement:

'In this environment palliative care was given poorly, because death is seen as a failure and therefore the focus is on making people well, the environment is not family friendly and the focus of care is of a technical nature so that skills in palliative care are often lacking, and other priorities prevail.' (3A44)

As mentioned here, palliative care can often be seen as a failure to provide a cure and reflects the pervasive scientific perspective on health care where human experiences of illness are reduced to diseases and their treatments:

'I was aware that the doctors were reluctant to spend time with the family as it was a reminder of their so-called failing.' (3A44)

However, by writing the story down, the student may have become aware of the tensions between the values of critical care and invasive interventions and the need for palliative and compassionate care. Students could learn from story the aspects that are special to them. They may notice things they would not have seen without the story, and they may gain ideas and insights that otherwise would not have occurred to them, by developing a way of engaging with their stories that can be of value in future situations, thereby making a contribution to their lifelong learning.

#### 6.3.4 Insights into the preoccupations of student nurses in practice

The learning accounts highlight the preoccupations of student nurses, issues which are constantly on their minds while gaining clinical practice experience:

'One need is to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve lifelong learning.' (3A33)

'Feelings of guilt I experienced for not giving the patient the level of care I felt he needed. Nurses are required to develop professional knowledge and competence to meet the demands and the complexities of modern professional practice through lifelong learning.' (3A38)

These preoccupations involve students having to give a patient the level of care needed, gain a wide understanding of health care and develop professional competence. This is a challenge and demonstrates how difficult it might be for nurses, who are close to the bottom of a hierarchical health care system, to obtain such a sufficiently high level of understanding for the benefit of their patient(s). In meeting this problem, they may often feel satisfaction at a job well done.

In their stories and learning accounts, students stress the need to confront their preoccupations with clinical practice issues. Students need a high level of competency, skill and knowledge to meet the demands of increasingly complex practices within the contemporary health care system:

'The story has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it' (3A38)

Often the student is the passive receiver of knowledge, such as in the classroom, but when engaging with stories, students can confront their concerns and preoccupations, and challenge the circumstances they face, thereby becoming actively engaged with their own learning.

### 6.3.5 Exploring mental models or implicit theories

This section explores the mental models or implicit theories that nurses may use. The NMC is attempting to fashion a theory or model of nursing, but progress is proving difficult. Students relate professional practice to the Nursing Midwifery Council (NMC) codes of conduct, by which nurses are guided in their practice (Appendix 11, section 11.13):

'Following the NMC professional code of conduct in relation to confidentiality' (2A14)

'Fulfilling the nursing role according to the NMC' (2A12)

'NMC: nurses can identify accountability by documenting an event as soon as possible after its occurrence' (2A10)

'The NMC recognises that nurse's practice is constantly changing environment, with new advances in treatment and care, reorganisation and redirection of resources' (3A38)

However, professional practice in nursing is difficult to pin down in any definitive way and even the NMC are currently finding it difficult to come up with a definition that can be recorded on the nursing register for employability purposes.

Mental or 'implicit' theories of nursing are revealed in stories. One student seems to believe implicitly in the importance of identifying skilful ways to handle emotions (Appendix 11, section 11.11):

'I took deep breaths and tried to stay as calm as possible as it helps to focus, however, I found it was not easy.' (3A40)

and others appear to place themselves in positions where they are able to ask questions and challenge care and practices when necessary (Appendix 11, section 11.13). Their tacit model is that of active critic or interrogator rather than just someone conforming to given practice. Questioning a medical instruction is acceptable, though not common practice. Such students reveal

their belief in the need to use critical thinking in their work because learning from stories of clinical practice on the wards encourages them to think critically, resulting in improved patient care. Learning points noted include:

'.... a greater challenge by extending my clinical practice contributing to my continued learning, a prerequisite for the provision of professional nursing. I can further expand my knowledge and skills base.' (3A35)

'I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing.' (3A37)

In addition, the importance of critical thinking is confirmed by the focus groups (Appendix 10). When students were asked to document learning from their stories in a mind map, they record:

'Questioning / challenging' (1b)

'Critical thinking' (1b)

'Arguments for and against' (3a)

and they use critical thinking to generate their own evidence, which could be implemented in practice:

'Critical thinking is an educational need to allow students to use independent judgement and evaluation.' (2A2)

Jarvis *et al.* (1998) use cognitive theorising to justify critical thinking, highlighting the questioning and challenging dimensions of learning and the way a critical perspective can benefit any decision-making process, and this position is adopted by many nurses, as suggested by these excerpts:

'Questioning of practices when things have been forgotten' (2A12)

'Questioning doctors, confidence in this practice, an ability to speak up within large interdisciplinary forums' (2A12)

Higgs and Titchen (2001) show that introducing students to challenges and encouraging a questioning approach helps them to become professional practitioners:

'Nurses are required to develop professional knowledge and competence to meet the demands and complexities of modern professional practice ..... This demands an enquiring approach to nursing practice' (3A38)

and the focus groups suggest that stories can prompt nurses to engage in critical thinking at the broader system level rather than the micro-level of the ward and the patient. Bruner (2002) points out that the socio-cultural approach to learning implies that stories provide insight into the mental models or implicit theories nurses are using to think about their work. Therefore, stories can be a window into the way of life of nurses, their priorities, concerns, preoccupations and ambitions as a group or as individuals.

### 6.3.6 Defining the student role in relation to patients

The role of the student vis-a-vis the patient is relatively undefined, ever-changing and ethically challenging. This is particularly the case in regard to educating patients in the acute setting as well as the issues around health promotion for patients (Appendix 11, section 11.6).

In regard to the latter, students seem unclear as to what the parameters of their responsibilities are, and how best to inform patients, many of whom are very ill or uninformed, of how to look after their own health and what steps they should take after leaving hospital. Some learning accounts mention the need to educate patients, by which they mean giving information to patients about the drugs they are taking, and the importance of diet in the control of conditions such as diabetes e.g.:

'Patients cannot often identify the drugs they are taking, their names, the side effects of them' (2A21)

'Importance of diet and control of diabetes' (2A21)

'Support others to help increase their knowledge' (2A16)

Sometimes a more detailed account of the patient's condition and future health needs may be required, and in this instance a more formal didactic approach may be necessary:

'Through health education and health promotion patients are empowered to make informed choices about their own well being' (3A38)

'While caring for this patient I contributed to the health improvement of the patient through health promotion by educating the patient's mother' (3C2)

However, it remains the case that their stories do not detail health promotion a great deal, although this aspect is considered by many to be an integral part of nursing practice. Instead, it is usually directed towards targets such as stopping smoking, eating a more balanced diet, or taking more exercise. This may be because the majority of students are gaining clinical experience in acute care and do not see health promotion as a major part of their role, or view it as a long-term consideration which is of secondary significance compared with their main responsibility of everyday nursing.

Nurses are understandably more focused on issues concerning acute care and devote much time and energy to this:

'Part of my responsibility to my patient was to educate him on his condition and how best to promote his rehabilitation' (3A38).

'I explained to the patient how important it is to maintain a good oxygen supply, and indicated the monitor which showed his saturated oxygen levels had fallen to an unsafe level' (3A38).

'I showed her the correct way to suction the patient, which was shown to me by the physiotherapist' (3C2)

Where they touch upon aspects of health promotion in their stories, it is often in regard to communication or helping patients (and their families) to increase their knowledge of their own conditions. For example:

'The patient realised that something out of the ordinary was occurring and had questions that he wanted answers for, due to my previous experiences and knowledge I was able to provide him with answers and if I was unable to answer his question I was able to locate someone who could' (3A39).

'I explained to the child's mother the reasons for providing extra pillows and propping her up' (3C3).

'Answered any questions in my ability or found out the answer to any question I did not know the answer to' (3C4)

'Advised the family on universal precautions' (3C4)

Therefore, teaching of patients is more about supporting them and their families to increase their knowledge of their own conditions.

#### **6.4 Stories as more direct aids to learning**

It is suggested that stories can aid learning in more direct ways than so far considered. These include utilising the temporal element of story, finding meaning from experience otherwise hidden or tacit, and clarifying the problems that occur in practice. At the same time, stories can be an aid to reflection-on-action, as well as providing effective ways of expressing emotions and of overcoming and articulating difficulties. Story can also be a medium for self-exploration and identifying aspects of nursing which are hard to define theoretically. Finally, it will also be argued that story can illuminate or capture a situation imaginatively and help to achieve transferability. Stories may exemplify possible ways of aiding reflection-in-action, as well as the practical moment-to-moment decision-making taking place during caring for a patient. These latter claims are harder to evidence but it may be possible to exemplify ways in which stories can do this.



#### 6.4.1 The temporal function of story

Writing before the Second World War, Dewey (1938, reprinted 1997) pointed out that all of our experiences are, in some way, 'tinged with time', in that we are forever going forwards and backwards from a point in time in order to make sense of, and learn from, our experiences. If this is so, then story is both a process whereby students are encouraged to make links between the past, present and future, and an accessible means by which such links become explicit rather than tacit. Story can help the student to understand the present in the context of the past and the future (Appendix 15), and act as an important step in lifelong learning and career development (Appendix 11, section 11.13b).

In terms of the present, the main concern of most students, story can illustrate how reference is constantly made to current literature and published documents:

'NMC Code of Practice states that a third year nursing student can under direct supervision calculate and administer medicines by a variety of routes.' (3C2)

'Referred to statistics each year 600,000 children under the age of five have an accident as a result of neglect by parents or carers. The British Thoracic Society says any child with an oxygen saturation level of less than 92% requires immediate administration of oxygen either via nasal prongs or a mask.' (3C3)

Government directives such as the National Standard Framework (NSF) and the Knowledge and Skills Framework (KSF), and legislation such as the Mental Health Act are all likely to be influencing present practice:

'According to the Mental Health Act Code of Practice, the use of seclusion is neither for the purpose of meting any punishment nor suitable where the patient has any risk of suicide or self-harm.' (3MH1)

In the present, students identify the different situations in which they find themselves, and use story to make sense of these experiences:

'I was impressed by how fast the doctor came to see my patient after I told him the situation, maybe there was urgency in my manner or voice.' (2A17)

but, at the same time, most of these accounts only make sense by placing them against past experiences. Therefore, the use of story encourages students to revisit their previous experiences, recalling aspects of caring for patients, as these excerpts demonstrate:

'When I worked in theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again.' (3A51)

'I used my previous knowledge of wounds to monitor the site of the gastrostomy, as previous knowledge influences care' (3C2)

They remember patients they have cared for before and knowledge gained on previous placements:

'Some kind of recollection of a person similar to her, a year previous who have done the same thing' (3A23)

'A previous placement on a cardiac care unit had given me some understanding of cardiac rhythms and I was concerned that this symptom could have stemmed from electrolyte imbalances and was entirely treatable' (3A39)

and are clearly aware of the significance of the patient's history up to the present illness and how this can impact on current interventions and care:

'The child had been previously admitted with severe hydrocephalus, this could be defined as excessive cerebrospinal fluid within the skull. Resulted from a congenital condition and was one problem amongst many that this child was suffering from.' (3C1)

'How past medical history (PMH) and knowledge of it can affect nursing interventions.' (2A21)

The student focus groups (Appendix 10) also identified how the past can become integrated with events in the present, as a student mind map notes:

'Adding past experience and literature and stuff' (3a)

The students' accounts indicate how learning is a constant interaction of the past and the present, and that, however unknowingly, students are forever moving between the two.

Story also allows the student to link explicitly learning in the present with that of the future (Appendix 15). For example, one student draws out quite explicitly the implications for the future of a certain mode of treatment:

'The implications can be enormous for the patient; physically, psychologically and socially, there are knock-on effects for other patients waiting in line for treatment.'  
(3A51)

and another details how certain interventions can prevent a complication for the patient in the future:

'Exercise such as wiggling of the toes to promote blood flow and other range of exercises performed with the physiotherapists her condition could get better.'  
(3A21).

Looking ahead and recognising possible consequences is about future learning and planning future action. Students identify how their current learning can impact on their future practice in relation to, for instance, infected patients and adherence to infection control policies:

'In the future I will care for infected patients like any other patients but I will always adhere to the infection control policy of the unit.'  
(3A21)

'In the future I will contribute to improve effective communication between me and the staff.'  
(3A21)

and one student identifies 'a next time', whereby they can change behaviour and, in this case, use the British National Formulary (BNF), which can be taken along for reference during a drugs round:

'If this situation arises again I will check in the BNF to clarify doubts.'  
(3A21)

Story encourages students to identify future learning needs and to undertake additional reading, as well as endeavouring to develop further clinical judgement skills to facilitate decision-making:

'My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading.' (3A34)

'My decision-making skills, in particular those incorporating 'reflection-in-action', and the ability to think on my feet are still evolving and will continue to improve with further experience.' (3A35)

'If the situation arises again I will make sure that I have a good position to prevent injury to myself.' (3A21)

These examples highlight the way a story can combine the influence of the past on the present in order to illuminate, and perhaps guide, the student's future. In other words, the student's learning from story can be contextualised within a longer-term historical narrative, implying progression and continuity.

In conclusion, this notion of learning through time creates an ongoing process from the students' remembered past in one place to a present moment in another, all the while constructing an identity for the future. The students' individual learning is not connected in a simple way to their former experience in terms of it being able to improve their practice in the future, as is assumed by exercises in theory-based reflective practice. Some students write their stories with their previous experiences as a starting point or look back to a patient's history prior to admission. Through examining and re-examining the data, I have begun to see how a variety of stories individually interpreted can produce a sense of how learning from practice may be progressing and is likely to proceed in the future.

Nevertheless, although stories can usefully link present circumstances to the future, data in this study tends to focus on nurses' engagement with a patient in the present and what appears to be fulfilling to these students is the here and now. 'He fully recovered and went home' was rarely spoken of, although it is assumed that nursing is, to a large degree, about this. This study

indicates that what matters is being with the patient, performing to the students' satisfaction and helping a patient through a period of suffering. In short, the temporal function of a story is not mainly concerned with connecting past, present and future, but to fixing a 'present' moment in such a way that it can be studied and learned from.

#### 6.4.2 Stories as aids to problem-solving

Stories can be an aid to problem-solving, revealing how clinical problems might be resolved and providing an aid to further learning mediated by real life illustrations. They can open up areas for discussion of issues of general concern, and identify problems that are still unresolved.

My argument is that nurse education needs to develop problem-solving techniques and theories directly relevant to the situations in which nurses actually find themselves, and thereby discover a way to accommodate and develop a more differentiated understanding of the processes involved. For example, one student comments:

'Ignoring the hierarchy determined by the culture of health care – break into the inner circle for the benefit of my patient' (2A12)

This student made a decision and acted upon a problem that was meaningful to him / her in the situation concerned. The story crystallised the position s/he took, developing the student's learning by providing insight into when it is appropriate to 'break free'. This has great potential as nurses struggle to become professionals in a hierarchy that is dominated by doctors and other professionals. For example one excerpt states:

'Breaking into the inner circle for the benefit of my patient to be a part of the decision making process' (2A12)

The theme of story 2A12 concerns a student solving the problem of being at the back of a ward round and breaking through to the front in order to find out what is happening to her patient on that particular day. The student is aware

of her place at the back, but this is superseded by his / her role as a nurse caring for the patient and wanting to know what is being decided. The student moves from feelings of fear and uncertainty to feelings of pleasure, but seems to find the solution to the problem unpleasant.

In this case, the student's very specific problem and the solution s/he reached were influenced by his / her struggle with their position in a complex hierarchy within the health care system. The student tries to solve the problem by pushing herself forward – a personal solution to a personal problem. Story can offer rich possibilities for crystallising such situations, given that a student is not usually allowed enough time or space in the curriculum or classroom to explore or reflect on such problem-solving issues.

Stories can reveal students developing insight into problem-solving in clinical situations:

'Did it to benefit my patient, did not care about how I was perceived or the repercussions of going straight to the doctor over the nurse who ignored me' (2A18)

'Problem solving is part of decision making, a systematic process of focuses on analysing a difficult situation and problem solving always includes a decision-making step. Because decisions may have far-reaching consequences' (3A40)

'I am aware that in nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems' (3A40)

'My clinical judgement was that the child needed to be attached to the monitor continuously' (3C3)

'The use of problem-solving processes to facilitate patient's confidence in the use of coping skills' (3MH3)

'Problem solving and decision making skills are important to professional nursing practice' (3MH4)

Often decisions are made in clinical practice without the input of a nurse, and they need to put themselves forward, if they wish to influence patient decisions and actions.

A story can help students overcome difficult problems specific to themselves and to achieve equilibrium in the Piagetian sense, and difficulties that can disrupt their equilibrium in this way are not uncommon. For example:

'Finding it difficult to care for a patient or group of patients over a span of duty' (2A23)

Stories provide a means for the exercise of problem-solving skills by nurses and provide time and space for developing these skills, and using story as an aid to developing problem-solving strategies may be an important way to support learning in the nurse curriculum.

#### 6.4.3 Stories as an aid to reflection-on-action

Students are involved in reflection on a daily basis, but find it difficult to explain their reflections to others. However, story can be an aid to this sharing of professional practice.

Students' stories and learning accounts demonstrate that they may be engaging with reflection to learn about themselves and the care they deliver to patients (Appendix 11, section 11.12). Comments include:

'Reflection on practice experiences needs to be improved, to evaluate self' (2A16)

'Could have dealt with the situation better' (3A36)

'Change practice in the light of learning and experience' (2A10)

In story form, the interrelationship between practice and theory can be clarified in a way that might not be easy through the actual experience, and it is interesting to see how much students seem to struggle with relating theory to practice. The data suggest a role for story directly relevant to student learning, demonstrating how stories can aid reflection-on-action in various

ways – especially by focusing on related aspects of theory and practice. Students often fail to see how their practice interventions relate to theory, and vice-versa, and as one student states:

'Not understanding the implications for a high blood pressure and an increase in heart rate 'peculiar' heart rate' (2A18)

I wrote in my research journal about an incident in which students were unable to make such connections:

The students and I were going through a story about a patient who had malnutrition, the complexity of feeding this patient and the issue of stress. Through discussion with the group I made some fundamental links for them between the three concepts (malnutrition, feeding and stress) and I remember them saying at the end "We would never have been able make those links, if you had not shown them to us!"

In the nurse curriculum, theory and practice are generally taught separately as individual modules, and linking them is often left to chance, leaving students to attune themselves to the links. The following excerpts show students' awareness of the need to make such links:

'I also recognise there are gaps in my knowledge of certain skills and theories, which are required when managing the care of patients. The theory side of nursing knowledge is good but I need to be more aware of it and utilise it in practice situations.' (3C2)

It enabled me to put theory into practice, directed at a patient in need of my assistance.' (3A35)

These excerpts show that students recognise how they can manage a patient's care better in practice situations with the use of theory, and how story may enable them to put theory into practice to meet a patient's needs. They also see the need to form 'story schemas' bringing disparate experiences together meaningfully.



As viewed in Appendix 12, the pattern of theory and practice occurred frequently, but seems to be linked more often with other learning categories as these excerpts show (the link to the category is shown in italics):

*Theoretical / practical / communication / teamwork / ethical*

'I asked *patients permission* if I could do this. When *explained to colleagues* used *posture*, appropriate accurate and *appropriate language*, I wanted to ensure I my *colleagues* fully understood my *explanation*.' (2A15)

*Theory, practice, communication, professional learning*

'What is involved in good *communication – listening, guiding, thinking, engaging, making sense of knowledge and information sharing* – associated with *life-long learning* and required for improving *patient care*.' (2A1)

Students are engaging with theory and practice in their stories but also linking them to a range of other practice issues. In fact, there is evidence that, when story is used as an aid, theory and practice can be united if facilitated by a more experienced practitioner. For example:

'My mentor also highlighted that I have the knowledge; however, having the knowledge is of no use if it is not applied. In effect, I was being told to think as I worked.' (3A51)

More experienced practitioners can create the conditions for a student to incorporate theory and practice as 'reflection-in-action' (Schon, 1991). They can also help the student grow into the intellectual life around them and engage in the complex business of 'being human' (Vygotsky, 1978). The potential for story as an aid to linking theory and practice may help nurse educators in the designing of nurse curricula.

More generally, examining the connections discussed could help me as a nurse educator to see how students are relating the different categories of skill and knowledge and applying them to caring for a particular patient. This is possibly achieved by generating relevant 'schemas' for bringing together different areas of study, as Piagetian theory might recommend. This may be compatible with exemplifying a possible way stories can evidence reflection-

in-action (treated more directly below). Such learning would need to be more sharply differentiated – something a story might help to facilitate.

This study suggests that value can be gained from engaging with one's own stories to aid learning in nurse education. Students need suitable tools to access and preserve 'lived experience' which can then be further used to adapt to a variety of practical situations. The students learn to relate theory and practice in a way experience itself does not readily allow.

#### 6.4.4 Stories as an aid to reflection-in-action

The argument in this section is that stories make what would otherwise be tacit (moment-to-moment decision-making) explicit. This is helpful to nurses developing the kind of professional skills Schon argues for (Schon, 1998). Here I attempt to illustrate how the tacit can become explicit in the story and how useful this is to student learning (Appendix 17). There is a role for story in exploring practical experience, about which so little is known, and putting experiences into story form can make what is implicit and tacit, overt and explicit. Story reveals details of experience that might be missed and insights that might be overlooked. This function of story is dealt with using theoretical accounts developed by theorists such as Dewey (1934, reprinted 2005), Moon (1999), Mason (2002), Bruner (2002) and McDrury and Alterio (2002).

Early in this work, before writing their stories, students may not have noticed their experiences of practice or recognise their potential for learning and future development. In the language of story, this can be called the pre-narrative stage – the lived world of the students in everyday clinical practice made up of experiences encountered. Students take their clinical practice for granted, just as I did in my early days on the ward, and, in examining students' stories, I can identify this pre-narrative phase, which can easily be passed over or taken for granted. A student wrote:

'I was involved in the care of a patient brought in by the police from the Samaritans where she had been found, there was no name of the patient and the police could not at the time find a name for her, she had taken an overdose of what was thought to

have been crack cocaine, this patient upon arrival was not conscious her Glasgow coma scale was 3.' (3A23)

The pre-narrative stage is given some insight in Dewey's writings about experiential learning (1934, reprinted 2005). First, there is the way feeling and emotions become connected with storied events. In their stories, the students are faced with challenges presented by patients dealing with pain, suffering and loss and also by their own emotional reactions. In my experience, learning takes place during or after powerfully emotional events. Second, there is probing of what is taken for granted (i.e. what is in the pre-narrative, not yet crystallised) in preparation for making sense of it within a story. Students will have searched through many stories to find one worthy of remembering and writing down (Appendix 6).

Third, filtering experiences embedded in the pre-narrative enables a judgment to be made about which stories are worth writing down and sharing, and which to discard. For a story to be selected for writing, it has to have made an impact and be seen by the student to be of value:

'Once the hand over was over and I was left alone, I mentally took a step back and realised that the patient had many aspects of care that needed to be considered. Just from looking at the patient, I could see that the patient had a CVP, and central line insitu, she was fed via a nasogastric (NG) tube, the patient was diabetic with a syringe driver of actrapid running, and was being given regular nebulisers to help her breathing.' (3A36)

Adapting Dewey's (1934, reprinted 2005) interpretation of aesthetic experience, which includes paying attention to quality experiences, may help here. From this perspective, a student's 'taken-for-granted' experience may involve engagement with testing urine, getting a stool sample or disposing of a dirty bed pan. It would be possible to write about all of these in a story and they would all warrant analysis.

The 'taken-for-granted' appears in the student stories and here I attempt to detail how students can move from embodied learning to awareness of, and

participation in, their stories (Appendix 17). This phase is important as it is where all the students' stories are held and the data show how it relates to emotions. Students need to be encouraged to probe their pre-narrative experiences and allow their stories to emerge. The pre-narrative will determine the next phase of learning from story, that of remembering, where the world becomes a more comprehensible place. Moon (1999) refers to this phase as 'noticing'.

Noticing is about how we perceive what is around us and is something we do all the time (Mason, 2002). McDrury and Alterio (2002) refer to this stage as finding the stories that urgently need to be told. Remembering our own stories can be stimulated by hearing a story told or read by someone else. For example, the students know me and have been exposed to my use of stories in the classroom, written and shared. This may have served to provoke emotions in them and led to them remembering their own experiences in similar situations, referred to as story finding by McDrury and Alterio (2002).

What triggers remembering has been explored by Bruner (2002) and Mason (2002). Bruner (2002) suggests that a story begins with some imbalance in experience; something goes right or wrong, otherwise there is no story to tell. He is influenced here by the Piagetian idea of 'disequilibrium' (discussed earlier) where meaningful learning is seen as a way of adapting to 'dissonant' or disturbing circumstances. One student seems to remember their story as a result of such circumstances:

'It then became apparent that there had been some serious miscommunication on my part. I felt out-of-my depth when John presented to us because I had never been involved in the care of an ophthalmic patient.' (3A32)

Mason (2002) also suggests that there is some kind of disturbance which triggers this process, and highlights the element of surprise to explain this disturbance. There is a hint of surprise at the information the student had received from the mentor in Appendix 6, 3<sup>rd</sup> year adult story 3A51, suggesting that speed of a dressing in this instance is significant for the patient.

However, Mason (2002) suggests that a surprising incident can prevent noticing and the remembering of a story can be missed. Perhaps an explanation of this disagreement about the usefulness of surprise to remembering is found in Bruner (1986), when he discusses the role of the nervous system in this general process. When the nervous system is stimulated by surprise, the same neurological pathways are followed each time, i.e. via the sensory nervous system to the brain and via the motor nervous system away from the brain (Edwards, 2001b). In this way, the body reacts in the same way each time it is surprised. The body adapts and, when surprised, stops noticing whatever else is happening. It remains unclear whether the element of surprise is disruptive to remembering (by putting experiences into narrative form) or key to aiding this process. However, in another student learning account, the element of surprise did seem to help the student change practice and to move on:

'When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence.' (2A16)

In general, how the material to be learned is presented may help students to remember. For example, after experiencing restraint and seclusion on a mental health ward, a student wrote:

'The alarm sounded and a broadcast on the two-way radio system requested for assistance at one of the wards in the psychiatric unit. I had to hurry along to the distressed caller's ward. On arrival we found one of the nurses writhing in pain as he had been punched and kicked several times by one of the patients. Part of the members of the response team attended to the injured member of staff whilst the rest of the team promptly restrained the assailant in a well-rehearsed move.' (3MH1)

The same student was influenced by what s/he perceived the purpose of learning to be in a particular specialist area of nursing practice. The remembering occurred when things were not as s/he expected:

'.....seclusion was morally indefensible as it defeated the essence of a therapeutic relationship.' (3MH1)

For another student, remembering occurred when s/he was put in an awkward position and made to feel stupid:

'A member of staff asked me about the procedure the patient was undergoing, I replied I was not sure and went to check the patient's notes. He then said in a sarcastic manner that as a student nurse I should know what the patient is going to theatre for and the type of procedure to be performed.' (2A2)

There are additional instances in the stories and learning accounts which might help students to remember otherwise undifferentiated experiences and crystallise them for learning purposes, indicating that stories vary in terms of their value and purpose for the individual.

There was evidence of emotional responses, evoked by the learning situation, detailed in the students learning accounts, and this may have encouraged remembering:

'I had felt a bit out of my depth in the resuscitation room. Although the patient appeared to be unconscious I had stayed with her the whole time and was reassuring her that everything was going to be OK by talking to her and generally given her my nursing care for example taking her neurological observations.' (3A23)

'My feelings were of concern for my patient as she had become clinically unstable.'  
(3A34)

Some stories may be written in order to express concern for a patient:

'I was concerned for her care, the nurse-patient relationship is central to nursing and to nurses feeling fulfilled in their caring role; I was initially concerned about my lack of managerial experience.' (3A33)

and some students might have written their story in order to express a growing understanding of what nursing means:

'Helping Sarah identify her excessive alcohol consumption was a contributing factor to the day's events.' (3A35)

At this stage, the students were not so much learning as learning to notice. The mentor's action in 3<sup>rd</sup> year adult story 3A51 was one of caring and supporting the student by noticing and observing the patient's wound:

'Since the wound-dressing incident I have found that I am more aware of my actions when fulfilling my duties.' (3A51)

According to Mason (2002), our attention is highly selective, otherwise we could not cope, for there is often too much to attend to or notice in any interaction. The mentor and student in the story above noticed many things, but relatively few were recorded and many more failed to be noticed at all. It makes sense to work at broadening remembering to increase the likelihood of noticing different incidents that could be recorded as stories. For example, once the student had remembered the story, it:

'.....prompted me to use my nursing knowledge and skills in order to care for the patient' (3A38)

The student is engaging with story and seems to be moving from the pre-narrative i.e. a stage of undifferentiated awareness, to conscious appreciation of the situation through writing it down. This can allow further analysis of the situation now represented as a story and the potential to enhance learning and practice. As one student explained, remembering the story:

'.....has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it.' (3A38)

The data illustrate a shift from the pre-narrative to remembering the key elements of situations re-presented as stories to a critical examination of practice, leading to an enhanced understanding of it. The difficulty is in trying to understand or explain what is occurring in this rather complex process, when undifferentiated events begin to be seen differently, i.e. when the tacit is made overt or the implicit explicit.

As said earlier, remembering stories can be stimulated by hearing the stories of others, which can provoke emotions leading to the remembering of one's own experiences of similar situations. Students may have been inspired to remember their stories by reading my stories in the information sheet given to them at the beginning of data collection, which leads me to consider how I influenced the types of stories they remembered. So I compared my stories with those of the students and there is a difference between my stories given in the information sheet to students (Appendix 5) and the students' stories (Appendix 6). This is borne out by my notes from the focus groups whereby the students discussed how they were able to identify different practice stories and their uses.

By using stories as an aid to reflection-in-action, students may be able to develop a connected and more focused understanding of their clinical practice. Through attunement to their own stories, i.e. making explicit experiences which might otherwise be tacit, students can then shape the experience and build upon them. In this way, story can become an aid to expressing learning, which in turn reinforces and reconstructs that learning. Then it may be possible to make visible the unique and individual ways a student comes to be both a nurse and a professional.

#### 6.4.5 Stories as a way of expressing emotions

By expressing emotions, stories can help a nurse come to grips with this crucial aspect of professional practice. Lalor *et al.* (2006) point out that emotional learning becomes possible when students are able to identify their own feelings in a given situation, including the concerns, fears and frustrations students are experiencing in clinical practice, which offer me as an educator some insight into their lives as nurses (Appendix 11, section 11.11).

If students are not encouraged to face up to their own emotions, they may be overwhelmed by a patient's grief and suffering, rendering them less capable of helping in a professional manner. For example:



'Human beings have diverse characteristics and emotional thresholds, some of which can stall the nurses' quest for excellent service' (3MH1)

Student references to feelings and emotions reflect the way the reality of story may impact significantly upon their practice. The emotionally expressive words found in the students' stories and learning accounts are their choice. These words not only draw attention to the emotional dimension of student learning but also show this to be powerful. Expressing emotions in writing may help students confront them:

'I felt out-of-my depth when John presented to us because I had never been involved in the care of an ophthalmic patient.' (3A32)

'Many patients died over night, and I was expected to cope with my own emotions.' (3A44)

Christiansen and Jensen (2008) suggest that focused learning may occur when students show how they acted as a result of their emotional encounter. One student states:

'Made me want to critique the idea of seclusion' (3MH4)

From a more general perspective, learning from emotionally charged situations may involve a review of current practice. Emotional learning can, for example, include the ability to master skilful ways to handle situations that are emotionally challenging:

'I took deep breaths and tried to stay as calm as possible as it helps to focus, however, I found it was not easy' (3A40)

The excerpts highlighting emotional circumstances spotlight particular events in students' practice where emotional learning becomes relevant, even vital, to their professional growth and development:

'The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear, and uncertainty but finally confidence' (3A40)

The data relating to such learning allows me to take more notice of the words students are using to describe their emotions. This is very poignant and becomes more elaborate when the words the students use to express emotions function together, such as: I wished; I was nervous, out of my depth, disappointed; I acknowledged; I lacked; I was impressed; I find it difficult; my behaviour; I was pleased; I was concerned, I believe. Students wrote:

'I was nervous because I had no experience of managing my own patients.' (3A33)

'I was relieved when the nurse came back, administered the medication and Mrs Smith's respiration stabilised. I was very nervous and panicked at the task, which has the potential to make other people nervous, as well' (3A40)

'I believe I could have become more actively involved in reassuring the patients and letting them know they were in good hands and they were being taken care of' (3A48)

'I felt inadequate as the unexpected feedback caused me initially some stress' (3A51)

The data appear to demonstrate an emerging ability in students to recognise the complex emotional situations they are encountering in clinical practice. Confronting these emotions can enable students to deal with them appropriately in the future. In one case, writing the learning account might have helped a student focus on thoughts and emotions of the patient and given insight into the importance of being non-judgemental:

'I did my best to make the patient comfortable and I connected with her. She told me that she knew her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear.' (3A33)

One student recalled in his/her learning account an incident relating to the delivery of the nursing care provided for one patient called Wendy (Appendix 13, student story 37). The case was very complex, but the student was still able to connect with the patient.

'I introduced myself and talked to her to find out why she was upset. She said she felt like she had been in hospital forever, and would never get out. She felt like she could do nothing for herself and resented people coming in and forcing her to do things,

even when she was so tired. I thought about what she was saying and realised that some of these problems could be handled by a change in her care.

'Over the shift, working with my mentor we spoke briefly to the physiotherapist and worked out how Wendy could benefit from altering the times of therapy and being exhausted by everything being done in the morning, as by 10 a.m. she had had a bath, breakfast, physiotherapy and walked to the toilet and stairs, a doctor visit. This was all too overwhelming for her. So her schedule was changed and some of these activities were moved to the afternoon.' (3A37)

The student's story mentions interaction and negotiation with the physiotherapist, yet this action was given limited attention in the learning account. The nurse's focus was on the patient. The student incorporates elements of communication, the development of a therapeutic relationship in combination with team-working skills in the form of a discussion with a physiotherapist. In addition, the student makes reference to theory, is guided by her own professional status as a student nurse, and is all the time thinking critically about what can be done about it. More importantly, Wendy was no longer upset.

One nurse wrote:

'.....to share my emotions and expectations in care, to be sensitive to the dynamic and rapidly changing needs of all patients and helped clarify and resolve my original feelings of guilt and doubt.' (3A38)

In this learning account, the student's feelings move from those of fear for the patient to those of uncertainty, and finally to feelings of confidence. Quite possibly, learning from such stories can occur simply through the student identifying the emotional elements within a personal story in the way illustrated.

While dealing with an emergency situation, the student in story 3A40 concentrates on herself, the mentor and the patient, and does not mention any other person. S/he seems to be in harmony with caring for the patient, with her mentor for support, in the hospital environment. According to the

student, although stressful, it is a great feeling when the patient's emergency condition is dealt with promptly. The student wrote:

'I believed I had managed this emergency situation well, this experience was very stressful for me' (3A40)

The student's focus is on the quality of care s/he delivers, which reflects on their competency:

'I started to believe in my own competency .....I feel I did well and I found this experience positively contributed to my overall nursing skills' (3A40)

Students adopt a variety of strategies to help them cope with emotionally charged situations (Appendix 11, section 11.11). These include staying calm in an emergency, regulating emotions as the situation demands, and assessing possible consequences for the patient. For example:

'...(I) tried to stay as calm as possible as it helps to focus and also to reassure Mrs Smith' (3A40)

'The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear and uncertainty but finally confidence' (3A40)

'Problem-solving is part of decision-making, a systematic process of focuses on analyzing a difficult situation and problem solving always includes a decision-making step' (3A40)

'Decisions may have far-reaching consequences' (3A40)

According to Dewey (1934, reprinted 2005), feelings we have about features of the environment make some stand out and others fade away. Students' stories can be vehicles for the expression of positive feelings, and, as such, are aids to the assimilation of related situations into students' repertoires of caring experiences:

'I feel I did well and I found this experience positively contributed to my overall nursing skills' (3A40)

By helping students become emotionally aware, these stories thus become a part of the student's journey towards becoming a nurse. Vygotsky (1978) views emotional learning as vital in order to meet an individual's full potential. If nurses do not develop emotionally in the ways discussed above, their life in clinical practice will remain 'bland' (Holloway and Freshwater, 2007).

In summary, according to Christianson and Jenson (2008), students' emotional learning benefits when they access their own stories. As discussed, these are often tacit, embedded in practical knowledge, and not easily accessible, but, once externalised, become easier for students to regulate and harness to appropriate action. Nurse education should make space for emotional learning in the curriculum, using students' own stories for this purpose.

#### 6.4.6 Stories as a medium for self-exploration and professional development

Stories can be a medium for self-exploration as my personal account in chapter 4 testifies and this can be useful for professional development. Reflection can be used to facilitate self-exploration and this can help students identify their own learning and learning needs.

##### *6.4.6a The use of stories for self-exploration*

The stories and associated learning indicate how story potentially orders events in such a way as to reveal a nurse's self i.e. reflexively (Appendix 11, section 11.12). The language used by individual nurses reveals something about their individual personalities in such a way that self-exploration is a real possibility.

By examining the stories, it seems students can become more aware of their own values and beliefs and learn more about themselves. For example, a student wrote:

'This story has been beneficial in terms of developing and increasing my self-awareness.' (3A33)

This type of learning may be vital if students are to move beyond the limited confines of learning outcomes and mechanistic reflection (see chapters 1 and 2). Other learning accounts detail how students can gain personal insight into themselves as nurses:

'I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of a patient for a whole shift. From the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice.' (3A37)

'... it has highlighted the need for me to improve my self-awareness' (3A40)

When story is applied as an aid to learning, students can become aware of their actions as recounted in the stories, and thereby learn more about themselves. One student suggested that learning more about oneself facilitates the understanding of another's individuality. The student wrote:

'Only the acceptance of one's self, can a person begin to acknowledge another person's uniqueness' (3A40)

In the case of self-exploration, it is the student's role in the learning process that is stressed. Self-direction of learning is encouraged, as well as the development of self-evaluation strategies promoted through students working alongside the lecturer. This is congruent with Vygotsky's (1978) idea of giving weight to the role of other students in learning, and to interaction and collaboration between students in various partnerships.

However, when story is applied as a medium for self-exploration, student learning can become more differentiated e.g.:

'Using my clinical judgement, I decided that stabilising the patient had priority over the dressing change' (3A40)

'Personal change and growth' (3MH1)

'I have gained new perspectives to set myself personal goals that facilitate effective patient care that may eventually eliminate the use of seclusion' (3MH1)

'Placing self when patient decisions are being made to make present known and placing self in a position of authority on equal par to other members of the MDT – ignoring the hierarchy' (2A12)

These students seem to have undergone some change through self-exploration using story, which may lead to a change in each person, and the setting of new goals and achievements to become a better nurse.

#### *6.4.6b The use of reflection to facilitate self-exploration*

Individual learning may be enhanced in a number of ways through the use of story, which might lead to improvements in the understanding of reflection and its role in self-exploration. Students can become more aware of their own values and beliefs through reflexivity, and using story can improve a nurse's reflective ability to deal with complex emotional situations. The student can become aware of the tensions of modern-day practice, which in turn raises awareness of professional development needs and goals, providing a potential mechanism for continuing learning as a lifelong process.

Students' use of reflection in self-exploration can become a means of self-criticism:

'Limitations of counselling skills needed to share the wife's concerns with others' (2A15)

'This culminated in a situation whereby I lost contact with what was happening to my patient.' (2A23)

'I felt disappointed in the outcome because I had jeopardised John's sight by giving an ineffective handover. I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship.' (3A32)

'Effectiveness of my care delivery was adequate still needs improvement.' (3A34)

'Indeed, engaging in reflection can in fact lead to self-doubt. This made me question the importance of my role. I lacked experience relating to the advanced nursing practice conducted within that specialist area.' (3A35)

'When I consider my interventions in retrospect, I can see that the majority of my actions were reactive rather than proactive. By not planning and sharing my workload, the patient's care suffered, and many tasks took longer to achieve than normal. My initial problem of inadequate information could have been dealt with if I had been more assertive. I could have dealt with the above situation differently, resulting in better patient outcome.' (3A36)

This negativity toward one's own practice and oneself may hint at a limitation of reflective practice as it is presently conceived. Reflective frameworks can also restrict exploration of practice insofar as these suppress creativity and thinking (Nicholl and Higgins, 2004). Indeed, engaging in critical reflection can lead to uncertainty about self (Parahoo, 2006), as demonstrated in a student's learning accounts:

'.....ineffective / weakness in communications skills' (2A9)

'.....engaging in reflection can in fact lead to self-doubt' (3A35)

The emergence of self-doubt may result from students being faced with incidents which exceed the scope of questions posed within the reflective framework. Too infrequently students praise themselves and their actions:

'I feel that I can deliver good nursing care to all my patients' (3A23)

In a reflective learning environment, there is a great deal of emphasis on the power of the tutor and less on the abilities of the students to evaluate their own progress and direct their own learning. This is demonstrated in the learning accounts by situations where students are exposed to power relationships between nurses and doctors:

'I felt apprehensive, I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship, I felt nervous about using medical terminology



such as 'ophthalmic' because I thought I would sound stupid if I pronounced them wrong.' (3A32)

Nevertheless, not all of the above will be experienced by all trainee nurses as each person's learning may be different due to his / her individual emotions, personality and past experiences. Story allows for a more personal approach to learning than other approaches, such as theory-based reflective practice and critical incident analysis. This is because engaging with their own stories of practice is a way students can vicariously relive experiences. The direct impact a story can have may signal a kind of learning that rarely leaves the nurse unchanged. For example, students wrote:

'Helped me focus on my thoughts and emotions ..... to ensure continual professional development' (3A33)

'I have found that I am more aware of my actions when fulfilling my duties, constantly seeking to justify my actions and underpin these with theoretical knowledge' (3A51)

#### *6.4.6c Stories as an aid to student recognition of their learning*

The data tend to show a gradual recognition by students of their own learning and hint at the role of stories themselves in making this recognition explicit (Appendix 17). For example, students are gradually becoming aware of the skills they are developing for the delivery of integrated, equitable and effective patient care:

'I had to deal with the practical and physical problems caring for this patient, in particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin.' (3A33)

One student's learning account details awareness of professional development in relation to how managerial skills were being developed, such as the ability to delegate duties and report relevant information to other MDT members. As the student wrote:

'I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients.' (3A37)

It was evident from another learning account that the student was able to link practice to wider professional goals, social issues, ethical and political concerns and emotions as well as to their own learning needs. The student would also be able to return to the story in the future as – possibly – part of a lifelong learning process:

'This story writing experience helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection.' (3A33)

As well as explaining learning from nursing practice, writing and analysing story promotes, enhances and improves such learning. It is through story that students can clarify their own individual skills and passions and decide which path to follow in the future (Appendix 15):

'This experience led to my decision to head into palliative care in my nursing career. I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably to me to quitting nursing.' (3A44)

They become aware of their stories at the same time as they attempt to find meaning in the care given. From their stories and their identification of their own learning, students may notice aspects of themselves and of the situations around them that they may not otherwise have seen. They can become aware of their own emotions and feelings, the tensions or conflicts in care, and the harsh reality of clinical practice environments. This awareness can make it possible for them to respond to circumstances in an informed way, and help them to identify their own learning needs.

Therefore, students can gain from their stories insight not only into their own values and beliefs but also heightened self-awareness of themselves as nurses. Reflection can be used to enhance this process and help students to develop insight into their own learning and learning needs.

#### 6.4.7 Stories can illustrate aspects of nursing hard to define explicitly

What is written about in one story and learning account may probably not be unfamiliar to other students, who may be able to relate to the feelings being presented, as well as to the successes and failures of any related strategies. Student nurses have many stories which seem to connect storied events to their emotions with the potential of making the events themselves more meaningful. Giving meaning to a situation is a form of learning or – in context – applied learning. Teachers can guide students toward understanding how emotions can connect, and add meaning, to an experience through the illustrative use of story.

Dewey (1934, reprinted 2005) invites us to think of story as something that embraces what is being experienced. It seems to me that, when I read through the students' learning accounts, I glimpse the students' own social reality and the meanings they give to their experiences through story. The reality and accompanying meanings are contained within the students' lines, if only implicitly. Indeed, these stories, and the learning accounts derived from them, could be an invitation for a reader to become part of the students' practice-learning journey, to enter imaginatively the world in which the story, and any learning arising from it, was formulated.

These ideas on the illustrative potential of giving meaning to experience have implications for how story could be used in nurse education. Students are rarely given an opportunity to become attuned to their own learning or to contribute something of themselves to the learning process. They are often only expected to accept what someone else has delivered. Student nurses need to be given a space to learn in their own unique ways. Within such a space, what a nurse can gain from his/her own stories might be exploited, and students' own contributions to learning from practice valued more highly than at present in nurse education. When stories are shared they can illustrate caring (Appendix 11, section 11.2) e.g.:

'The first practical step I took was to order an appropriate chair and bed. The patient was able to use a zimmer frame to walk into the bathroom to clean her teeth, and I was able to attend to the washing of her back and legs. I needed to ensure that her legs were dried completely and moisturised, in order to reduce cracks in the skin and to prevent the formation of lesions.' (3A33)

'I checked the wound site as part of the assessment, I noticed a small amount of blood on the dressing, which I decided to monitor closely, as blood loss can be potentially dangerous.' (3A40)

'The child was attached to an oxygen saturation monitor and required regular nebulizers throughout the day to stabilise her condition. I decided it would be best to prop the child up in the cot rather than her laying down flat, which would hopefully help her chest and make her saturations rise.' (3C3)

'I also did not want to cause the patient any pain although pain was taken care of by medication.' (3A51)

'While I was there I was actively encouraged to interact with the patients in terms of reassuring them and informing them of where they were.' (3A48)

as well as aid empathy (Appendix 11, section 11.3):

'Wondered how her parents would be feeling, as I am a parent myself, I seemed to put her under my wing and took over as a mum, as she had no one with her and no way of contacting anyone as she was a unknown' (3A23)

'The opportunity to understand what the patient was going through (empathy) and thereby improving the quality of care I could have given to the patients' (3A48)

'The implications can be enormous for the patient; physically, psychologically and socially, there are knock-on effects for other patients waiting in line for treatment' (3A51)

'I tried to look at the situation through the patient's perspective and from the view that I shall soon be a staff nurse' (3A33)

Stories can also illustrate ways a nurse might show compassion toward patients. One student demonstrated this when breaking through the hierarchy of power discussed earlier:

'Went directly to show the ECG to the doctor, as nurse not taken seriously, immediately know what was wrong' (2A18)

Out of genuine concern and compassion for the patient, this student negotiated successfully the power relationship between doctor and nurse, as the extract articulates. Students can demonstrate their compassion in other ways:

'I began to recognise the detrimental effects of social isolation on the health of elderly individuals' (PG1-6)

'What it means to a person to be socially isolated, and the effect it can have on health' (PG1-6)

'More alert to individual needs and can now provide necessary information to patients being barrier nursed in this way' (PG1-6)

'I was 'available' and concerned for her care' (3A33)

'I learned much about their successes in life, about their families and also, sadly, about their worries about how it would all end' (2A33)

'I was an incredible experience to be with these courageous people in their time of need' (2A33)

Christiansen and Jensen (2008) propose that it is only when students develop empathy that they learn compassionate concern. The stories reveal how they concern themselves with facing the emotional challenges presented by patients, such as dealing with pain and loss compassionately. Students describe having to face up to not only their own emotional reactions:

'Being a part of the patients' journey, the sad times at the end. On occasions there were many tears.' (2A33)

'I felt nervous and was unsure if I could manage the patient's care myself. 'I felt tired after the event, but also very positive and confident that I managed the situation well' (3A40)

'It can be very emotionally draining' (3A48)

but also those of the patient:

'Concern for the patient's stress' (2A15)

'I did feel very scared for the patient as she was under 16 years old' (3A23)

'Sometimes patients can be emotionally distressed by their experience in surgery' (3A48)

'He began to cry during the visit. He wept uncontrollably and could not be stopped or consoled' (3MH3).

'I tried to look at the situation through the patient's perspective and form the view that I shall be a staff nurse' (3A33)

Another area not easily dealt with in a purely theoretical way but usefully exposed through story is that of respect and dignity. For example:

'In providing care to the patient in seclusion, the team respected and upheld the patient's dignity' (3MH1)

Privacy and dignity were discussed in the focus groups (Appendix 10, 2a, 2c), where students were asked to pay attention to these very important areas of clinical practice. This is where the evidence of the focus groups is important in that the sharing of stories led to rich discussion and increased understanding of their content and the students' learning from them. Terms such as caring, empathy, compassion, respect, privacy and dignity are hard to define in ways applicable to practice. The sharing of the stories themselves is important in building a bridge between theoretical understanding and applying such terms in clinical situations.

#### 6.4.8 Stories as an aid to illuminating and capturing a situation imaginatively

Some stories imaginatively encapsulate a situation, and the vividness of expression clearly is in the story, not in the situation. Moreover, as stated above, emotions are ways of evaluating situations so, by putting an experience in story form, events gain emotional emphasis. That is, the

experiences reported become open to evaluating, checking, assessing, and putting into perspective. This is shown in a 3<sup>rd</sup> year adult story below:

Student story 52

'S has severe cerebral palsy with contractures. He was totally bed-bound and had been admitted to our ward awaiting re-insertion of his jejunostomy which had accidentally come out. In addition to this, he was suffering from cancer of the tongue and had undergone a hemi-glossectomy, had a permanent tracheostomy in place, poor eyesight and communicated with an alphabet chart. He was nursed in a side room and was totally dependent on the nursing staff. I was assigned to S daily and within a few days felt a real bond had developed between us. We hoisted him daily into his specially adapted wheelchair which supported him and positioned him by the door so he could watch what was going on and read his bible. S appeared to be exceptionally bright but trapped in his useless body. Everyone loved him as he seemed such a gentle character.

The following week, I arrived at work to find S suffering from severe diarrhoea. I washed him from head to toe, cleaned the bed and floor and changed his sheets. I tried to be as cheerful as possible but had begun to feel dreadfully sorry for this poor soul. This was no way to live a life. It must have been hell.

When I had finished, I cleaned S's glasses and combed his hair. He suddenly looked upset and indicated he wanted to communicate so I fetched his alphabet chart. He spelt S O R R Y. His eyes said it all and I couldn't believe that this poor man, who's suffering was so immense, was saying sorry to ME! Who was I? I touched his arm to reassure him and told him that it was what I chose to do and that the nurses all loved to look after him and he was not to worry. Then I left the room, ran to the toilet and cried uncontrollably. I will never ever forget S's story. Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own. Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us.'

Presenting an experience vividly or with emotional resonance helps focus on the central features of the learning required or at least highlighted within it.

#### 6.4.9 Stories helping to achieve transferability

Stories can help achieve transferability and there is evidence to suggest that students are using their learning from stories to transfer learning from situation to situation. Students felt that, by analysing the learning from their stories, they began to understand their actions, and gain new knowledge about their practice and transferable skills (Appendix 11, section 11.13b):

'The skills gained on an oncology are invaluable and will be useful during future ward placements' (2A33)

The possible role of stories in gaining transferable skills was strengthened by the focus groups (Appendix 10). When students were asked to document learning from their stories in a mind map, one group chose to record:

'Learning transferable to other situations' (2a)

What students learn when using story should be transferable to a similar situation with similar types of participants. In any practice-based profession it is difficult to encourage learning directly from day-to-day practice, as each incident in a practitioner's day is distinct from every other and generalising theoretically may miss the unique but key factor, the particular incident which makes a difference to a patient's well being, and this matters. Stories have the appearance of being real, something that theory often lacks.

*In this chapter I used narrative analysis to provide an insight into the issues and concerns of student nurses as they learn in the practice environment. Following data analysis involving content analysis, the analysis of form and a final more functional analysis forming the basis of a presentation of findings, I discussed these findings under three main headings: the revelatory role of story, its more interpretive, exploratory role and the way it can function as a more direct aid to learning.*

*It appears that there are many possible perspectives one can take on student learning. This chapter shows evidence especially of emotions and feelings*



*playing a powerful role when working with story. It also illustrates how students may need support, guidance, space and time to become attuned to their stories. Attuning students to significant incidents in their clinical lives through stories releases a flow of potential learning opportunities and exposes a world of nursing practice so rich that even I have been surprised. As students become more attuned to a story's events, the story itself becomes potentially a powerful learning tool. The idea of attuning to stories or to events captured by the stories emerges from the analysis, focusing on making explicit undifferentiated experiences, i.e. in the language of story moving from the pre-narrative to remembering.*

*This evidence supports the idea of teachers finding time to engage with their students' stories and encouraging them to explore these as an aid to learning. It may help teachers to understand the learning needs of students more effectively and appreciate the potential of learning from stories. As teachers, we need to make an effort to listen to students. Learning from clinical practice cannot always be predetermined by learning outcomes. The students were empowered by their stories and the learning that arose was determined by them and not by a teacher. The students' learning was personal and had special significance as it was drawn from the story by the student experiencing it. This is why story has an important role in learning and teaching in nurse education, bringing a more individual personal focus to the nurse curriculum.*

## Chapter 7

### Recommendations and concluding reflections

*In chapter 1, I highlighted the excessive use of technical rationality in nurse education, particularly in modules that rely on learning outcomes and assessments to ensure they are met. In chapter 2, I considered the use of reflective practice as a way of acknowledging learning that takes place through practice. However, strategies using reflection have generally been top-down and mechanistic rather than practical and student-centred, and fail to recognise adequately, or realise the potential of, learning from practice. This led me to consider in chapter 3 the way story might remedy this potential failing in the education of student nurses, leading me, in turn, to think about what I have learnt from my own stories about my own professional practice - as presented in chapter 4. The desire to explore the outcome of this thinking was the motivating factor behind this thesis.*

*In chapter 5, I searched for a methodology that could meet this challenge, a journey that started with the exploration, but ultimate rejection, of a number of possible qualitative methodological approaches, followed by the selection of a narrative approach using students' own stories, written down and analysed by students and confirmed by focus groups. The data analysis does not rely wholly on nurses' judgments but is supported by reference to theory. It includes the application of Leiblich et al's (1999) holistic content analysis and holistic analysis of form followed by a final more functional analysis, the basis for a presentation of findings. Using this approach, I interpreted my findings from a number of different perspectives to help confirm the kinds of learning discussed. In chapter 6 I gave an analysis of the stories collected for this study and presented them under three main headings related to their content, their form and a more direct role story might play in learning.*

*In this chapter, I summarise my final interpretations of the research and discuss how its findings might impact on, and contribute to, learning from practice and the potential value of story to do this. I acknowledge that the*

*data presented cannot conclusively demonstrate that learning results directly from story, but would contend that the data strongly suggest that story facilitates and encourages learning and contributes positively to a fuller understanding of the nature of learning from story. Finally, I suggest some ways in which this work could contribute to areas outside of nursing and reflect on how it might develop in the future.*

*Through this journey of exploration I have learned so much more in addition to what is presented here, and I describe my current understanding in my final reflections, demonstrating how my thinking and understanding have changed as a result of the actions and experiences described in the previous chapters. They detail my personal growth as a researcher, and contribute to the embodiment of the practical and educational aspects of my learning. This chapter considers how the experience of undertaking this work has contributed to my personal and professional development, as well as highlighting those issues that need further thought and investigation.*

## **7.1 General summary of the role of story**

Story can elucidate what is happening in the clinical setting. Putting learning from practice into story form clarifies students' understanding in a way that raw experience gained in practice cannot. From a research viewpoint, gathering learning from practice in story form brings together a diversity of examples of experiential learning that would otherwise be hard to accomplish. From the viewpoint of the individual nurse, bringing clinical experiences together in a coherent story makes experiences accessible for learning purposes.

Through story, students can differentiate and structure clinical experiences that might have stayed undifferentiated and unstructured. Experiences articulated in this way might also help students to meet set learning outcomes. Story can give form to what might otherwise be formless, and can make an experience accessible to analysis in ways not usually possible in a complex

social setting, ordering or structuring them in ways that the experience itself would not do.

There is a potential role for story in the self-direction of learning and the development of self-evaluation strategies promoted with students working alongside the lecturer. This is congruent with Vygotsky's (1978) idea of giving weight to the role of other students in learning, and to interaction and collaboration between students in various partnerships. It is an especially important concern, given that, in a reflective learning environment, there is a great deal of emphasis on the power of the tutor and less on the abilities of the students to evaluate their own progress and direct their own learning.

Story potentially allows for a more personal approach to learning (in the Piagetian sense) than other approaches, such as theory-based reflective practice and critical incident analysis, often do not. Engaging with their own stories of practice is a way students can vicariously relive practice. The direct impact of a story can produce a kind of focussed thinking or mental readjustment that may not leave the nurse unchanged, and students can gain insight into their own values and beliefs and gain a heightened self-awareness into themselves as nurses.

The ability to connect with practice through story in nursing can indicate what may be personally significant and valuable for nurses in their everyday practices, as well as signalling a progression from the 'unreflective' pre-narrative stage, giving a view of nursing from the perspective of the student nurse. If stories can make practice more transparent from their own perspective, nurses can come to understand their practice better. This may only be a beginning in the struggle to reposition nurses' connections with practice through the use of story, in an environment within nurse education that often appears dominated by theory. To feel a part of others' practice is special, and stories viewed from the perspective of nurses respects them as professionals and may be one way of helping them endure the trials of practice.

Also, because the world of the students experiencing clinical practice and presenting it as stories is a world easily silenced by current practices, the use of students' own stories is about giving them a voice (Ironsides *et al.*, 2005) and allows them to express how they understand their own world (Belenky *et al.*, 1986). Through the medium of story students can gain and develop their own ways of expressing what they are experiencing and learning in clinical practice. The use of students' own stories is, therefore, about giving them greater autonomy rather than their being forever guided by others.

At the same time, in using story as an aid to learning, students can learn to relate theory and practice in a way experience alone does not readily allow. Stories can be regarded as forms of mental 'schemas' (to use the Piagetian term) bringing together different aspects of learning. Students need suitable tools to access and preserve 'lived experience' which can then be further used to adapt to a variety of later situations. By engaging with their own stories, students can link the past identified in the story to a possible future, with such temporal links developing a possible process useful for future career ambitions and lifelong learning.

Therefore, although direct learning from story may be difficult to pinpoint conclusively, the data demonstrate the extent to which story can be an aid to learning, and suggest that, in many situations described above, learning itself can take place.

## **7.2 Revisiting the research questions**

The following sections set out to answer each of the four research questions given in chapter 3, section 3.5. These are worth restating before being considered in terms of research findings. The questions are:

1. How does story help illuminate the lived real world of the nurse?
2. How far does story crystallise the personal preoccupations of a nurse and help resolve personal issues s/he may have?

3. How might stories aid nurse education, especially taking into account relevant theoretical perspectives?
4. Overall, therefore, does story have a useful role to play in nurse education, and how might this role be better realised?

The way these questions are answered *via* data analysis in chapter 6 is summarised below.

### 7.2.1 Stories can illuminate the lived world of the nurse

Through story, student nurses can gain insight into their own world. They have many stories which connect storied events to their emotions with the potential of making the events themselves more meaningful. According to constructivist theories, giving meaning to a situation is a form of learning, or – in context – applied learning. One of the most important instances of this possible role stories may have in adding meaning to generally undifferentiated circumstances is their potential for revealing the emotional impact of some clinical situations on students in a way they and their teachers should find useful. For example, stories put into context sensitive or ‘difficult’ issues by presenting them as lived situations relevant to nurses’ own experiences.

Story can help students organise and highlight important features of what they are engaging with in practice, and reveal the main concerns and priorities of nursing, elucidating what nurses are most sensitive to, aware of, and find hard to cope with. This kind of evidence is worth having in its own right as potentially useful for further research into nursing practice as well as for informing nurse education more directly. For example, students are rarely given an opportunity to become attuned to significant features of their own unique experiences or to contribute something of themselves to the learning process. They are often only expected to receive what someone else has decided as being important or relevant to their further development. Student nurses through their stories can be given a space to learn in their own special ways, where what a nurse can gain uniquely from his/her own stories might

be exploited, and students' own contribution to learning from practice valued more highly .

Data drawn from story may also be useful to the nurse educator in relation to the activities students are generally not exposed to, such as health promotion, research or the failures of health care. Story can identify what may be missing from the learning of student nurses in students' own practice situations. By using story, steps can be taken to correct this without a teacher needing to resort to illustrating such learning indirectly and, perhaps, artificially.

Story also illuminates a continued reliance on the use of mentors to support students, as the students highlight both the benefits and limitations of this in clinical practice. Facilitation of student learning requires someone who is supportive, can act as a good role model, and has the students' interests at heart. The processes of training staff to undertake this role is often complex and theory-laden and, as a result, some are deterred from undertaking it. Story can contribute to mentors understanding better the needs of the students for whom they are responsible.

#### 7.2.2 Stories can crystallise personal preoccupations, resolve personal issues of nursing and aid nursing practice

Stories help students to solve the problems and tensions they experience in practice and the difficulties they may be having in expressing emotions and with self-exploration. Stories can be aids to problem-solving, as they can reveal how clinical problems might be resolved, providing an aid to further learning mediated by real life illustrations. They can also open up areas for discussion by raising issues of general concern, identifying problems that are still unresolved or suggesting how a story and learning might be a vehicle for problem-solving. My proposal is that nurse education could develop problem-solving techniques and theories directly relevant to the situations in which nurses actually find themselves, and thereby develop a more differentiated understanding of the processes involved. Stories acknowledge the need for

the exercise of problem-solving skills by nurses and give time and space for developing these skills. Using story as an aid to developing problem-solving strategies may be an important way of supporting learning in the nurse curriculum.

By expressing emotions as part of the story or as part of the story-telling, stories can reveal the important emotional dimension of nursing. Bruner (1986) points out that individual's own stories can express significant emotions, and have been remembered for that reason. The bringing of emotions to the fore may be the beginning of a focused engagement with those emotions. Using story as an aid to learning can expose students' emotions in a generally safe and supportive context. By helping students become emotionally aware, stories become a part of their journey towards becoming a nurse. For Vygotsky (1978), emotional learning is vital in order to develop an individual's full potential. Holloway and Freshwater (2007) state that, if nurses do not develop emotionally, their life in clinical practice will lack an important and essential dimension, and may even render the nurse unfit to practice successfully.

According to Christiansen and Jensen (2008), focused learning may occur when students discuss how they acted, as a result of their emotional encounter, and emotional learning can benefit from accessing their own stories. As discussed, these responses are often tacit, embedded in practical knowledge, and not easily accessible, but, once externalised, they become easier for students to harness and take appropriate action. Stories are invariably emotionally charged, and arouse feelings that help us to remember other stories. In current nurse education, there is little space for exploring the emotional aspect of practice. Nurse education should make space for emotional learning, potentially using students' own stories as a vehicle.

Story can help a nurse overcome difficulties specific to him/herself and to achieve equilibrium in the Piagetian sense. Difficulties that can disrupt a nurse's equilibrium are not uncommon, and putting difficulties into story form can make them more accessible. Story may have a role in helping someone



cope with a difficulty by articulating it, rehearsing scenarios and introducing possible ways of resolution, or by putting the elements of the difficulty in a particular order.

Stories can be a medium for self-exploration, as my personal account testifies in chapter 4, and this can be useful for professional development. The stories and associated learning indicate how story can order events in such a way as to reveal a nurse's self to herself i.e. reflexively. When story is applied as an aid to learning, students may become aware of their actions and may be learning more about themselves. When story is applied as a medium for self-exploration, students' learning can become more differentiated and undergo significant change.

In regards to self-exploration, it is the student's role in the learning process that is stressed, and story can lead to improvements in the understanding of how reflection can be used beneficially. Students can become more aware of their own values and beliefs through reflexivity. Using story can improve a nurse's ability to reflect on and deal with complex emotional situations – as implied by Lalor *et al.* (2006), who give a picture of the pleasure that caring for a patient, despite its complexities, can bring. The student can become aware of the tensions of modern-day practice, which in turn raises awareness of professional development needs and goals, providing a potential mechanism for lifelong learning.

In summary, from their stories and their identification of their own learning, the students may notice a problem or difficulty in themselves and in the situations around them of which they may otherwise have been unconscious. They can become more aware of their own emotions and feelings, the tensions or conflicts in care, and the harsh reality of clinical practice environments.

### 7.2.3 Story can aid nurse education from various theoretical perspectives of learning

Students see the need to work with experienced HCPs, as learning from peers and colleagues contributes to personal and professional learning (Calman, 2000). In developing this view, Andrews and Roberts (2003) state that senior staff should provide role models and support for juniors, and show by example the relevance and importance of learning from others. Vygotsky (1978) is the most influential theorist regarding the importance of helping students to achieve their potential development level under guidance from more advanced individuals or in collaboration with others.

From a Piagetian viewpoint, students no longer remain the passive recipients of theory and practice-based knowledge, but become the originators of their own context-specific learning. My own views are similar in many ways to those of Schon (1991), who developed ideas of reflection-on-practice and reflection-in-practice to promote individual learning, but this research recommends going beyond reflection as a main pedagogic strategy to determine learning directly from clinical practice, as suggested by Bradbury *et al.* (2010). Rolfe (2000) recommends multiple approaches to capture the essence of nursing, such as story and narrative, reflection, dialogue, writing and poetry. In his words (2000, p.144):

‘How we perceive an individual human being, health, and nursing’s work in our imagination literally makes a world of difference..... Everything is totally interdependent and interrelated..... Let us re-infuse the light of nursing with an open consciousness that acknowledges the uniqueness of each individual .....

By using story, it may be possible to go beyond the social construction of learning managed by more experienced colleagues, internalising it as proposed in the Vygotskian sociocultural paradigm, to, just as importantly, valuing learning that is constructed emotionally and personally as in the Piagetian tradition. This is to help ensure that both these important traditions are able to illuminate nurse education. Recounting students’ own stories may

be one way of developing a richer repertoire of learning, illuminated and informed by the two established developmental accounts.

#### 7.2.4 The role of story in learning to become a nurse

Story may give a picture of students' practice to demonstrate how this has contributed to their becoming a nurse. This study emerges from my use of stories and sharing them in the classroom. But in the beginning these stories were solely my own. Fairbairn and Carson (2002) suggest that educators should attach more value to the sharing of stories. Nevertheless, although story sharing can usefully guide student thinking towards areas set out in the curriculum, the formal curriculum may not fully encapsulate the value of story as a learning space in its own right.

This study demonstrates how a story can be remembered, recorded and valued, but additionally how, as a permanent record, it may have the potential to help students to learn. I am hoping, through this work, to find space to put students' own stories into nurse education. Nursing needs to maintain the significance of practice (Rolfe, 2000; Fairbairn and Carson, 2002) and the potential of learning from practice if it is to survive as a practice-based profession.

### **7.3 Further impacts on practice: student-led teaching**

I further propose to explore the potential value of using stories in my own practice as a nurse educator by creating a student-led module and developing an appropriate pedagogy. As an outcome of this EdD study, I hope to hand over responsibility of one of my taught modules to students. The aim of such a module will be, especially, to make the implicit explicit, bringing the pre-narrative to the fore and getting students to remember their own stories. By this means, they should gain more differentiated learning and understanding of practice. A student-led module of this type is currently under discussion for inclusion in the new nurse curriculum, and will be at undergraduate level six. It will value the student journey of learning outside the set learning outcomes

of other modules. It will also contribute to the overall development of students as autonomous, self-managing learners, and will incorporate innovative and creative assessment strategies that will allow students to examine practice directly, rather than only through a theoretical lens.

It is envisaged that the students, in negotiation with teachers, will organise their own strategies to assess the learning gained through their stories. The assessment(s) chosen will allow student participation as well as the analysing and theorising of their own real life practice situations. Such a strategy will transform the role of students from passive receivers of information to active participants, and contribute to making aspects of a student's university experience more engaging, inclusive and meaningful.

The proposed module hopefully will enhance student motivation since this is an essential element in learning, partly by creating a safe learning environment in which students will feel able to demonstrate the enjoyment and pleasure that nursing can provide. They will be stimulated to explore their clinical practice and, through their stories, access the nuances of nursing. The current reality is that students tend to want to learn only what is needed to pass the assessment, but this new approach, involving them in their own learning, could reverse this trend.

I feel this approach can establish better partnerships between teacher and students, encouraging a life-long quest for learning together, a possibility that has a particular impact on how I interact with my own students. The writing and sharing of stories allows students a voice to express their practical experiences in their own words, which in turn allows me as the teacher to become attuned to the students' stories and recognise their individual learning. In this way, the student-led module should help to improve the student-teacher relationship.

Ironside (2001), Ironside *et al.* (2005) and Nehls *et al.* (1995) draw attention to evidence that the student-teacher relationship is fundamental for effective learning to take place from story. Heinrich (1992) points out that, when

students' own stories are shared, a unique pedagogical interaction between the teacher and student is created. According to Bowman (1995), for this to happen, teachers have to relinquish control, and a space needs to be provided for the communication of stories between teachers and teachers, teachers and learners, and learners and learners.

When I meet with my students and we recall our stories of clinical practice, our relationships with patients and our early encounters, I am struck by how warm our voices become and how lively and imaginative the conversation becomes. I never push students into directions they would not choose for themselves and I have never felt the need to censor a story, nor denote a story as deficient or flawed. Because I have respected students' contributions to their own learning, in this way, more equality between students and teacher has been achieved.

However, achieving this student/ teacher partnership through the use of story gives rise to a further question, considered also at earlier stages of the thesis: when to intervene in the learning and teaching process? If a student asks for assistance, it is difficult not to respond in terms of what I consider the student should be focused on. I have a body of knowledge and I am tempted to use it, but sometimes I need to suspend my own 'knowing the answers' and focus on what the student is attending to. I can then ask genuine questions posed by Mason (2002, p.207) about 'What did you do?' or 'What do you think?', 'What prompted you to do that?', 'Talk to me about what you are doing', 'Read me this bit .....' or 'Tell me in your own words'. If I truly want to be open to what students can learn from their own stories, I have to be able to resist intervention with my own experiences, and subordinate my own views about what I think students 'should accomplish'. I need to be aware of my own experience, but at the same time empathise with what it is like to be speaking and thinking as the student does.

In the development of a student-led module, students can be given the space to determine their own special learning from stories. They can depict incidences of high personal achievement and experiences with which they

can easily and sympathetically identify. As they become attuned to these learning episodes, they can establish positive self-images of themselves as nurses, as well as develop qualities which they are likely to value throughout their careers. Through a student-led module that allows students to learn from their own stories, not only might the student-teacher relationship be improved, but the balance in nurse education could be shifted from a teacher-directed learning approach to a more student-centred learning approach.

#### **7.4 More general contributions to practice**

In academia, it has been a struggle to find a space for using story as an aid to learning where learning and teaching strategies focus on both theoretical and practical pursuits. As conceded earlier, I experience a tension between accommodating higher education policies, rules and regulations, and my own ideas of encouraging individual learning. This tension – among other things – has led me to develop environments where individual learning can be promoted and students helped to gain insight into the world of the nursing profession.

Giving students a space in which to learn from their own stories would nonetheless be a radical inclusion in the curriculum. Getting students to engage with, and attune to, their stories would be central to such an approach, and, as Hussey and Smith (2010) point out, finding new approaches could begin to address the limitations of an outcomes-led curriculum. Students' learning from stories cannot just be accommodated by predetermined learning outcomes, and, by using stories, students can explore aspects of practice not easily accessed theoretically.

It is imperative, then, that, in creating a space for students to potentially learn from their own stories, they are shown how to become attuned to significant clinical practice issues through their stories and value their learning from practice. If we tentatively accept that story may have a valuable contribution to make to nurse education, the question arises as to how we find, in an already crowded curriculum, time for students to learn through their own

stories. There are already proposals to un-clutter the curriculum (Dalley *et al.*, 2008), but whether this would make room for learning from students' stories and more student-centred approaches remains to be seen.

### **7.5 Tensions and difficulties that occurred in the research**

What I have come to understand about myself is the constant tensions I felt between the use of story to explore mainstream curriculum issues, the holistic curriculum and being able to look outside conventional curricula to make a case for space for story as an aid to learning .

The position I started from was that learning from my own stories of clinical practice was difficult to match with current curriculum content learning. By acknowledging an awareness of this difficulty, I felt that I was not seeing my learning from stories as very different from the learning using stories as advocated in the literature. This was not what I had intended. I felt that I had failed to respond to the full significance of what the participants had learned from their stories and had written for me. It was not until I realised that my learning, and students' learning from their own stories, were special and students needed an opportunity to gain this special learning that I made the breakthrough that this study builds on.

Another tension concerned my readership and whether, or in what way, my texts might speak to my readers. There is tension as I turn inward between whether I can capture and represent the shared stories of my participants and myself, and respect the individual voice. There is also tension as I turn outward to think about issues of audience and form. Another source of tension lies in my wanting to respect the experience of my participants and be true to the relationship which grew between us.

A further tension is the potential conflict that I experience when functioning as both a teacher and researcher, which occurred, for example, during the running of the focus groups. Pallet (2003) identifies the difficulties of attempting to amalgamate the two roles, and during the focus group

discussions, I became lost in issues around my teaching relationship with the students and ceased to be primarily concerned with creating data for my research. Conversely, when I did use the groups as a research tool, I managed to collect valuable data, but felt that the students themselves did not gain very much.

However, I was reminded (Chan, 2005) that movement between the roles of teacher and researcher is not necessarily prejudicial to myself or my students. Instead, the interaction created learning situations that motivated students and furthered their learning. Through the process of the focus groups, I learned so much more about myself as a person in addition to that of being a teacher in the classroom.

Difficulties also occurred because, at the outset, I was very critical of theory, although aware that the case for story would be strengthened if it could be supported by theory. It was of little consequence to know that Schon (1983) had faced a similar problem. I became increasingly aware that an account of learning from professional practice directly through story would be convincing only if allied to theory. A further difficulty was that of focusing on narrative, which is not a well-theorised area, and for which an extremely wide range of methodological approaches is available. This was both an advantage as well as a potential disadvantage, particularly as the literature suggests you can build your own narrative approach (an invitation I was happy to accept). In the process of narrative analysis of content and form emerged the analysis of function highlighting the diverse and varied roles story can play in nurses' learning and general education.

## **7.6 Rigour in the research**

This study is a small scale qualitative study and it makes no claims to generalisability. This does not mean that the research lacks relevance for others involved in nurse education. Nor does it lack rigour, and, in undertaking this study, I have attempted to be both robust and rigorous. I have sought to achieve rigour by using interpretations of the students' stories



and learning accounts together with appropriate reference to nursing and educational literature. In addition, I have diverted the lens and looked at the data from many perspectives, using holistic content analysis, and holistic analysis of form and of function.

I have also identified the issue of power between teacher and student and involved students as participants, creating an environment whereby students can be partners in the learning process. I feel that I have been consistent in my approach, and have gone where the analysis of data has taken me. Where data have not allowed me to claim definitively that learning has taken place, I have been happy to acknowledge this. I developed the methodology as I went along, but all the time making it clear, through reflexivity, the direction I was taking and why. Consistency is also achieved through how I have used my own experiences as relevant data throughout the study.

The validity and reliability in my research are best seen as arising out of trustworthiness and authenticity, in that my data accurately represent the stories and beliefs of student nurses. Trustworthiness and authenticity were highlighted by Lincoln and Guba in 1985 and have since become standardised for qualitative research. My approach is trustworthy because it reliably gave me the data I sought, and is authentic because it elicited from nurses real stories about clinical practice from which they are learning. This matters as the nurses' stories used are accounts of real practices as nurses see them (Appendix 8). The students are reporting something important to them in their roles as nurses and believe they will have a beneficial impact on a listener.

Lincoln and Guba (1985) see trustworthiness as equivalent to methodological soundness and adequacy, implying a degree of dependability, credibility, transferability, confirmability and authenticity which, according to Holloway and Freshwater (2007), includes fairness. I have tried to be as fair as possible in representing students' stories and learning accounts. In terms of credibility, I have presented in the appendix how interpretations have been arrived at. The research approach is transferable as it could be used by

researchers in other practice professions. A similar study adopting this methodology with students in comparable situations should achieve equivalent results, though the content of the stories themselves and, therefore, any learning from them would be different. In addition, my interpretations were in most instances confirmed by the focus group data. This is evidenced in the development of some of the categories, connectivity and patterns analysis.

The inclusion of the learning theories gives theoretical support to the claims of how story can impact upon learning made by the nurses and myself. Exploring the theories alerted me to the varied roles stories might have as aids to nurses' learning and as aids to my own pedagogy. I am not claiming that stories only achieve an extra dimension that is hard to pin down but rather that they are ubiquitous in the way they might usefully function within a nurse education curriculum. What has been gleaned most from the theories utilised in the analysis is the construction and reconstruction of meanings, making the tacit explicit, uniting disparate events schematically, retrieving equilibrium, the embedding of individual learning in socio-cultural settings, and engaging self-reflexivity with experience via story.

By engaging in reflexivity, I have attempted to be open and transparent, and, throughout this research, the reader can observe transparency and recognise how I have arrived at my own learning and how I used it as a guide for the collection and analysis of the data. Holloway and Freshwater (2007) suggest that transparency in research is needed so as to be honest, clear and sensitive to the experience being studied. The context, background and feelings of this researcher have been identified and are open to scrutiny.

## **7.7 Suggestions for improvement**

In terms of methodology, I feel that I could have returned analysis of the data to the participants to cross-check that it represented what they perceived their learning from the story to be. However, this would have been difficult as, by the time the analysis had been completed, most of the students had qualified

and left the university. In addition, I could have made more of the focus groups and fixed more on the process of learning from story. It might have been useful to tape the focus groups, but I decided against this as I wanted to maintain the consistency of writing down ideas.

Another methodological issue is that there is no foolproof solution to ensuring precision of analysis. By using partial sentences for allocating texts to categories I may have missed the complete expression of a student's learning. However, I developed an analysis that worked with key phrases / partial sentences because these reflected ideas that were somehow discrete. I gave descriptions of how I allocated the sentences or paragraphs into the approaches to analysis and presented these as an appendix (Appendix 10, 16 and 18). I have tried to be open and transparent, and have given faithful descriptions drawn from the data evidenced by cross-referencing each illustrative quote used in the text to the data and data analysis presented in the appendices.

This study makes no attempt to investigate the problems of using story for research and pedagogic purposes and, as with reflection, critical reflection and critical incident analysis, story too has another side. Calman (2000) suggests that stories are not always 'good' and the power of such stories can be so strong that the listeners will agree without question. Therefore, stories can be highly influential on a person and affect a listener in undesirable ways. This suggests that, when using story, the wrong practices, meaning or understanding can be adopted and this may have adverse clinical consequences. I have always advocated that strategies using story should be supervised by a teacher in higher education, a mentor or other healthcare practitioner, and are not to be tackled alone.

The other elements of story not explored in this work are stories we do not or cannot tell, the so-called hidden other stories, demonstrated by the following:

## My story 26

When I was a lecturer at a School of Nursing attached to a Hospital teaching on and running a post graduate intensive care nursing course. I was involved in setting up and contributing to clinical supervision of staff using John's model of structured reflection. The sessions used to go on at various times, generally weekly. The staff members had determined a list of ground rules to work by; one of these was confidentiality. At one of the clinical supervision sessions, that I attended, a member of staff shared a situation she had observed another member of staff doing that she did not feel was correct or appropriate. The staff member wanted to discuss the issue and gain support. However, one of the other members at the clinical supervision session reported the incident. This led to a completion of an incident form and it ended up that the staff member, who was not at the meeting, got a verbal warning.

Sometimes a story should not be told, and a student should not detail a story that identifies a serious breach of professional practice, as was pointed out to students at the outset of the research (Appendix 4). The negative side of using story in practice could have been explored further.

The limited time span of the research is worth noting. It took me a long time to get to this point and the time-frame of my engagement with stories was different from that of my students. My own learning from story was over a long period of practice, whereas, in the study, it was only a short period of around 3 months between story, analysis of learning outcomes and discussion in focus groups. However, despite the context and time-frame in which I remembered, wrote and analysed learning from my stories being different, by understanding the potential of learning through their own stories, students may progress more quickly than I did. A longitudinal study would have been appropriate to examine the longer term process of learning through story. However, this was not possible in the time frame used to prepare and write this thesis. These suggestions for improving the research do not undermine the findings, the rigour or the recommendations for nurse education which follow.

## **7.8 Value of this study to fields outside nursing**

The idea of creating a space for students to learn from their own stories of clinical practice may have relevance to other practice-based professions. Lincoln and Guba (1985) suggest that qualitative research should have transferability, whereby the findings in a particular context are transferable to comparable situations with comparable participants. For this study, this could include other healthcare professional settings that have a related context such as medicine, physiotherapy, paramedics, social work, radiotherapy, microbiology and pharmacy. There are also other practice professions where creating a space for story may be beneficial, including education, management, business, engineering and law.

In any practice-based profession it can be difficult to encourage learning directly from day-to-day practice, as each incident in a practitioner's day is distinct from every other and generalising may miss the unique but key factor, the particular incident which – for example – makes a difference to a patient's well-being.

## **7.9 Further development of this work**

It would be useful to explore more deeply whether, and in what circumstances, learning might result directly from story, and to demonstrate, with a broader range of evidence, over a longer period of time, precisely how nurses improve their practices by engaging with story. This could involve observing nurses in clinical settings to measure how stories they tell impact upon their practice. More research of this sort is needed to establish the use of story as a reliable, valid and likely effective tool in nurse education.

I intend to draw from this work a number of articles that might stand alone for publication in relevant journals. There is the possibility of two books, one of an autobiographical nature, including reflections from my research journals, my development through the thesis, and struggles encountered, and the other detailing the process of learning from story, including the

stories themselves and examples of what can be learned from them. I also intend to present the findings at a number of forthcoming academic conferences.

Finally, I would like to express each story and learning account as dramatic poetry (Patai, 1998; van Manen, 1990). Patai (1998) pioneered this approach by reading and re-reading the life stories of her interviewees, and then presenting them as dramatic poetry. The potential for poetry in my data was not evident until the end of this study, but poetry can serve to make stories feel more real, imagining the student there with the patients, which Sarbin (2004) would attest, is the power of story. The students' world of practice can be brought to life in the form of poetry.

### **7.10 Final reflections**

Through the identification of my own narrative, I detailed my personal journey, and it helped me to understand better my own professional development. I recognised how my previous experiences had impacted on me as a teacher and facilitated student nurses' learning. My experiences as a teacher (and before) are as important as the theory that supports them. I do not believe that a reflective teacher only follows the interpretations of others, with nothing new or personal added to their teaching. This is an issue about voice, and I will never forget that my journey started with writing my narrative, and for the opportunity my doctorate gave me to engage with this I will be eternally grateful.

As I grow more confident, I am determined to communicate to others the potential value of narrative and story-telling. Prior to undertaking this work I rarely spoke out, as I did not think my views were significantly powerful to add substance to an educational argument. Now, I am able to discuss my views and opinions at length and confidently with others, and speak with passion about the value of learning from practice, using narrative and story-telling, to anyone who will listen. What I have found is that, when I do speak out,

people surprise me by agreeing with me. I have recently seen this process at work:

#### My story 27

I was at an internal study day on employability with many of my peers and colleagues from the Learning & Development Unit, and Research Department were present. We were all asked to detail in small groups what we thought the inherent values were in incorporating the issues of employability into the curricula. We discussed in our small group many issues related to undertaking this role, but I had specifically had the confidence to say 'storytelling'. Not only did I say it in the group, but also when we had to reconvene with the larger group, I said it again and it was written on the flip chart. Even more significant and too my utter surprise, the Professor who was leading the session, said 'Yes, I have been working on the use of story-telling and how it can a useful strategy myself, I would like to talk to you about it afterwards'.

I am more self-assured in what I value and believe in and what I would like to know more about and, regardless of my differences with others, I can now put my ideas and thoughts into words, structuring my thinking and getting myself heard. I have found a new voice within higher education, my own.

Finally, reflecting on my development as a researcher, a teacher and a person, I realise I am not the same person I was when the story began. This research has given me the opportunity to share and participate in the potential learning from practice that is gained through engaging with story, and I cannot help but be moved by it. My ongoing relationship with the participants has made me realise that story will always impact on my teaching and I will continue to develop the process, which is an exciting and dynamic one.

### **7.11 Final conclusions**

The story of this thesis is one of a search for a way of enabling students to use story as an aid to learning from practice, which was such an important part of my own personal process of learning. I feel that I learned from my own stories, which potentially highlighted their many layers of learning e.g. my story 14. However, I recognise the challenge of demonstrating conclusively the extent to which students' learn directly from story. What I have presented

here is an argument that students can potentially learn from practice through the construction of story. Story helps students to reconstruct their practice, thereby making learning possible. Stories shared by students revealed that important aspects of learning are potentially inherent in everyday practice, learning that cannot always be accessed through raw experience, theory, assessment or reflection.

There are some issues that still need to be solved in relation to reflection-in-action, the moment-to-moment experience which remains undervalued, and story has the potential to explore this area more usefully than it has to date. This is especially relevant to how story as an aid to learning can potentially bring about change in individuals, and the resonance that comes with engaging with story through time. We could create a space for students to become more attuned to significant clinical experiences via their own and others' stories. Finally, there needs to be a discussion around the structure of nurse education curricula, and creating a space for the inclusion of such learning within health care education.

Therefore, it is the conclusion of this thesis that stories can be an important aid to student learning from practice, and that learning can be accessed through story. The data in this study have demonstrated a significant number of ways in which students' learning could be furthered and enriched by a direct engagement with stories from their own clinical experience.

As this story comes to an end, I realise that what I have presented here is only a small part of a bigger picture. Here are the written stories the students chose to tell, but they continue to inhabit clinical practice and the stories go on. I am heart-warmed, though, to find nurses still telling their stories at handover time in the ancient way. It was this picture I had in my head and the ringing of their voices in my ears that kept me going through the tension and struggles I experienced in undertaking this study.



*This chapter brings me to the end of my research story. I have detailed my interpretations of the research and made some suggestions as to how they impact on, and contribute to, my practice. The stories are powerful and can help illuminate the lived world of the nurse. This thesis suggests immersing students in their own practice so they might gain deeper understanding of the messy complexities of nursing as well as finding their own meaning. They should understand that nursing is emotional as well as intellectual and a large part of the work is practical.*

*I have highlighted how stories can connect to practice and give access to the real world of nursing. There are also pedagogical implications from this study, as stories from practice in the curriculum can make nurse education more student-directed rather than teacher-led. The role of the educator can be more concerned with facilitating the exploration of practice rather than disseminating knowledge.*

*What I have also come to understand are the tensions I felt whilst undertaking the work and, through understanding them, to understand myself better and make a case for using story as an aid to learning. This has inherent value for other fields outside of nursing, for example, teacher education. In addition, I hope to move this research on, by informing others who may be interested, and through publications and conferences. After this engagement with story, interesting and important issues remain to be explored, so in different ways the story continues.*

## References

- Adam, E. (1987) Nursing theory: what it is and what it is not, *Nursing Papers*, 19(1), pp.5-13
- Alderson, P. (1998) The importance of theories in health care, *British Medical Journal*, 317, pp.1007-1010
- Alexander, R. (2008) Culture, dialogue and learning: notes on an emerging pedagogy, In: N. Mercer and S. Hodgkinson (Editors), *Exploring talk in school: a celebration of the work of Douglas Barnes*. London: Sage
- Allcock, N. and Standen, P. (2001) Student nurses' experiences of caring for patients in pain, *International Journal of Nursing Studies*, 38(3), pp.287-295
- Altschul, A. T. (1987) Why higher education for nurses? Issues and development, *Nurse Education Today*, 7, pp.10-16
- Andrews, M. and Roberts, D. (2003) Supporting student nurses learning in and through clinical practice: the role of the clinical guide, *Nurse Education Today*, 23(7), pp.474-481
- Andrews, M. (2009) Never the last word: revisiting data, In: M. Andrews, C. Squire and M. Tamboukou (Editors) *Doing narrative research*, London: Sage Publications
- Appleton, J. V. and Cowley, S. (2003) Valuing professional judgement in health visiting practice, *Community Practitioner*, 76(6), pp.215-220
- Aranda, S. and Street, A. (2001) From individual to group: use of narratives in a participatory research process, *Journal of Advanced Nursing*, 33(6), pp.791-797
- Arsianian-Engoren, C. and Scott, L. (2003) The lived experience of survivors of prolonged mechanical ventilation: a phenomenological study, *Heart and Lung*, 32(5), pp.328-334
- Attard, K (2011) The role of narrative writing in improving professional practice, *Educational Action Research*, 20(1), pp.161-175
- Bailey, P. H. (2001) Death stories: acute exacerbations of COPD, *Qualitative Health Research*, 11, pp.322-338
- Bailey, P. H., Colella, T. and Mossey, S. (2004) COPD-intuition or template: nurses' stories of acute exacerbations of chronic obstructive pulmonary disease, *Journal of Clinical Nursing*, 13(6), pp.756-764
- Bailey, P., Tilley, S. (2002) Storytelling and the interpretation of meaning in qualitative research, *Journal of Advanced Nursing*, 38(6), pp.574-583

- Baillie, L. and Curzio, J. (2009) A survey of first year student nurses' experiences of learning blood pressure measurement, *Nurse Education in Practice*, 9(1), pp.6-71
- Ball, S. (2003) *The more things change...: educational research, social class and 'interlocking' inequalities (professional lecture)*, London: Institute of Education Publication
- Barnes, D. (1976) *From communication to curriculum*, Harmondsworth: Penguin Books
- Beitz, J. (2005) The lived experience of having a chronic wound: a phenomenologic study, *Dermatology Nursing*, 17(4), pp.272, 281-305
- Belenky, M. F., Clinchy, B. M., Goldberger, N. R. and Tarule, J. M. (1986) *Women's ways of knowing: the development of self, voice, and mind*, USA: Basic Books
- Bell, N. (2003) Using patient stories to improve lung cancer care, *Cancer Nursing Practice*, 2(6), pp.21-24
- Benner, P. (1983) Uncovering the knowledge embedded in clinical practice, *Image: The Journal of Nursing Scholarship*, 15(2), pp.36-41
- Benner, P. (1984) *From novice to expert*, Menlo Park: Addison-Wesley
- Benner, P. and Wrubel (1981) Skilled clinical knowledge: the value of perceptual awareness, part 1, *Journal of Nursing Administration*, 12(5), 11-15
- Bergstrom, N., Braden, B., Laguzza, A., Holman, V. (1987) The Braden scale for predicting pressure sore risk, *Nursing Research*, 36, pp.205-210
- Billet, S. and Newton, J. (2010) A learning practice: conceptualising professional lifelong learning for the health-care sector. In: H. Bradbury, N. Frost, S. Kilminster and M. Zukas (Editors), *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge
- Boud, D., Cohen, R. and Walker, D. (1993) *Using experience for learning, society for research into higher education*, Buckingham: Open University Press
- Boud, D., Cressey, P. and Docherty, P. (Editors) (2006) *Productive reflection at work*, London: Routledge
- Boud, D. (2010) Relocating reflection in the context of practice, In: H. Bradbury, N. Frost, S. Kilminster and M. Zukas (Editors) *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge
- Boud, D., Walker, D. (1998) Promoting reflection in professional course: the challenge of context, *Studies in Higher Education*, 23(2), 191-206

Bowman, A. (1995) Teaching ethics: telling stories, *Nurse Education Today*, 15, pp.33-38

Bradbury, H., Frost, N., Kilminster, S. and Zukas, M. (Editors) (2010) *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge

Bruner, J. (1986) *Actual minds, possible worlds*, Cambridge Massachusetts: Harvard University Press

Bruner, J. (1990) *Acts of meaning*, Cambridge, MA: Harvard University Press

Bruner, J. (1997) Celebrating divergence: Piaget and Vygotsky, *Human Development*, 40, pp.63-73

Bruner, J. (2002) *Making stories: law, literature, life*, Cambridge, MA: Harvard University Press

Burnard, P. (1988) The journal as an assessment and evaluation tool in nurse education, *Nurse Education Today*, 8, pp.105-107

Burns, N. and Grove, S. K. (2003) *Understanding Nursing Research* (3<sup>rd</sup> Edition), Philadelphia: W.B Saunders Company.

Burton, A. J. (2000) Reflection: nursing's practice and education panacea? *Journal of Advanced Nursing*, 31(5), pp.1009-1017

Bury, M. (2001) Illness narrative: fact or fiction? *Sociology of Health and Illness*, 23(3), pp.263-285

Buzan, T. and Buzan, B. (1996) *The mind map book: how to use radiant thinking to maximise your brain's untapped potential*, New York: Plume

Calman, K. C. (2000) *A study of storytelling humour and learning in medicine*, London: The Stationery Office

Carper, B. (1978) Fundamental patterns of knowing in nursing, *Advances in Nursing Science*, 1(1), pp.13-23

Carr, W. (1995) *For education: towards a critical educational enquiry*, Buckingham: Open University Press

Carroll, M., Curtis, L., Higgins, A., Nicholl, H., Redmond, R. and Timmins, F. (2001), Is there a place for reflective practice in the nursing curriculum, *Nurse Education in Practice*, 2, pp.13-20

Carson, A. and Fairbairn, G. (2002) The whole story: towards an ethical research methodology, *Nurse Researcher*, 10(1), pp.15-29

- Casebeer, A. L. and Verhoef, M. J. (1997) Combining qualitative and quantitative research methods: considering the possibilities for enhancing the study of chronic diseases, *Chronic Diseases Canada*, 18(3), pp.130-135
- Chan, E. A. (2005) The narrative research trail: values of ambiguity and relationships, *Nurse Researcher*, 13(1), pp.43-56
- Charmaz, K. (1990) 'Discovering' chronic illness: using grounded theory, *Social Sciences & Medicine*, 30, pp.1161-1172
- Chinn, P. L. and Kramer, M. K. (1991) *Theory and nursing: a systematic approach* (3<sup>rd</sup> Edition), St Louis: Mosby Year Book
- Christiansen, B. and Jensen, K. (2008) Emotional learning within the framework of nursing education, *Nurse Education in Practice*, 8, pp.328-334
- Clandinin, D. J. and Connelly, F. M. (2000) *Narrative enquiry: experience and story in qualitative research*, San Francisco: Jossey-Bass Inc.
- Clarke, A. (1999) Focus group interviews in health-care research, *Professional Nurse*, 14(6), pp.395-397
- Clouder, L. and Sellars, J. (2004) Reflective practice and clinical supervision: an interprofessional perspective, *Journal of Advanced Nursing*, 46(3), pp.262-269
- Clynes, M. P. (2008) Providing feedback on clinical performance to student nurses in children's nursing: challenges facing preceptors, *Journal of Children's and Young People's Nursing*, 2(1), pp.29-35
- Cohen, L., Boud, D. and Walker, D. R. (2000) Understanding learning from experience, In: D. Boud, R. Cohen and D. R. Walker (Editors) *Using experience for learning*. Milton Keynes: SRHE/Open University Press
- Coles, R. (1989) *The call for stories: teaching and the moral imagination*, Boston: Houghton Mifflin
- Conle, C. (1997) Images of change in narrative inquiry, *Teachers and Teaching*, 3(2), pp.205-219
- Cornish, J. and Jones, A. (2010) Factors affecting compliance with moving and handling policy: student nurses' views and experiences, *Nurse Education in Practice*, 10(2), pp.96-100
- Cotton, A. H. (2001) Private thoughts in public spheres: issues in reflection and reflective practices in nursing, *Journal of Advanced Nursing*, 36(4), pp.512-519
- Cramer, C. (1997) Born again, *Journal of Emergency Nursing*, 23, pp.199-200
- Creswell, J. W. (2007) *Research design: qualitative, quantitative and mixed method approaches* (3<sup>rd</sup> Edition), Thousand Oaks: Sage Publications

- Crist, J. D. and Tanner, C. A. (2003) Interpretation / analysis methods in hermeneutic interpretive phenomenology, *Nursing Research*, 52(3), pp.202-205
- Dalley, K., Candela, L. and Benzel-Lindley, J. (2008) Learning to let go: the challenge of de-crowding the curriculum, *Nurse Education Today*, 28, pp.62-69
- Daniels, H. (2001) *Vygotsky and pedagogy*, London: Routledge/Falmer
- Daniels, H. (2005) Vygotsky and educational psychology: some preliminary remarks, *Educational and Child Psychology*, 22(1), pp.6-17
- Davidhizar, R. (2003) Storytelling as a teaching technique, *Nurse Educator*, 28(5), pp.217-221
- Davidson, M. R. (2004) A phenomenological evaluation: using storytelling as a primary teaching method, *Nurse Education in Practice*, 4(3), pp.184-189
- Davies, C. (Editor) (1986) *Rewriting nursing history*, London: Groom Helm
- Davis, B. D. (1990) How nurses learn and how to improve the learning environment, *Nurse Education Today*, 10, pp.405-409
- Dealey C (1996) The background to the national clinical guidelines for the prevention and management of pressure sores, *British Journal of Nursing*, 5(1), pp.52-53
- Department of Health (1999) *Continuing professional development: quality in the new NHS*, London: HMSO
- De Poy, E. and Gitlin, L. N. (2010) *Introduction to research: understanding and applying multiple strategies* (4<sup>th</sup> Edition), Edinburgh: Elsevier
- Denzin, N. K. (1983) Interpretive interactionism, In: Morgan G (Editor) *Beyond method: strategies for social research*, Beverly Hills, CA: Sage Publications
- Denzin, N. K. (1989) *Interpretive biography*, New York: Sage Publications
- Denzin, N. K. and Lincoln, Y. S. (Editors) (1998) *Strategies of qualitative inquiry*. Thousand Oaks: Sage publications
- Denzin, N. and Lincoln, Y. (2000) Paradigms and perspectives in transition, In: N. Denzin and Y. Lincoln (Editors) *Handbook of qualitative research* (2<sup>nd</sup> Edition), Thousand Oaks: Sage Publications
- Derbyshire, P. (1994) Understanding the life of illness: learning through the art of Frido Kahlo, *Advances in Nursing Science*, 17(1), pp.51-59
- DesGupta, S. (2004) Personal illness narratives: using reflective writing to teach empathy, *Academic Medicine*, 79(4), pp.351-356

Dewey, J. (1934, reprinted 2005) *Art as experience*, New York: Perigee Books

Dewey, J. (1938, reprinted 1997) *Experience and education*, New York: Touchstone

Diekelmann, N. (2005) Engaging the students and the teacher: co-creating substantive reform with narrative pedagogy, *Journal of Nursing Education*, 44(6), pp.249-252

Diekelmann, N. L. and Ironside, P. M. (2002) Developing a science of nursing education: innovation with research, *Journal of Nursing Education*, 41, pp.379-380

Diekelmann, N. L. and Smythe, E. (2004) Covering content and the additive curriculum: How can I use my time with students to best help them learn what they need to know? *Journal of Nursing Education*, 43, pp.341-344

Dreyfus, H. and Dreyfus, S. (1986) *Mind over machine: the power of human intuition and expertise in the era of the computer*, Oxford: Blackwell

Edwards, S. L. (1997a) Reasonable refusal? - an ethical dilemma, *Nursing in Critical Care*, 2(2), pp.76-80

Edwards S L (1997b) Measuring temperature, *Professional Nurse*, Study Supplement, 13(2), S5-S7

Edwards S L (1997c) Recording blood pressure, *Professional Nurse*, Study Supplement, 13(2), S5-S7

Edwards S L (1998a) Malnutrition in hospital patients: where does it come from? *British Journal of Nursing*, 7(16), pp.954-958, 971-974

Edwards S L (1998b) High Temperature, *Professional Nurse*, 13(8), May pp.523-526

Edwards S L (1998c) Hypovolaemia: pathophysiology and management options, *Nursing in Critical Care*, 3(2), pp.73-82

Edwards S L (1999) Hypothermia, *Professional Nurse*, 14(4), pp.253-258

Edwards, S. L. (2000) The person as an holistic being (Chapter 7), In: K. Manley and L. Bellman, *Surgical Nursing: advancing practice*, Edinburgh: Churchill Livingstone.

Edwards S L (2001a) Regulation of water, sodium and potassium: implications for practice, *Nursing Standard*, 15(22), pp.36-42

Edwards S L (2001b) Using the Glasgow Coma Scale: analysis and limitations, *British Journal of Nursing*, 10(2), pp.92-101

- Edwards, S. L. (2002) Nursing Knowledge: defining new boundaries, *Nursing Standard*, 17(2), pp.40-44
- Edwards, S. L. (2003) Critical thinking at the bedside: a practical perspective, *British Journal of Nursing*, 12(19), pp.1142-1149
- Edwards, S. L. (2008) Leadership and management in curriculum design: bureaucracies, subservience and subordination, *Nurse Education Today*, 28, pp.131-133
- Effken, J. A. (2001) Informational basis for expert intuition, *Journal of Advanced Nursing*, 34(2), pp.246-255
- Elliott, J. (2006) *Using narrative in social research*, London: Sage Publications
- Entwistle, N., Skinner, D., Entwistle, D. and Orr, S. (2000) Conceptions and beliefs about 'good teaching': an integration of contrasting research areas, *Higher Education Research and Development*, 19(1), pp.5-26
- Fairbairn, G. J. and Carson, A. M. (2002) Writing about nursing research: a storytelling approach, *Nurse Researcher*, 10(1), pp.7-14
- Faulkner, A. and Thomas, P. (2002) User led research and evidence based medicine, *British Journal of Psychiatry*, 180, pp.1-3
- Fejes, A. (2011) Confession, in-service training and reflective practices, *British Educational Research Journal*, 37(5), pp.797-812
- Field, D. E. (2004) Moving from novice to expert – the value of learning in clinical practice: a literature review, *Nurse Education Today*, 24(7), pp.560-565
- Fincham, L., Copp, G., Caldwell, K., Jones, L. and Tookman, A. (2005) Supportive care: experiences of cancer patients, *European Journal of Oncology Nursing*, 9, pp.258-268
- Fowler, J. (2008) Experiential learning and its facilitation, *Nurse Education Today*, 28, pp.427-433
- Freeman, M. (2003) Identity and difference in narrative inquiry: a commentary on the articles by Erica Burman, Michelle Crossley, Ian Parker and Shelley Slater, *Narrative Inquiry*, 13(2), pp.331-346
- Frid, I., Ohlen, J. and Berhborn, I. (2000) On the use of narratives in nursing research. *Journal of Advanced Nursing*, 32(3), pp.695-703
- Friedson, E. (2006) *Professional dominance: the social structure of medical care*, New Jersey: Transaction Publishers



- Frost, N. (2010) Professionalism and social change: the implications of social change for the 'reflective practitioner', In: H. Bradbury, N. Frost, S. Kilminster and M. Zukas (Editors), *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge
- Gaydos, H. L. (2003) Understanding personal narratives: an approach to practice, *Journal of Advanced Nursing*, 49(3), pp.254-259
- Gibbs, G. (1985) *Learning by doing: a guide to teaching and learning Methods*, Oxford: Polytechnic FEU, Oxford
- Gilbert, N. (Editor) (2008) *Researching social life*, London: Sage Publications
- Gilbert, G. N. and Mulkay, M. J. (1984) *Opening Pandora's box: a sociological analysis of scientists' discourses*, Cambridge: Cambridge University Press
- Gilbert, T. (2001) Reflective practice and clinical supervision: meticulous rituals of the confessional, *Journal of Advanced Nursing*, 36(2), pp.199-205
- Gilbert, H., Rose, D. and Slade, M. (2008) The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK, *Health Services Research*, 8(92), pp.1-11
- Glaser, B. (2001) *The grounded theory perspective: conceptualisation contrasted with description*, Mill Valley, Ca: Sociology Press
- Glaser, B., Strauss, A. (1967) *The discovery of grounded theory: strategies for qualitative research*, Chicago: Aldine
- Glaser, V. (1991) Conceptual models in educational research and practice, *Journal of Educational Thought*, 25(2), pp.91-103
- Gray, C. and Malins, J. (2004) *Visualizing research: a guide to the research process in art and design*, Farnham: Ashgate
- Hammersley, M. and Atkinson, P. (2007) *Ethnography: principles and practice* (3<sup>rd</sup> Edition), Abingdon, Oxon: Routledge
- Hampton, D. C. (1994) Expertise: the true essence of nursing art, *Advances in Nursing Science*, 17(1), pp.15-24
- Hargreaves, J. (1997) Using patients: exploring the ethical dimension of reflective practice in nurse education, *Journal of Advanced Nursing*, 25, pp.223-228
- Heidegger, M. (1962) *Being and time*, Bloomington: Indiana University Press
- Heinrich, K. (1992) Create a tradition: teach nurses to share stories, *Journal of Nurse Education*, 31, pp.141-143

- Henderson, A. (1994) Power and knowledge in nursing practice: the contribution of Foucault, *Journal of Advanced Nursing*, 20, pp.935-939
- Herbig, B., Bussing, A., Ewert, T (2001) The role of tacit knowledge in the work of nursing, *Journal of Advanced Nursing*, 34(5), pp.687-695
- Higgs, J. and Titchen, A. (2001) *Practice knowledge and expertise: in the health professions*, Oxford: Butterworth Heinemann
- Hilliard, C. (2006) Using structured reflection on a critical incident to develop a professional portfolio, *Nursing Standard*, 21(2), pp.35-40.
- Hochschild, A. (1983) *The managed heart*, Berkeley: University of California Press
- Holloway, I. and Freshwater, D. (2007) *Narrative research in nursing*, Oxford: Blackwell Publishing
- Hubermann, M. and Neufield, J. (1983) *The lives of teachers*, London: Cassell
- Husserl, E. (1965) *Phenomenology and the crisis of philosophy*, New York: Harper
- Hussey, T. and Smith, P. (2002) The trouble with learning outcomes, *Active Learning in Higher Education*, 3(3), pp.220-233
- Hussey, T. and Smith, P. (2003) The uses of learning outcomes, *Teaching in Higher Education*, 8(3), pp.357-368
- Hussey, T. and Smith, P. (2010) *The trouble with higher education: a critical examination of our universities*, London: Routledge
- Ironside, P. (2001) Creating a research base for nursing education: an interpretative review of conventional, critical, feminist, postmodern and phenomenologic pedagogies, *Advances in Nursing Science*, 23(3), pp.72-87
- Ironside P., Diekelmann, N. and Mark, H. (2005) Students' voices: listening to their experiences in practice education, *Journal of Nursing Education*, 44(2), pp.49-52
- Ixer, G. (1999) There is no such thing as reflection, *British Journal of Social Work*, 29(4), pp.513-528
- Jarvis, P., Holford, J. and Griffin, C. (1998) *The theory and practice of learning*, London: Kogan Page
- Johns, C. (1995) The value of reflective practice in nursing, *Journal of Clinical Nursing*, 4(1), pp.23-30.
- Johnson, J. L. (1994) A dialectical examination of nursing art, *Advances in Nursing Science*, 17(1), pp.1-14

Jones, M. and Jones A. (2006) Prescribing new ways of working, *Mental Health Practice*, 9(6), pp.20-22

Josselson, R. (1995) Imagining the real: empathy, narrative and the dialogic self. In: R. Josselson and A. Lieblich (Editors) *Interpreting experience: the narrative study of lives*, Thousand Oaks, CA: Sage Publications

Kelley, C. M. (2002) Investing in the future of nursing education: A cry for action, *Nurse Education Perspectives*, 23, pp.24-29

Kilminster, S., Zukas, M., Bradbury, H. and Frost, N. (2010) Introduction and overview, In: H. Bradbury, N. Frost, S. Kilminster and M. Zukas, *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge

Kim, H. S. (1999) Critical reflection inquiry for knowledge development in nursing practice, *Journal of Advanced Nursing*, 29(5), pp.1205-1212

Kim, I., Anderson, R. C., Nguyen-Jahiel, K., and Archodidou, A (2007) Discourse patterns during children's collaborative online discussions, *Journal of the Learning*, 16, pp.333-370

King, L. and Appleton, J. V. (1997) Intuition: a critical review of the research and rhetoric, *Journal of Advanced Nursing*, 26, pp.194-202

Kirkpatrick, M. K. and Brown, S. (2004) Narrative pedagogy: teaching geriatric content with stories and the 'Make a Difference' project (MADP), *Nursing and Health Care Perspectives, Nursing and Healthcare*, 25(4), pp.183-187

Koch, T. (1998) Story telling: is it really research? *Journal of Advanced Nursing*, 28(6), pp.1182-1190

Kolb, D. A. (1984) *Experiential learning*, Prentice Hall: Upper Saddle River, NJ

Krueger, R. A. And Casey, M. A. (2000) *Focus groups: a practical guide for applied research* (3<sup>rd</sup> Edition), Thousand Oaks, CA: Sage Publications

Labov, W. and Waletzky, J. (1967) Narrative analysis: oral versions of personal experiences, In: Helms J (Editor) *Essays in the verbal and visual arts*. Seattle: University of Washington

Lalor, J. G. Begley, C. M. And Devane, D. (2006) Exploring painful experiences: impact of emotional narratives on members of a qualitative research team, *Journal of Advanced Nursing*, 56(6), pp.607-616

Latter, S., Maben, J., Myall, M., Courtenay, M., Young, A., and Dunn, N. (2004) *An evaluation of extended formulary independent nursing prescribing: final report*, London: University of Southampton and Department of Health

Lave, J. And Wenger, E. (1991) *Situated learning: legitimate peripheral participation*, Cambridge: Cambridge University Press

Lieblich, A., Tuval-Mashiach, R. and Zilber T (1998) *Narrative research: reading analysis, and interpretation*, Thousand Oaks: Sage Publications

Lightfoot, S. (1985) The lives of teachers. In: Shulman, L., Sykes, G. (Editors) *Handbook of teaching policy*. New York: Longman

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*, Newbury Park, CA: Sage Publications

Linde, C. (1993) *Life stories: the creation of coherence*, Oxford: Oxford University Press

Lindsay, B. (1990) The gap between theory and practice, *Nursing Standard*, 5(4), pp.34-35

Liotard, B. (1984) *The post-modern condition: a report on knowledge*, Minneapolis: University of Minnesota Press

Macleod, M. (1994) 'It's the little things that count': the hidden complexity of everyday clinical practice, *Journal of Clinical Nursing*, 3, pp.361-368

McCance, T. V., McKenna, H. P. And Boore, J. (2001) Exploring caring using narrative methodology: an analysis of the approach, *Journal of Advanced Nursing*, 33(3), pp.350-356

McCormick, R. (1999) Practical knowledge: a view from the snooker table. In: R. McCormick and C. Paechter (Editors) *Learning and knowledge*, London: Paul Chapman Ltd

McDrury, J. and Alterio, M. (2002) *Learning through storytelling in higher education: using reflection and experience to improve learning*, London: Kogan Page Limited

McKinnon, J. (2005) Feeling and knowing: neural scientific perspectives on intuitive practice, *Nursing Standard*, 20(1), pp.41-46

McLafferty, I. (2004) Focus group interviews as a data collecting strategy, *Journal of Advanced Nursing*, 48(2), pp.187-194

Maguire, J. (1998) *The power of personal storytelling*, New York: Longman

Maivorsdotter, N. and Lundvall, S. (2009) Aesthetic experience as an aspect of embodied learning: stories from physical education student teachers, *Sport, Education and Society*, 14(3), pp.265-279

Mattingly, C. F., (1998) In search of the good: narrative reasoning in clinical practice, *Medical Anthropology Quarterly*, 12(3), pp.273-297

Manley, K. and Bellman, L. (Editors) (2000) *Surgical nursing: advancing practice*, Edinburgh: Churchill Livingstone

Marks-Maran, D. and Rose, P. (1999) *Reconstructing nursing: beyond art and science*, London: Bailliere Tindall

Martin, B. (2002) *Tied knowledge: power in higher education*, London: Sage Publications

Mason, J. (2002) *Researching your own practice: the discipline of noticing*, London: RoutledgeFalmer

Masson, V. (2005) Voices of experience: nurses' personal stories illuminate and enrich clinical practice, *American Journal of Nursing*, 105(12), pp.78-79

Meleis, A. I. (1991) *Theoretical nursing: development and progress* (2<sup>nd</sup> Edition), Philadelphia: J. B. Lippincott Company

Mercer, N. (2008) Talk and the development of reasoning and understanding, *Human Development*, 51(1), pp.90-100

Midgley, K. (2006) Pre-registration student nurses perception of the hospital-learning environment during clinical placement, *Nurse Education Today*, 26(4), pp.338-345

Moon, J. (1999) *Reflection in learning and professional development*, London: Kogan Page Limited

Moon, J. (2004) *A handbook of reflective and experiential learning: theory and practice*, New York: RoutledgeFalmer

Moon, J. (2008) *Reflection in learning and professional development theory and practice*, London: RoutledgeFalmer Taylor and Francis Group

Nairn, S. (2004) Emergency care and narrative knowledge. *Journal of Advanced Nursing*, 48(1), pp.59-67

Nehls, N. (1995) Narrative pedagogy: rethinking nursing education. *Journal of Nursing Education*, 34(5), pp.204-2

Nelson M H (1993) Chapter 9 - Teacher's stories: an analysis for the themes, In: Day C, Calderhead J, Denicolo P (1993) *Research on teacher thinking: understanding professional development*, London: The Falmer Press

Nicholl, H. and Higgins, A. (2004) Reflection in pre-registration nursing curricula, *Journal of Advanced Nursing*, 46 (6), pp.578-585.

Nolan, C. A. (1998) Learning on clinical placement: the experience of six Australian student nurses, *Nurse Education Today*, 18, pp.622-629

Norton, D., McLaren, R. and Exton-Smith, A. N. (1962) *An investigation of geriatric nursing problems in hospital*, Edinburgh: Churchill Livingstone

- Ogier, M. (1989) *Working and learning: the learning environment in clinical nursing*, London: Scutari Press
- Orland-Barak, L. and Wilhelem, D. (2005) Novices in clinical practice settings: student nurses stories of learning the practice of nursing, *Nurse Education Today*, 25(6), pp.455-464
- Packard, S. A. and Polifroni, E. C. (1991) The dilemma of nursing science, current quandaries and lack of direction, *Nursing Science Quarterly*, 4(1), pp.7-13
- Pagano, J. A. (1991) Relating to one's students: identity, morality, stories and questions, *Journal of Moral Education*, 20(3), pp.257-266
- Pallet G (2003) Ethnography and reflexivity: emotions and feelings in fieldwork, *Nurse Researcher*, 10(3), pp.28-37
- Palley, J. (1996) Intuition and expertise: comments on the Benner debate, *Journal of Advanced Nursing*, 23, pp.665-671
- Palmer, A., Burns, S. and Bulman, C. (1994) *Reflective practice in nursing: the growth of the professional practitioner*, London: Blackwell Scientific Publications
- Papp, I., Markkanen, M. and von Bonsdorff, M., (2003) Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences, *Nurse Education Today*, 23(4), pp.262-268
- Parahoo, K. (2006) *Nursing research: principles, process and issues*, Basingstoke: Palgrave MacMillan
- Parker, D. (1997) Nursing art and science: literature and debate, In: D. Marks-Maran and P. Rose, *Reconstructing nursing: beyond art and science*, London: Bailliere Tindall
- Parse, R. R. (1992) Nursing Knowledge for the 21<sup>st</sup> century: an international commitment, *Nursing Science Quarterly*, 5(1), pp.8-12
- Patai, D. (1998) Constructing a self: a Brazilian life story, *Feminist Studies*, 14(1), pp.143-165
- Pearcey, P. and Draper, P. (2007) Exploring clinical nursing experiences: listening to student nurses, *Nurse Education Today*, 28, pp.595-601
- Penson, R. T., Partridge, R. A., Rudd, P., Seiden, M. V., Nelson, J. E., Chabner, B. A. and Lynch, T. J. (2005) Laughter: the best medicine? *The oncologist*, 10, pp.651-660
- Peplau, H. E. (1988) The art and science of nursing: similarities, differences and relations, *Nursing Science Quarterly*, 1(1), pp.8-15

- Phillips, S. (1982) Career exploration in adulthood, *Journal of Vocational Behavior*, 20, pp.129-140
- Piaget, J (1962) Commentary on Vygotsky's criticism of the language and thought of the child, and judgement and reasoning in the child, *New Ideas in Psychology*, 18, pp.241-259
- Platt, H. (1964) *A reform of nursing education: report of the special committee on nursing education*, London: RCN
- Plummer, K. (1995) *Telling sexual stories: power, change, and social worlds*, London: Routledge
- Polit, D. and Beck, C. (2008) *Nursing Research Principles and Methods*, Philadelphia: Lippincott Williams & Wilkins
- Pope, C. and Mays, N. (Editors) (2006) *Qualitative research in health care* (3<sup>rd</sup> Edition), Oxford: Blackwell Publishing
- Pyles, S. and Stern, P. (1983) Discovery of nursing Gestalt in critical care nursing: the importance of grey gorilla syndrome, *Image: Journal of Nursing Scholarship*, 15(2), pp.21-28
- Radcliffe, M. (1995) Unimpressive stuff, *Nursing Times*, 91(30), pp.189
- Reason, P. (Editor) (1994) *Participation in human inquiry*, London: Sage Publications
- Reed, J. and Procter, S. (1993) *Nurse education: a reflective approach*, London: Edward Arnold
- Rheznitskaya, A., Anderson, R., McNurlen, B., Nguyen-Jahiel, K., Archodidou, A., and Kim, S. (2001) Influence of oral discussion on written argument, *Discourse Processes*, 32, pp.155-175
- Riessman, C. K. (1991) Beyond reductionism: narrative genres in divorce accounts, *Journal of Narrative and Life History*, 1, pp.41-68
- Riessman, C. K. (1993) *Narrative analysis*, Thousand Oaks, CA: Sage Publications
- Robinson Wolf, Z. (1997) Nursing students' experience bathing patients for the first time, *Nurse Educator*, 22(2), pp.41-46
- Rolfe, G. (2000) *Research, truth authority: post modern perspectives on nursing*, London: MacMillan Press Limited
- Rolfe, G. (2001) Reflective practice: where now? *Nurse Education in Practice*, 2, pp.21-29

- Rolfe, G., Gardner, L. (2006) 'Do not ask who I am....': confession, emancipation and (self)-management through reflection, *Journal of Nursing Management*, 14, 593-600
- Sarbin, T. (2004) The role of imagination in narrative construction, In: C. Dainte and C. Lightfoot (Editors) *Narrative analysis: studying the development of individuals in society*, London: Sage Publications
- Saltiel, D. (2010) Judgement, narrative and discourse: a critique of reflective practice, In: H. Bradbury, N. Frost, S. Kilminster and M. Zukas, *Beyond reflective practice: new approaches to professional lifelong learning*, London: Routledge
- Sargent, S. E., Sedlak, C. A. and Martsolf, D. S. (2005) Cultural competence among nursing students and faculty, *Nurse Education Today*, 25(3), pp.214-221
- Schmidt Bunkers, S. (2001) Reflections on suffering, *Nursing Science Quarterly*, 14(3), pp.199-204
- Schon, D. A. (1987) *Educating the reflective practitioner*, London: Jossey-Bass
- Schon, D. (1983) *The reflective practitioner: how professionals think in action*, Guildford: Arena
- Shor, I. and Freire, P. (1987) *A pedagogy for liberation: dialogues on transforming education*, Westport: Bergin and Garvey Publishers
- Shuster, J. L. (2001) Crossing over: narratives of palliative care, *Psychosomatic Medicine*, 63(3), pp.512
- Silcock, P. (1994) The process of reflective teaching, *British Journal of Educational Studies*, 42(3), pp.273-285
- Silcock, P. And Brundrett M. (2002) *Competence, success and excellence in teaching*, London: Routledge-Falmer
- Silcock P. (1999) Chapter 4 - Managing teaching and learning, In: M. Brundrett (Editor) *Principles of school leadership*, Guildford: Peter Francis Publishers
- Slavin, R. E. (1980) Co-operative learning, *Review of Educational Research*, 50, pp.315-342
- Smith, M. C. (1992) Is all knowing personal knowing? *Nursing Science Quarterly*, 5(1), pp.2-3
- Somekh, B. and Lewin, C. (2005) *Research methods in the social sciences*, London: Sage



- Sorlie, V., Kihlgren, A. and Kihlgren, M. (2005) Meeting ethical challenges in acute nursing care as narrated by registered nurses, *Nursing Ethics*, 12(2), pp.133-142
- Sorrell, J. M. (2000) Remembrance of things past through writing: aesthetic patterns of knowing in nursing, *Advances in Nursing Science*, 17(1), pp.60-70
- Spouse, J. (1998) Scaffolding student learning in clinical practice, *Nurse Education Today*, 18, pp.259-266
- Squire, C. (2009) Experience-centred and culturally-orientated approaches to narrative, In: Andrews, M., Squire, C. and Tamboukou, M. (Editors) *Doing narrative research*, Los Angeles: Sage Publications
- Steinaker, N. W. And Bell, M. R. (1979) *The experiential taxonomy: a new approach to teaching and learning*, San Francisco, CA: Academic Press
- Strauss, A., Corbin, J. (1993) *Grounded theory in practice*. London: Sage Publications
- Street, A. (1992) *Inside nursing: a critical ethnography of nursing*, New York: University of New York Press
- Sutton, F., Smith, C., Wright, K., Arbon, P., Eldredge, K., Forbes, D., Robbiliard, N. and Zeitz, K. (1996) Discovering and affirming knowledge in nursing practice, *International Journal of Nursing Practice*, 2, pp.63-70
- Tangherlini, T. R. (1998) *Talking trauma: paramedics and their stories*, Jackson, Mississippi: University Press
- Taylor, C. and White, S. (2000) *Practising reflexivity in health and welfare: making knowledge*, Buckingham: Open University Press
- Teasdale, G. and Jennett, B. (1974) Assessment of coma and impaired consciousness, *Lancet*, 2(7872), pp.81-84
- The Salisbury Centre (2000) *The capable practitioner*, The Sainsbury Centre: London
- Thomas-MacLean, R. (2004) Memories of treatment: the immediacy of breast cancer, *Qualitative Health Research*, 14(5), pp.628-643
- Tilley, S. (1995) Accounts, accounting and accountability in psychiatric nursing, In: R. Watson (Editor) *Accountability in nursing practice*, London: Chapman Hall
- Tschudin, V. (1986) *Ethics in nursing: the caring relationship*, London: Heinemann Nursing
- UKCC (1990) *The report of the post registration education and practice project*, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, London: UKCC

- Van Der Post, L. (1972) *A story like the wind*, London: The Hogarth Press Ltd
- Van Manen, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*, New York: State University of New York Press
- Vaughan, B. (1992) Exploring the knowledge of nursing practice, *Journal of Clinical Nursing*, 1, pp.161-166
- Vaughn, S., Schumm, J. S., Sinagub, J. (1996) *Focus group interviews in education and psychology*, London: Sage Publications
- Vygotsky, L. (1978) *Mind in society: the development of higher psychological process*, Cambridge Mass: Harvard University Press
- Waterlow, J. (1985) A risk assessment care, *Nursing Times*, 81(48), pp.48-55
- Watson, J. (2000) Artistry and Caring: heart and soul of nursing, In: D. Marks-Maran and P. Rose, *Reconstructing nursing: beyond art and science*, London: Bailliere Tindall
- Way, C. and Segatore, M. (1994) Development and preliminary testing of the neurological assessment instrument, *Journal of Neuroscience Nursing*, 26(5), pp.278-287
- Webb, C. (1981) Classification and framing – a sociological analysis of task-centred nursing and the nursing process, *The Journal of Advanced Nursing*, 6, pp.369-376
- White, R. (1985) From matron to manager – a historical perspective, *Nursing Review*, 3(3 & 4), pp.21-26
- Wilhelmsson, S. And Foldevi, M. (2003) Exploring views on Swedish district nurses' prescribing – a focus group study in primary health care, *Journal of Clinical Nursing*, 12, pp.643-650
- Williams, S. and Keady, J. (2008) Narrative research and analysis, In: R. Watson, H. McKenna, S. Cowman and J. Keady, *Nursing Research designs and methods*, Edinburgh: Elsevier Churchill Livingstone
- Winter, R. (1995) *Learning from experience: principles and practice in action research*, London: Falmer Press
- Wood, R. (1947) *Report of the working party on the recruitment and training of nurses*, Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service: HMSO
- Worsley, P. (Editor) (1987) *The new introduction to sociology*, London: Penguin Books

Wright, N. (2001) Leadership, 'bastard leadership' and managerialism: confronting twin paradoxes in the Blaire educational project, *Educational Management & Administration*, 29(3), pp.275-290

Yanay, N. and Shahar, G. (1998) Professional feelings as emotional labour, *Journal of Contemporary Ethnography*, 27, pp.346-373

# APPENDICES

## Appendix 1 – Generic assessment criteria for health courses Level 5

### GENERIC ASSESSMENT CRITERIA FOR HEALTH COURSES: LEVEL 5

	A (85-100%) (70%-84%)		B (60-69%)	C (50-59%)	D (40-49%)	E (34-39%)	F (33% - 0%)
Criterion	>12.7	12.6-10.5	9-10.4	7.5-8.9	6-7.4	5.1-5.9	<5.1
<b>Presentation</b>  15	Demonstrates exceptional academic writing style for this level of work	Grammar and spelling accurate Thoughts and ideas clearly expressed Fluent academic writing style Within the word limit Work displays a professional approach Word count declared	Minimal errors in grammar and spelling accurate Thoughts and ideas clearly expressed Fluent academic writing style Within the word limit Work displays a professional approach Word count declared	Minimal errors in grammar and spelling Meaning apparent but not always clearly expressed Writing style not consistently fluent and academic Within the word limit Work displays a professional approach Word count declared	Errors in grammar and spelling Meaning apparent but not clearly expressed Writing style not consistently fluent and academic Within the word limit Work displays a professional approach Word count declared	Major problems with grammar and spelling Meaning unclear in places Non-academic writing style Not within the word limit Work lacks a professional approach Word count not declared	Major problems with grammar and spelling Meaning unclear Non-academic writing style Not within the word limit Work lacks a professional approach Word count not declared
<b>Referencing</b>  15	Draws predominantly on primary sources of evidence	Harvard System used consistently and accurately Wide range and sizeable amount of reading from a variety of academic sources Accurate and comprehensive reference list supplied	Harvard System used consistently and accurately Good range and amount of reading from a reasonable variety of academic sources Accurate and comprehensive reference list supplied	Harvard System used consistently with minimal errors Adequate range and amount of reading from an acceptable variety of academic sources Accurate and comprehensive reference list supplied	Harvard System used with minimal errors Limited range and amount of reading, using limited academic sources A mainly accurate and comprehensive reference list supplied	Harvard System used but unsystematically and with minimal errors Inadequate range and amount of reading and few academic sources utilised Reference list not accurate or comprehensive	Harvard System not used or used unsystematically and with many errors Insufficient range, amount of reading and academic sources utilised No reference list supplied
<b>Knowledge and understanding</b>  25	>21.2	17.5-21.1	15-17.3	12.5-14.8	10-12.3	8.5-9.8	<8.5
Demonstrates a full grasp of the contextual nature of knowledge relevant to the topic.	Demonstrates extensive and relevant exploration of the topic Identifies and demonstrates understanding of all key issues and discusses these in depth Safe practice maintained throughout	Demonstrates a fairly extensive and relevant exploration of the topic Identifies and demonstrates understanding of most of the key issues and discusses these in some depth Safe practice maintained throughout	A good range of topics is explored Identifies and demonstrates understanding of some key issues but not all are given due consideration Safe practice maintained throughout	Exploration of the topic restricted in range Identifies and demonstrates understanding of some key issues but discussion is superficial Some irrelevant material may be included Safe practice maintained throughout	Exploration of the topic very restricted in range Many key issues are not identified, level of understanding is superficial and discussion is lacking in focus Irrelevant material included Unsafe practice is demonstrated* <b>*NB this constitutes a failed assignment overall</b>	Exploration of the topic very restricted in range Key issues are not identified and understanding is poor. Discussion is absent or lacks focus Irrelevant material included Unsafe practice is demonstrated* <b>*NB this constitutes a failed assignment overall</b>	

## Appendix 1 – Generic assessment criteria for health courses Level 5

	A (85-100%) (70%-84%)		B (60-69%)	C (50-59%)	D (40-49%)	E (34-39%)	F (<34%)
Criterion	>17	14-16.9	12-13.9	10-11.9	8-9.9	6.8-7.9	<6.8
<b>Integrating academic learning and practice</b>  20	Resourceful and imaginative ability to integrate academic learning into practice.	All relevant implications for practice are clearly identified and explained Demonstrates effective integration of academic learning with issues from practice Confidentiality is maintained.	Relevant implications for practice are clearly identified and explained Demonstrates effective integration of academic learning with issues from practice Confidentiality is maintained.	Relevant implications for practice are clearly identified but explanations may be lacking Integration of academic learning and issues from practice is evident but incomplete Confidentiality is maintained.	Some relevant implications for practice are identified but explanations may be lacking Integration of academic learning and issues from practice is limited Confidentiality is maintained.	Few relevant implications for practice are identified and explanations may be lacking, incomplete or incorrect Integration of academic learning and issues from practice is very limited. Confidentiality is not maintained* <b>*NB this constitutes a failed assignment overall</b>	No relevant implications for practice are identified Fails to integrate academic learning and issues from practice Confidentiality is not maintained.* <b>*NB this constitutes a failed assignment overall</b>
<b>Analysis</b>  20	Work shows evidence of a mature and independent analytical approach.	Understanding of theory, principles and research evidence is used very effectively to analyse issues and problems Demonstrates a sustained analytical approach	Understanding of theory, principles and research evidence is used effectively to analyse issues and problems An analytical approach is reasonably well maintained	Understanding of theory, principles and research evidence is used to analyse issues and problems but with some limitations evident	The use of theory, principles and research evidence to analyse issues and problems is evident but not always successful The work tends to be descriptive	The use of theory, principles and research evidence to analyse issues and problems is limited The work is very descriptive	The work is descriptive and there is a failure to use of theory, principles and research evidence to analyse issues and problems
<b>Synthesis and evaluation</b>  5	Evaluates data to develop a strongly reasoned and articulated argument.	Demonstrates some creativity in building a reasoned argument to reach a logical conclusion	Demonstrates the ability to build a reasoned argument to reach a logical conclusion	Attempts to build a reasoned argument and derive a conclusion but with some limitations	Is ineffective in developing a reasoned argument and does not reach appropriate conclusions	Fails to develop a reasoned argument and does not reach appropriate conclusions	Fails to develop a reasoned argument and does not reach appropriate conclusions

## Appendix 2 – NMC PDP using reflection

### PROFESSIONAL DEVELOPMENT PLAN

The Nursing and Midwifery Council, the nursing governing body, expects all nurses to:

“acknowledge any limits of personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients of clients”  
(NMC Scope of Professional Practice)

It requires nurses to identify their development needs and undertake training as a condition of pre-registration every 3 years. The minimum allocation for this should be 5 days over 3 years. Most employers and professionals undertake in excess of this to maintain their skills.

The GMS Contract requires all qualified nurses to have a PDP. This should be reviewed annually at appraisal.

#### Definition

A Professional Development Plan (PDP) sets out the identified learning and training activities that support staff development, this is so the job can be undertaken effectively.

This is recorded and reviewed. A PDP record sheet is available for your use in this section.

#### Process of developing a PDP

1. Nurses should realistically consider **(e.g. using cue questions)**:
  - What are the practice goals?
  - What are the skills you possess? Are they current?
  - Am I confident using them?
  - What are my gaps? Therefore what are my goals?
  - What have I done? What did I never get around to?
  - What do I want or need to do in the future?
2. Prioritise 4-6 goals with a timescale for achievement.  
Remember that skills needed may cover a wide spectrum. They could be clinical skills, but may often be IT, administrative, knowledge building e.g. new GMS contract, management, chairing meetings, communication / consulting skills.
3. Agree the PDP with practice manager/GP/employer/appraiser.  
They will need to set these goals against the staff and resources available. Planning for all staff PDPs within a small surgery team can be very difficult. It is always preferable that employees give as much notice as possible to the employer of their developmental needs. All parties should be able to fully justify how any training event will support patient services.

## Appendix 2 – NMC PDP using reflection

Additional training does not necessarily mean a change of grade or hourly rate. This would only be the case where the PN role changes significantly. (Please refer to the Core Competencies document).

### Learning styles and methods

Developing a new skill can be achieved in many ways. This process of learning should be set realistically against competing demands of time, resources and the objectives.

Consider alternatives to a formal taught course such as:

- Reading professional journals
- Coaching by an expert
- Shadowing another undertaking the role/skill
- Enrol on a training programme that might use CD Rom, video or a distance learning package

It is important that new skills acquired can be immediately consolidated within clinical practice. This should be identified before the training is undertaken. It may need support of other clinicians within the surgery.

### Learning record

As part of the NMC requirements for registration, all nurses are required to keep a Professional Portfolio. This records learning and skill acquisition and integration of this professional development into practice. In section of this portfolio document can be requested by the NMC at any time, as this provides evidence of meeting professional standards.

A form to facilitate the **recording and reflection process** of maintaining a Professional Portfolio is included for your use. It should be completed after each learning event and filed in your Portfolio.



### Appendix 3 – Student consent form

FACULTY OF SOCIETY AND HEALTH  
**Learning from practice: the value of story in nurse education**  
CONSENT FORM

With regard to the above study:

Please tick each box

I have read and understand the information sheet .....

I have had the chance to ask questions about it .....

I have read and understand the information sheet and am aware that participation in the research study is completely voluntary .....

I am free to change my mind and withdraw from the study at any time .....

Involvement / withdrawal from the study will have no bearing on my role as a student

I agree to write a story

I also consent to the use of material (level 5 and 6 students) for any consequent book / article publication or conference presentation .....

I understand that the information collected will be kept confidential\* and will be stored in a locked cabinet accessed only by the investigator .....

\*It is recommended that in your story you do not highlight a serious breach of professional practice as confidentiality cannot be guaranteed, incidents of this type should be omitted from being used.

On this basis I am happy to participate in the Learning from practice: the value of story in nurse education.

Participant's name:..... Participant's signature ..... Date: .....

Researcher's name:..... Researcher's signature ..... Date: .....

**If you have any queries or concerns, please contact:**

Sharon Edwards: Faculty of Society and Health, 01494 522141 Ex 4434,  
[sharon.edwards@bucks.ac.uk](mailto:sharon.edwards@bucks.ac.uk)

## Appendix 4 - Information letter to students

Dear Student,

I am currently undertaking my doctorate in education and doing a study entitled:

### **Learning from practice: the value of story in nurse education**

*I am looking for volunteers to participate in this study:*

The study is designed to investigate how the knowledge you gain from your own stories of clinical practice potentially helps you to learn. It also investigates how this knowledge and learning may have an impact on your nursing practice. I would like to find out how your story may have an impact on your learning about nursing practice. The purpose of the research is to encourage nurses to have greater confidence in the knowledge they have gained through professional practice. Furthermore, it is hoped that the study will enable nurses to value the learning gained through their own stories and use it to enhance their practice. As a student nurse you have a wealth of stories of clinical practice, but this is not always captured or valued. This deprives nursing of the potential uniqueness and richness of learning gained through clinical practice. Nurses need to have opportunities to express their stories gained in the complex and unpredictable environment in which they work.

*If you agree to be a participant in this research:*

If you agree to be a participant in this research you are asked to give your signed consent and to remember a story about a memorable or meaningful moment from your practice, write it down detailing you're learning from it and share it with me. The stories can be in the form of informal anecdotes. Guidance to help you write a story is attached. If you choose to participate, send (in the envelope provided) or email to me your story and learning from it. On this information giving sheet you will find a unique number (top right hand corner) keep a record of this number, so if you wish to withdraw from the study, at any time, your story can be identified (all data will be managed in accordance with the Data Protection Act 1998). Just contact me by email, text or phone (details given below) informing me of your number and I will remove your story and learning.

You will then be invited to participate in discussion sessions (focus groups) about the process used e.g. remembering, writing, learning and sharing, and to discuss the learning drawn from writing your story within a small group. Notices for the dates of these focus groups will be placed on blackboard for 3<sup>rd</sup> years, 2<sup>nd</sup> years and post graduate students.

Some of the stories may include sensitive information but it is neither expected nor desirable that anyone should experience distress as a result of participating in this study. Any questions about the study and the research can be answered by using the contact telephone numbers or email address at the end of this letter.

As a condition of undertaking this study I have signed a pledge of confidentiality and I can assure you that no information from this study will be reported in a way that identifies individual participants. All identifiable information will only be held by me and will be destroyed at the end of the research study in accordance with the conditions required by the Ethics Committee of my university - The Buckinghamshire New University. My contact details are:

Address	Telephone / email
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If you wish to discuss this further, please do not hesitate to contact me, as I would be pleased to answer any questions that you may have. Thank you for your time.

## Appendix 5 - Cues to writing a story and some examples

Recount a story from your own practice, you may have already written it down for another purpose or you may have to recount it anew (some examples of stories are given overleaf). It can be:

- A situation that occurred, which is funny or sad
- A controversial decision made regarding a patient / staff member / relative
- A particular incident you remember very well and you would easily be able to recount in a story
- A story that is an example of good practice

It is recommended that in your story you do not highlight a situation that identifies a serious breach of professional practice. If you have witnessed any serious breaches of professional practice you should not report these in your story. If you do, I cannot guarantee confidentiality because it would be my duty to assure that these were dealt with. If you have witnessed serious breaches of confidentiality, you should report these locally according to the policy of the organisation in question.

You can remember your story, and then write it down as it happened, share it with me together with your perceived learning from it. There are no hard or fast rules or you can use the following as six cues to help.

1. Write a summary of your story (to help you gather your thoughts together), you may find that this amounts to the total story you want to tell, or you may want to write and give more information.
2. Consider the setting (no ward or hospital names please), place, situation, participants (the subjects contained within the story are important, so try to detail their involvement and their relevance to the story as best you can).
3. What actually happened, what happened next (try to give as much detail about the events that occurred).
4. What do the events mean to the storyteller (you)? Try to make your point clear to the researcher (this will later provide insight into how you have chosen to write down the events and recounting these elements will be of particular interest to the research).
5. How it ended (consider the end of the story if this is known, this may have occurred sometime later, but that does not matter).
6. Return to the perspective of the story to the present.

Please note the story does not have to be:

- Written in any particular tense
- You can use the first person
- Grammar within the story is not being judged and therefore does not have to be perfect.

## Examples of stories

### Story 1

My first clinical ward as a student nurse was on orthopaedics. I had a very good charge nurse who was my guide. On one occasion I was bed bathing a young man of 18 who had been involved in a car accident. He was semi-conscious and really confused and disorientated. He had cerebral oedema. While doing the bed bath with the charge nurse the patient had an erection. I was 18 and blushed when the charge nurse suggested that I hit his penis on the tip with a spoon.

### Story 2

As a first year nurse I was on night duty. In the morning at around 6 a.m. the staff and I would circulate the ward and change and wash any patient who had been incontinent, sit them up or out of bed for a cup of tea. In the end bay were 4 elderly ladies whom the staff nurse and I set about sitting up for their cup of tea. One of the ladies was persistent in her request for a cup of tea, 'I need a nice cup of tea, get me a cup of tea' she repeated over and over in her high pitched tone, that was reminiscent of this particular patient. I explained that we had nearly finished and we were now going to distribute tea to all patients. When I got to her bedside with her cup of tea, she had died.

### Story 3

I arrived one morning as a student nurse and following an assessment of my patients found that Fred needed to be washed and changed first, as he had been incontinent in the bed. I go to my colleague and ask for assistance. She replies that her patient Angus needs to go to the toilet first, for which he requires two people and he needs to go now. It was difficult at the time to decide who went first, I had to concede with my qualified colleague that Angus should go to the toilet first and we took him together.

### Story 4

A patient presented on A & E with diabetic keto-acidosis and was unconscious. As a student I needed to get my competency completed for a catheterisation on a woman. I had observed it once and my mentor said that I could do the catheterisation on this particular patient. I set up the trolley for an aseptic technique and was ready to start. I opened the patient's legs, with the patient's knees bent I exposed the vaginal area. I opened the labia to find the urethra but when I looked it could not be found. I said to my mentor, 'I cannot do this'; my mentor replied 'Of course you can'. The woman was found to have been circumcised, her vagina had been sown up and the orifice to pass urine was very small. The procedure was abandoned. The gynaecologist registrar had to be called to insert the catheter with a paediatric tube. Following this knowledge my attitude toward her husband changed and I judged him.

### Story 5

I was caring for Jack who was recovering from Guillain-Barre syndrome. He had been on ITU for a long time, had a tracheotomy and continued to require ventilation. He was still unable to move his arms or legs but he could move his head and neck. Communication was a problem, due to the tracheotomy and Jack was becoming more and more frustrated by this. It was decided in conjunction with the physiotherapist and occupational therapist that a portable computer could be obtained for him so that he could use an instrument in his mouth and type what he wanted to say to staff. This helped to relieve his frustration, anxiety and stress a great deal and so aid in his full recovery.

## Appendix 6 – Participants’ stories and learning accounts

### 6.1 - 2<sup>nd</sup> year adult student nurses’ stories and learning accounts

#### Story 1

This clinical experience will be focused on an 85-year-old man who lives in a residential home. I was involved with his care whilst on my district nursing placement. He had a stroke and he is also a diabetic patient. The purpose of the district nurse’s visit is to draw up his insulin for him to self-administer. One day we arrived to draw up his insulin, and it was not there, so we had to go back to the surgery, to collect the insulin from the pharmacy. This affected the patient because he had to wait for us to get back before he L7 could eat. This could have been prevented, if the nurse who visited the patient on the previous day had mentioned this in the hand over. This therefore, shows, without effective L9 communication the holistic care of a patient is compromised.

#### *Story 1 - Learning account*

- What diabetes mellitus is, the two types, treatment and complications
- What a stroke is, the blood vessels involved and what happens to them to cause a stroke
- The care this type of patient requires
- The influence of mentors on the student learning and if they are not consistent throughout the impact this can have on student learning
- The use of experienced staff to support student nurses is fundamental to professional socialisation and skilful role models can enable students to discover knowledge embedded in clinical practice.
- The role model observing mentors enables students through the process of reflection, to internalise their mentor’s behaviour and build on previous knowledge and experience.
  - An imitation and observational form of learning whereby students simply absorb their role model’s qualities and skills
  - Students are responsible for their own learning needs and must be actively involved in the modelling process to glean the knowledge the expert takes for granted.
  - Opportunity to work with experienced and knowledgeable practitioners and observe them providing care
  - Enthusiasm for professional development unparalleled by any other learning experience
- If the quality of the hand over by the nurses who visited the patient the day before had been better the situation could have been prevented, if effective hand over prepares and enables nurses to take over the care of patients and continue to deliver high-quality care.
- Failure to communicate effectively with someone and cause them concern, especially if they are vulnerable through illness, the effects of poor communication can result in more than minor irritation
- What is involved in good communication e.g. listening, guiding, thinking, engaging, making sense of knowledge and information and sharing – associated with life-long learning and required improving patient care
- Communicating well with colleagues and others is about seamless care – a continuum where patient care is delivered smoothly.
- The NMC give guidelines for professional practice, recognises the vital role good communication plays in delivering patient focused care.
- The importance of MDT care and communication as the key to successful health care provision.
- Learning from the story:
  - Nursing hand over that is accurately documented information promotes effective time management and quality of continuing nursing care.
  - The link between application of nursing care and communication to ensure nurses focus on the fundamentals of care and uphold the principles of clinical governance
  - Hand over needs to be practised, structured and effective, reinforcing the professional status of nurses in modern health care provision.

## Story 2

Whilst working in my clinical placement, it was a very busy morning on the ward. I had admitted the patients that had been allocated to my mentor and I. An operation department practitioner (ODP) wanted a nurse to escort a patient to theatre. This patient was not one of my allocated groups of patients, but I could see the nurse who had been allocated was busy with another patient, so I agreed to escort the patient. I checked to make sure all the documentation was present and proceeded to theatres.

When I arrived in theatres there was an anaesthetist waiting to acknowledge the patient, a junior anaesthetist who was drawing up the medication the ODP was talking to the patient and explained what was going to take place in the anaesthetic room. A theatre nurse came to collect the patient's label for the operation register and the surgeon came in to say hello and go over the operation with the patient in the anaesthetic room. A member of staff asked me about the procedure the patient was undergoing, I replied I was not sure and went to check the patient's notes. He then said in a sarcastic manner that as a student nurse I should know what the patient is going to theatre for and the type of procedure to be performed. I tried to explain that the nurse, who had admitted the patient was busy with another patient, I tried to apologise to this member of staff, and accepted that I should have checked before arriving in theatres.

### *Story 2 – Learning account*

- Communication depends on the nurse, client and other team members' relationship.
- Theories can be taught and attitudes need to be experienced and lived.
- Conscious of other people in the room listening to the conversation
- Other staff members making sarcastic remarks about students not doing their job properly
- Taking the whole experience on board to ensure it did not happen again, updating myself with regards to patients going to theatre, read patient's notes before taking a patient to theatre, so I had a better and broader understanding of the procedure they are having done and understanding what I am doing.
- Critical thinking is an educational need to allow students to use independent judgement and evaluation which allows the nurse to analyse the use of language, assumptions and be able to highlight good and bad situations and their outcomes.
- Could have dealt with the situation better brought it to my attention after the procedure, or even on the ward, where I could have been spoken to privately and not in front of the patient
- Other nurse acting superior, excuses for his arrogance
- Students have to overcome many barriers to learning, nurses are responsible for their own learning and must be able to adapt to certain situations.
- Learning from my story:
  - The comments were negative and I felt degraded, I turned the situation around to a positive one:
    - It is important to know the type of procedure each patient is undergoing even if the patient is not allocated to you.
    - It is vital to read the patient's notes and gain as much information regarding their procedure and to have the knowledge to be able to hand over a patient as you may be asked some questions in theatre.
  - Should not be judgmental in how the nurse managed the situation, he was trying to teach me to become a better nurse for the future
  - People communicate in different ways, some people's mannerisms may come across as rude or arrogant, but they are merely unaware of how they are perceived to others.
  - Student nurses need to understand that working within health care environment you are going to come across certain people who are frustrated, and stressed within their professional roles and peer pressure.
  - The issues related to taking a patient to theatre
  - That I can take negative criticism and not like it but that I can learn from it in a positive way and something good can come out of it
  - Evaluate self, take further action to update learning from the experience
  - Some days people raise their voices and become angry and is expected in a large environment such as theatre

- Communication can break down, but HCP need to sort out their problems and differences with other in an amicable way that does not affect the patient.
- Create a strategy for learning through uncovering the knowledge we have and identifying what more we need to know will help enhance our practice effectively.
- As a student with limited experience, but I become more confident in dealing with situations of this nature
- The needs of patients in theatre and other team members and why communication is imperative whether it is positive or negative

### Story 9

I communicated with another member of the multidisciplinary team. Whilst on placement in A&E I had the opportunity to transfer a patient I had been looking after to the ward nurse. On arrival to the ward I settled the patient into bed and went to find the nurse to hand over. Upon finding the nurse I remember she appeared very busy, she was typing at the computer but nodded at me to start. After I had started the hand over I looked at the nurse for eye contact, and noted that she was still typing, I felt she was not listening to me. I stopped handing over to the nurse and waited for her to finish what she was doing before I asked if she would like me to start again. The nurse said she would and apologised. At this point I felt more anxious but managed to hand over successfully.

#### *Story 9 – Learning account*

- Felt pleased that my mentor had delegated the task to me as she felt I was competent to perform the task correctly and made me feel a part of the team
- I felt appreciated of the work I had done on the ward and the opportunity to become competent, improving my confidence in this particular area of practice.
- The nurse not listening to my hand over made me feel inadequate and they did not want to listen to me because I was a student nurse.
- The nurse not listening to me made me fumble around with the notes, I felt quite foolish, did not present myself as confident and garbled my words.
- This related to the fact that the nurse was distracting me by the fact she was continuing to do something else while I was trying to hand over and listening to what I was actually saying.
- I realise also that my actions e.g. body language and ineffective communication skills may have contributed to what happened in this situation.
- Learning from the story:
  - I could have been more assertive in my verbal communication and asked the nurse to go to another room or to stop what she was doing.
  - The other nurse gave me no eye contact and how this made me feel, I knew she was not listening to me and this put me under pressure.
  - I could have waited until she had finished, but this would have affected patient care.
  - Working from memory and not taking notes can mean information is incorrectly passed on and needed to prioritise, plan and meet unstable patient needs
  - Appropriate timing of my actions
  - The importance of non-verbal communication and the barriers that can affect communication
  - Aware of how I communicate with members of the care team
  - My weaknesses in communication, I need to improve future communication and support other health care professionals as much as possible, seeking help when necessary.
  - Communication is core to care and one of the most valuable skills a nurse can have.

### Story 10

The nursing situation took place in a medical high dependency and cardiology ward where patients with acute heart conditions are monitored and treated. I was allocated to Mr A to manage his care for the whole shift under the supervision of my mentor. Mr A was admitted to the ward with supra-ventricular tachycardia and had a past medical history of ischaemic heart disease, myocardial infarction and diabetes and therefore required continuous monitoring while he received treatment. It was usual practice on the ward for patients who

required continuous monitoring to be connected to cardiac monitors. These monitors continuously displayed the patients' vital signs and the cardiac electrocardiogram (ECG) tracing and they were set to alarm in the event of any irregularities. I ensured that the monitor was in working order and that Mr A was properly connected to it. I sought his consent, drew curtains for privacy and maintained his dignity at all times. I monitored and documented his blood pressure, heart rate, respiration rate and oxygen saturation hourly, his temperature four hourly and his blood glucose levels two hourly. His fluid balance was also monitored hourly and I administered his oral medication whenever they were due. I also took telephone enquiries and received information from members of the multidisciplinary team about procedures regarding him, to the best of my knowledge and ability while regularly consulting with my mentor.

Once during the shift, Mr A's monitor started to alarm, I went over to him and saw that his heart rate was high, my mentor noted this as well and explained that Mr A was having an episode of abnormal heart rate and rhythm. He asked me to bleep the doctor while he proceeded to carry out an ECG on him in order to record the electrical activity of his heart. The doctor saw Mr A and confirmed that he had a non-sustained ventricular tachycardia (VT) and though it was just for a short period of time and his heart rate and rhythm were back to normal, advised continuous monitoring. My mentor then proceeded to take a blood sample from Mr A so he could send it off for the electrolytes to be checked. At that point, I found that Mr A's blood glucose level and fluid balance for that hour were overdue to be checked and I still needed to collect some of his medication from the pharmacy. Moreover, he was scheduled to have an ultrasound scan of the heart which I wanted to observe; therefore I went on to carry out these tasks bearing it in mind that my mentor had taken over his care for a while. After sometime, it became less busy on the ward, Mr A remained stable and I continued monitoring his vital signs and administering care to him. I was then able to update and complete my documentations in the nursing notes.

At the end of the shift, I was asked to give a verbal handover report on Mr A to the night staff while my mentor observed me. I gave the handover report with continuous reference to my documentations on the observation charts and nursing notes for accuracy. I informed them about his medication, ultrasound scan and outstanding investigations. However, I omitted the fact that Mr A had an episode of VT and the subsequent interventions, which I had failed to document. Fortunately, my mentor noted this and handed over the information. He later explained to me that Mr A's blood result had shown some electrolytes imbalance and the doctor had prescribed some electrolytes supplements for him which the night staff were to commence. I was made to understand that reporting a run of VT is important so that blood investigations can be done and any abnormalities in the results can then be quickly corrected. This could prevent sustained VT which can lead to cardiac arrest.

#### *Story 10 – Learning account*

- I was very enthusiastic and confident that I could manage Mr A's care having previously observed my mentor administer care to him, but then I began to feel really overwhelmed and nervous because though I had just one patient to care for, there were so many things to do within specified periods of time and this put my time management skills to the test.
- Getting regular feedback from Mr A that he was comfortable and the fact that my mentor commended me on various aspects of the care I gave, especially on my observation and monitoring skills, made me regain my confidence.
- When I was asked to give a handover report to the night staff, I was nervous and felt intimidated because I was conscious of the fact that I was a student required to give information to a group of qualified professionals. Once I started speaking, it got easier because they were very patient and attentive and my mentor supported me through it.
- I felt bad that I had failed to document the episode of VT and therefore not reported it to the night staff and this was a vital aspect of Mr A's care.
- The information I omitted in the handover report was as a result of my failure to document the event, as most of the verbal handover I gave was based on what I documented. This could have hindered the continuity of Mr A's care had my mentor not intervened.
- I was made to understand that although it became busy at certain periods, taking down short notes on the handover report sheet I was given at the start of the shift, which can later be transferred on the nursing notes, would have been helpful.
- My mentor had taken over Mr A's care for a short while; I should have followed up by asking questions and taking note of subsequent events. I was able to manage his care



effectively within the specified times, adhering strictly to the different policies and putting into practice what I had observed earlier.

- Effective communication among healthcare professionals is important.
- Documentation is a vital source of communication and is an integral part of the nurse's role which plays an important part in the effectiveness of teamwork.
- It helps to identify what has been done and what needs to be done for the patient and therefore should serve as the basis for verbal handover reports.
- Handover reports help promote consistent continuity and quality of nursing care by providing information which focuses on the patient and drawing attention to specific nursing interventions such as the monitoring of vital signs and documentation.
- Poor communication among healthcare professionals can have a negative impact on patient care.
- It can lead to errors, omissions and wasted time and has an adverse effect on patient and staff morale.
- Reports written for handover could be more accurate and save more time.
- My direct involvement in clinical practice has given me a clearer view of the importance of documentation as a form of communication and as a basis for verbal handover reports to ensure effective continuity of nursing care.
- If the situation arose again, my action would be to document care provided as soon as possible after its provision to avoid omissions and communicate it to other members of staff.
- I would also ensure to ask questions and read patients' notes and other forms of literature that would help me understand the patients' condition and consequently prioritise the nursing care I would give to them.

### **Story 12**

I will focus on my role of co-ordinating Mrs Smith's care through discussion with the medical team on a ward round. I interacted, liaised and shared information with the medical team. The medical team comprising Consultant, registrar, two doctors, and pharmacist and ward Sister gathered around Mrs Smith's bed. I joined the group because I wanted to know the intended plan a typical desire of a nurse. Understanding that I was to follow Mrs Smith's plan and arrange for her computed tomography pulmonary angiograph (CTPA), I knew I had a duty of care to my patient to fulfil my nursing role. I stood behind the group beside the Sister, assuming this to be my dutiful place. I was feeling frustrated as I could not hear the conversation and mild panic presented, fearing I might miss an important point.

#### *Story 12 – Learning account*

- This frustration was met with a feeling of isolation and loneliness, being outcast from the group and feeling undervalued.
- My feeling of inadequacy could be driven by my belief process; allowing the Consultant to exercise his authority and cause my defensiveness.
- As a student nurse I was simply living up to a self-fulfilling prophecy, perceiving myself to be at the very bottom of the healthcare hierarchy.
- By accepting my 'subordinate role' I was welcomed into this forum.
- My negative feelings were affecting my self-esteem a reaction I think of feeling subordinate is to stand outside.
- My subsequent response to move in closer to the Consultant might have been in part, a rebellious but meaningful action. Plagued by thoughts of insubordination and fear, I decided to assert myself and make my presence known. Ignoring the hierarchy I excused myself, squeezing through the inner circle and stood beside the registrar.
- I was courageous to break into this circle, as a great physical and mental effort was involved. Retrospectively I felt empowered and crucial to function as the team.
- My feelings are symptomatic of the power-struggle that exists between doctors and nurses.
- Relegating myself to the background would have been unproductive given that the ward round is considered a multi-professional effort to plan treatment and care.
- In hindsight I believe my reaction to reposition myself was correct as to stand away from the group creates a barrier. This would have prevented my nursing input and shown my disregard for the nursing ethic to co-operate with others, thereby communicating a lack of support for Mrs Smith and for the professional team.

- Different cultural values divide the medical and nursing profession and assert it is the skill of the nurse to acknowledge the hierarchy and tailor the communication process accordingly.
- Verbal interaction is a core social skill and ultimately affects the outcome.
- I believe my interaction was appropriate which enabled me to gain respect and function within the team.
- Concerned the Consultant had forgotten his proposal for the CTPA; I considered it my duty to pass on this information. I felt nervous as to how my question would be received; thinking I might be shouted at or belittled because I was a student.
- The ward round is considered an important event to transfer information amongst the MDT and to plan ongoing care. This should help inform my future nursing practice.
- I believe I judged my intervention well; conscious of not interrupting the flow and was aware of the interpersonal cues.
- The ward round follows a communication routine and unwelcome disruption can cause upset.
- My query was well received.
- My verbal interaction possibly too reinforced the value of my presence.
- Experience on the ward had taught me CTPA was a favoured investigation used to diagnose pulmonary embolism (PE) and given Mrs Smith's shortness of breath, I was duly concerned. My contribution and confidence communicated my support for Mrs Smith and my professional obligation as an advocate to ensure she received safe nursing care.
- Poor communication between nurses and doctors can impact on the patient outcome
- Mrs Smith's treatment could have been delayed or jeopardised by my inaction. Such delay to Mrs Smith's planned discharge may have caused distress and affected others.
- My ability to question the Consultant directly suggests I was confident.
- As a result the Consultant informed me the CTPA was no longer necessary.
- I can now identify I felt valued when the Consultant conversed with me on a professional level and my confidence came with a feeling of empowerment.
- It is questionable how much I really contributed to Mrs Smith's care. I did not seek clarity for the decision to ignore the CTPA. I believe I felt confused by the medical jargon and failed to understand the rationale for the lung function test. I suppose I should have felt reassured by the Sister's presence and trusted her competency to pick up on any omissions; perhaps there was no urgency to question the medical investigations after all.
- I valued my duty to document care and noted the new plan in Mrs Smith's notes with regard to preparation for discharge.
- My verbal handover to my mentor was well received and his feedback reinforced the importance of communication.
- I feel I have learned from this experience; discovering my deficit of medical knowledge which limited my input in the team.
- This has enabled me to reassess my learning needs.
- I am pleased that I was confident to liaise with the Consultant and enabled me to break down and examine the communication event and my feelings, allowing realisation of my own interpersonal skills.
- I feel reassured that my feelings of inferiority are shared amongst nurses, particularly during ward rounds owing to the dynamics of the MDT.
- The medical hierarchy has brought a realisation that some attitudes and stereotypes are ingrained and may pose a challenge in my career as a professional nurse.
- I feel I am more prepared to deal with such interpersonal conflict and hope to gain more experience with ward rounds to understand communication cues.
- I realise at times, I lack confidence and assertion skills and these are fundamental to effective communication within a multidisciplinary ward round meeting.
- Next time I participate in a ward round I believe I will approach this respectfully, with a clear objective to liaise and co-operate with the MDT to ensure a duty of care to my patient.

### Story 13

This is an incident that I was involved in during my clinical placement at a nursing home. A 95 year-old lady came in with a leg ulcer in her leg. The patient was complaining of tiredness and thirst. She did not eat much or drink. During her stay at the nursing home I was assigned with the help of the staff nurse to draw up a food and liquid chart and monitor it to check on her food and liquid intake.

### *Story 13 – Learning account*

- What is heart failure physiology behind it, incidence in elderly people, complications of it and the formation of leg oedema and its relationship to the development of leg ulcers
- Leg ulcers, healing process, effects on lifestyle, management of leg ulcers, economic burden of managing these patients
- Wound dressing and aseptic technique,
- Assessment with a Doppler ultrasound to determine arterial blood supply:
  - Calculation of the ankle pressure index (API) and what this means (comparison between the highest ankle pressure in one leg and the higher of the two brachial pressures)
  - The range e.g. if API 0.8 or higher it is safe to apply high compression bandage (patients was 0.94)
- The significance of pedal pulses.
- Application and use of compression therapy for arterial leg ulcers
- Recording the information and explanation of the situation to patients is essential

### **Story 14**

This is a description of an incident that occurred during my community placement. My mentor assigned me the care of a patient (under her direct supervision) who was receiving palliative care. The patient was referred to us from the hospital prior to discharge. The information sent to us from the hospital was not sufficient to carry out a comprehensive assessment. My mentor and I decided to visit the patient's general practitioner (GP). Unfortunately the GP was not available. We approached his secretary who was able to obtain her computer held record and retrieve the full medical history of the patient. According to the patient's medical records she was also suffering from heart disease, had liver metastasis, and was a type II diabetic, controlled with medication. We used this information to assess the patient's clinical needs and plan care for her. An arrangement was made to visit the patient at home at her earliest convenience.

### *Story 14 – Learning account*

- Obtaining information / records from elsewhere when not available and gaining patient consent to do this
- Proper process following NMC code of professional conduct maintaining patient confidentiality
- The importance of effective communication between HCP is essential
- Carrying out of the appropriate assessment:
  - Using non-verbal communication e.g. posture, gestures and keeping eye contact
  - Listening to identify how the patient feels about her illness, telling her story in fighting the battle against their disease, expressing her feelings of fear
  - Communication is a very important therapeutic skill, which is deep.
- Identified learning from the situation:
  - Importance of communication in care delivery
  - Ineffective communication and record-keeping can influence the care given to patients within the community.
  - In the assessment of patients effective listening skills and reassurance is therapeutic in communicating with palliative care patients.
  - The significance of inter and intra professional communications amongst health care professionals and the significance of accurate documentation in clinical settings

### **Story 15**

Mr X is suffering from pancreatic cancer and is terminally ill. The district nurses are currently offering palliative care to him. His medication and syringe drive are reviewed on a regular basis and emotional support is also provided for him and his wife to go through this difficult situation. In one of the visits to the patient's home Mr X's wife approached me, while the nurse was busy with Mr X and told me that she believed that her husband was abusing his medication and how concerned she was about it. I felt that was of crucial importance to tell the nurse about this situation so I asked Mrs X permission to share this information with my colleagues in order to take further actions. After sharing the information with the nurses we decided to speak to Mr X about this matter.

### *Story 15 – Learning account*

- Pancreatic cancer has a very high rate of mortality, by the time diagnosed it is at the incurable stage and metastasised, only 19% of untreated patients live for more than a year after diagnosis and less than 4% will survive for more than 4 years.
- Pain receive Diamorphine through syringe driver revised on a daily basis, 4 Fentanyl lollypops a day, a potent opioid analgesic chemically related to Pethidine (80 – 100 times stronger than morphine) commonly used for break through cancer pain
- High doses of medication can create toxicity, excessive depression of the CNS and death.
- Maintaining patient confidentiality, but telling when things cannot be kept confidential and need to be shared, asking permission to do this from wife of patient.
- In such communication the use of eye contact was important, nodding agreement and encourage patient of disclose information.
- Lack of counselling skills, needed to tell and share this information with my more experienced colleagues.
- I asked Mrs X permission if I could do this. When I explained this to my colleagues I used posture, appropriate accurate and appropriate language, I wanted to ensure my colleagues fully understood my explanation.
- Effective listening showing good verbal and non-verbal behaviour, body posture, noises and gestures of conformity, demonstrate concentration in conversation.
- Concerned for Mrs X stress in being able to handle the situation appropriately and the amount of medication Mr X was taking
- Learning:
  - Confidence in delivering correct information in an appropriate manner,
  - I was able to spot something that was bothering Mrs X and ask her appropriate questions and the time to reveal her concerns.
  - Listening techniques such as nodding, signs of agreement to encourage her to talk
  - The use of my voice e.g. tone and using simple language, making emphasis on relevant aspects of the circumstances to facilitate absorption and understanding
  - Imperative role of the nurse within the family environment, the wide range of services available to families to cope with these situations to provide the best quality of life possible
  - The fundamental importance of verbal and non-verbal communication and the impact on clients and colleagues, good use of tools improve the absorption of information by the listeners
  - My lack of counselling skills which would have helped Mrs X to feel more supported and reassured and knowledge of palliative care and how to communicate with the dying patient
  - Best care was achieved e.g. through good conversation, but I could have been improved.
  - I need to get more involved in situations where nurses are advising and counselling patients as I have realised how important it is to acquire experience to satisfactorily manage these situations.

### **Story 16**

It was during my first placement during my second year in a gynaecology ward. I was working towards performance level 2, which involved learning to work independently within a supervised environment. I had been caring for one patient during my shift, a 20-year-old girl who I will call Claire, who had been admitted for treatment of hypodermises. Although I had been caring for her for the duration of my shift I was unprepared to give the next shift a nurse hand over. I assumed that my mentor would do it as she had been doing it on all of my previous shifts. However, on this occasion my mentor said to me to do it at the last minute. I listened to her giving the hand over for her patients then when it was my turn I panicked and got all of the information mixed up. I started with the essential information about Claire such as name, date of birth and reason for admission. Unfortunately, I became flustered after that and it was clear to both my mentor and other staff members that I was out of my depth and needed help. My mentor then took over and continued the hand over.

### *Story 16 – Learning account*

- Beginning to work independently within a supervised environment

- Patient admitted for hypodermises
- When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence.
- Unprepared to give the next shift a nursing hand over, assumed mentor would do it as my previous shifts, asked me to do it last minute
- I panicked and got information mixed up, became flustered clear I was out of my depth, my mentor took over.
- The root of the problem was the model of hand over used to communicate clinical information whereby the patient's central to the care activities and does not rely on the nurse purely giving verbal information in an office away from the patient, this includes two types:
  - Bedside hand over emphasis on individualised patient care
  - Bedside reporting most frequent model of hand over
- I need to gain confidence in verbal office hand over, look at various nursing journals, plan how to give hand over, write down all the information I want to convey, yet this can lead to a heavy reliance on my notes and just reading them out.
- This is a process of learning through time and building up my own confidence, I learned that I need to just write down key items that I want to say and continue to do this.
- This style of hand over still consists of a one-way communication, where the nurse gives the relevant information and instructions to the nurses resuming their shift in the ward manager's office or at the nurses' station.
- To learn I need the back up of nurses with useful experiences to provide me with support and guidance for the future, knowledge and back up of a qualified member of staff.
- Improved my ability to reflect on practice experiences as an important step in professional development, support others and increase my knowledge of issues surrounding patient hand over
- The use of questioning to improve my knowledge and improve my understanding

### **Story 18**

I was caring for a young patient in A&E, I knew something was wrong, but I could not put it into words eloquently. The patient's blood pressure was high and their heart rate felt a little peculiar and not normal. The patient had cardiomyopathy I knew this, but did not know what it was. I went to inform the staff nurse of my concerns and suspicions about the patient, and I was told that he would be there in a minute. I remained concerned, and the patient's sister who stated she had never seen him this bad before supported this. With this in mind I undertook a 12 lead ECG. I took the ECG straight to the doctor, as the charge nurse had not taken me seriously. The doctor immediately saw this patient was in atrial fibrillation and the patient was transferred immediately into the resuscitation room.

#### *Story 18 – Learning account*

- The use of the ECG was non-invasive do no harm only good
- By passed the nurse and went straight to the doctor who listened to me, despite being a student
- Can be assertive in situations that require it
- Patient contacted me 2 days later and thanked me for the care s/he received
- Observed the concern on sister's face, as never seen him like this before, learning to take cues of others who know the person better.

### **Story 21**

I cared for a patient admitted to A&E. I began my assessment and started to ask her relevant questions about her past medical history. 'Do you have any medical history?' The patient answered 'No!'. I continued with the assessment of the patient's blood pressure and heart rate and found them both to be raised. I asked another question 'Do you have any problems with your blood pressure?' 'Oh yes!' replied the patient, 'I take a small white tablet for it, in the morning.' This additional information shed a little more light on the patient's condition. I again resumed with the assessment and did a blood sugar (BM Stix) to test for diabetes. This result was higher than normal 18 mmol/l. I asked the patient if she was a diabetic. 'Oh yes, I take another tablet for that, must not eat too much sugar, my daughter is always on at me, but a little bit does not hurt.' I again continued with my evaluation of the patient and I did a 12 Lead ECG. I had decided to do this in the light of her now known past medical history, which

I was beginning to obtain at a very slow pace. I did the ECG, which showed an irregular rhythm, which I thought was atrial fibrillation. I asked the patient if she had problems with her heart rate. 'Yes I have another tablet for that one.'

#### *Story 21 – Learning account*

- How PMH and knowledge of it can effect nursing interventions
- Questioning in practice to patients to obtain a history needs to be at a level they can understand.
- Often patients cannot give a detailed history as they cannot identify the drugs' names they are taking, which could indicate further interventions as would have side effects of them, especially if poly-pharmacy is involved.
- In some clinical areas such as A&E the students are caring for patient go in blind as a PMH cannot always be available and difficult to care and priorities in these situations
- Old notes are not always stored at the hospital maybe at GPs or community centre or other

#### **Story 23**

I was gaining experience on a general medical ward and I felt that I was not being able to gain the experience I needed. I am in my 2<sup>nd</sup> year and finding it difficult to care for a patient or group of patients over a span of duty. I felt it was my mentor role to facilitate this process and she was not able to fully relinquish the charge of the patients to me and just supervise or be there for me when I needed her. She did not confirm with other members of staff that I was managing this patient today. This invariably was leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice. This culminated in a situation whereby I lost contact with what was happening to my patient and so my mentor took over. This could have been avoided.

#### *Story 23 – Learning account*

- I realised that I need to take responsibility for my own learning and state my own learning needs clearly and inform all members of staff myself.
- Assertiveness in relation to my own learning needs
- Effective mentor-ship and supporting students learning and development in practice

#### **Story 26**

I was asked to go and assess a patient who was sitting down in the trolleys area in A&E. Often when the department is busy, patients have to sit and wait here, as there are no available trolley spaces. I went to speak to the patient to assess her. This area is not very private and even on a trolley there are only curtains to separate the patient from the next. She had come in with an infected abdomen following lipo-suction at a private clinic. Her husband accompanied her. I started the interview and I soon realised the patient's English was limited and her husband was translating to her. I realised from the patient's facial expressions related to the translation of the questions that the patient was not comfortable with the type of questions being asked in the open trolley area. The husband seemed fine about it, but his wife was uncomfortable. A quieter area needed to be found, not an easy task in the busy A&E setting.

#### *Story 26 – Learning account*

- The husband felt comfortable with the questioning, probably because his wife was being seen to.
- I am used to working in a busy area with patients around, did not have any concerns related to interviewing the patient in this type of area.
- The patient however did, her non-verbal facial expressions and her unwillingness to answer the questions interpreted this.
- The barriers to communication were environmental and language, which the patient did not feel comfortable and adequately able to communicate, effective communication was blocked.

### **Story 27**

I was on my first inter-hospital transfer from an acute general hospital to a specialist hospital in the inner London area. The patient had a palpable abdominal aortic aneurysm, was conscious and co-operative but there was evidence of the abdominal aortic aneurysm getting bigger. The patient needed immediate surgery. This type of surgery did not take place at this hospital, hence the need for transfer as soon as possible. The referral hospital agreed to accept the patient and everything was arranged, I was asked if I would like to go with the patient and qualified nurse. I was travelling in a blue light ambulance through the centre of London and it was exciting. The trip was uneventful and on arrival at the hospital we were met at the main door and directed toward theatre, all the way to theatre a member of staff had been positioned so that we did not lose our way. When we arrived, both the staff nurse and I handed over the patient. I was disappointed that I was unable to follow the patient up, as I would not be able to phone up and expect to get any information regarding the patient's condition.

#### *Story 27 – Learning account*

- Not being able to follow up the patient and find out how he did due to confidentiality and too far for me to travel into London to enquire
- The amazing communication / organisation and co-operation of all staff were phenomenal and very impressive.

### **Story 33**

The Oncology ward was a particularly busy ward and the sisters and staff nurses had all gone through extra courses so that they could give chemotherapy and so forth. Some patients just came to the ward whilst they were going through cycles of chemotherapy. Others came during fractions of radiotherapy. Yet others came because their symptoms were getting worse or the pain was becoming intolerable. The goal was to get the patients home and to keep them out of pain. If this was not possible, then they would discuss other options with the patients and their families. Sometimes they would be transferred to hospices. In other cases, this was not possible and the patients would die on the ward. Over one particular weekend, we had four deaths. On my first day on the ward, one of the patients died during morning hand-over. Although I had not known him, I helped the charge nurse with the last offices. The number of deaths on the ward was particularly sad and difficult for the staff. One got to know some of the patients and their families very well. It was as if one had lost one of one's own family.

All of our patients had metastases of their cancers. Many of them had been ill for a number of years. I was impressed to see that they were usually offered massages, counselling and alternative therapies in addition to their normal treatments. We had physiotherapists, occupational therapists, speech and language therapists, pharmacists, dieticians and the new doctors' assistants (who did all the phlebotomy tests, electrocardiograms and other tests which used to be done by junior doctors). In addition, we had a number of Macmillan nurses, who all specialised in a particular area of cancer. They were particularly good when it came to pain control.

During my time on the ward, I helped to look after patients with a whole range of cancers, usually with metastases. So, for example I looked after patients with cancer of the bladder with liver and lung metastases, cancer of the breast with brain metastases; sometimes the primary cancer was unknown whereas they knew that it had metastasised elsewhere; squamous cell cancer of the tongue and floor of the mouth, end stage renal failure, patients on strict fluid balance input and output; some on half-hourly or hourly observations of vital signs due to being on blood transfusions, etc., hepatosplenomegaly, gross ascites, cancer of the lung, pneumonia, neutropenia, pancreatic carcinoma with jaundice post-chemotherapy, cancer of the oesophagus, Non-Hodgkins's disease, sickle cell episodes, multiple myeloma, asthma, MRSA, cancer of the endometrium, astrocytoma of the frontal lobe, paralysis, seizures, COPD, atrial fibrillation, closed tuberculosis, cancer of the larynx with a total laryngectomy, patients with colostomies, cancer of the prostate, and cancer of the stomach.

Many patients were on nasal-gastric tubes and radiologically inserted gastrostomy (RIG) tubes; We also had patients with cancer of the bowel, diabetic patients needing blood sugar monitoring and insulin injections; ascitic drains, emphysema, anal carcinoma, small cell lung

cancer, dysphagia, fractures of neck of femur and other limbs, grade 3 heel ulcers and so forth. It was an amazing variety. We had to do vital sign observations for patients on blood transfusions, enteral medication and feeds, observe patients on chemotherapy, and a great deal of pain control with controlled drugs. It was an incredibly busy and stressful ward.

### *Story 33 – Learning account*

- I believe that my experience on this oncology ward helped me to think critically about improvement in the care that I give to my patients.
- I was initially quite concerned that I did not know enough about cancer and that most of these patients were severely ill.
- After I had been to my first meeting with my clinical tutor and had attended my first weekly lecture on oncology I was able to consider these experiences in a more positive manner.
- I got to know patients well.
- I learnt much about their successes in life, about their families and also, sadly, about their worries about how it would all end.
- The experience on this oncology ward was immense.
- I learnt patience, compassion, adaptability and communication skills.
- I learnt basic nursing skills which will always be useful to me in my nursing career.
- This specialised care of the oncology patients made me realise how important communication is with not only the patients but also their families, partners and friends.
- On occasion there were many tears.
- It was an incredible experience to be with these courageous people in their time of need.
- They all appreciated warm and positive care.
- I did relatively well on this oncology ward.
- I felt that most of the patients and their families liked me and felt that I was trying hard to assist them in any way possible.
- The most important conclusion is that I feel that what I learnt in communicating with and assisting these very ill and often dying patients will be invaluable to me during my future ward placements.
- Care, compassion and communication are the basic elements of nursing. They have to be genuine and I believe that I have learnt this from this oncology placement.

### **Story 36**

This story took place on a ward at a west London training hospital. My mentor was carrying out her duties dispensing medication in one of the bays of the ward. One of her patients was in pain and asking for her morphine. My mentor noted she was written up for Zomorph SR 40 mg. My mentor could not find this exact named drug in the patient's locked bedside cabinet or in the CD cabinet. As the patient had been transferred from another ward in the hospital she wanted to ensure she administered the right form of the morphine-based drug: sustained release. She also noted that this patient's chart had been signed off as Zormorph being administered the night before by one of her colleagues. My mentor approached her colleague and questioned her about the drug that had been administered. It was found to be Morphine Sulphate. My mentor was unsure this was the correct form of the drug and so looked up Zomorph in the BNF. Zomorph is a trade name for morphine sulphate but a question still remained whether what had been given was sustained release or not. The sister on the ward was consulted and she advised my mentor not to give any drug until it had been established by the pharmacist or prescribing doctor that these two drugs were one and the same. The pharmacist was bleeped but did not get back to the ward.

My mentor used her initiative and visited the ward from which the patient had been transferred and questioned staff there what they had administered as Zomorph SR 40 mg, one purple table of 30 mg and one yellow tablet of 10 mg.

We returned to our own ward and administered the Morphine Sulphate to the patient. My mentor then bleeped the doctor and advised her that some confusion had arisen because she had used the trade name of Zomorph instead of the generic name of Morphine sulphate. The pharmacy had administered a packet labelled morphine sulphate. As this was a controlled drug my mentor wanted to ensure she was giving the right drug to her patient. The doctor amended the prescription sheet and everyone was relieved to know that the right drug had been administered but no-one else had questioned the trade name being written up.



#### *Story 36 – Learning account*

- How a simple prescription error can lead to the feeling that something serious had happened and fearful of the outcome
- Immediately who is to blame changing from ‘all working together’ to ‘who is the individual to blame?’
- The involvement of the MDT e.g. doctor and pharmacist was implicated in the learning and how it is imperative to involve everyone, as it is not generally just one person's mistake, it is a collection of errors gone unchallenged and undetected. No one had sought clarification and speak directly to the prescriber.
- The story helped to resolve an issue that we may not have handled in the best possible manner at the time. By making us look at the situation, break it down into salient points and consider what would have been a better course of action to achieve a more positive outcome is personally therapeutic and professionally diligent.
- Writing down the story also helped with my thoughts and to clarify what my current state of thinking is about a subject.
- It was an important learning curve for me to observe how my mentor took control of the situation and brought it to a successful conclusion diplomatically
- The best lesson learned was being proactive is the best way to deal with complaints or incidents and it forced me to face this uncomfortable facts about my workplace and myself and carrying with me the lessons learned from this story, especially communication between HCP, in a productive, professional manner to sort out the problem faced.

#### **Story 44**

Mr S and I exchanged a couple of frank and honest conversations about his illness and state of mind. He had cancer of the prostate that had spread to his spine and was now bedbound. The patient was aware that he had been admitted for end of life care. This is classified as caring for people who have an advanced, progressive and incurable illness so they can live as well as possible until they die. It is about providing support that meets the needs of both the person who is dying and the people close to them.

Mr S was happy to be in the hospice environment. He had reached the stage where he simply wanted to die as soon as possible and verbalised his disappointment every morning that he hadn't passed away during the night. His wife on the other hand found this honesty hard to accept and wanted him to maintain a positive attitude. Although I was unable to change his circumstance, I was able to give him time to listen and express the views he had to shield from his wife as not to cause her more distress.

#### *Story 44 – Learning account*

- Informed consent, the need for privacy dignity, individuality and respect
- Pressure ulcers and the causes, dressings Mr S did not want his dressing changed and the ethical dilemma of leaving Mr S with his dressing unchanged and the difficult this posed in respect to Mr S's well-being against his decision, facing how conflicting moral issues, whilst trying to maintain the nurses professional obligations to these principles when they do not match the patient's, in all of this pain relief was essential
- The patient not wanting to wash, or to be repositioned, but it was important to do this as cleaning his wounds and skin helps prevent infection and cross contamination
- Pneumonia, immune suppressed and susceptible to infection
- This story left me emotional fatigued with emotional and physical exhaustion that I felt this story had left behind in me, in was however both challenging and rewarding, I feared this would distance me from the suffering of patients in the future and disengage from the patients and families I cared for.
- I felt I had gained confidence in talking to patients about challenging and difficult issues, discussing their options and individualising my care to meet my patient's needs, whilst ensuring moral and ethical principles. Getting in touch with emotional situations and the problems this can pose to me as a nurse.
- I can transfer these specialist skills to other areas where I practice using it in future care and placements and throughout my career.

## Story 50

Eileen was admitted with a UTI but she also suffered from vascular dementia. I will reflect on the observations I made and the challenges I had to face when caring for her and what I learned from the telling of this story. Eileen lived in a nursing home and asked me what her son had said on the phone earlier. As I could not answer the question I told Eileen I would be two minutes to find out that information. I went to the nurse in charge who informed me she had no family that they were aware of, and that she was just 'crazy'. I knew that was not the right approach to take so thought about what I could say in response to her question. However, before I had a chance to speak Eileen began to shout at me. Eileen believed that I had just walked off and dismissed her question; this was obviously not the case. The whole ward was able to hear her screaming. Eileen told me that I did not care about her and that I was keeping her there until she died. This was very distressing for me, as it was far from the truth, and I did not want someone to think this about me. I tried to explain to her this was not the case and she was here to treat her infection, then she would return home where her friends and carers are waiting for her. This unfortunately did not settle her and she carried on screaming. I found the fact that I could not seem to calm her hard to deal with.

Other staff just seemed to dismiss it and other patients began to 'tut', saying that she was a nuisance and shout sit down and be quiet. It seemed that no one had the time or patients to listen to her. I could see she felt lonely and wanted to help, however it seemed that whenever I tried to speak to her it angered her more. Eventually I realised that I was not going to make Eileen understand and there were other patients who needed help with their breakfast and washes. Therefore, I left her to calm down, and perhaps another member of staff would be able to calm her. During the shift it became obvious to me that the comments Eileen had made to me were not personal. After a short while I returned to her and I was greeted with the same smile I saw initially, I asked her how she was now feeling and she replied that she was fine, almost unaware of why I was asking. It was difficult to know what her needs were as she could not make them known to us and therefore it was difficult for staff to know what level of interventions is required. It was difficult to reason with her due to the confusions they may experience.

Eileen was often found wandering the ward. Occasionally she could be found sitting on another patient's bed, especially those within the side rooms. Eileen would often become aggressive and loud sometimes, but I did find time to spend with her and at these times Eileen enjoyed. Eileen enjoyed having her nails painted, introduce her to other patients, and as we spoke she would recall her family, she told me her husband John and how he had passed away shortly after they married, she seemed happiest at these times talking about her past. She mentioned her son, but he lived abroad and rarely range to see how his mother was, let alone visit her.

### *Story 50 – Learning account*

- Vascular dementia – is the 2<sup>nd</sup> most common type of dementia, after Alzheimer's disease. It is due to a lack of blood supply to the brain, damaging cells. Certain symptoms are displayed when an area of the brain is damaged by certain diseases; they may have difficulties remembering or memory loss, solving problems or concentrating, acute confusion, getting lost and changes in behaviour, difficulty in showing their emotions. The patient may suffer from acute memory loss, confusion and feel lost all at the same time.
- This story has made it apparent to me that an individual may come across as aggressive or unfriendly, but this does not necessarily what they mean to do. The patient may feel scared and vulnerable or they may act in a certain way because of a condition. As I nurse I realise that nurses need to take into consideration all factors which may influence person's behaviour.
- Antibiotics
- Coping alone at home that some patients have to face
- When the patient told me that I did not care for her I was distressed, but knew this what part of her condition, and this knowledge helped me to understand.
- The importance of taking time to be with patients and just talking to them was so powerful.

### **Story 54**

Out on placement I had many experiences that I learned from. Sharing these experiences with others not only made me realise that I'd learnt from it but also enlightened others on the lessons learned.

One particular story I shared that had an impact on my nursing practice was when I took a patient to have a colonoscopy. This patient had previously had this treatment but unfortunately it was unsuccessful, so had to be performed again. The patient had been in hospital for over 3 weeks and had a bad experience during the first colonoscopy feeling incredible pain. Therefore was becoming extremely agitated before the treatment. As a student nurse I went with the patient to endoscopy so I could watch one procedure. On arrival we were told there was a short wait but the patient will be seen within the next hour. After 3 hours the patient was still waiting becoming more and more nervous by the minute. This patient became so nervous a mild panic attack overwhelmed him and he was put on oxygen encouraged to breathe deeply.

Although I was reassuring the patient as much as I could not. The nurse in the department came over to help me reassure with telling the patient how long left to wait or just good old fashioned sympathy. Everyone was very cold, and when keep getting asked how long until this patients turn and quite rude.

#### *Story 54 – Learning account*

From telling this story to other nurses, students, friends family I learned that even though professionals may do the same procedure treatment many times a day a patient only experiences it once or just a few times and may be very anxious or scared. Treating each patient as an individual is important as in this story I believe this patient did not get the care they deserved. Just a few simple words of care to tell them how long left to wait and maybe why it took so long to tell them everything is going to be OK was all it would have taken. Gaining others views on the situation lets you see other perspectives and helps you learn from all angles and not just from your own.

## 6.2 - 3<sup>rd</sup> year adult student nurses' stories and learning accounts

### **Story 17**

I was caring for two patients as part of my management 3<sup>rd</sup> year module. The first patient was a man in his 50s who had presented in A&E with rib pain, this condition could have been for a number of reasons e.g. pneumothorax, MI, pleurisy, cancer or chest infection. The second patient presented in A&E with an asthma attack, difficulty in breathing, anxiety exacerbating the situation. The patient needed oxygen and a nebuliser prescribed ASAP to help with her breathing.

#### *Story 17 – Learning account*

- Who has the priority in this situation – the rib pain patient could collapse as his condition could be very serious, whereas the asthma was equally distressed and needed interventions
- It was obvious the patient with asthma needed to be treated first the doctor was sought and the patients story was told. The doctor listened to the patient's chest.
- I wished I had asked the doctor to show me what he was listening for so I could have identified a wheeze again when I saw a patient with asthma.
- The doctor prescribed a nebuliser as predicted, but I did not know how these drugs worked, I knew they were often prescribed for difficulty in breathing e.g. COPD patients.
- I was impressed by how fast the doctor came to see my patient after I told him the situation, maybe there was urgency in my manner of voice?
- In all of this the other patient had been forgotten and his care could have been delegated to another as he needed to have investigations to rule out the seriousness of his pain. This included:
  - A chest X-Ray
  - ECG
- This oversight on my part as a student nurse in my role as trying to gain management experience in the care of two patients probably meant the patient with rib pain stayed in the A&E longer than necessary as his investigations could have been done sooner.

- I put a judgement on the priority of his care 'a time waster' in relation to his rib pain, not serious as opposed to asthma; despite I knew he could be serious.
- This was a problem but I was also finding it difficult as I was also having to deal with all this as well as other demands being made upon me e.g. from other patients/staff in A&E and being asked to do other things as well.
- The management of patients does not take place in a vacuum as many things continue to go on around as you try to organise / arrange for the care of particular patients. Asked to do other tasks:
  - Check drugs
  - Take a urine sample to the sluice
  - Inform sister of a result
- It is sometimes difficult to learn about one particular thing as often practice is sometimes a mess and there is mayhem, and drawing learning from it is difficult.

### Story 21

The clinical area where this learning experience took place is an adult ward, a haematology unit that cares for patients with blood disorders such as sickle cell disease and human immunodeficiency virus (HIV), tuberculosis (TB), cancer and other infectious diseases like methicillin resistant staphylococcus aureus (MRSA). The situation in the ward on this day was that we had four staff nurses, one health care assistant and two students including myself. *Being a third year student, I was allocated with three patients to manage their nursing care for the entire shift* although I was supervised by my mentor. My patient Mr A was diagnosed with HIV and Epilepsy and under treatment, he had left sided weakness which restricted his mobility and reduced his independence. Mrs B my second patient was diagnosed with HIV and she was currently receiving treatment. She also suffered from Gastroesophageal Reflux Disease. She had reduced mobility due to ulcers on her left and right big toes. She needed support with personal hygiene, transfer from bed to chair and elimination because she was mainly dizzy throughout the shift. Mrs C is a patient diagnosed with cancer and was receiving treatments. She is self caring, mobile and mostly in a good mood.

Being responsible for the nursing care management of the above three patients, I started the shift by checking their vital signs. Mr A's Blood Pressure was 168 / 97 with a pulse rate of 84 which was of concern and I did consider his present state including physical, mental and emotional states and informed a senior nurse. I assumed that the high observations were due to his emotions because he was angry that the night staff took his bottle and did not bring it back. I tried to persuade him that they did not do it intentionally but might rather have been busy and forgot and I gave him a bottle. My main motive was to calm him which I believed would help to stable his observations.

#### Story 21 – Learning account

- Checking the vital signs I thought I was intrusive to the quietness needed by Mrs A and B hence I found them sleepy but I did feel settled because their observations were stable.
- The readings were recorded so any health professional could use them during this shift.
- Mr A's observations raised concerns but when they were checked an hour later they were stable.
- The experience from Mr A proved the sense that emotional change can affect stability of vital signs.
- Once my patients were served with breakfasts, I assisted Mr A with slicing his bread and butter and placed his table at an easy access for him.
- The reason for assisting him with feed was that he could only manage with one hand.
- After breakfast I assisted them to have a wash or a shower. Mrs B was given a full shower but the other two patients insisted to have a wash. This was followed by aiding them to sit up in the chairs, making their beds, tidying up their bedsides and giving them their prescribed medications.
- The level of independence of my patients were different, I began the personal hygiene of Mr A and Mrs B who required more time and assistance. The reason was that the time allocated for personal hygiene and that of the dispensing and administration of drugs nearly overlapped.
- By planning and prioritising this way, I was able to manage the time efficiently and I finish the personal hygiene of two patients before the required time for giving of medications.

- There were no delays for the 10.00 a.m. medications for the three patients and I had only one patient who required less assistance.
- Planning is the basic process of explaining objectives and illustrating how to achieve them.
- Assisting my patients with their personal hygiene I was thinking about the HIV condition of Mr A and Mrs B although I was aware that HIV is transmitted through the blood of the patient and sexual intercourse.
- I was helping Mrs B with her full shower I was feeling uncomfortable because she asked me to hold the water over her while she washed her genital areas.
- The dirty water was splashing onto my trousers and I knew I had to wash my trousers with other clothes including underwear in my house. So I was worried about transmission of infection from the splashes of water on my trousers to my underwear.
- My patients were happy that they had been attended professionally and they have been encouraged to take part in their care to enable better independence.
- I looked back at the literature and found that HIV is not transmittable through splashes of shower from the patient although effective measures like wearing of aprons and gloves should always be maintained.
- In the future I will care for infected patients like any other patients but I will always adhere to the infection control policy of the unit.
- I required supervision from my mentor with the administration of medications for my patients.
- It was my responsibility to ensure that the right medications are for the right patient and observe that my patients had swallowed their medications.
- I was thinking that my mentor did not ask the functions and categories of the drugs for my patients. I felt very ashamed when she did and I could not tell her most of the drugs functions.
- This forced me to familiarise myself with majority of the drugs used in the ward.
- As a third year student I was not sure of the functions of the drugs I was dispensing to my patient.
- It is vital to be aware about what types of medications I am giving to my patients because in case the patients have queries about the drugs then I will be in a better position to answer their questions.
- I accept I should at least have the BNF with me. If this situation arises again I will check in the BNF to clarify doubts.
- I checked in the care plans of Mrs B for the type of dressings needed on her ulcers. I applied aseptic technique as required by the infection control policy.
- I talked to her about how she was feeling, explained the state of her ulcers and gave her reassurance that through treatment, cooperation and exercise such as wiggling of the toes to promote blood flow and other range of exercises performed with the physiotherapists her condition could get better.
- At this junction most of the nursing cares required by my three patients were done. Nevertheless, I was alert of their ongoing needs such as elimination, frequent change of positions or having drinks in between meals.
- I felt honest and professional.
- My knowledge about dressings has improved.
- I did not have a good posture because I was bending which hurt my back.
- It made sense that some form of health education is necessary for the patient and I should ensure that I did bring the bed up to a level that will prevent me from hurting my back.
- If the situation arises again I will make sure that I have a good position to prevent injury to myself.
- I had to delegate some responsibilities to a staff nurse and another student. Mrs B had three episodes of vomiting during this shift. I needed to delegate. At lunch I had to ask the other student nurse to help Mr A with cutting of his food into smaller pieces which he asked for.
- I felt unease in delegating to senior staff; I was democratic because I explained why I needed them to undertake the activity.
- Management skills are vital and necessary for nurses in order to fulfil responsibilities. In the future I will stick to the democratic form of leadership and management skills since it allows team members to be secured, supportive and willing to give their best in most times.

- I had to communicate and document all care given to my three patients verbally during handover to staff and as well written on their nursing notes.
- Communication is a complex process of sending and receiving verbal and non-verbal messages.
- I was sensitive, concise, clear, reflective and comprehensive.
- Documentation is an essential and crucial part of nursing care because it ensures continuity of care by healthcare professionals.
- I was thinking it was my responsibility to provide information.
- I felt very nervous and a bit scared about these because the staff I was dealing with were much more experienced and I felt my standard was poor compare to theirs.
- In the future I will contribute to improve effective communication between me and the staff.
- Observation and assessment forms the basis for nursing care and each patient should be nursed as an individual.
- Patients should be involved in their care, be encouraged to participate in order to improve the effective implementation of their care plans.
- Nurses should listen to their patients and be aware that body language matters a lot to patients and even to other members of the team.
- Nurses should be emphatic, responsible and respect the dignity, wishes and emotions of their patients even though sometimes, some of the wishes are impossible to be granted.
- It is vital to be aware that planning ahead, prioritising, delegating and good time management help to maintain effective management of nursing care.
- It is important for nurses to focus on their roles and responsibilities as well as having good interpersonal skills with team members to produce good standard of care.
- The nurse should pass information about the patient to other staff in the ward and the multi-disciplinary team to help create a supportive network that will work together to better the health of patients.
- This will help develop competence that can be applied to clinical practice, rectify past mistakes and can help one to handle future situations with professionalism.
- These skills are essential because they allow nurses to provide competent and safe care to patients and their families.

### **Story 23**

A time whilst I was working in resuscitation, this patient who at the time had taken an overdose of crack cocaine, I was a third year student nurse. During this time I was involved in the care and management of this patient, the communication between the team which was involved. It is important for nurses and health care professionals to possess management skills, as this can lead to influencing the behaviour of others, every nurse has the responsibility to be an effective manager.

#### *Story 23 – Learning account*

- I was involved in the care of a patient brought in by the police from the Samaritans where she had been found, there was no name of the patient and the police could not at the time find a name for her, she had taken an overdose of what was thought to of been crack cocaine, this patient upon arrival was not conscious her Glasgow coma scale was 3/15.
- The doctors had taken the decision to intubate and insert a tracheostomy tube but this was not tolerated.
- A catheter was inserted so they could get a urine sample to check what drugs she had taken. The communication of the team was brilliant during this time no one felt out of place everything was going according to plan
- Communication is essential for all the team involved and clearly it was in this circumstance. The patient appeared unconscious I had stayed with her the whole time and was reassuring her that everything was going to be ok by talking to her and generally given her my nursing care for example taking her neurological observations .
- I had felt a bit out of my depth in the resuscitation room as this was for emergencies and that I had not the knowledge or the experience to be in total management and care of this patient, but I had given it my best shot in the nursing care of her.
- I was under the supervision of the other doctors and nurses there, and in the resuscitation room in an emergency the doctors mainly take over and the nurses do as the doctors request.
- I did feel very scared for the patient as she was under 16 years old.

- Some kind of recollection of a person similar to her, a year previous who had done the same thing
- Wondered how her parents would be feeling , as I am a parent myself, I seemed to put her under my wing and took over as a mum, as she had no one with her and no way of contacting anyone as she was a unknown.
- I did feel more at ease when I did this as things were coming to me a bit better instead of just standing by and watching I involved myself in her best welfare.
- I feel aided in helping me to increase my knowledge and understanding of the situation and the different ways of the interdisciplinary team work, the communication between the team was great and I feel she was under the best possible team.
- I do not feel that anything could have been done differently as I feel that everything was done in the right order and worked out fine and to a successful outcome as the patient recovered and was transferred to a children's ward with myself and another nurse.
- The patient had regained consciousness and would not let me go as she recalled the time in resuscitation that I had stayed with her throughout and had in fact not been as unconscious as thought.
- I had managed to get her to open up to the doctors in telling her name and address, and that she was truly grateful for my help and even wrote me a letter of thanks.
- I feel that my nursing care for this patient was obviously correct at the time and was grateful for the chance to show it.
- A few days after this event it had emerged that she was not under 16 years at all and that she was 23 years old and had played along with the fact that they had thought she was younger as she thought she would get a better time on the children's ward and the affection she craved. This tells me not to judge a book by its cover.
- Critical thinking plays the most important role in delivering a dependable high standard of nursing care.
- Over the next few days I wondered what had happened to her. I had gone back in on another long day shift and as soon as I had gone in one of the clinical sisters had called me over and said the paediatric doctor was looking for me. I caught up with her and she thanked me for doing such a good job with the patient and I had managed to get her to open up and no one had got her to do this before this had gone on over a period of years.
- This story has made me more appreciative of the fact that one day I will be a fully qualified nurse and be able to do this kind of work every day which I would love to do.
- I was a bit hesitant at first as I do not have the knowledge of children's nursing.
- I feel that I can deliver good nursing care to all my patients.
- I would like one day to be able to work in the emergency department as this is what I think I would like to do, being on the front line and dealing with the patients first hand, saving lives which is the first and last thing I would want to do as I get great pleasure in helping others . And I feel there is a lot more to be learnt.

### **Story 30**

Most of the nurses wanted to change from working 8-hour 'earlies' and 'lates' to 13.5-hour shifts. As a student nurse, who wanted to see 'long-day' shifts implemented, it was interesting to see how the change was initiated, taking into account the 'power' of nurses in the work environment. Initially, the Charge Nurse (CN), who would become the internal change agent, was not keen to implement the change. This was due to the possibility of detrimental effects on patient care and due to organisational and ward's culture. It was also due to possible additional costs (human and material), politics (nursing power within the multi-disciplinary team) and the need for risk management assessment in order to maintain a safe environment. In addition, due to research that pointed towards staff fatigue and the negative effects on health and performance and problems with multi-professional roles.

#### *Story 30 – Learning account*

- In Towards a Strategy for Nursing Research and Development change is shown as a continuous process, which must occur for robust nursing evidence.
- In Delivering the NHS Plan the word 'flexibility' is used as a keyword in healthcare literature and policy documents.
- The belief is that the more innovative and creative the strategies that individuals are able to use in their daily work, the more responsive they will be in the delivery of effective healthcare.

- There is a close relationship between the working environment and the capability and capacity of teams and individuals to handle issues they encounter in an innovative and creative manner.
- Theory of change management has drawn on a number of social science disciplines and tradition.
- Change is an alteration in the status quo and is inevitable.
- Planned change theories provide theoretical concepts in order to achieve changes.
- Different models of change are appropriate in different situations.
- Classic theory of change is a three-stage process, others later proposed more detailed processes, planned change and innovation adoption were presented as adapted linear models and problem-solving approaches to managing change.
- Change is integrated into personal experience because it explains attitudes and reactions towards change processes and because it links to clinical practice and the proposed change.
- Forces driving towards and restraining individuals from adopting a change must be identified.
- The CN allowed as much individual choice and fairness in relation to length of duty periods, in order to encourage career and private life improvements. An important factor influencing job satisfaction is leader support, increasing recognition, and a manager's need to evaluate and minimise the adverse effects of shift work on their staff.
- The CN needed to look at the knock-on effects on other health professionals and to be responsible for moving the change process forward.
- Change requires an adaptive organisational culture and it should be implemented with a patient-focused care model.
- Managers should be catalysts and motivators for change.
- Change is often resisted despite the potential positive outcomes.
- The CN combined his talents as a transformational leader (where the leader is a role model who inspires followers and encourages their creativity) and a situational-contingency leader (who showed that he could be an adaptive leader according to the particular situation). He was aware of the importance of communication, negotiation and agreement in order to reduce resistance to change.
- He also needed to know current change management and quality assurance theories.
- Trusting the creativity of individuals contributes to finding solutions, and, therefore, he used the mechanism of questionnaires which were given to all nurses.
- The CN asked for volunteers to carry out a literature review examining the impact of 13.5 hour shifts. This was to inform the planning of rosters based on current evidence-based best practice and to ensure the optimal care of patients.
- I realised that he had no experience of the effects of 13.5-hour shifts on staff nurses and, therefore, he became an 'innovator' by assisting in the literature search
- Nursing needs coverage of shifts on a seamless 24-hour basis, and fatigue, which can negatively affect the quality of nurses' performance, is a feature of any shift work but not enough information exists on the effects of shift work on health care professionals, particularly due to their permanent contact with human suffering and death.
- The effects and challenges of 8-hour 'earlies', 'lates' and rotating night duties, and whether changes in shift patterns are beneficial. Those who work night shifts experience more tiredness and disturbed sleep, a high accident and error rates in staff that worked an early shift after a late shift and concluded that this should be avoided at all costs. The fewest problems and least amount of disruption for individuals were experienced on regular shift systems (for example, five 'earlies' one week followed by two days off; five 'lates' the next week, and never more than five consecutive days together).
- Turning now to 12-hour duty days and less effective performance and fatigue versus more effective performance (an important aspect for the CN to consider)
- The serious implications of ineffective information processing and psychomotor skills performance in shifts lasting over 12.5 hours. The CN was particularly concerned about this aspect of the proposed change the problems of mental and physical tiredness affecting the nurses' overall performance may be compounded by the cumulative effect of working several 12-hour shifts consecutively.
- There are controversies regarding the type of shift that best suits human physiology, and individual differences in work capacity, tolerance, performance and coping strategies.
- Every effort should be made to enhance the well-being and effectiveness of nurses by the effective management of their shift work



- The CN realised that for nurses who preferred long shifts, this was due to having more leisure time.
- However, this needed weighing up against safe practice. Critical care nurses concluded that 12-hour shifts had a positive effect not only on patient care but on their work-life balance.
- Staff should have the choice of whether to work 12 or 8-hour shifts.
- 12-hour shifts held benefits for patients and nurse satisfaction, because nurses follow patient care for longer periods throughout a single day and patients see fewer different faces (thus improving continuity of care).
- Nurses admitted to feeling tired on long days, they felt that this was partly due to factors such as patient dependency, workload, rota and personal reasons.
- It was found that working long, unsociable and predictable hours was found to have a negative impact on health and well-being, due to the effect that it had on individuals' home life. It is essential to achieve a balance between work and home lives in order to enhance job satisfaction and health.
- Although the CN implemented the change for an initial three month period after the consultation process and meetings with the multi-disciplinary team, the change was monitored, evaluated and audited regularly with risk factors addressed. It has proved to be a success and is still implemented after one year
- Managers need to take into account the effect of shift patterns on individuals and meet the needs of the organisation optimally. However, managers who set rosters must become familiar with the latest evidence-based practice and ensure that nurses produce the most effective performance whilst improving their personal wellbeing and health.

### **Story 32**

During my second year placement, I was working a night shift with the triage nurse in the emergency department of a hospital. Our role was to ensure that patient care was managed according to clinical priority as opposed to waiting time. During the shift, a 26-year old Polish man, who I will refer to as John for reasons of confidentiality, presented with pain and redness in his left eye. John was with a friend who had been with him when the accident happened, but both men had difficulty speaking English and was unable to explain the mechanism of injury. Due to this communication barrier, we wrote in John's notes that the injury was possibly caused by acid/liquid and triaged him as high priority. I then took the notes to minor injuries and gave a verbal hand-over to the on-call doctor. I explained that John had possibly splashed acid in his eye, described the care given and outlined the care required. The doctor acted like she was not listening to me, but thanked me for handing over the patient and took the notes. I presumed she had understood what I said and returned to triage.

Around forty minutes later, the doctor came to triage asking why John had not been handed over as high priority because he had splashed hydrochloric acid in his eye. It then became apparent that there had been some serious miscommunication on my part. The doctor thought I said that John had splashed liquid into his eye, which was definitely not acid, so she had placed him in a queue according to waiting time. This delayed John's treatment, but fortunately he sustained no permanent ocular damage.

#### *Story 32 – Learning account*

- By analyzing and understanding their actions, nurses gain new knowledge about their practice.
- I felt out-of-my depth when John presented to us because I had never been involved in the care of an ophthalmic patient.
- Triage system indicated he should be high priority, I thought this was wrong because he did not need the same urgency of care as someone having a cardiac arrest.
- I realised that many nurses are misguided by the apparent health of most ophthalmic patients.
- I felt apprehensive.
- I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship.
- This is a common feeling amongst nursing students as most have had little experience in communicating with professionals outside of nursing.
- I felt nervous about using medical terminology such as 'ophthalmic' because I thought I would sound stupid if I pronounced them wrong.

- When I thought the doctor was not listening to me, I felt disrespected as a member of the care team.
- I felt disappointed in the outcome because I had jeopardised John's sight by giving an ineffective hand-over.
- I find it difficult to look back at the incident without questioning my abilities as a student nurse, but this encourages expression of such negative feelings because this determines why the situation sticks in our mind.
- John was triaged as high priority and this coincides with the Manchester Triage System for acute chemical eye injuries.
- I used short sentences when delivering the report to facilitate effective communication.
- More importantly, John did not sustain any permanent ocular damage.
- The miscommunication between myself and the doctor led to a delay in providing treatment.
- Effective communication is essential in nursing because it ensures continuity of patient care.
- It was important the doctor was told he had possibly splashed acid in his eye because delayed irrigation allows further penetration of the chemical. This could have resulted in John sustaining ocular damage, which would have had profound effects on his visual prognosis, lifestyle and self image, yet most damage caused by acids happens immediately after exposure.
- Lacking confidence in my abilities immediately created tension between the doctor, making communication less effective and myself.
- My behaviour when speaking was typical of a submissive person as I was fiddling with my hands had a nervous smile and spoke in a low pitch.
- This would have contradicted the urgency of my verbal message and could explain why the doctor did not listen
- I am now aware that body language is as crucial a part of communication as speech.
- The doctor interpreted the low pitch of my voice as non-urgent vocalic signals are misinterpreted over 55% of the time.
- Submissive behaviour is typical of an inexperienced student because assertiveness takes practice, nerve and confidence, all of which I was lacking.
- When handing over the patient, the doctor did not maintain eye contact with me.
  - This body language is indicative of someone whose channels of communication are closed, although it could have been the doctor's usual cultural behaviour.
  - She was not listening because she did not attend to the patient straight away, unless you have an established rapport, I had never met the doctor before, this could explain her lack of attention.
  - The doctor not listening contributed to the problem of mis-communication as I presumed she had gauged the urgency of the situation from what I said.
  - I did not wait for her to feed back what she had understood from the hand-over and this is the only way to ensure that correct information has been received.
- Communication skills needed to provide an effective verbal report can often only be gained through observation, practice and experience.
- This explains why I was lacking in my ability to effectively hand over the patient.
- Verbal reports are prone to data loss, but I believed the doctor would consult John's notes if she needed clarification of anything.
  - The notes detailed both care provided and care required and were written in short sentences which should, theoretically, have made the passage easy to understand.
  - I did not show the doctor the written notes and literature.
  - There are no non-verbal cues to suggest urgency with written communication, so this explains why the doctor did not read the notes until sometime later.
  - My submissive behaviour when handing over the patient contradicted the urgency of what I said.
  - Non-verbal messages override verbal ones when they do not match; this explains why the doctor did not listen.
  - The lack of communication was emphasised because I did not clarify from the doctor what she had understood from my report, even though I felt she was not listening.
  - Effective communication ensures continuity of care, the best course of action would have been to wait for feedback from the doctor to ensure correct information had been received.

- If necessary, I could have repeated the hand-over to another nurse to minimise the potential for misunderstandings.
- I do wonder whether it was really a good idea to hand over an urgent case without the support of a registered nurse.
- I am now aware that I need to be more assertive when handing over patients in future and ensure my body language coincides with what I say.
- I will wait for feedback from whoever I am communicating with to ensure I have said what I intended and I will draw attention to any documentation.
- Identified learning needs:
  - Develop confidence in own abilities
  - Become familiar with medical terminology surrounding ophthalmology
  - Gain experience in handing over patients to other members of the care team
  - Become more assertive
  - Develop body language skills

### **Story 33**

The patient had been a senior Theatre Sister and was now a Complementary Medicine Practitioner. She was well aware of the common morbidities that accompany obesity, such as hypertension, type 2 diabetes mellitus, stroke, coronary heart disease, gallbladder disease, hypercholesterolemia, osteoarthritis, respiratory problems and several cancers and wished to alleviate these as far as she could. Whilst her daily physical activity has declined significantly, caloric consumption has increased steadily.

Bariatric surgery is just one of the treatments that can offer hope for obese patients and is not the only panacea. The patient had an elective Laparoscopic Gastric Sleeve Resection due to obesity. She weighed 161 kg and had a Body Mass Index of 61.

#### *Story 33 – Learning account*

- What I was feeling and what made me feel that way (aesthetics)
- This was my final year and the staff nurse informed the multi-disciplinary team that I was managing the care of four particular patients.
- This managerial duty made me nervous because the consultants, doctors, physiotherapist, occupational therapist and dietician came to me regarding the management of those patients.
- I had to prioritise their care, deal with input from various sources and to document everything.
- Obese patients are at high risk of wound dehiscence and slow wound healing because of poor blood supply to adipose tissue.
- I had to deal with the practical and physical problems caring for this patient, in particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin
- I did my best to make the patient comfortable and I connected with her. She told me that she knew her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear.
- I believe that I responded to this situation effectively by ensuring that the bed was elevated 30-45 degrees in order to decrease abdominal pressure on the diaphragm and to maximise tidal volume.
- I assessed her vital signs and pain levels regularly and I used an appropriately sized blood pressure cuff in order to prevent false high readings. The knowledge that informed my decision was my need to be aware of the possibility of gastrointestinal haemorrhage, wound infection, pneumonia, pulmonary embolus (because she could not wear TED stockings) and prolonged nausea or vomiting.
- Time management point of view, this patient needed a great deal of care and her size made it very difficult
- She had an indwelling catheter, a nasal gastric tube, patient controlled analgesia (PCA), a Robinson drain, and she was on intravenous fluids and antibiotics.
- She had clips, her dressings needed attention, and she needed to start a clear liquid diet.
- By managing the care of this patient I realised that nurses are in a unique position to educate, care for, support and guide patients through major life-style changes.

- I gained experience in delegating duties to healthcare assistants, student nurses, and to ask for assistance from staff nurses when necessary. Regarding what others were feeling and why, the patient realised that her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear.
- Initially, I washed the patient on her bed.
- The main problem was moving her from her bed to the chair (neither of which were of the correct size).
- The first practical step I took was to order an appropriate chair and bed.
- The patient was able to use a zimmer frame to walk into the bathroom to clean her teeth, and I was able to attend to the washing of her back and legs. I needed to ensure that her legs were dried completely and moisturised, in order to reduce cracks in the skin and to prevent the formation of lesions.
- Evaluation should also be the central part of a dynamic process of reflective learning and critical thinking.
- Initially, I was nervous because I had no experience of managing my own patients.
- I was pleased that the patient felt more comfortable due to my care.
- Experience comes from external factors such as actually managing and taking responsibility for the care of patients.
- The doctor asked me to administer methyl-thioninium chloride to ensure that there was no leakage in the gastric sleeve.
- After one hour, I was responsible for removing the patient's nasal gastric tube, Robinson drain (my first experience of removing a stitch) and catheter.
- The doctor also instructed me to discontinue the PCA, intravenous fluids and antibiotics (the staff nurse did these for me).
- She was supportive and encouraging and allowed me to learn through supervised practical experience.
- She later told me that she felt confident of leaving me in charge.
- The choices I made were the correct ones in relation to the effectiveness of my delivery and management of nursing care.
- I believe that I gave managerial and personal support, guidance and after-care to this vulnerable patient in a respectful therapeutic relationship.
- I was 'available' and concerned for her care.
- The nurse-patient relationship is central to nursing and to nurses feeling fulfilled in their caring role.
- I was initially concerned about my lack of managerial experience.
- I tried to look at the situation through the patient's perspective and from the view that I shall soon be a staff nurse.
- I was able to support the patient by providing psychosocial needs and a supportive, encouraging and respectful therapeutic environment.
- Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind
- The multi-disciplinary team members were encouraging and appeared to perceive me as a good manager and a caring member of the team.
- I encouraged the patient to exercise gently, discussed her nutritional regime with her, and made her aware of psychological adjustments.
- This experience has been beneficial in terms of developing and increasing my self-awareness regarding managerial care.
- In particular *helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection.*
- One needs to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve lifelong learning.

### **Story 34**

On this particular day, I admitted a patient into my bay who had been transferred from the accident and emergency department (A+E) with a low heart rate (bradycardia). I received a handover from the A+E staff nurse, whilst being supervised by my mentor. It was brought to my attention that this patient had a pre-existing diagnosis of ovarian cancer and had undergone two cycles of chemotherapy. As a result of her bradycardia, she was connected to a cardiac monitor.

I was given a handover from the A+E staff nurse and the main details presented to me were that this patient had a slow pulse rate (bradycardia) with a current rate of 47 beats per minute (bpm). It was noted that she was awaiting assessment by the medical team. The outcome of this review was to refer my patient to the cardiology team and I was told that they would assess my patient as soon as possible. The patient had no relevant past medical history of heart problems. I took her vital signs. The tympanic thermometer measured her temperature at 36 degrees C, a manual blood pressure reading revealed 110 systolic with the diastolic at 68 and in addition, the respiration rate was at 14. My patient's pulse rate was 48 beats per minute, which suggested that she was still bradycardic. Regular ECGs were taken.

Throughout my shift, I closely monitored my patient and took hourly observations. At approximately 1400 hours, whilst I was taking my patient's blood pressure, another patient asked me for a commode. As I was busy, I quietly asked a nearby health care assistant if she could get a commode for my other patient.

I noticed that my patient's pulse rate had fallen to 43 beats per minute, as a result of this, I informed my mentor and contacted the cardiology team. They promptly arrived to the unit and following their assessment, they asked me to arrange for a transfer to the cardiac care unit. With the supervision of my mentor, I informed the bed manager to inform him of the need for transfer. I transferred my patient to the cardiology care unit as soon as a bed became available.

#### *Story 34 – Learning account*

- Initially, my feelings were of concern for my patient as she had become clinically unstable.
- My main objective was to try and reassure my patient with the intention of keeping her relaxed as not to increase oxygen demand as that bradycardia results in a diminished oxygen supply to the body and therefore I did not want to place any further pressure onto her heart.
- Patients presenting with bradycardia should be closely monitored for signs of deterioration and the nurse should inform the patient to report if they feel dizzy or have episodes of fatigue.
- My patient did report episodes of tiredness and fatigue which is believed to be a common side effect of chemotherapy.
- To differentiate between tiredness due to bradycardia and tiredness as a result of chemotherapy could prove difficult. Moreover, a further reduction in pulse rate determines a worsening bradycardia and therefore prompt action is required.
- Contact the cardiology team was the correct decision to make.
- *My prompt action resulted in my patient being transferred to the specialist cardiology unit*
- Exercise is believed to be an effective method of combating fatigue in cancer patients.
- My patient had also presented with bradycardia and therefore, exercise in this instance is contradicted due to not wanting to place further strain on her heart.
- By keeping my patient still and relaxed, there is an increased risk of developing a deep vein thrombosis and therefore in order to minimise this risk, anti embolism stockings were used.
- The need to prioritise my patient's care was of paramount importance nursing priorities change throughout the day as new events occur.
- Offering her support and reassurance by utilising the interpersonal skills I had mastered during my training
- When another patient asked me for a commode, I delegated the task to a health care assistant.
- This delegation of duty was not meant to offload work, but was done out of necessity in order to effectively manage my time and also to ensure that the task got done.
- When tasks are not prioritised or delegated, then duties that require urgent attention can get forgotten.
- I felt nervous about requesting the help, but I now realise that it was necessary as it is impossible to accomplish all tasks by myself.

- It is acknowledged when a registered nurse delegates tasks, the accountability remains with the nurse.
- Effectiveness of my care delivery was adequate still needs improvement.
- My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading.
- An underlying heart condition is also a known causative factor.
- It is highlighted with the National Service Framework (NSF) for coronary heart disease that maintaining heart health is important in the prevention of this disease and therefore in the wider social context, advising patients on the benefits of a healthy balanced diet is vital within the realms of health promotion.
- This experience has had a huge effect on my own management skills. Time management and prioritisation are essential skills within nursing for successful, efficient and effective patient care.
- Decision making is also an essential skill within nursing during the course of a day, many decisions are expected of a nurse and almost all of these centred on patient care.
- It is a difficult task in caring for a patient being family friendly and working well with colleagues.
- Clinical judgement skills for the newly qualified nurse are difficult as accurate decision making skills are derived from experience.
- Effective communication and documentation within nursing are vital and it is suggested the ability to communicate effectively is the most important area that requires expertise in order to manage patient care efficiently.
- Previous clinical experiences have encouraged me to improve on my communication skills.
- The decision to contact the cardiology team was the correct decision as my prompt action resulted in my patient being transferred to the specialist cardiology unit.
- My nursing management skills require development for my future nursing practice and these include my time management, delegation and prioritisation skills, and therefore my action plan is to address these issues.
- Provided a critical analysis of my care delivery for a patient whilst I was on clinical placement in an assessment unit within a local NHS trust.
- I have identified areas of my own nursing practice that require attention.
- Considered the areas of health promotion not only for my patient, but also for patients in the wider social context.

### **Story 35**

Whilst on my first placement with the Accident and Emergency (A&E) department of a local general hospital I was given the responsibility of managing the care and delivery for a small group of patients who were admitted onto my section. One patient was a 43 year old lady who was brought in by ambulance with respiratory failure, due to excessive alcohol consumption. In addition, the ambulance crew advised that there was the possibility that she had taken an unspecified amount of medication which had been prescribed in relation to her sleeping problems.

The resuscitation team were called immediately, and under their supervision, together with that of the casualty registrar, she was treated and given fluids and medication to stabilise her condition. There were a number of healthcare professionals involved in this process, and although at first the situation appeared daunting, I was able to effectively demonstrate my inter-professional skills by the monitoring, recording and relaying of her observations, which were conducted every 2 minutes.

Once she was medically stable, and before she was admitted to the Medical Assessment Unit (MAU) I was given the responsibility of ensuring that she was made comfortable, as well as offering her support and reassurance by utilising the interpersonal skills I had mastered during my training.

It transpired that she was well known to A&E, with a history of alcohol abuse. During the short time she was in the department I was able to build such a rapport with this lady that she was able to confide in me many of the issues that impacted on her life

and contributed to this incident. She was an accomplished artist and a single mother, coping with a young teenage daughter, who herself had social problems and she came from an unsupportive family. When ready I was able to accompany her onto the MAU and assist in the handover of her details to the staff there. Later I had the opportunity of discussing the situation with the staff nurse working with me and then reflecting on that day's events.

#### *Story 35 – Learning account*

- It must be remembered that reflective frameworks can actually restrict the deeper exploration of practice, and suppress creativity and thinking, especially if the nurse is a novice, or is faced with incidents which exceed the scope of the questions posed within the framework.
- It is debated whether dominant cultural practices within a hospital choose to discourage reflective learning, considering it of limited value to the nurse who they believe has restricted power within the organisation.
- When I returned from lunch Sarah had already been taken to resuscitation and was surrounded by a team of healthcare professionals, each with their individual roles in treating her condition. She had been attached to a monitor, and I was asked to regularly record her observations, and relay this information to the team when required. When her condition stabilised, and before transferring her to the medical assessment unit, I intermittently chatted to Sarah about the circumstances surrounding the day's events, whilst providing routine nursing care to other patients within the department.
- Students are taught the importance of establishing a caring relationship with the patient, the involvement of active listening and the need to respond with genuineness and empathy to promote trust and rapport.
- Many nurses still fall short of this basic skill, even though it is well within the responsibility and control of their profession.
- Initially I had mixed feelings when asked to assist in Sarah's care. This being my second day in that department, I was unfamiliar with its staff and procedures. I was excited, but also apprehensive about the task, not because it was outside of my experience, but because of the environment in which it was being performed.
- I was daunted by how busy it was and although team members performed their tasks calmly, it was extremely noisy.
- I was also aware that the team could have preconceived opinions of me as a student nurse, especially if they had encountered problems in the past. There is always a feeling that you need to prove yourself when starting a new placement, which is greatest when a third year.
- I truly wanted to feel part of that team by not letting them down on the tasks I had been asked to perform.
- Following the incident, a member of the resuscitation team asked if I had any questions, and I later had a de-briefing session with the ward manager, who had been overseeing events. He was pleased with my professional approach and said I looked calm and 'in control', even though he knew I was nervous. These comments boosted my confidence and confirmed my sense of belonging to the team on that day.
- I felt more confident and comfortable when talking to Sarah prior to her transfer, as having researched the issue of alcohol and its effects on society for a health promotion presentation, I had specific knowledge to impart to her during our conversation.
- This incident posed a greater challenge by extending my clinical practice beyond its normal confines, contributing to my continued learning, a prerequisite for the provision of professional nursing.
- This situation availed me with valuable experience in the form of development of my inter-personal and inter-professional skills, in building an open and trusting relationship with Sarah, and my effective collaboration among the team.
- Seen as an extension of my health promotion presentation, it enabled me to put theory into practice, directed at a patient in need of my assistance. Helping Sarah identify her excessive alcohol consumption was a contributing factor to the day's events, I hoped in part I had motivated her to reduce her intake, consider seeking advice, and eat at least one good meal a day.

- Throughout, I was able to demonstrate my prioritisation, time-management and delegation skills, thus ensuring the delivery of care was appropriate and effective, being the right of every patient in my charge.
- I lacked experience relating to the advanced nursing practice conducted within that specialist area. This impacted on my decision-making skills and made me doubt my own ability, even though the tasks were well within my clinical experience. Indeed, engaging in reflection can in fact lead to self-doubt. Initially this made me question the importance of my role, considering the contributions made by other team members to be more significant than mine.
- During discussions with my mentor and the ward manager, I realised the importance of teamwork and shared vision, essential for the smooth running of the department and contributing to patient care.
- This incident demonstrated the merits of collaborative practice, which is especially important within an environment influenced by time limits and targets.
- The team, including myself, were supporting, motivating and encouraging each other throughout by positive feedback and the sharing of information, and this was made possible by our enhanced communication skills.
- This facilitates individual self-worth and value which are central needs in the workplace.
- I now recognise that individual strengths can be utilised to complement other team members' weaknesses, further demonstrating transformational characteristics of self-confidence, delegation and prioritisation.
- The drinking of alcohol in the United Kingdom has escalated over the past decade, most significantly among women. It is not surprising that alcohol is considered a major source of current health and social problems, impacting greatly on increasingly stretched healthcare resources.
- This experience further reinforced the need for effective health promotion in this area, and demonstrates a nurse's unique place in delivering such information.
- This highlighted the involvement of my clinical judgement when determining how the initiative was to be conducted, based on knowledge gained from the patient, her perceived needs and the environment.
- The talks I performed on the day were carried out to the complete satisfaction of my mentor and to the best of my ability and in hindsight; I should not have doubted my ability so readily.
- Nurses often base their decisions on experience and intuition, in addition to evidence-based practice. I am sure these additional dimensions enhance outcome and are beneficial to the patient.
- My decision-making skills in particular and the ability to think on my feet are still evolving and will continue to improve with further experience.
- The incident has developed to some degree my creative problem solving skills, allowing me to transfer those new skills to similar situations, and expanded my clinical abilities to enhance the quality of care I deliver to future patients.
- In similar situations I should no longer doubt my ability, but consider the aspects of my nursing abilities and complement those tasks performed by my colleagues.
- I have discovered a greater awareness of my current nursing skills and highlighted those which need development.
- I can further expand my knowledge and skills base, which are seen as a prerequisite to fulfilling my forthcoming role as an effective staff nurse.

### **Story 36**

The focus of this story is the management of care for a patient, covered over a day shift. This was a long-term patient that was admitted to the Intensive Therapy Unit (ITU) in my 3<sup>rd</sup> year and I was assigned the care of a patient that had been on the ward for twenty eight days. The patient was now stable enough to be nursed as a level 2 High Dependency Unit (HDU) bed. The patient in question was a fifty five year old woman that was admitted due to community-acquired pneumonia, but also had a past medical history of Systemic Lupus Erythematosus (SLE) and Primary Sjogren's Syndrome (SJS). Whilst the patient's respiratory condition had improved, the patient had developed critical illness polyomyopathy.

I began the shift with a hand over from the night staff, who asked me if I had cared for this patient before, I replied that I had not, and added that I didn't have any experience of caring



for a patient with this condition. The nurse told me that she would just update me on the changes, and the staff nurse that I was working with would explain because they had previously worked with the patient.

Once the hand over was over and I was left alone, I mentally took a step back and realised that the patient had many aspects of care that needed to be considered. Just from looking at the patient, I could see that the patient had a CVP, and central line insitu, she was fed via a Nasal gastric (NG) tube, the patient was diabetic with a syringe driver of actrapid running, and was being given regular nebulisers to help her breathing. The night nurse handed over that the patient had suffered diarrhoea which had led to her opening her bowels on several occasions. It was also handed over that the patient needed to be regularly turned because the polymyopathy had caused the patient to develop grade 2 pressure ulcers which unless regularly monitored, would worsen. After reading notes, I realised that the patient had many medications needing to be administered several times via the NG tube, had hourly monitoring for vital signs and fluid balance. To compound difficulties the polymyopathy had left the patient with speech difficulties, which made communication difficult.

I began to work through the daily routine of safety checks and hourly monitoring, when the medical team's ward round began, followed by physiotherapy that I was asked to assist with. Following this, the patient opened her bowels, unfortunately I was alone, and therefore needed assistance in cleaning the patient, however, the nurse that I was working with was busy with another patient that he was assigned to. After 10 minutes I found another nurse to assist me with washing, changing sheets, applying cavalon cream and turning the patient. I then realised that it was approaching 10am and medications needed to be given, but again the nurse assigned to work with me was busy, therefore I needed to wait. Returning to the patient I found out that the patient's catheter bag needed emptying, and I had missed recording two hours of observations, which I quickly completed. I then noticed that the patient had a very dry mouth and damaged lips that needed mouth care. Eventually the nurse assigned to me arrived and quickly supervised the drug round for the patient, then promptly went back to caring for her other patient, As soon as she had gone, the patient once more opened her bowels.

Throughout the shift, this process of needing to seek help with various elements of patient care continued which subsequently caused me to miss completing observations, and documentation.

I was trying to take care of the patient alone, without the help from others, which is difficult for a qualified staff nurse, let alone a student who does not have autonomy in patient care. The reason that I was attempting to care for the patient without help, was to prove to myself and other staff that I was capable of patient care without supervision.

#### *Story 36 – Learning account*

- When I consider my interventions in retrospect, I can see that the majority of my actions were reactive rather than proactive, and little if any planning was given in the patient's care. By not having a firm understanding of the patient's condition and her needs I feel that I could not judge effectively the order of prioritisation. By not planning and sharing my workload, the patient's care suffered, and many tasks took longer to achieve than normal.
- Rather than feeling empowered by successfully taking charge of patient care, I actually felt constantly worried, and nervous about how much I had to do.
- This also affected other members of staff, because they were asked to help me regularly and with little warning, which would not have happened if my actions had been better planned.
- I know that the patient was glad that I was trying to get as much done for her as possible, however, I think that the stress that I felt was probably sensed by the patient and may have exacerbated the helplessness that she felt from her lack of control, this was evident by her nervous expression, as the shift progressed.
- I have always found organisation difficult, and because of this, I try to over compensate for my difficulties by rigidly sticking to activities at set times. This inevitably leads to difficulties when my routine becomes altered, because I then become flustered and lose confidence in what I am doing.

- I am also aware, that this is my final placement before graduating, so I try to achieve as much patient care as possible without others intervening, as I know that this is what will be expected from me within a few months.
- I also felt nervous about the care of this patient because I didn't have a grasp of part of the patient's condition during the shift.
- Not receiving an adequate handover from the nurse, because without the complete information on the care given over the previous shift, I was forced to check care documentation which slowed my own planning down.
- I was left alone whilst the staff nurse working with me cared for another patient. This was made worse by working in an isolated part of the ward, in which other members of staff rarely passed.
- Several aspects of care for the patient, such as manual handling, giving medication, and administering fluids involves a need for a nurse to be with me, and became time consuming because staff were frequently busy elsewhere.
- I could have dealt with the above situations differently, resulting in better patient outcome.
- My initial problem of inadequate information during my handover, could have been dealt with if I had been more assertive with the night nurse. By explaining that I needed further information, I would not have needed to spend valuable time hunting for patient care information.
- Would also have helped if I had called others to assist me, for example clustering actions, such as rolling the patient, giving medications and checking the patient continence all at one time, is preferable to calling for assistance three separate times.
- Better organisation of my actions would allow me to give the other nurses adequate warning that I needed assistance.
- I now also realised, that as a student it is important to communicate with the nurse assigned to work with me when I find it difficult to cope with the workload.
- By regularly using a structured approach to patient care my nursing practice should begin to improve.
- Integrating a form of structured rapid assessment, to my daily checks such as 'know, see find' or 'look listen', can help me to quickly assess basic patient needs.
- Assessments such as these fit in well to the nursing process model, which when used in conjunction can provide a useful tool in critical thinking.
- After researching the disease processes, I now have a better understanding of the priorities for this type of patient care.
- I should communicate when I don't feel able to cope with the level of care that has been assigned to me, because ultimately patient care should be of primary importance to all health care professionals.
- Patients with conditions that are not understood by myself will continue to be a part of the experience of being a nurse. I am now trying to see each experience as learning opportunity, rather than a barrier to patient care.
- I believe that this experience has given me a practical insight into the need for good interpersonal communication, planning and organisation. The effective nurse needs to utilise all these skills for good patient care to be achieved.

### **Story 37**

The patient involved is an 85-year old lady with left buttock pain and lumbar stenosis. When I first nursed Wendy, she was reluctant to leave her bed, and although had good physiotherapy input, lacked confidence in walking. The pain in her left buttock exacerbated the situation. Wendy felt hesitant to move from lying fairly immobile on her back (defined as a "comfortable position") to either side ("painful positions"). The pain in her buttock had also led to a loss of appetite.

The health improvements for the patient at this stage were to encourage mobility and to ensure maximised independence and improve food and fluid intake. I introduced myself and talked to her to find out why she was upset. She said she felt like she had been in hospital forever, and would never get out. She felt like she could do nothing for herself and resented people coming in and forcing her to do things, even when she was so tired. I thought about what she was saying and realised that some of these problems could be handled by a change in her care.

Over the shift, working with my mentor we spoke briefly to the physiotherapist and worked out how Wendy could benefit from altering the times of therapy and being exhausted by everything being done in the morning, as by 10 a.m. she had had a bath, breakfast, physiotherapy and walked to the toilet and stairs, a doctor visit. This was all too overwhelming for her. So her schedule was changed and some of these activities were moved to the afternoon.'

Over the shift, I encouraged Wendy to leave her bed with minimal assistance, practicing the safe transfer in and out of bed. I also encouraged Wendy to transfer to and from the lavatory with a stick. Encouraging Wendy to sit in her chair also enabled her to feel more inclined to eat and drink.

Through the practice of such 'basic' nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, mobilised to and back from the bathroom, improved her confidence in walking with a stick, and had regained some of her appetite. I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of a patient for a whole shift. Upon reflection, from the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice.

#### *Story 37 – Learning account*

- A brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided to my patient, over a whole shift.
- I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients.
- The situation encompasses how I used the nurse-patient therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist. The patient will be named 'Wendy' to ensure that confidentiality is maintained.
- When I first nursed Wendy, she was reluctant to leave her bed and lacked confidence in transferring from bed to chair. Wendy felt hesitant to move from lying fairly immobile on her back (a 'comfortable' position) to either side ('painful positions'). The pain in her buttock exasperated her loss of appetite; pain can reduce a patient's desire to eat.
- During the shift, I noticed that a physiotherapist (physio) had entered Wendy's room. I was aware of the physio session, but had not connected this with my nursing care. It then occurred to me that such input might also be useful to encouraging Wendy out of bed and to eat properly.
- I am aware of the importance of team-working. I am also aware of tendency, of healthcare professionals to remain within the safety of their own specialist area.
- It is critically important for Wendy to increase her mobility and sit up to eat.
- Along with mobility, a nutritionally sound diet will play an essential component in improving and maintaining Wendy's recovery.
- I am pleased that I worked closely with the physiotherapist to encourage Wendy to get out of bed and transfer safely to the chair.
- I am also pleased that I adequately communicated to the physio that I wanted to work with her to see how she assisted Wendy in safe mobility.
- In this respect, good communication is fundamental to good nursing practice.
- Over the shift, through the practice nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, transferring to and from bed safely, improved her confidence in mobilising and had regained some of her appetite.
- I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of the patient for the shift.
- The nurse-patient relationship is a privileged relationship, based upon trust, empathy and a rapport with the patient.
- I feel that I should, as a matter of course, use other healthcare professionals to enhance quality of care.
- I see that my management of the patient, until the physiotherapy session, had concentrated upon nursing issues such as adequate analgesia, bowel output and recording vital observations.
- Managing the care of my patient is more than just providing a range of nursing duties; it is to provide a complete package of holistic care.
- I did not want to interfere with the physiotherapy session and that if I asked, feared that the request would be rejected but the physiotherapist was pleased to assist.

- It would appear that to provide effective care, a nurse should co-operate with others within a team (including the patient).
- I consider that the situation went very well and I am pleased with the outcome. I also feel pleased that, towards the end of my shift, Wendy safely transferred back to her bed.
- I communicated Wendy's successful mobility status at handover and it was duly noted.
- I realise that in future I must use other healthcare professionals to better effect.
- It would appear that the use of physiotherapy input could be used to better effect by the nursing profession as a whole. It could also be the case that Wendy might not want to move out of her bed. In this regard there is both an ethical and moral obligation on nurses to ensure that they gain consent for all decisions involving treatment, ensuring that the principle of patient autonomy is respected.
- Wendy's situation has demonstrated to me the importance of team-working in providing enhanced care.
- I have been able to assess how I feel about my nursing delivery and management of care for a patient over a whole shift.
- I have found that I can adequately manage the nursing care of a patient. However, I have determined that I need to improve upon my team-working skills, to ensure the quality and effectiveness of care.
- I now view team-working as more than just a theoretical concept that should be applied to nursing practice; rather it is an essential nursing skill that can lead to enhanced quality of care.
- Whenever I encounter a similar situation to Wendy's, I can use practice enforced by theory to improve my relationship with physiotherapists and other healthcare workers, using their skills and abilities to increase patient care. I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing.
- I have learnt about myself and my nursing practice. I found that a brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided for Wendy. I now understand that team-working really can make all the difference.

### **Story 38**

While on placement in a surgical High Dependency Unit (HDU) I was given responsibility for the care of a male patient for an entire shift. My mentor allowed me to plan the patient's care, and was available for advice and assistance and to perform those tasks which I was unqualified to carry out myself (such as administering intravenous medication).

The patient had been admitted into hospital for surgery to repair a ruptured abdominal aortic aneurysm. Due to complications following surgery, the patient had remained in the Intensive Care Unit for two months and had been receiving respiratory support. A temporary tracheostomy was in place to assist breathing. On transfer to HDU the patient was receiving BiPAP (bilevel positive airway pressure) ventilation via the tracheostomy, the plan for this patient was to slowly wean him of BiPAP, and eventually remove the tracheostomy tube. The patient was able to self-ventilate via a tracheostomy mask, with 5 litres of oxygen.

During the shift, the patient was constantly monitored with any changes in respiration and cardiac function. Nursing care in the HDU is based on the Mead model, and using this model I also monitored renal, neurological, pain, nutrition, elimination, psychological and social aspects of the patient's care. Observations were taken and recorded hourly throughout the shift. In addition, I attempted to use my nursing knowledge and skills in order to care for the patient. I was aware of the need to react quickly to changes in the patient's condition. I tried to be proactive, to anticipate potential problems and act in a way which would avoid these problems arising.

One area of safe practice was that of caring for the tracheostomy. This included: maintaining an adequate airway through suctioning and encouraging the patient to cough up secretions, positioning the patient correctly, knowing how to re-establish an airway if necessary, checking that equipment was available and working, and interpreting data to assess the patient's condition.

The patient asked if he could wash and change his gown and I agreed to assist him. Because I wanted to encourage his independence, I prepared the washing items for him and allowed him to wash himself. My attention was distracted and I failed to notice that he had

removed his oximeter finger probe and had accidentally moved his oxygen mask so that he was no longer receiving the full amount of oxygen supplied. When I turned to my patient, I saw that he was struggling to breathe. I immediately repositioned the mask and re-attached the finger probe. I explained to the patient how important it is to maintain a good oxygen supply, and indicated the monitor which showed his saturated oxygen levels had fallen to an unsafe level.

*Story 38 – Learning account*

- The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it.
- Due to complications the patient had remained in the Intensive Care Unit for two months.
- I was able to analyse my clinical practice, this related to the development of a therapeutic nurse-patient relationship and the feelings of guilt I experienced for not giving the patient the level of care I felt he needed.
- Patient-centred care has become a priority in the National Health Service (NHS) and is considered a necessary element of care in the NHS Trust where I work.
- There is evidence that patient-centred care has positive outcomes for patients and their families and patients often value a high level of competency and skill in nurses, and also a relationship in which they can share their emotions and expectations with a trusted partner in care.
- This highlights the challenge for nurses to be sensitive to the dynamic and rapidly changing needs of all patients.
- I felt conflict between the person-centred care I wished to provide and the restrictions of operating within the contemporary health system.
- The demands of every day nursing can often prevent individualised care at a time when a person is most at risk of losing their independence.
- During the time that I cared for this patient, we developed a trusting professional relationship.
- My understanding of the patient came from knowledge of his symptoms and how he coped with them.
- I attempted to use my knowledge to support the patient in his rehabilitation. Even though my relationship with him was short term, I considered it 'therapeutic' based on commitment and trust.
- He trusted my abilities and judgement, and welcomed me warmly at the beginning of each shift.
- Although our relationship was purely professional, I felt a personal responsibility for neglecting him.
- Feelings of guilt I experienced for not giving the patient the level of care I felt he needed
- I felt I had failed to uphold the level of care which he had come to expect from me, and this led to feelings of guilt.
- Early recognition of potential and actual deterioration in a patient's condition is essential, and should be accompanied by an appropriate response for early intervention.
- HDU nurses must be able to make decisions quickly and accurately, based on their nursing knowledge and patient cues.
- When action is based on desirable practice, it has the potential to empower both the practitioner and the patient.
- Working with others, including physiotherapists, speech and language therapists, pharmacists and doctors, the patient's nurses had developed a plan of care which would enable the patient to be weaned off BiPAP therapy and have his tracheostomy removed.
- To ensure that these goals were achieved, it was important to monitor his respiratory system and note the ease with which he was able to perform the activities of daily living.
- As his nurse, my responsibilities included close monitoring of the patient's condition, on this occasion I allowed my attention to be diverted, my reactions had been quick and effective. Fortunately, no long term damage had been incurred.
- My feelings of guilt were due in part to the realisation that I had not provided the patient with sufficient information about his own care.
- Learned to share my emotions and expectations in care, to be sensitive to the dynamic and rapidly changing needs of all patients and helped clarify and resolve my original feelings of guilt and doubt.
- Through health education and health promotion patients are empowered to make informed choices about their own well being.

- Part of my responsibility to my patient was to educate him on his condition and how best to promote his rehabilitation. This included the need for continuous monitoring and the importance of maintaining an adequate supply of oxygen.
- After I had explained this to the patient, he understood the need for keeping his oxygen mask in place, and apologised for causing alarm.
- The Nursing and Midwifery Council (NMC) recognises that nurses' practice is a constantly changing environment, with new advances in treatment and care, reorganisation and redirection of resources.
- Nurses are required to develop professional knowledge and competence to meet these demands and the complexities of modern professional practice through lifelong learning.
- This demands an enquiring approach to nursing practice.

### Story 39

Whilst on placement I was engaged in providing care under the direction supervision of a registered nurse to a group of post-surgery patients. While the nurse I was working with had gone for her break I found that the heart rate of one of the patients had developed into a cardiac arrhythmia characterised by a rapid but irregular pulse, the patient's pulse had increased from within the normal range of 60 to 100 to over one hundred pulses per minute. I reported this to a registered nurse who believed that the patient was suffering from dehydration and recommended that I advise the patient to drink more and continue to monitor them. I did this and continued to care for the other patients.

The patient's heart rate did not improve and so I sought further advice on how to handle the situation. I was then advised that the patient's heart rate could be the result of pain as the patient had complained of pain subsequent to developing the cardiac arrhythmia. I continued to monitor the patient's vital signs but was still concerned regarding the irregularity, *a previous placement on a cardiac care unit had given me some understanding of cardiac rhythms and I was concerned that this symptom could have stemmed from electrolyte imbalances and was entirely treatable.*

At this point the nurse I was working with returned from her break and I voiced my concerns to her, she asked me what I thought would be the appropriate course of action. I wanted to take an ECG and blood sample to attempt to locate the source of the arrhythmia, the nurse said that would be fine, but first we should inform the doctor. When we did the doctor asked us to take the ECG and proceeded to take blood samples and interview the patient. The ECG suggested that the patient was in atrial fibrillation and so the patient was given medications and potassium to help monitor them closer than the ward they were currently on.

### Story 39 – Learning account

- I recall being quite concerned about my observations, previous experience had taught me to be wary of cardiac arrhythmias and the irregular pulse I had observed coupled with the patient's report that the episode started with a painful sensation made me especially wary. Every time I monitored the patient's pulse I also made sure I palpated it manually and did not just rely on the electronic equipment, by physically palpating the patient's pulse I could also feel the strength of each pulse and thus was aware that it was not only irregularly irregular, but also varied in strength.
- When the doctor was consulted I felt relieved and even a little proud that the first tasks he asked us to perform were the tasks I wanted to perform as well.
- I had mentioned to the nurse I was working with that I felt that I might be over reacting but that I wanted to take an ECG and blood samples in order to rule out electrolyte imbalances.
- I feel that the patient was eventually given medications in order to stabilise his heart rhythm as well as subsequently being transferred to a cardiac ward demonstrated that I wasn't over reacting and that I had performed my duties well.
- I also felt that I had prioritised my care correctly.
- I had given a lot more attention to the patient who had developed the cardiac arrhythmia than I had to the other patients on the ward who I was caring for.
- While I didn't neglect the other patients and still made sure that their vital signs were also monitored I paid extra attention to the patient with the rapid, irregular heart rate.
- The first two times I raised my concerns I was given a different but simple and logical explanation for the arrhythmia, instead of ignoring my own feelings about this situation I

persisted with voicing my concerns and this led to the patient receiving the appropriate treatment.

- The patient was experiencing the cardiac arrhythmia for over one hour before it was reported to a doctor.
- While communicating with the patient I maintained a professional but friendly relationship and did not allow my concerns to panic the patient.
- I continued to provide care to the other patients that were allocated to myself and the registered nurse and did not allow the situation to impact upon the quality of the care I was providing.
- In the case of the described incident part of the decision to report the cardiac arrhythmia was based on knowledge, a previous placement on a cardiac care unit led me to read about cardiac care and provided me with a deeper insight into arrhythmias than I had previously attained. It was the application of this knowledge that led me to suspect that there was something more than just dehydration or pain causing the patient's rapid, irregular heart beat.
- I have been very fortunate to have been given placements both on a cardiac care unit and on an intensive care unit. Both of these placements gave me experience of interpreting cardiac rhythms and made me aware that a patient can experience an arrhythmia without it causing continual pain or other acute symptoms.
- The quality of decisions as measured by the rate of error reduces when the nurse is under stress or is in a stressful environment. Thankfully the environment I was in was both supportive and stress free.
- The nurse-physician relationship is one of collaboration when applied to clinical decision making. In this case the nursing staff, consisting of myself and the registered nurse I was working with, had already reached the decision that the patient's cardiac rhythm required further investigations, this was collaborated by the doctor upon consultation when they requested an ECG and took blood samples for analysis.
- The nurse always has a multifaceted role to play when delivering care, in the situation described, the role I held was one of assessment, patient reassurance, patient education and liaison with other professionals and the patient's relatives. It was due to my assessment that sought the treatment of the patient.
- By maintaining my careful monitoring of the patient and acting in a relaxed professional manner I avoided alarming the patient and as such the patient remained calm and reassured that everything that could be done to rectify the situation was being done.
- The patient realised that something out of the ordinary was occurring and had questions that he wanted answers for, due to my previous experiences and knowledge I was able to provide him with answers and if I was unable to answer his question I was able to locate someone who could.
- By remaining calm and acting professionally my role as liaison, both to other professionals and to the patient's relatives, was a productive and informative one.
- It took over one hour before I raised my concerns with a doctor, this was in part due to the simple explanations for the cardiac arrhythmia presented by the other nurses working on the ward and the fact that the patient was in no discomfort other than the sensation of "butterflies" in their chest, while both dehydration and pain can cause tachycardia, they do not also produce an irregular heartbeat. If I had been more persistent in stressing the importance of the irregular heart beat the doctor may have been consulted sooner and the patient's condition treated quicker.
- Assertiveness is a positive quality for a nurse to exhibit and I believe that a barrier to assertiveness is perceived lack of experience and knowledge.
- In the case being examined here I rapidly accepted the alternative explanation as it was being put forward by a nurse who has greater experience and a greater knowledge base upon which to draw.
- While this is true I should not have overlooked the fact that I too have a knowledge base and experience upon which to draw on.

#### **Story 40**

During the first week of my clinical placement in theatre, I was placed at the recovery room to experience the care of patients post-operatively. On my third day my mentor asked me to look after a patient and deliver all care necessary with indirect supervision. The Anaesthetist and the Operating Department Practitioner (ODP) brought Mrs Smith a 71 year old woman who had had a left total knee replacement into the recovery room and handed the patient over

to me. I stood at the head of the bed to have a clear view of the patient, observing the patient's breathing pattern, chest movement and vital signs. As soon as Mrs Smith had awoken from her anaesthetic, I took her Laryngeal mask off. I kept observing her vital signs and especially her respiratory rate as she had had morphine administered in theatre, and one side affect of morphine is that it can depress the respiratory rate. My mentor was nearby to observe my nursing skills, communication skills and give me reassurance.

As I checked the wound site as part of the assessment, I noticed a small amount of blood on the dressing, which I decided to monitor closely, as blood loss can be potentially dangerous. A few minutes later I thought that the dressing should be removed to see why it was bleeding further. I delegated the duty of preparing the dressing trolley to the recovery nurse, as I had to stay with my patient. I observed Mrs Smith's breathing further and noticed a prominent decrease in oxygen saturation and respiratory rate. I checked the drug chart to see if naloxone was prescribed, a medication that reverses the action of Morphine in patients with respiratory depression. As I found that it was not prescribed, I asked the nurse to stop the dressing preparation and instead find the anaesthetist to prescribe naloxone and an alternative analgesic for Mrs Smith's pain. Using my clinical judgement, I decided that stabilising the patient had priority over the dressing change. I elevated Mrs Smith's headrest to aid her breathing and reassured her verbally and held her hand until the nurse came back with the prescribed medication. My mentor administered the naloxone intravenously, and a couple of minutes later, Mrs Smith's respiratory rate had increased and all her observations were in normal range, therefore, I was able to safely check the wound and changed the dressing, ensuring patient care and safety. As Mrs Smith was comfortable she returned to the ward.

#### *Story 40 – Learning account*

- I felt very excited and intrigued when my mentor told me that I was to look after the patient and give all the necessary care.
- I felt nervous and was unsure if I could manage the patient's care myself.
- I reminded myself that I was not on my own and I could have full support from my mentor if I needed it.
- When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence.
- I also felt confident assessing the patient and taking the laryngeal mask off, as I had previously had opportunities to practice these skills.
- I had to ask a recovery nurse to prepare everything for the dressing change. This made me feel uneasy as I was the student; however, I knew that I had to learn to delegate duties to other team members. I was unsure of how to delegate, so I decided to ask her in a very friendly manner, as I believe you are more likely to get a friendly response. The nurse was very understanding and did not mind helping me.
- When I noticed the change in Mrs Smith's oxygen saturation and respiratory rate, I almost panicked and wanted to handover to my mentor, but she reassured me and told me to check the drug chart for prescribed medication.
- I took deep breaths and tried to stay as calm as possible as it helps to focus and also to reassure Mrs Smith.
- I tried to reassure Mrs Smith and I tried to stay as calm as possible, however, I found it was not easy.
- I was relieved when the nurse came back, administered the medication and Mrs Smith's respiration stabilised.
- I felt tired after the event, but also very positive and confident that I managed the situation well.
- The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear, and uncertainty but finally confidence.
- This experience has shown me that I can achieve more than I initially thought I could.
- Nurses use their own judgement every day in practice and therefore they need to have the relevant background knowledge to do so.
- Nurses are expected to access, appraise, and incorporate research evidence into their professional judgement and clinical decision making.
- In this situation I had to use my interpersonal problem-solving and prioritising skills, as well as making clinical decisions and delegating duties to other staff members.
- I also had to think about Mrs Smith's needs and communicate well with her and other healthcare professionals.



- I was very nervous and panicked at the task, which has the potential to make other people nervous, as well. I also acted hesitantly at times, but feel this was down to a lack of confidence.
- Looking back and analysing the situation made me realise that managing patient care is more complicated than I thought. There was so much to consider, as patients should always be seen as a whole and healthcare professionals should not just concentrate on one issue.
- Patients also have feelings and rights which should always be considered.
- Communication is the process of transmitting messages and interpreting meaning. As an important nursing skill, communication competency is acquired through study and application. Effective communication is an essential necessity for effective nurse-patient relationships as well as inter-professional relationships.
- If nurses are aware of their body language, for example, presenting closed posture or not making eye contact, this could have a negative impact or change the message received by the patient.
- I felt that I communicated well with other team members and with the patient verbally and non-verbally, and that I had reassured Mrs Smith successfully.
- I started to believe in my own competency and I recalled a past experience in which a similar decision had been made. I also knew that if it was not the right decision, my mentor would have corrected me. I feel I did well and I found this experience positively contributed to my overall nursing skills.
- Problem-solving is part of decision-making, a systematic process of focuses on analyzing a difficult situation and problem solving always includes a decision-making step.
- Decisions may have far-reaching consequences.
- I am aware that in nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems.
- I feel that I had solved Mrs Smith's acute emergency situation accurately, but I am aware that I had relied upon some assistance from my mentor. My mentor contributed to this experience with psychological support and minimal verbal guidance.
- Priority setting is also an important skill in nursing, and a skill deficit can have serious consequences for patients, factors that might impact on priority setting include: the experience of the nurse, the patient's condition, the availability of resources, ward settings, and cognitive strategies.
- I believed I had managed this emergency situation well, this experience was very stressful for me, and it has highlighted the need for me to improve my self-awareness.
- Only with acceptance of one's self, can a person begin to acknowledge another person's uniqueness and build upon this to provide holistic care.
- If this situation arose again, I would try to be more confident in myself and I would be more aware of my facial expressions to prevent anxiety for the patient.
- I have gained a new perspective on my practice which is to set myself personal goals in facilitating effective communication between the patient and myself.

#### **Story 44**

It was agreed that I would work with a senior nurse and look after a fifty six year old gentleman who had suffered a subarachnoid haemorrhage (SAH). The senior nurse would oversee my nursing care and take responsibility for the administration of intravenous fluids and monitoring of arterial blood gas (ABG) analysis. We agreed that I would work within my limitations as a student and seek her advice or direction as required.

Mr X was sedated since he was on a ventilator using continuous positive airway pressure; this type of ventilation enabled him to take spontaneous breaths with support. He was having hourly neurological observations and had continuous cardiac monitoring using an arterial line and electrocardiography and central venous pressure line. Due to raised intracranial pressure Mr X was required to be nursed with his head at a 30 degree angle, thus reducing the risk of further damage being caused by a raise in pressure.

When taking over a patient at the beginning of each shift it was the job of the allocated nurse to check all of the equipment was safely stored and in working order. As well as ensuring that all of the necessary supportive equipment was available and working it was also necessary to check ventilator alarm settings and limits and that the patient was receiving the correct oxygen (FiO<sub>2</sub>). Once the ventilator was checked the infusions were checked making sure the

rates were correct, lines were labelled and within date. Once this was done it was necessary to check the central venous pressure and arterial lines making sure they were zeroed at the mid-axilla level to gain an accurate trace. Throughout this it would be necessary to record the readings and that the safety checks have been completed at the start of the shift.

The next step was to carry out the first of the hourly observations including the checking of wounds, drain sites, chest auscultation, and the neurological status using the Glasgow coma scale (GCS) and ensuring their comfort by carrying out mouth care and position changes. I carried out the above checks under the supervision and with the assistance of the charge nurse supervising me. Then we planned the shift, it was agreed that we would conduct four hourly ABG readings; along with hourly GCS readings, vital signs and fluid balance readings.

Unfortunately Mr X remained hypertensive despite having a glycerine tri-nitrate (GTN) infusion and some other medications administered via the naso-gastric (NG) tube. When we took over the nursing care of Mr X he had four intravenous infusions running; crystalloids, GTN, Propofol and phosphates as well as an NG feed. Mr X also had a low GCS score of only 3 all night. During our initial assessment it became clear that Mr X's pupils had become fixed and dilated. The Doctors were informed during their morning round and believed this could reflect a further bleed. Mr X did not even respond to deep suctioning. They therefore decided he was no longer for active treatment, but for palliative care. They were also informed that we believed Mr X was no longer managing the NG feed because there were signs of regurgitation. They made a decision to stop the feed and all the infusions, apart from the GTN infusion.

This change in treatment needed to be explained to the next of kin of Mr X so that they could understand the medical decisions and also prepare themselves for the death of Mr X. It was decided that the doctors should along with the shift leader discuss the possibility of organ donation with the family as well. The family were shocked and distressed by the news that Mr X was not responding to treatment and that the doctors believed he was now dying. The family met with the transplant co-ordinator, but they were not in favour of this. While the family discussed the option of organ donation Mr X was kept on the ventilator, however, when they decided against donation the doctors decided to extubate Mr X and make him comfortable with a Diamorphine infusion and oxygen delivered via Hudson mask. His airway was protected with a guedel airway. It was also decided that Mr X would be transferred to a side room to allow greater privacy for the family to have time with Mr X. We also ceased hourly monitoring so that the family would not become fixed on the values of the vital signs.

Mr X's immediate next of kin was a young boy around eighteen years old; unfortunately Mr X's wife was out of the country. During the shift I made sure that the son knew the chaplaincy team, who had access to a member of their faith, would be available to talk with him and spend time with his father, however, they declined.

Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family, although I respected this, I also had a duty to ensure they knew that external support was available as needed. The shift ended with Mr X maintaining his own airway and breathing unaided, his GCS remained at 3 and pupils were fixed and dilated. He appeared comfortable and showed no signs of agitation or distress. Later that night he died.

#### *Story 44 – Learning account*

- That shift highlighted how hard it is for both staff and families to see the change from active highly intensive treatment to palliative care. It also highlighted how hard it is to deal with a sudden loss, Mr X had been fine up until the evening of the haemorrhage where he developed a blinding headache and vomited, collapsed unconscious and was rushed to hospital.
- I feel that in twelve and a half hours a patient went from being intensively nursed and cared for with lots of medical intervention in a busy intensive care setting through to being nursed for in a palliative manner. Intensive intervention measures were removed and the focus changed from life prolonging / saving to comfort care measures ensuring that the patient's family had some time to say goodbye and understand that their relative in all likelihood would die.

- I found the intensive care setting a very hard place to work, for me I found the biomedical model of care incongruent with my ideals of nursing. Many patients died overnight, and I was expected to cope with my own emotions. I enjoy spending time with patients and their family giving holistic nursing care. As opposed to the intensive care environment where although communication with patients is essential even if they are unconscious the bulk of the work is intensive and involves careful monitoring of equipment and vital signs etc. but not necessary hands on patient care and care for the patient's family.
- In this environment palliative care is given poorly, because death is seen as a failure and therefore the focus is on making people well, the environment is not family friendly and the focus of care is of a technical nature so that skills in palliative care are often lacking, and other priorities prevail.
- I was aware that the doctors were reluctant to spend time with the family as it was a reminder if their so-called failing. This was another experience which led to my decision to head into palliative care in my nursing career.
- I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably lead to me to quitting nursing.
- I do however have respect for intensive care nurses and health profession. Intensive care is an amazing place and full of highly skilled personnel, a place where people's lives are saved but just not a place for me, and I think it is essential for all nurses to recognise their individual skills and passion and follow this into an area of nursing which embraces their core beliefs and values rather than opposing them.

#### **Story 48**

Whilst on placement I was working in a surgical ward. My mentor suggested I should spend some time in each area that our patients visit while in hospital as well as spending some time in the surgical ward itself. A typical patient's journey involves the following areas: the pre-assessment area, the surgical ward, the operating room, the recovery and then return to the ward. I gained some valuable experience in each of these areas. In this story I would like to concentrate on my experience in the recovery room. I will outline some of the things I learned while I was there, explain the importance of the recovery room and summarise what is involved in the smooth and efficient running of the recovery room.

I got the permission of the charge sister of the recovery room, the charge sister in charge of the surgical ward and also my mentor to go to the recovery room for a day; I also informed all the other staff on the surgical ward of my whereabouts. When I reached the recovery room, I was introduced to all staff members and was asked to "shadow" one particular nurse for the duration of my stay there.

While I was there I was actively encouraged to interact with the patients in terms of reassuring them and informing them of where they were. I was also (under supervision from the nursing staff) encouraged to perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient.

While I was there I observed quite a number of differences between the treatment patients receive in the recovery room and the treatment received in the ward. Firstly patients are on quite a lot of medication when undergoing surgery; the effects of this medication need to be monitored closely immediately after the operation until the effects of the medication wear off. Patients for example can sometimes wake up from an anaesthetic shivering. Some argue this is a reaction to the anaesthetic, others disagree. The treatment for this is to encourage the patient to breathe deeply while on oxygen therapy. Secondly I would have learned that the emotions of the patient may vary quite a bit after an operation. One patient for example, woke up crying after an operation on her foot. In this case it was important to continuously reassure the patient and let her know that she was in safe hands and that she will be ok. Another interesting aspect of the recovery room is that patients who would ordinarily go to the high dependency unit do not go through the recovery room; these patients go straight back to the high dependency unit, this is despite the fact that the patients while they are in the recovery room receive a very high level of care (as a general rule there is one nurse for each patient).

Patients are usually stable within a half an hour after surgery (although some patients with underlying conditions such as diabetes may have to stay longer) after which they are sent back to the ward. This means there can be a very high throughput of patients in one day leaving very little time to see the progress a patient can make from the date of admission to the date of discharge. Some patients do not remember all of their time in recovery and find gaps in their memory, This can be very worrying for some patients as they feel they should remember everything. This is why it is very important to continuously reassure the patient in every way possible in this situation. Once the patient returns to the ward their nursing care continues until their eventual discharge.

For the effective running of a recovery room a number of procedures need to be in place, communication between the different disciplines is one of them. If for example a patient just arrives into the recovery room it is imperative the nurses know exactly what medication the patient has had. Some medications like morphine for example tend to depress the respiration rate of the patient and can make them a little dehydrated. Good communication also has a good impact on patient care for example if a problem develops shortly after the operation it is important to be able to communicate that to a doctor or another relevant member of the multi-disciplinary team if the nurse does not have the necessary skills or training to assist the patient.

Because the patient is after having surgery the patient tends to get more intensive care in the recovery room than they otherwise would on the ward. This is an important part of patient care as the side effects of some of the anaesthetics need to wear off before the patient can be permitted to return to the ward. It is also imperative that the patient is stable before he/she returns to the ward. The only type of patient that does not go to the recovery room is those bound for the high dependency unit or the ITU.

It can be very emotionally draining from the point of view of giving emotion. The main downside is, however, nurses cannot allow themselves to get too emotionally attached to the patients. Because the patient moves from one area to another very quickly it can feel more like “assembly line medicine” rather than taking care of the patient as a whole.

#### *Story 48 – Learning account*

- I mean I should have reassured and encouraged and communicated with the patients a little more than I actually did.
- This would have given me the opportunity to understand what the patient was going through and thereby improving the quality of care I could have given to the patients. It would also ensure I would learn a little more.
- In the future this is an area I will have to work on.
- I believe I got to see some of the best practices a nurse can offer a patient.
- In terms of reassuring patients, and being made aware of the level of knowledge needed to offer that care, I have consistently applied these practices since my visit to the recovery room by taking a more active role in learning why certain procedures are taken and being prepared to interact more with patients.
- I chose this area because I believe it is important to realise that exposing oneself to other areas can have very beneficial side effects.
- This is especially true when it comes to learning how other wards work and how the two wards have an impact on each other. Sometimes this gets forgotten to the detriment of patient care.
- I did not interact with the patients as much as I should have, reassured, encouraged and communicated with the patient a little more.
- This is something the qualified nurses did not actively do on an ongoing basis with each patient.
- This I believe would have given me the opportunity to understand what the patient was going through, I would learn a little more, taking a more active role in learning to interact more with patients.
- Sometimes patients can be emotionally distressed by their experience in surgery. This is why the nursing staff needs to continually let the patient know that they are ok.
- In future I will be more proactive in my dealings with the patients. Offering them advice and support when they need it, in addition to asking patients what they need from the nursing staff. I also intend to seek advice and support from the multi-disciplinary team when appropriate.

## Story 51

One of the patients I had been assigned to care for is a patient who had a total hip replacement operation. The patient was on his third day post-operatively and needed his wound dressing changed. The wound had been closed using clips and covered with opsite dressings. I carefully removed the old dressing, using the aseptic technique; I cleaned the area adjacent to the wound using saline solution and sterile swabs. As I wiped the area close to the wound my mentor suggested I carry out the procedure more speedily which I did. He asked if I knew why and replied that it was to minimise exposure of the wound to the surrounding environment and thus minimise the risk of the patient developing a wound infection.

He explained it again to me stating that with post-operative patients especially those where the bone had been operated on, the risk of infection entering the bone presented a serious threat to the patient with the risk of amputation or worse. When I worked in theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again.

Whilst dressing the wound, I had taken care not to get the swab caught up in the clips and one clip was not fully homed and presented a risk of getting pulled and opening the wound. I also did not want to cause the patient any pain although pain was taken care of by medication. The comments my mentor had made to me highlighted that there was a need in me to focus on the broader picture. I had focused on what I could see, the wound, and had anticipated the patient's pain.

Although these were both important, of greater importance was the long term risk to the patient, infection setting in and compromising bone tissue and the whole system, this was not immediately apparent. Also highlighted was the fact that I have the knowledge, however, having the knowledge is of no use if it is not applied. In effect, I was being told to think as I worked. My mentor was pleased with my work and qualified his comment on speed by stating that speed develops with practice and at times haste causes errors which can have dire consequences. The comment on speed caused me to assess myself and has definitely enhanced my practical ability as a nurse.

### *Story 51 – Learning account*

- The individual learning and surgical site infection and its far reaching effects highlight how a seemingly innocuous act such as not speedily dressing a wound can have grave consequences.
- When a patient, entrusted into my care, having undergone hip replacement surgery required a wound dressing changed. I prepared the trolley following hospital guidelines and attended to the wound in accordance with aseptic technique practice.
- I carefully attended to the wound my mentor, who had been unobtrusively watching me, came over and suggested I speed up my actions and asked whether I knew why speed was essential.
- I replied that it reduced exposure time to infections micro-organisms. The patient smiled. I completed the dressing as speedily as possible, taking care to prevent causing the patient pain and contaminating the wound or dressings.
- This was executed to my mentor's and my satisfaction.
- I noted my immediate response was to increase the pace at which I worked and rather than simply focusing on dressing the wound, I became very conscious of its significance
- The comments my mentor has expressed made me conscious of my actions, causing me anxiety due to nervousness, and my initial feelings of confidence as I dressed the wound was eroded by the criticism levelled against my work. I felt inadequate as the unexpected feedback caused me initially some stress.
- The patient's smile which I viewed as reassurance eased my troubled feeling and reflected the rapport we shared. I was not immediately unduly concerned reasoning that speed develops with experience and this my first post-operative orthopaedic dressing required adequate care and consideration to minimise patient distress caused by pain and the possibility of undermining the surgeon's work due to excessive limb handling and movement. I felt pleased knowing that I was considerate of the patient's well being.
- My mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality.

- Since the wound-dressing incident I have found that I am more aware of my actions when fulfilling my duties, constantly seeking to justify my actions and underpin these with theoretical knowledge. I spend more time reviewing my work practice to determine the not-so-obvious consequences of my actions.
- My analysis suggests that if wounds are not dealt with in a timely manner infection can set in, therefore, I as a practitioner would fail in my duty of care to the patient and must be held accountable for my actions or in-actions
- I had given the patient adequate care and consideration to minimise distress and relieve pain during the dressing procedure, and was demonstrated in the patient's relaxed posture, gesture (a smile of trust and confidence in the student's knowledge and ability) and speech (asking questions).
- If a hospital acquired infection (HAI) sets in, such as MRSA, the patient may require an extended hospital stay, occupying much needed hospital beds.
- The infected patient becomes a source of infection to his carers and other patients if infection control policy is not adhered to. Should the infected limb require amputation, this too will necessitate prolonged hospital care and if mobility is compromised pressure wounds could set in compromising and distressing the patient further.
- The patient's social, work and home life will be affected; specifically dependants of the patient who may be devastated if that infection resulted in the patient's death. If I as the nurse or the hospital were found to be negligent the patient or patient's family could take legal action and seek recompense.
- The increased financial burden for the extra care materials etc. or defending legal action can seriously affect the trust's funds resulting in reduced or loss of services.
- If I did nothing to improve my speed while dressing wounds the likelihood of infection setting into the wound has a high probability of becoming a reality with all the above consequences, it is therefore essential that I practice dressing as many wounds as possible to improve my wound dressing knowledge and technique, this will have to incorporate revisiting and increasing theoretical knowledge about wound types, dressings and infection control through reading. *Having this knowledge will enhance my confidence enabling me to work faster and more professionally.*
- Speedily dressing a wound is not often highlighted as a contentious issue nor one that lends itself to health promotion, however, when it is associated with the transmission of infection it became a healthcare issue.
- Although the criterion highlighted by my mentor was my lack of speed, the greater and more important implication was the risk presented to the patient should the wound become infected and pathogens spread to and compromise bone tissue.
- The implications can be enormous for the patient; physically, psychologically and socially, there are knock-on effects for other patients waiting in line for treatment.

### Story 52

S has severe cerebral palsy with contractures. He was totally bed-bound and had been admitted to our ward awaiting re-insertion of his jejunostomy which had accidentally come out. In addition to this, he was suffering from cancer of the tongue and had undergone a hemi-glossectomy, had a permanent tracheostomy in place, poor eyesight and communicated with an alphabet chart. He was nursed in a side room and was totally dependent on the nursing staff. I was assigned to S daily and within a few days felt a real bond had developed between us. We hoisted him daily into his specially adapted wheelchair which supported him and positioned him by the door so he could watch what was going on and read his bible. S appeared to be exceptionally bright but trapped in his useless body. Everyone loved him as he seemed such a gently character.

The following week, I arrived at work to find S suffering from severe diarrhoea. I washed him from head to toe, cleaned the bed and floor and changed his sheets. I tried to be as cheerful as possible but had begun to feel dreadfully sorry for this poor soul. This was no way to live a life. It must have been hell.

When I had finished, I cleaned S's glasses and combed his hair. He suddenly looked upset and indicated he wanted to communicate so I fetched his alphabet chart. He spelt S O R R Y. His eyes said it all and I couldn't believe that this poor man, who's suffering was so immense, was saying sorry to ME! Who was I? I touched his arm to reassure him and told

him that it was what I chose to do and that the nurses all loved to look after him and he was not to worry. Then I left the room, ran to the toilet and cried uncontrollably.

#### *Story 52 – Learning account*

- I will never every forget S's story
- Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own.
- Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us

### 6.3 - 3<sup>rd</sup> year child student nurses' stories and learning accounts

#### **Story 1**

Whilst on placement on a busy general paediatric ward I managed the care of my own group of patients with minimal supervision of my mentor. Following morning handover on a particular shift I was allocated to care for a child at the request of his parents. I was allocated to manage the care of a dying paediatric patient, admitted to the general paediatric ward for tender loving care following increased severity of congenital hydrocephalus.

Whilst on placement on a busy general paediatric ward I managed the care on my own on a variety of shifts. The ward where I was placed is a very busy general paediatric ward where a variety of children required various types of care are admitted on each shift. At the start of every shift we received a handover from the previous shift regarding each patient and the patients were then allocated to the members of staff. I was allocated my own patients to manage with minimal supervision from my mentor. Support was available from my mentor as well as other members of staff.

A child was admitted to the ward with severe hydrocephalus, this can be defined as excessive cerebrospinal fluid within the skull. This child's hydrocephalus was as a result of a congenital condition and was one problem amongst many that this child was suffering from. The child's condition and care so far was handed over to me in the morning, it had been decided on the previous shift that the child's condition was terminal and he was admitted to the ward for Tender Loving Care (TLC) and support. The child was a frequent patient on the ward and therefore he and his family were well known by all the members of staff on the ward, including myself.

#### *Story 1 – Learning account*

- I was glad that the care of the child had been allocated to myself during this shift as I had previously handled his care and the family had requested that I care for their son.
- I was however nervous because we were all aware that the child was only on the ward for Tender Loving Care (TLC) and would therefore die on the ward, we did not however know how long the child would live for and be on the ward before this happened.
- The focus of my attention and care needed to be focused around this family and this child, however, this meant that I had to manage communication between various professionals' time management for the care of this child and others on the ward whose care I was participating in.
- Time management is extremely important when caring for any patient however when the patient is terminally ill it is extremely difficult to manage your time.
- I found it extremely difficult to look after this child and undertake other ward duties including observations and ensuring that prescribed medication was given on time because I was required to give support to the child and his family.
- However handling the care of this child gave me an insight into a different type of nursing care than the one I had previously experienced and participated in.
- I had an established professional relationship with the child and his family because the child was a frequent patient on the ward. This meant that the child's family were able to approach me with any questions or queries that they had.
- On this shift I found that I spent a large amount of time with the child and his family supporting them, answering any questions that they had and generally talking with them about their son.

- Communication between myself and the family and myself and other members of the care team was extremely effective in this situation. The communication and teamwork ensured that the best possible care was provided to the child and his family and that all necessary information was shared between the necessary healthcare professionals. To ensure safe practice for the patients on the ward communication and inter-professional working within a team are essential.
- As a third year child branch nursing student I felt that I lacked experience in caring for children who were dying, I had observed and minimally participated in caring for children in this situation before but never managed or delivered their care before.
- The lack of experience made me nervous however my mentor and the other members of staff made it clear to me that I could ask for their help and support at any time.
- I felt that I had handled the care of this child effectively and with respect and dignity on this shift, although I was unsure about how effectively I would be able to care for a terminally ill child I was extremely grateful to have this given the opportunity.
- I learnt how effective communication, team work and support are essential factors when caring for children with such complex needs.
- This situation has enabled me to see how effective communication can ensure that the best available care is provided in sensitive situations and how the involvement of a variety of professionals ensures this.
- I spent a large amount of time talking with the family about their child and this communication enabled me to feel that this child and his family received the best quality of care and was looked after with respect and dignity.
- If I was managing the care of a dying child in a similar situation to this one I would handle the care of this child in a similar way to the way that I handled the care of this child.
- I would continue to involve the family and the child, if appropriate in the management and delivery of care. I would also continue to seek support and guidance from fellow members of the team.
- I feel that the support available whilst on this paediatric ward was extremely helpful and encouraged me to share my emotions and feelings with the team at the end of the shift.

## Story 2

While on a day shift at a paediatric ward, I managed the care of a 6 year old patient for a whole shift. Whilst managing the care of this patient I was indirectly supervised by a registered nurse. The patient in question had profound learning difficulties and melanosis, which is a condition that is distinguished by a lack of skin colour (hypopigmentation) effecting many areas of the body.

The care I delivered to this was outlined in her care plan. The care the patient required was personal care such as oral mouth care, bed bath and frequent changes of the patient's pad. With the help of the patient's mother I carried out the personal care needs of the patient in the morning. The patient was completely dependent on the care of her mother who stays with her on the ward during most of the day. However, the child's mother also has four other children at home who are under the age of 16 who also require her attention. Therefore the child's mother went home during the day to care for her other children.

In addition to this, the patient had severe epilepsy. The patient was admitted to the ward for frequent, prolonged, uncontrollable seizures, which were being treated with a continuous infusion of phenobarbitone (phenobarbital) which the patient has through a subcutaneous in dwelling line. Due to the side effects of the phenobarbitone the patient requires hourly monitoring of pulse, respirations, oxygen saturations and blood pressure observations. I also recorded the type of seizures the patient was having. Recording the seizures is recognised as being vital in order to make an accurate diagnosis and therefore to prescribe the correct treatment.

The patient has a femoral line, which she has numerous other medications through. In order to maintain safe practice I had to delegate the administration of the patient medicines which she has through her femoral line to the registered nurse. The NMC code of professional conduct (2004) and the practice area's medicines policy states that as a third year nursing student I can under direct supervision calculate and administer medicines by a variety of routes, however, I am not allowed as a student nurse to give intravenous (IV) medication. One of the disadvantages of femoral lines is that it is difficult to keep site sterile and it



prevents patient mobility, because the patient requires regular turning and repositioning. I made sure I regularly checked the femoral line, which was still in the patient, intact.

I also carried out the patient's feeds which were set out in a nutrition plan which was arranged for her by the dietician. The patient had all her feeds through a gastrostomy which is a surgical opening into the stomach for the purpose of nutritional support. I used my previous knowledge of wounds to monitor the site of the gastrostomy for signs of infection. Signs of fever, redness, swelling, or hardening around the site often indicate infection. The patient's feeds were scheduled for every 4 hours, in between the patient required 4 hourly feeds of water, also through her gastrostomy.

The patient had recurrent pneumonia, causing the patient to produce vast amounts of mucus secretions and therefore required frequent suctioning and physiotherapy. I communicated over the phone with the physiotherapist to arrange for the patient to have physiotherapy to help with her breathing and allow her to cough-up some of the secretions. While the physiotherapist was with the patient I was shown the most safe and effective way to suction the patient.

### *Story 2 – Learning account*

- While caring for this patient I contributed to the health improvement of the patient through health promotion by educating the patient's mother.
- I had noticed earlier that the patient's mother sometimes suctioned the patient herself, but her technique appeared to be incorrect.
- When the patient's mother returned later during the day, I showed her the correct way to suction the patient, which was shown to me by the physiotherapist. I also explained to the patient's mother about the importance of positioning the patient in a manner that prevents a heavy build-up of mucus secretions. I also explained to the patient's mother about the importance of regularly turning the patient in order to prevent pressure sores.
- While caring for this patient I utilised management skills such as prioritisation, time management and delegation
- My experience involved me managing the care of a 6 year old patient with profound learning difficulties and a severe neurological condition for a whole shift.
- The patient required a number of nursing cares and treatments due to her multiple health problems. I had not previously managed the care of this patient and therefore I was unaware of what needed to be done. I therefore spoke to the nurse who was caring for her during the previous shift.
- I also read the patient's medical notes in order to gain an in-depth history of the patient. I made sure I was present during the ward round in order to know of any changes the doctors made to the patient's treatment plan.
- I first made a check list of everything I needed to do for this patient during the shift. After establishing the care the patient required I made sure the most important tasks were highlighted and given greater priority.
- The patient required hourly observations and monitoring of vital signs due to the adverse effects of phenobarbitone. I made sure the observations were done on time every hour. I gave the observations priority because evidence from practice has highlighted that patient observations are an important part of nursing care in that they allow the patient's progress to be monitored and also ensure prompt detection of adverse events or delayed recovery.
- Vital signs are quite limited in terms of detecting important physiological changes, also there is only limited information regarding the frequency with which patient observation should be undertaken and much of this is based on surveys of nurses, clinical practice reports and expert opinion.
- The patient is neurologically impaired and cannot communicate, therefore, I did not rely on the vital signs alone, I also used a pain assessment tool. Because the patient cannot communicate, the regular pain assessment tools for children were not useful; I relied on the patient's sounds and facial expressions, as well as the movements she was making to indicate to me whether she was in pain.
- In the absence of pain assessment measures specifically designed for use with people with profound learning disabilities, the nurse will need to rely on careful observation and interpretation of the patient's communicative behaviour, clinical judgement and knowledge of the person during assessment.

- While looking after this patient I sometimes felt overwhelmed as she required constant care and attention. At times I felt stressed and by the end of the shift I was physically tired.
- The more time I spent with the patient the more attached I got to her and I felt a lot of empathy towards her mother, I began to understand some of the stresses of caring for a chronically ill, neurologically impaired child with learning difficulties every day.
- I found that there were certain things I was not competent in and could not do for the patient. For example, some of the patient's medication was administered through the I.V route which I am not competent to give; I therefore delegated this task to a registered nurse.
- At the time however, I feared that I may be criticised by the other nurses.
- I examined the influencing factors which affected my decision making; these were feelings of empathy for the child and the child's mother. Before the patient's mother left the ward she felt worried that by staying on the ward with the patient all the time her other children were missing out. I reassured her that we would give her child the best possible care from me.
- While caring for this patient I contributed to the health improvement of the patient through health promotion by educating the patient's mother. I showed her the correct way to suction the patient, which was shown to me by the physiotherapist.
- I also explained to the patient's mother about the importance of positioning the patient in a manner that prevents a heavy build-up of mucus secretions. I also explained to the patient's mother about the importance of regularly turning the patient in order to prevent pressure sores.
- I believe I could have managed this patient's care better if I had more medical knowledge of the reasons behind certain interventions and procedures at the time, as this would have increased my confidence in caring for such a demanding patient.
- My previous knowledge allowed me to learn as I went. I communicated over the phone with the physiotherapist to arrange for the patient to have physiotherapy.
- I could have utilised the help of other members of the nursing team more for advice and support, while managing the care of this patient.
- I realise that I learnt a great deal about what is to be expected of me as a qualified nurse. Although at times I was stressed due to the amount of care this patient required, I now realise that as a nurse you will be expected to look after patients like this but also look after other patients as well.
- This situation highlighted that in order to become more confident as a nurse I will need to actively seek out situations where I care for my own group of patients as a student. This will help me gain experience, confidence and help me to improve my management skills.
- The experience has also demonstrated to me that the theory side of nursing knowledge is good but I need to be more aware of it and utilise it in practice situations.
- I have identified that I need to expand my nursing knowledge on the care and health promotion of children with neurological conditions and learning disabilities.
- I also need more practice in the management of patients. I aim to manage the care of a group of patients while on placement to become more confident in my nursing skills.
- I also recognise that even as a third year student there is gaps in my knowledge of certain skills and theories, which are required when managing the care of patients.
- I acknowledge that these shortcomings will need to be addressed and be worked through as nursing is a lifelong process of learning.

### **Story 3**

I was working on the children's ward and had been asked to look after a 10-month-old baby who had been admitted the previous evening with a chest infection. I received handover from the night staff and read the child's notes and felt well informed about her condition.

The child was attached to an oxygen saturation monitor and required regular nebulizers throughout the day to stabilise her condition. As the child's saturation levels were quite low I decided it would be best to prop the child up in the cot rather than her lying down flat, which would hopefully help her chest and make her saturations rise. I explained to the child's mother the reasons for providing extra pillows and propping her up. It was at this point that I realised that the child's mother's English was very limited; however I felt that she had understood me. But as soon as I left the child the mother removed the

pillows and laid her down again, which in turn made her saturation levels fall, and I needed to administer oxygen to the child to ensure her saturation level rose. I was also concerned regarding a safety issue, as with the child propped up mum had left the cot sides down and walked away. I again tried to explain to the mother the need to keep the child upright and the cot sides up to maintain her safety. The mother smiled at me and acknowledged that all was OK. Again on my return to the child, she was lying flat in the cot and requiring oxygen. At this point I was feeling very frustrated with the mother and disappointed that my communication skills had been misunderstood.

After many attempts throughout the day at making mum understand the need to keep the child propped up, I decided to contact the hospital interpreters to ask if one was available to interpret for me. An interpreter came to the ward, and explained to mum the reasons behind the need to keep the child propped up, while she was unwell and to always put the cot sides up when she wasn't there for safety reasons. It transpired that mum had been watching the saturation monitor and as soon as she saw that the child's saturations had risen she felt the child was well enough to be laid down. It was a relief to me that mum understood the situation and I felt justified in involving the interpreter, which reminded me of the need for effective communication between parents, myself and other agencies.

### *Story 3 – Learning account*

- The learning gained using story is different from the theory we learn that provides the knowledge base for our practice. By thinking about stories in a purposeful way we understand the knowledge differently and take action as a result.
- Whilst introducing myself to the child and mother and assessing her condition, I noticed that the child was detached from the saturation monitor. Continuous monitoring will give valuable information on the child's response to interventions and being attached to a saturation monitor is intended to be a simple and non-invasive method of recording oxygen saturations in children.
- Reference made to The British Thoracic Society (2007) - any child with an oxygen saturation level of less than 92% requires immediate administration of oxygen either via nasal prongs or a mask.
- Reduced oxygen levels can cause cell death and reduced respiratory drive, with the risk that the child will proceed to respiratory and subsequently cardiac arrest, by knowing this prevented it from happening.
- Although students are not held professionally accountable for their actions, they are morally responsible for ensuring that patients receive good standards of care.
- Shared concerns with the mother
- My clinical judgement was that the child needed to be attached to the monitor continuously.
- Realised that the mother's English was limited.
- I assumed she had understood me as she had smiled and nodded.
- The need to work in partnership with the mother to identify goals and needs and act as an advocate in assisting the family
- Throughout the day the saturation monitor kept alarming. Each time I walked away the mother would lay her child down causing her saturation level to drop thus causing the machine to alarm.
- Feeling extremely frustrated and irritated, as when the child was propped up her saturation levels were fine.
- Kept calm and spoke to the mother clearly still assuming she understood me as she kept on smiling and nodding.
- Feeling under pressure as I had other patients to see and the effort of attempting to communicate was such a slow, painstaking process that after a few attempts I felt like giving up altogether.
- The need to consider the other patients that I had responsibility for and prioritise my time towards them whilst ensuring patient safely at all times
- Prioritising can create tensions for nurses because the needs of one patient compete with those of another in terms of urgency.
- After many attempts throughout the day to get the mother to understand I decided to seek guidance from the nurse in charge. I explained the situation and suggested I ring an interpreter to ask if they could translate for me.

- It is essential to ask advice from other members of the multi-disciplinary team who may have input into the child's care.
- Difficult situations are only opportunities which are an optimistic way of looking at managing a situation and give a positive approach to professional life.
- Working as part of a multi-disciplinary team brings ideas together, sharing relevant information which achieves continuity of care.
- Translation services for interpreter required mother's consent.
- Realised mother thought she was helping me by laying the child down and also felt that as she was sitting right next to the cot that there was no need for the cot sides to be up. I was able to point out to her through the interpreter the dangers of leaving cot sides down thus reducing the risk of an accident.
- Referred to statistics each year 600,000 children under the age of five have an accident as a result of neglect by parents or carers
- Contacted a health visitor for her as they deal with public health issues including parenting education, health advice information. They would visit her home with an interpreter to look at safety within the home and see if we could be of any further help regarding communication issues within the community. The mother was extremely pleased that she was being offered some support.
- A great relief the mother had finally understood the situation.
- Should have contacted the interpreter much earlier thus avoiding frustration and annoyance both for the mother and myself.
- Referred to The Department of Health National Service Framework for children 3.5 (DoH 2003) acknowledges that children and their parents can only participate fully as partners in care if they have access to accurate information that is valid, relevant, up to date, timely, understandable and developmentally, ethically and culturally appropriate.
- Referred to internal and external factors which influenced my actions in getting an interpreter to the ward.
  - Feel incompetent and helpless
  - Wanting to ease the mother's anxiety and my own
  - My intuition had told me to get an interpreter sooner; on a previous occasion I had been advised by the nurse in charge that interpreters were only to be used in emergency situations due to the financial cost to the trust which had made me apprehensive regarding instructing one.
- This experience has demonstrated that interaction such as a smile and a nod is not an indication that patients/parents have understood my advice.
- I felt I could have dealt with the situation better if I had had previous knowledge of the protocols of instructing an interpreter.
- Also I felt I should have been advised of the language difficulties in handover that morning.
- I have learnt through this situation:
  - I need to be more confident in making decisions earlier on in the day and not to leave things until they become unmanageable.
  - Increasing my empirical knowledge on guidelines and protocols before embarking on patient care will assist me in future clinical practice and will help me understand some of the problems that I may encounter.
  - This experience has allowed me to consider personal feelings, how I would feel in the mother's situation.
  - How ethnically I had a duty to promote family centred care based on evidence to the child and the communication difficulties produced a barrier by causing irritation and time conflict caring for my other patients.
  - I feel I have gained aesthetic knowledge of communication realising that my interpretation of her responses were not as they were meant.

#### **Story 4**

I undertook the admission of a patient with suspected bacterial meningitis. I then proceeded to care for this patient throughout the remainder of the day. From first contact, I ensured the patient was barrier nursed to prevent the spread of infection to other patients. On assessment, I reviewed the patient's condition by observing how the patient looked and taking a set of clinical observations, including blood pressure, temperature, heart rate, saturation levels, respiration rate, and capillary refill. The

patient had a petechial rash to their lower limbs, which appeared to be slowly getting worse. All observations were within normal limits except for a high temperature; however, this had already been treated in accident and emergency with paracetamol and Ibuprofen. This also ensured the patient was pain free as on assessment the patient appeared settled. However it was vital to ensure the patient was not too settled with a low level of consciousness, therefore the level of consciousness and neurological status were also assessed.

Once I was satisfied that the patient was stable I took a detailed history of the patient's present illness, past illnesses and normal routine including diet and sleep patterns. This information was obtained from the parents as the patient was too young to communicate, although developmental stage was observed. Advice was then given to the parents about infection control, and limiting visitors until an official diagnosis had been provided. Throughout the day care was given in accordance with the suspected meningitis care plan.

After the initial assessment, which was discussed and approved by my mentor, I continued to monitor any deterioration in the patient by observing how the patient looked and carried out regular clinical observations. These observations were recorded in the nursing notes along with a fluid balance chart that recoded all of the patient's intake and output. Medication was also administered as per the drug chart. Intravenous antibiotics were administered by my mentor as I observed. I also spent a lot of time supporting and comforting the parents who were very upset and felt guilty that they had decided against their child having any immunisations, which may have been able to prevent this outcome. At the end of my shift I handed over this patient to the night staff via tape recorder, conveying all information about the patient and the care I had provided.

#### *Story 4 – Learning account*

- During this experience I believe it was essential that I followed the department's pre-printed care plan for suspected meningitis that have been created based on evidence based research.
- I ensured all aspects of care were considered they save time and formed a good basis to follow, but argued they are impersonal to the patient's individual needs.
- Working with the multi-professional team to ensure the care given was the best as can be was another essential requirement in caring for this patient.
- All professionals need to communicate effectively and share their knowledge, skills and expertise with other members of the team for the benefit of the patients.
- The aim was to ensure the patient made a complete and uneventful recovery whilst protecting others from the spread of the illness and supporting the family during their time of fear and uncertainty.
- My role was to assess and monitor this patient for any deterioration, aided the doctor in the process of cannulating and taking bloods from the patient, and helped liaise with the public health and the family.
- Referred to the UK rules with regard to meningitis, all clinically diagnosed cases of meningitis and meningococcal septicaemia must be reported to the local health doctor who then ensures anyone at risk is contacted.
- Antibiotics may be given
- Meningitis can progress very rapidly - time management and constant monitoring of any changes is an essential component for the care of this patient.
- Assessing the patient on admission able to identify the patient's needs and organise what care was required throughout the day
- Planning ahead and writing plans down is an efficient way to manage time and ensures important tasks are not overlooked.
- Helps in the management of prioritising patient care
- Worked the care of this patient around the care of two other patients that I was caring for.
- At times when my attention was required in more than one place, I had to prioritise the care based on what patient was more sick and what impact would there be on the patient that I would attend to second.
- Prioritising care is an important skill for all nurses in the management of patient care.

- Reassessed the patient's status carried out clinical observations regularly, identifying if the patient was deteriorating, I could inform the doctors and the appropriate treatment would be provided before considerable deterioration had occurred.
- I believe my role was very important in the assessment, treatment and monitoring of this patient and also in supporting the family:
  - Answered any questions in my ability or found out the answer to any question I did not know the answer to
  - Advised the family on universal precautions
  - Educated them on why we would be barrier nursing the patient in an individual cubical and implemented limitations for visitors
- The mother highlighted her guilt for not taking the patient to have her immunisations, I felt stuck in a situation of whether to offer support or educate about the benefits of having immunisations.
- It appeared obvious that the parents had their child's best interest at heart, they took the patient's choice away from her and jeopardised or even neglected the patient's safety in doing so.
- As the patient was too young to talk or convey her opinion it was my role to act as her advocate and ensure her welfare was at the centre of all decisions.
- Referred to family centred care is also a core principle within children's nursing care and the Department of Health (2004)
- The need to work in partnership with the family for the benefit of the child, it was felt at a time of such anxiety and upset, it was inappropriate to start trying to educate them as it may have been interpreted as criticism or blame. Therefore I decided it would be appropriate for this education to be given by the health visitor once the patient was discharged from hospital. My mentor agreed with this decision and the hospital liaison health visitor was contacted by myself and informed of the patient's admission and what input was required by the health visitor.
- I feel this was the right decision and considerations need to be made, as the parents may have researched the topic thoroughly before making their decision, and the parents' decision should be respected.
- I remained cautious and kept a close eye on the patient and her family as there was still a possibility that the patient was not immunised because of neglect, and I needed to ensure this child's safety was not at risk.
- I believed the parents were genuine, I did not want anything to be missed, therefore I discussed this issue with my mentor and the nurse in charge at the time who agreed that this was not a case of social services and that the parents just required education.
- I feel the support I gave the parents was much appreciated because as I finished my shift, they thanked me for all my help and appeared to have more understanding of the situation.
- Many of my decisions made throughout the care were based on the department's care plan for suspected meningitis that was produced around evidence based research.
- Referred to a protocol previously used called Early Management of Meningococcal Disease in Children - highlights the importance of close monitoring and carrying out regular vital signs as well as monitoring fluid input / output and consciousness level, 'Glasgow Coma Scale'.
- I feel the way in which I managed this patient was successful; however, there were limitations to my role that required input from my mentor:
  - Administration of intravenous drugs and have to be observed whilst drawing up and administering other medication, this was:
    - time consuming
    - my mentor was often busy with her own work load
    - I was required to find her and wait until she had finished the task she was currently completing
    - I allowed plenty of time for this process as I did not want the medication to be administered late.
- From this experience I have learnt that I am capable of managing my own workload and making the correct decisions for my patients.

- This exercise has emphasised the importance of prioritising care, safe practice, working as part of the multi-professional team, providing needed health education and basing my work on evidence based research.
- I implemented structure to my day by organising in advance how I would use my time effectively.
- Worked as part of the multi professional team and collaborated well with the relevant professionals, I ensured safety was maintained at all times by basing my care on evidence based practice. I believe my clinical decisions throughout the day were based on what was best for the patient, whilst also ensuring I equally met the needs of my other patients and families of these patients.
- By reflecting on this experience, I was able to identify the importance of managing my time for the benefit of the patient and learnt the significance of prioritising the care I provide.
- I believe this experience has highlighted my ability to manage my own patient load and has demonstrated that I am ready to make the transition from 'student nurse' to 'newly qualified nurse'.

## 6.4 - 3<sup>rd</sup> year mental health student nurses stories and learning accounts

### Story 1

The alarm sounded and a broadcast on the two-way radio system requested for assistance at one of the wards in the psychiatric unit. As I was shadowing the response nurse, I had to hurry along to the distressed caller's ward. On arrival at the ward that had requested assistance from the response team, we found one of the nurses writhing in pain as he had been punched and kicked several times by one of the patients. Part of the members of the response team attended to the injured member of staff whilst the rest of the team promptly restrained the assailant in a well-rehearsed move. It was not possible to use other means to de-escalate the situation as the patient appeared excited and agitated.

A decision to seclude the patient was made by the nurse-in-charge in liaison with the nursing team and the ward doctor was informed of this decision. The patient was led into a seclusion area. Seclusion involves the containment of patients who are severely disturbed by confining them in supervised rooms may either be locked or not locked to protect others from significant harm (DoH, 1999). Seclusion does not diminish the rights of the patient and is used sparingly as a last resort. According to the Mental Health Act Code of Practice, the use of seclusion is neither for the purpose of meting any punishment nor suitable where the patient has any risk of suicide or self-harm.

With part of the response team still holding the patient, and all aspects of patient privacy and dignity being maintained, the nurse in charge communicated with the patient and explained the actions that were being taken. Meanwhile, other patients in the ward were given the necessary support and reassurance. The toughened doors of the seclusion room were slammed shut. For me, this was the beginning of managing the care of someone in seclusion! I noticed that the seclusion room was ergonomically designed for the purpose with adequate ablution services and a good communication system through intercom. The room provided privacy from other patients, appeared to be safe and secure and enabled staff to observe the patient at all times.

With the patient deemed safe in the seclusion room, a multidisciplinary team involving the ward doctor reviewed his immediate care plans. This review was recorded in the patient's nursing record and seclusion documentation. Subsequent medical reviews could be done in four-hour intervals for the first 24 hours of the period of seclusion.

In providing care to the patient in seclusion, the team respected and upheld the patient's dignity. The patient was informed on the reasons he was being placed in seclusion and was further informed of the conditions for the termination of the seclusion by the nurse-in-charge. Continuous nursing observations were initiated with a qualified nurse taking charge during the first hour. It was at his point that I requested to shadow the continuous nursing observation. The nurse reminded me of the competencies I was expected to have before I could shadow him.

During the hour, we made documented and signed records of what we observed at intervals of fifteen minutes and sometimes less when the need to do so was identified. Our observations were to note any changes in the patient's mental state, physical state, and dietary intake, his level of contrition, his level of hostility and his interaction with us.

During this hour, I was able to observe the nursing protocol for a patient in seclusion. I was able to talk to the patient. The nursing review was carried out after two hours of the medical review. The nurses had to enter the seclusion room after ensuring that it was safe to do so. The review could have led to the termination of the seclusion had the team viewed it necessary to do so. In this case, however, the patient still showed high levels of agitation and did not show any contrition at all. I left the ward just after the first nursing interview. I was convinced that I had learned a lot on seclusion and its psychological effect to the patient.

#### *Story 1 – Learning account*

- Caring for a secluded patient was emotionally draining
- Legitimised retribution
- Mental Health Act – protecting their human rights, legitimises seclusion others find restraint and seclusion a hindrance to innovative ways of dealing with violence in mental health care
- Student felt seclusion was morally indefensible as it defeated the essence of a therapeutic relationship
- Literature seclusion provides an opportunity for focused and intensive emotional care. consider it a provocation of fear, resentment, humiliation or distrust
- The student was confused whether to empathise with the patient or the victim of the assault. The student could have been the victim at war with the student's duty to care. A paradox; an ethical dilemma
- Graphic detail of the member of staff writhing in pain and the humiliating act of seclusion made everlasting impressions on the student
- Literature confirms staff member feelings on seclusion procedures include shock, depression, demoralisation, upset, loss and grief, accompanied by ruminations, guilt and anxiety.
- Nurses are expected to cope with their emotions and their patient's emotions.
- Necessary for the safety of others, restraint should last for no longer than 3 minutes, the patient was handled fairly despite the injuries he had inflicted upon a staff member.
- Zero tolerance towards violence in all health care settings did not lend overt expressions of animosity towards the patient, let alone any talk of persecution.
- Professional dilemmas that militate against prosecuting or claiming for damages from patients who may lack insight as it can damage the therapeutic relationship
- Measures to predict violence failed – nurses need cognitive, situational and predictive skills to recognise problems, health education in anger management
- A flawed risk assessment diminished the ward's level of safety resulting in reliance on drastic measures – restraint and seclusion of the patient.
- The process of seclusion requires teamwork and adherence to local restraint and seclusion policies, response team flawlessly assembled without showing hostility to the patient, confidence level of the team, staff support in a crisis hallmark of safety, communication co-ordinating the whole element of care.
- Nurses taking their various roles, working diligently, consequences could be dire as observed by other patients.
- Legal cases referred to e.g. inquiry into David Bennett after prolonged restraint, and Munjaz court ruling of 2003 local health authorities had rights to formulate local policies that depart from the Mental Health Act (1983) in the best interests of the patient
- Additional rulings in 2005 further stated that the Code of Practice guidelines were not always legally binding.
- The student felt part of the team in providing mandatory observations for the secluded patient.
- Identified learning:
  - Making sense of the lived experience from practice and getting into direct contact with it
  - I treat patients with unconditional positive regard.
  - Human beings have diverse characteristics and emotional thresh-holds, some of which can stall the nurses' quest for excellent service.



- Prepared the student to face similar situations with confidence and professional maturity
- Increase in the nurse's abilities and a greater awareness of the complexity of nursing practice
- Improve clinical effectiveness and legal implications of restraint and seclusion as this may help in preventing litigation.
- Improving and developing professional behaviour
- I have gained new perspectives to set myself personal goals that facilitate effective patient care that may eventually eliminate the use of seclusion.
- Understand the implications of caring for mentally ill patients with unpredictable behaviours
- Plan to find research-based methods of maintaining safety and order in psychiatric wards without breaching the tenets of humanity, dignity and human rights
- Past influences the present practice in restraint
- Frequently used safety and control measures are frightening or humiliating to those on the receiving end.
- Planned to keep a journal or action plan to record incidents that evoke soul searching and reflection
- Personal change and growth
- Rigorously and systematically develop self and work in a manner that fosters a deep sense of obligation, commitment and moral purpose to the nursing profession.
- This will enhance knowledge, skills, values and attitudes necessary for safe and effective practice and also lay a foundation for continued professional development and lifelong learning.

## **Story 2**

One morning I had the opportunity to coordinate a whole shift. Soon after delegating duties a patient asked me to look into his notes to see what the outcome of last week's clinical team meeting was. I took his notes and sat down in the office to look for the notes of which I did not see. I informed him that I could not find the entry, he did not take it kindly and he became angry stating I was messing it up for him and I should stop smirking at him. I then said to him, I did not think I was and he started wagging his middle finger at me. I asked him to stop but he then stated that no one tells him what not to do. He then shouted obscenities at me and I terminated the conversation at that point. He continued to shout abusive language such that other nurses had to intervene. The nursing team agreed to send him to his room as his behaviour was distressing other service users.

### *Story 2 – Learning account*

- Planned how best I was going to achieve the objectives of the day, a crucial part of my strategy to ensure effective management
- Delegation is a requisite of good supervision as it supports trust and confidence in your subordinates as you are sharing responsibilities.
- Better supervision cannot do anything alone.
- Communicated day's programme to the patients
- The way I acted was good practice, but the way the patient's behaviour was not acceptable, reference made to the zero tolerance campaign
- Managed to distinguish my problem and that of the patient, detaching myself a little in order to get things into perspective, if cannot engage in distancing risk of being drawn into people's problems and can no longer help them
- Leadership and communications are inseparable.
- I remained apprehensive as I was conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures.
- Learned how to manage and co-ordinate a group of patients during shift.
- I employed some problem-solving techniques.
- I was left with the final decision – but involved others including patients and colleagues, participative leadership, makes everyone feel valued
- I should have been more democratic in delegating tasks staff a chance to choose
- I have insight into dealing with a group of patients, be more assertive

- I used my delegating duties, communication, decision-making and problems-solving to execute duties as a nurse in delivering and managing care of patients while at the same time achieving learning needs.

### **Story 3**

This is an account of an incident that happened while on clinical placement as a third year student. I was attached to a crisis resolution and home treatment community mental health team. The NHS plan July 2000 called for the creation of Crisis Resolution teams in order to offer an immediate response to mental health crisis. Crisis resolution means responding rapidly to, and supporting adults, who are experiencing a severe mental health problem that might lead to hospital admission. The primary function is to maintain the service user's community tenure, through home focused assessment, support and short-term treatment and therefore avoiding unnecessary hospital admissions. Patients under home treatment care are visited at their homes throughout the day. Depending on the need they may be visited once or twice a day. The frequency of visits is determined by the severity of the illness or crisis.

As part of this treatment strategy, during a morning shift I was allocated a patient who had recently presented at A&E having taken an overdose triggered by social stressors and recent bereavement. I was paired with a member of staff who was a community support worker. Simon had a diagnosis of depression, which was managed by medication. In addition, he had a disturbed sleep pattern. Furthermore Simon was using alcohol as means of coping with his distress. My role during this visit was to assess, monitor his mental state and administer medication and offer any other relevant interventions required during the visit and later give feedback to the team about his progress.

The previous day to the current visit police and the ambulance staff had to be called to his house to assist gain entrance into the house as staff from home treatment had failed to do so. Simon had overslept and our staff fearing for the worst summoned for assistance. This further lowered his mood and he thought the presence of the police had relayed a wrong message to his neighbours that he was a bad person.

When we arrived the patient was very low in mood, stating feelings of worthlessness and indicating that he was better off dead than continuing to live. He began to cry during the visit. He wept uncontrollably and could not be stopped or consoled. He declined to take his medication, which was part of his treatment citing that he did not need it anymore.

#### *Story 3 – Learning account*

- Before the visit I had gained all of the necessary equipment and preparation required.
- Ongoing assessment of a patient with depression is one of the most fundamental functions and strengths of a competent nurse.
- It is the first step of the nursing process and is essential to the formation of appropriate care for all people in need of help.
- Administering of medication and feedback about his progress following this. Antidepressants are the first line of treatment for moderate to severe depression (ref given).
- When the patient was crying I did not know what to do to defuse the situation
- Trying to get the patient to express feelings can help identify accept and work through feelings even if these are difficult.
- The use of a problem-solving process to facilitate patient's confidence in the use of coping skills
- I learned that the patient was lonely and isolated, took him for a drive and went with him to the community day centre.
- Day services can help a person resolve their crisis and learn self-management techniques.
- Alcohol makes depression worse helped to explore healthier ways of dealing with stress and difficult situation e.g. physical activity to relieve tension in a healthy non-destructive manner.
- Referred to bereavement counselling loss of his grandmother
- Depressed patients have a potential for suicide, and suicide prevention was at the top of our agenda.

- I might have made him cry due to my inexperience and lack of confidence in my abilities, but was pleased when we went for a drive as I had proposed this activity making him feel relaxed.
- Making referral to other agencies and professionals using an holistic approach to a patient's needs
- I learned that I probably was expecting too much of myself without recognising the limitations of my abilities and knowledge and taking into consideration that I was still undergoing training.
- I could have utilised qualified staff's knowledge better.
- Aware of the potential hazards of lack of knowledge and how this can take away confidence and can impact negatively on patient care

#### **Story 4**

I am going to detail an area of practice experience that involved managing one patient for a whole shift on a forensic adolescent unit. It focuses on the management of violence and aggression with particular reference to James. The story demonstrates how I used leadership skills to manage this patient for a whole shift in my capacity as a third year student shadowing a qualified nurse.

After a morning hand over, I was allocated to look after a patient called James. James had been presenting with command hallucinations and as a result, he became restless, agitated, aggressive and violent. His behaviour was so disturbed that the psychiatric restraining team had to be called. Physical intervention was exercised. Restraining management skills were then used. To avoid prolonged physical intervention, rapid tranquillisation together with seclusion was considered to help him calm down. A staff member was then allocated to carry out continuous observations from outside the seclusion room. Every 2 hours nursing staff reviewed whether James had calmed down enough to end the seclusion. Additionally, every 4 hours medical staff reviewed whether James could be released from seclusion.

#### *Story 4 – Learning account*

- Conflict of feelings about physical restraining as a way of managing violence,
- Caught in between a situation in which patients and staff were perceived to be at risk of harm and the sense of duty to protect as well as the professional, legal and ethical responsibility to protect patients.
- Considering the after effects of restraining in terms of personal and emotional impact of restraint situation on other nurses and me.
- After the incident I felt relieved as it had been dealt with instantly, I felt safer with the patient locked up at the same time guilty about the need for secluding James.
- The restraining process is unfriendly, I dislike getting physical with patients and unsatisfied because alternative strategies such as de-escalation skills were not fully considered before restraining the patient.
- The patient felt punished, and I felt it had damaged the therapeutic relationship with the patient.
- Challenging the process of restraint in practice and the idea of seclusion
- Physical intervention should be avoided in the future.
- Help with violence management if the problem occurred again.
- Made me want to critique the idea of seclusion. Eliminate the use of seclusion in the future
- Physical interventions should be avoided, should not be used for prolonged periods and should be brought to an end at the earliest opportunity.
- The process of restraining requires more than 3 staff members, believed to restrict diaphragm motility in obese patients and contributes to deaths during restraint
- The restraining team demonstrated teamwork, inter-professional practice and record keeping as integral part of teamwork and help with violence management if the problem occurred again.
- The situation involved a lot of management and leadership skills, the shift leader delegated staff accordingly taking into consideration appointments, escorts, psychiatric response, medication, ward security and other activities that were going to take place that day.
- Clinical judgement was used as a clinical skill to determine whether James had calmed down so as to end the seclusion

- Observation is essential to help the patient and staff, engage in a positive trusting way.
- Problem solving and decision-making skills are important to professional nursing practice; derive clinical governance ideas involving quality improvement programmes on organisational developments.
- Clinical governance involves self management skills of professionals such as professional developments in education, audit, guidelines, managing time, increasing confidence, developing self awareness, learning from errors.
- All require effective communication that facilitates progress in a nursing environment; if not manipulated effectively, communication can breed anger, disagreement, uproar and confusion at the expense of health, promotion and education. Considered as a yard stick in nursing practice and if used in the de-escalation technique is a concept that has a great impact on the management of violence.
- I have learned:
  - Increased self awareness and professional expertise, provided an opportunity to examine practice and identify new knowledge
  - I need to improve my clinical judgement skills read more about teamwork and partnership.
  - It is important to document clearly and key issues
  - Before restraint is imposed other interventions should first be sought e.g. de-escalation skills, make use of the soft furniture room specifically designed for the purpose of reducing agitation.

## 6.5 - Qualified post graduate nurses stories and learning accounts

### Story 1

Spent half an hour learning to use the new Doppler machine with colleagues, looked up and read the history of the Doppler and advances in the present day use in the following:

- Leg ulcers – incorporated a practical guide to management
- Assessment of the lower limb
- RCN continuing education articles on arterial and venous ulcers

Performed Doppler assessment with the G grade sister supervising on patient with ulcerated ankle, the API was 1.21 indicating venous impairment. A compression bandage was applied.

#### *Story 1 – Learning account*

- What is an ultrasound Doppler assessment why undertaken, non-invasive evaluating ulcerated limbs
- Determination of the API systolic pressure in the ankle is divided by the systolic brachial pressure, resulting figure indicates the presence of either venous insufficiency or of arterial impairment
- If API less than 1.0 it is unsafe to use compression bandaging as it indicates arterial impairment
- Contraindicated in diabetes and rheumatoid arthritis
- Learning from the story:
  - Doppler is used on a variety of patients and new equipment and advanced equipment continue to be developed
  - Important for nurses to recognise the differences when implementing a new piece of equipment, research is important on the use of Doppler as an assessment tool.
  - Conflicting problems when testing leg ulcers, each case as individual.

### Story 2

Took a phone call from a patient needing a specific injection at 9 p.m. that night, and discussed procedure for referral to twilight nurses. Filled in and faxed correct form and confirmed this had been received.

Ordered a cushion from medical loans, but mattress arrived, due to insufficient information. From this I have learnt the correct procedure, including the use of Waterlow scale, for determining the risk of pressure ulcers.

I accompanied G grade on two first visits for assessment of needs. The patient informed about social services who will help to undertake personal care and the occupational therapist

(OT) who can advise on appropriate hand rails if needed. I discussed with G grade how to make referrals to these agencies.

Met OT in surgery and discussed a specific patient and his needs with her. I also met the MacMillan nurse who is visiting one of our patients. As often communicates by phone, knowing who you are speaking to makes for better communication.

#### *Story 2 – Learning account*

- Other agencies that patients are referred to on a regular basis:
  - Social services
  - Occupational therapy
  - Physiotherapists
  - Chiropodists
  - Twilight nursing services
  - MacMillan nurses
  - Marie Curie
  - Medical loans
  - Speech therapist
  - Health visitor
- Identifies the extent to which patients need help to achieve maximum independence and to maintain an acceptable quality of life
- The need to establish a good working relationship is required with all agencies
- Regularly assess and evaluate the input from agencies and be aware of the changing needs of the patient and families
- Began to function effectively in a team and participate in a multi-professional approach to the care of patients
- The referral process to other agencies for patients to gain access to the correct agency for the needs of that particular individual

#### **Story 3**

Accompanied G grade on first visit to a patient after discharge from hospital and observed a complete assessment based on the activities of living contained in our community patient's notes.

Obtained a discharge-planning checklist from local hospital to help identify the hospital's perception of a patient's needs on discharge, from our GPs audit we discovered that every point on the discharge literature does not always get covered in practice. The results obtained from the audit are being used to improve future discharges.

I attended primary health care team meeting to discuss results of the audit, which is known as significant event audit. It was stimulating and beneficial to take part in, as it has highlighted problems experienced by the patients and us. The patients had been informed of the audit after it took place, and were asked to fill in a questionnaire relevant to their discharges. This was very important as patient's participation is essential for improving discharges into the community.

#### *Story 3 – Learning account*

- Good communication between agencies involved in patient discharge from hospital starts before the patient leaves hospital
- Continue to evaluate and improve services to patients and relatives when newly discharged from hospital
- Be alert to current literature and research on the subject

#### **Story 4**

I cared for a 75 year old woman who had her hernia repaired, after spending 3 days on the ward contracted MRSA in her wound and had to be placed in a side room for barrier nursing. This involved being in a room on her own and members of staff and family having to go through a process of putting on gowns, masks and thoroughly washing hands before entering and on leaving the room. Consequently, I read a chapter on social isolation, which is defined in the nursing literature as 'aloneness experienced by the individual and perceived as

imposed by others as a negative or threatening state'. The chapter refers to social isolation of the elderly contributing to worsening health, leading to further isolation, unless this can be relieved.

#### *Story 4 – Learning account*

- I began to recognise the detrimental effects of social isolation on the health of elderly individuals.
- What it means to a person to be socially isolated, and the affect it can have on health
- More alert to individual needs and can now provide necessary information to patients being barrier nursed in this way.

#### **Story 5**

Phoned the local benefits agency to ask for latest information on the attendance allowance in particular and other benefits in general and since then I have become more aware of the disability living allowance for those who are aged under 65, who are ill or disabled as we have several patients who fall into this category. I requested and received the booklet FB28 entitled 'Sick or disabled' from the DSS with current rates and information. Also the current claim form DS2, which will be helpful when recommending a patient to claim the attendance allowance. I ensured that when necessary I informed patients who did not know about this benefit and how to apply for it to be in a better financial position.

#### *Story 5 – Learning account*

- What benefit is, who qualifies, exceptions, rates of pay, method of payment, rates for special rules
- How extra money can improve quality of life for a person who is sick or disabled. It may ease the burden on a spouse who may have been struggling to care for their loved one, and whose own health may have been put in jeopardy.
- Allowance can be used to improve life style of the sick person, enabling them to go out occasionally or have a sitter so that their carer can be given a regular break each week.
- This is not a means tested allowance and so people can apply even if they are well off and is available to everyone over 65 who needs help and personal care.

#### **Story 6**

I helped this patient over a period of a few weeks to resolve her constipation problem. In the process I observed her anxiety levels decreasing, which in itself helped her constipation. I also made an appointment for her to see her GP, which I knew she wanted, but would not do it herself for fear of being a nuisance. Read a report related to this on the use of wholemeal bread versus laxatives. The study showed that over a 4-month period of media marketing of brown bread, its sales went up by 60%, and the sales of laxatives went down by 60%. This method of promotion was proved to be more effective than patient education by doctors. It also states 'it is now well accepted that increased fibre in the diet is a better way of preventing constipation than the use of laxatives'. This information has been very useful for me when caring for elderly patients in the community.

#### *Story 6 – Learning account*

- Assessment of a patient who is constipated, medical history, daily bowel function
- Current types of treatment for constipation available, their action, the effects of these different treatments
- Suitability of diet and exercise to recommend to patients
- A sensitive approach to the subject.

#### **Story 7**

This story is about an encounter I had with a young woman in her late teen (17), who was electively admitted for right video-assisted thoracic surgery (VATS) and pleurodesis, as she had suffered two right sided pneumothoraces within the last 6 months. On admission Gloria was escorted by her mother. I began to interview Gloria with her mother present, and initially I did not think this a problem until I came to the part in the nursing plan which referred to asking questions around Gloria's sexual history and was there any possibility that she could be pregnant. I felt awkward asking such detailed information in front of Gloria's mother, as it

could be a breach of confidentiality as Gloria may not want her mother to know about her sex life. I noticed, however, despite my concerns around the issue of confidentiality with Gloria's mother, even when Gloria's mum had left the room for a coffee, I remained uncomfortable about asking the necessary and pertinent questions required to obtain a detailed structured history of a sexual nature especially with a young adult / adolescent.

#### *Story 7 – Learning account*

I learned about:

- The functions of a consultation – building a relationship, collecting data and agreeing a management plan with the patient
- Concordance which is described as a joint and shared approach and equal partnership during consultation between patients and health care professionals in the decision making process, the interesting issue here was that did the young adult have the same advantage
- Considering the difference between adults and adolescents and whether it is appropriate to use the same strategies of care and consultation
- My tendency to skim over details of a sexual nature was also found to be what makes many nurses feel uncomfortable, but information was needed such as if she was on the pill or sexually active, the date and time of her last menstrual period, was pregnancy a possibility. All of this information is relevant for the prescription of drugs
- The legal age of consent to give permission to perform the operation was Gloria old enough and when is she deemed competent, she can give consent at 16 as long as she is deemed competent, which is automatically assumed when over the age of 18

#### **Story 8**

This story begins with a consultation I observed between a nurse practitioner and a nervous young man in his twenties. Towards the end of the consultation the gentleman asked if the nurse would prescribe an asthma inhaler for his friend who was visiting him from abroad.

The nurse explained that she was unable to prescribe anything for his friend. She ascertained that the friend was not experiencing any immediate breathing difficulties. She also explained she would be happy to see his friend if he registered as a temporary resident at the surgery. She also told this could man how this could be done and what his friend should do if he experienced acute breathing difficulties i.e. attend accident and emergency. She discussed this with the practice manager to confirm her position. After the consultation she documented her actions.

Initially, apart from being impressed at the professionalism of the nurse practitioner I paid little attention to this consultation. However, after writing this story I realised the significance of this brief encounter seemed much more pertinent. I felt it was representative of the type of ethical dilemmas that Nurse Practitioners may be faced with daily. It made me realise that up until this point I had not taken the potential areas of tension we had been warned about seriously. Despite being an experienced nurse used to facing dilemmas of various natures, I had not truly considered the areas of tension that may arise from being able to prescribe.

#### *Story 8 – Learning account*

- I learned about the importance of practising within protocols, guidelines, recommendations and the law, to not prescribe outside of this.
- Untreated asthma can ultimately lead to death, which have been prevented if the NP prescribed the inhaler
- Seven steps to good prescribing:
  - Consider the patient
  - Consider strategy of treatment
  - Consider the choice of product
  - Negotiate a contract
  - Review the patient
  - Record keeping
  - Reflection
- Practising within the set guidelines though can sometimes be difficult, but the patient was not present, could not be assessed or examined or a complete history obtained.
- The NP could therefore not prescribe and could have been negligent.

- Yet nurses still may experience pressure from patients/carers colleagues and pharmaceutical companies
- A full appreciation of all implications is essential, and NP are accountable for all prescribing decisions they make including not to prescribe.

### Story 12

Mrs Y was a 15 week pregnant suffering from vaginal bleeding and was brought around to the major's area by the triage nurse. Mrs Y accompanied by her husband was placed in a side room. According to the A&E guidelines, any women suffering from PV bleeding should be placed in a side room. The need for privacy and dignity for any women suffering from a miscarriage is one of the great importance. From her presentation and PMH it was inevitable that Mrs Y was having a miscarriage.

Mrs Y was extremely anxious. My thoughts were, should she receive an explanation that she is probably miscarrying and possibly devastate her before a firm diagnosis has been made or should she be told everything would be OK, when it more than likely is not, just to reduce her anxiety. An explanation was made that bleeding was not a good sign, and could suggest a miscarriage, but it could not be confirmed until a doctor examined her. At that moment I was called out of the room to assist another colleague. I did not return until sometime later.

When I returned to Mrs Y to check on her she was hysterical. She was pointing towards her vagina and was passing the foetus. I called for the doctor. Mrs Y was holding onto me and crying. I tried to comfort her in the only way I knew how, by hugging her and talking to her.

#### *Story 12 – Learning account*

- I learned that it is easy to incorporate the care of patient's physical needs but not so easy to consider their psychological and social needs as well. These were not met appropriately and they could have profound effects on her later.
- I learned how one particular story can have such a profound effect on me. I found I was struggling not to appear upset, holding back the tears, trying to act as a professional. However, by acting as a professional rather than a sensitive human being and not showing any emotion, I did not show the depth of my understanding and empathy. I was sharing the experience with her, she was not alone, but I was not showing this to her, I felt it, but was held back by how I thought I should act which was professional
- Through sharing this story
  - I have gone away and researched miscarriages to enhance my knowledge and understanding
  - I have tried to visualise myself in the patient's situation and asked what would I do, how would I feel?
  - It has helped me to adapt the way in which I manage the psychological needs of a patient experiencing a miscarriage and improved my ability to manage future patients more effectively and holistically.

### Story 13

Mr V sustained burns to his right hand and wrist from boiling water. He was brought around to minors from triage. I had limited knowledge on burn injuries and was able to assess Mr V. I did an initial assessment which involved the rule of nines to assess the extent of the burns, and noted that he had sustained a combination of superficial and partial thickness burns as some areas were red, and others had blistered. The NP instructed that the wounds should be dressed with Jelonet and mefix and was to return for review clinic and a review dressing within the next 48 hours. Although I had never used mefix on superficial burns before, I did not question the NP experience and knowledge, and as there are no guidelines for management of minor burns, I did as I was instructed and Mr V was discharged home that evening. The following 48 hours another staff nurse challenged me over the choices of dressings used on Mr V as she had redressed his wounds that day. She was appalled that I had used mefix on Mr V as when she took it off it had removed some skin with it. I explained that I had dressed his wound on instructed by the NP, but as I had little knowledge on minor burns dressing was unable to justify the choice.



I felt irresponsible for the treatment I had given Mr V as I am accountable for my practice and in accordance with the code of professional conduct clause 6, nurse must maintain their 'professional knowledge and competence' with a responsibility to 'deliver care based on current evidence' and 'validated research when it is available'.

#### *Story 13 – Learning account*

- Through sharing this story
  - I have gone away and researched minor burns and their management extensively and there is little evidence on the most appropriate dressing
  - The evidence that I found advocates the use of mefix in superficial minor burn management, but implied that it should not be removed for seven days, as it promotes a moist wound healing environment and should not be changed at least for the first 48 hours and very infrequently after that as frequent changes interrupts the wound healing process.
  - I am hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries, to prevent confusion over the most appropriate dressing, and the importance of not changing the dressing too frequently.

#### **Story 14**

The patient referred to in this story is a 13 year old girl which presented to the A&E department alert but appeared to have dystonic symptoms. As a trained staff nurse working in the resuscitation area, I looked after the patient from admission to discharge. Ms Z family did not speak English and therefore a history could not be obtained. From her notes I could see that she had attended A&E the day before and asked reception to print off those notes. Whilst waiting for the notes I carried out her vital signs which were all within normal limits. From my experience Ms Z appeared to be having an oculogyric crisis and lateral torticollis. I had only seen two patients with these symptoms before, both of whom were reacting to metoclopramide. I was unable to get any information from the relatives due to the language barrier, but I knew that metoclopramide is contraindicated in under 20 year olds and therefore did not believe that it could have been due to this. A doctor joined me then to assess the patient and seemed as puzzled as I was and obtained IV access. I felt frustrated due to the language barrier and concerned for Ms Z. Eventually the old notes came which highlighted that she had been administered metoclopramide the day before as a TTA, which meant it had been dispensed from us as pharmacy would not have been open at that time of night. We immediately administered procyclidine IV to treat the reaction, which was successful.

#### *Story 14 – Learning account*

- I could not believe that metoclopramide had been prescribed to a 13 year old, as it is well documented and evidenced as to the extensive adverse reaction when given to children. I was shocked that it had been given and administered. Had I not previously remembered stories from my previous practice, I may not have recognised it.
- I have learned to question, if unsure, all prescribed medications to patients as we are accountable for our actions. As a result of this incident, guidelines have been introduced for prescribing anti-emetics for children.

## Appendix 7 – An overview of student stories

### 7.1 – Summary of 2<sup>nd</sup> year adult student nurses' stories

Student story	Overview of student story	Relevance to story
1	In the community arrived to give patient insulin but there was no stock, had to return to GP to get supplies	The student and mentor saved the day by getting the insulin.
2	Did a colleague a favour as was busy and escorted patient to theatre but did not know what operation the patient was having	The student was a hero for helping out a colleague in need.
9	Handing over a patient, but being ignored by the more senior nurse, no eye contact, waited for her to finish, started again, was challenging, assertive	The student was persistent to get the best for the patient. The power struggles that occur in practice.
10	Patient's condition deteriorated – forgot to hand over a vital piece of information e.g. changes in blood results	The student may not have known the importance of results as not qualified.
12	Discussion with medical team on a ward round, patient arranged to have a scan, stood behind the sister, assumed that was the student's rightful place.	Power struggles that occur between staff members
13	An elderly patient in a nursing home with an arterial leg ulcer due to heart failure	Loneliness of the elderly, suffering
14	A patient receiving palliative care, lack of assessment from the referring hospital, GP not available, records retrieved by secretary so when full medical history obtained a visit could be arranged.	Poor communication affects a patient's care and interventions
15	Pancreatic cancer terminal palliative care medication, support provided – wife thought patient abusing his medication	Wife concerned. The nurses confronting the situation and sorting it out.
16	Gynaecology ward learning to work independently, patient admitted with hypodermises.	Student learning how to become a nurse
18	Caring for a patient in A&E intuitively felt something was wrong but could not put it eloquently; remained concerned tried to explain finally got heard and the patient transferred to CCU	The student had acted so the patient got the care they needed.
21	Patient in A&E, PMH trying to be obtained, specific questioning needed when trying to gain relevant information, patient had little understanding of her medical conditions.	The student was attempting to gain detailed information.
23	Student not gaining sufficient experience on a general medical ward, the mentor could not fully relinquish the charge of the patients to the student.	The mentor was not able to support the student to gain managerial experience.
26	Patient in the sitting area of A&E and observed she was not comfortable here, so taken to a more private / quieter area.	Student was compassionate to her patient's needs
27	Inter-hospital transfer from an acute general hospital to a specialist hospital in inner London, the benefits of good organisation when transferring a patient.	This was pure excitement for the student but required high technological interventions while on the journey.
33	Experiences on an oncology ward	The student was experiencing so much it was difficult to draw out one thing.

36	Zoromorph SR prescribed or Morphine Sulphate	The complexities of prescribing and the different names used
44	Patient wanting to just die and not letting his wife know his feelings.	Ethical issues of not telling relatives vital information.
50	A confused patient, 'tut' by others at their behaviour	Others' prejudices
54	Patient having a second colonoscopy after first went very badly the patient was anxious and afraid.	Supporting the patient

## 7.2 – Summary of 3<sup>rd</sup> year adult student nurses' stories

Student story	Overview of student story	Relevance to story
17	I was caring for two patients as part of my management 3 <sup>rd</sup> year module. The first patient had rib pain, the second an asthma attack.	The student had to decide which patient to care for first.
21	I was allocated with three patients to manage their nursing care for the entire shift although I was supervised by my mentor.	Nurse had to assess the patients and decide which one to care for first.
23	I was working on a resuscitation department; was involved in the care and management of a patient taken an overdose of cocaine.	This patient was in a critical situation and may die.
30	A student nurse, who wanted to see 'long-day' shifts implemented, the charge nurse (CN) was not keen to implement the change.	The power struggles that the student was up against in practice
32	A Polish man with pain and redness in his left eye had difficulty speaking English and was unable to explain the mechanism of injury, possibly splashed acid in his eye.	Difficult to know what had happened; if acid he could lose his eye
33	The patient had an elective Laparoscopic Gastric Sleeve Resection due to obesity. She weighed 161 kg and had a Body Mass Index of 61.	The story was emotional and the nurse helped the patient significantly in this story.
34	A patient with a low heart rate (bradycardia), she was connected to a cardiac monitor. The patient had ovarian cancer and had two cycles of chemotherapy.	The patient was dying, suffering from other conditions, already undergone high technological treatments
35	A patient was a 43 year old lady with respiratory problems, consumed excessive alcohol and taken an overdose of sleeping tablets. The resuscitation team were called immediately.	The reasons for taking the overdose, the resuscitation team would have life saving equipment
36	A patient that had been on the ward for 28 days, now stable and nursed in High Dependency Unit (HDU). Patient had community-acquired pneumonia but also had a past medical history of Systemic Lupus Erythematosus (SLE) and Primary Sjogren's Syndrome (SJS).	This patient was critically ill and possibly dying, was attached to invasive equipment and had previously undergone many investigations to determine diagnosis.
37	An 85-year old lady with left buttock pain and lumbar stenosis, reluctant to leave her bed, the pain exasperated the situation. Encouraged patient to leave her bed, to transfer to and from the lavatory and to sit in her chair which enabled her to eat and drink.	Through essential nursing care the patient's condition improved.

38	The patient had been admitted into hospital for surgery to repair a ruptured abdominal aortic aneurysm. Had a temporary tracheotomy, was receiving BiPAP (bilevel positive airway pressure) ventilation, the plan was to wean him to be able to self-ventilate, with 5 litres of oxygen.	This patient was having high technological interventions to assist with his breathing.
39	I found the heart rate of one of the patients had developed into a cardiac arrhythmia. I reported this to a registered nurse. Could be dehydration, pain, electrolyte imbalance. Continued to monitor vital signs.	The nurse had noticed that something was wrong and prompt interventions were given.
40	Asked to look after a patient and deliver all care necessary with supervision for a patient who had a left total knee replacement; she bled and required intervention	The student noticed the bleeding of the wound and the patient required high technological interventions.
44	Looked after a 56 year old gentleman who had suffered a subarachnoid haemorrhage (SAH). Mr X was sedated since, on a ventilator, having hourly neurological observations, continuous cardiac monitoring, an arterial line, ECG, nursed with head elevated at 30° and had a central venous pressure line.	Multiple high technological interventions
48	My experience in the recovery room was encouraged to interact with the patients, perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient.	Constant observation of a patient to ensure stable condition
51	I had been assigned to care for a patient who had a total hip replacement operation and needed his wound dressing changed. I cleaned the wound and my mentor suggested I carry out the procedure more speedily which I did, because when bones are operated on, the risk of infection to bones is serious.	The student was a hero for changing her practice; the mentor could be seen as a villain.
52	A severely ill patient gets diarrhoea and says sorry to the nurse caring for him.	The caring shown by the nurse towards the patient.

### 7.3 – Summary of 3<sup>rd</sup> year child student nurses' stories

<b>Student story</b>	<b>Overview of student story</b>	<b>Relevance to story</b>
1	Allocated the care of a dying child, admitted to the ward for tender loving care following increased severity of congenital hydrocephalus.	The child had suffered in its young life and was going to die.
2	I cared for a 6 year old with profound learning difficulties, severe epilepsy and pneumonia. The child had a femoral line for administration of drugs, a feeding line, was completely dependent on the care of her mother who stayed with her on the ward most of the day. The child's mother had four other children at home.	The child was severely ill and required high technological interventions. The mother a hero for taking care of her sick child and taking time for the others
3	A 10-month-old baby with a chest infection, attached to oxygen saturation monitor and regular nebulised medications given. The child sat up in the cot, the child's mother kept laying her down and the child's oxygen levels fell. An interpreter explained the reasons to keep the child propped up.	The child was very ill and required high technological interventions. The mother the villain for not taking the time to understand the situation

4	Undertook the admission of a child with suspected bacterial meningitis. I took a set of clinical observations blood pressure, temperature, heart rate, saturation levels and respiration rate capillary refill. It was vital to ensure level of consciousness.	The child was seriously ill and bacterial meningitis can be fatal.
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#### 7.4 – Summary of 3<sup>rd</sup> year mental health student nurses' stories

Student story	Overview of student story	Relevance to story
1	The alarm sounded requesting assistance on one of the wards in the psychiatric unit. A nurse had been punched and kicked several times by one of the patients who appeared excited and agitated. A decision to seclude the patient was made.	The situation could be out of a horror story, the patient viewed as a villain, and a tragedy due to the event.
2	A patient asked me to look into his notes to see what the outcome of last week's clinical team meeting was. I could not find the entry, and he did not take it kindly. He became angry, shouted obscenities and I terminated the conversation. He continued to shout abusive language and other nurses had to intervene.	This has similarities to a horror story or a tragedy. The patient could also be viewed as a villain.
3	A patient had taken an overdose triggered by stressors and bereavement, diagnosis of depression managed by medication. Also had disturbed sleep pattern and was using alcohol as means of coping. He was declining to take his medication, which was part of his treatment citing that he did not need it anymore.	The patient cannot cope or be helped and this was a tragedy, a villain for not helping himself and taking his medication.
4	I was allocated to look after a patient presenting with command hallucinations as a result of which, he became restless, agitated, aggressive and violent and the psychiatric restraining team had to be called. Restraining skills were then used.	The event could be out of a horror story, the patient a villain for his behaviour and the nurses heroes for their interventions.

#### 7.5 – Summary of post graduate student nurses' stories

Student story	Overview of student story	Relevance to story
1	Spent half an hour learning to use the new Doppler machine with colleagues, used on patient with ulcerated ankle. The ABI was 1.21 indicating venous impairment. A compression bandage was applied.	High technological equipment
2	Two first visits of patients in the community for assessment of needs. Took a phone call from a patient needing a specific injection at 9 p.m. that night. Ordered a cushion from medical loans but wrong mattress arrived due to insufficient information. Patients informed about social services. Met OT in surgery and discussed a specific patient and his needs with her. Also met the MacMillan nurse who is visiting one of our patients.	The phenomenal amount of work involved in all of this, investigating issues for patients.

3	First visit to a patient after discharge from hospital, a complete assessment, a discharge-planning checklist. Attended primary health care team meeting to discuss results.	The student was constantly assessing the needs of the patient at home.
4	A 75 year old woman who had her hernia repaired, after spending 3 days on the ward contracted MRSA in her wound and had to be placed in a side room for barrier nursing. Constantly monitoring for problems with social isolation.	The student was constantly observing for signs of the serious complication of isolation in hospital.
5	Phoned the local benefits agency to ask for latest information on the attendance allowance in particular and other benefits in general, the disability living allowance for those who are aged less than 65, who are ill or disabled as we have several patients who fall into this category. I ensured that when necessary I informed patients who did not know about these benefits and how to apply for it to be in a better financial position.	The student was trying to help the social needs of the patients, to inform them of what they were entitled to.
6	I helped this patient over a period of a few weeks to resolve her constipation problem. This information has been very useful for me when caring for elderly patients in the community.	The nurse was taking the time to help her patient to feel more comfortable and prevent other serious complications.
7	A 17 year old is admitted, but difficult to ask her questions about her sex life in the presence of her mother.	Empathy towards a young patient and the nurses difficulty in discussing private issues of sex.
8	The tensions that occur in prescribing drugs	Tensions in clinical practice
12	A miscarriage on the ward	Coping with this issue
13	Minor burns and the dressings that are applied in such instances. The importance of using the correct type of dressing in this instance	The use of theory to support practice.
14	A 13 year old is given Metoclopramide which is not recommended for persons under 21, the child had a reaction.	The dangers of some drugs to young people.

## Appendix 8 – Descriptions of the learning categories

Identified category	Interpretation of the categories
Practical	Student referred to a skill / competency that the nurse might do e.g. heart rate, blood pressure, giving a bed pan, catheter care.
Theory	Student mentioned a theory related to nursing or a piece of research or literature. Biological or identified patho-physiology e.g. diabetes, COPD, heart failure.
Intuition	Student comments related to 'I just knew something' or had 'a gut feeling about something', 'something was wrong' but were unsure how they knew.
Professional / critical thinking	If the student mentioned the NMC, processes of decision-making, problem solving, a questioning approach to care, tensions, critical thinking, responsibility for own learning
Ethical	Any process or philosophies identified within ethics e.g. decision-making, problem solving, autonomy, conflict, morality, informed consent. Legal issues related to care, dilemmas, empathy.
Emotional	A sad or happy occasion or an excerpt that details feelings regarding a situation e.g. concerns, fear, frustration regarding the situation, struggling, seeing the funny side of a situation or a funny story from practice.
Communication / interaction	Experiences of verbal, non-verbal, written documentation, barriers, communicating while undertaking tasks / skills, building relationships.
Cultural awareness	Sensitive to values, beliefs, practices and ways of life, variations in communication varied between cultures, differing cultural background, differing cultural issues related to patients dying
Learning from and with others	This is where students identify learning from another health care professional (HCP) by working with them and observing their practice or they supported their learning or answered their questions.
Hospital and community	Students referred to local hospital policies e.g. infection control, referred the patient to GP or social services facilities that were available in the local community.
Management	When students cared for and managed a group of patients and gave account of the complexities of prioritising their care, sought help, timing of actions, organising self and situations.
Reflection / personal learning	Self awareness, self as a human being, looking inward and thought about how they could have done things differently, gaining insight, looking outside of the situation, assertive.

Teamwork	Working with multi-disciplinary teams (MDT), a broad range of healthcare professionals (HCP), other agencies, sharing work load e.g. supporting, motivating and encouraging, communication.
Educating patients	Support patient to help them increase their knowledge of their illness / condition / drugs they are taking, compliance, concordance.



## Appendix 9 – Category analysis for each story and learning account

### 9.1 - 2<sup>nd</sup> year adult nurses category analysis

#### Story 1 (also in chapter 5 text)

<b>Practice</b>	<b>Communication</b>	<b>Learning from and with others</b>
The care of stroke and DM Improving patient care Delivering patient focused care Record keeping / documentation Quality of continuing nursing care Nurses' focus on the fundamentals of care Modern health care provision Must be actively involved to glean the knowledge the expert takes for granted.	If the quality of the hand over by the nurses who visited the patient the day before had been better the situation could have been prevented. Effective hand over prepares and enables nurse to take over the care of patients and continue to deliver high quality care. Communicating well with colleagues and others The vital role of communication Importance of communication to successful care Application of communication Hand over needs to be practised, structured and effective Communication depends on the nurse, client and other team members	The influence of mentors on student learning if not consistent throughout can impact on student learning Skilful role models help discover knowledge embedded in clinical practice Limitation and observational form of learning – absorb their role model's qualities and skills Opportunity to work with experienced and knowledgeable practitioners and observe them providing care
<b>Educating patients</b>	<b>Cultural awareness</b>	<b>Emotional</b>
Information sharing	The use of experienced staff to support students' fundamental to professional socialisation.	Failure to communicate effectively with someone can cause him or her concern, especially if vulnerable through illness.
<b>Teamwork</b>	<b>Hospital, community and government</b>	<b>Management</b>
The importance of MDT care	Clinical governance	Effective time management
<b>Reflection / personal learning</b>	<b>Theory</b>	<b>Professional development / critical thinking</b>
The role model observing mentors' enables students through the process of reflection, to internalise their mentor's behaviour and build on previous knowledge and experience	DM – two types, treatment, complications Stroke – blood vessels involved, what happens to cause a stroke What is involved in good communication – listening, guiding, thinking, engaging, making sense of knowledge and information sharing	NMC gives guidelines for professional practice Reinforces the professional status of the nurse Lifelong learning Student responsible for their own learning needs and must be actively involved

## Story 2

<b>Teamwork</b>	<b>Communication</b>	<b>Practice</b>
<p>Depends on team work Other staff members making sarcastic remarks about students no doing their job properly Influences on other team members in the work place</p>	<p>Communication depends on the nurse, client and other team members' relationship. Sarcastic remarks to students Students have to overcome many barriers to learning. Handing over a patient you have to be knowledgeable How perceived by others Positive and negative communication Communication is imperative in practice</p>	<p>Patients going to theatre Reading the patient's notes Understanding of patient procedures they are having done Importance of knowing the procedure patient(s) are undergoing even if they are not your allocated patient Taking a patient to theatre More confident in dealing with situations, understanding what I am doing The needs of patients in theatre</p>
<b>Emotional</b>	<b>Cultural awareness</b>	<b>Management</b>
<p>Frustrated, stressed Raising voices, angry expected in environments such as theatre?</p>	<p>People communicate in different ways, Attitudes need to be experienced and lived Must be able to adapt to certain situations Should not be judgmental Need to understand that working within health care environment you are going to come across certain people who are frustrated and stressed within their professional roles and peer pressure People's mannerisms may come across as rude or arrogant.</p>	<p>Dealing with situations better and not spoken to in front of the patient but in private How situations are managed Sorting out of problems and differences in an amicable way that does not affect the patient Creating a strategy for learning through uncovering the knowledge we have and identifying what more we need to know will help enhance our practice effectively</p>
<b>Professional development/critical thinking</b>	<b>Learning from and with others</b>	<b>Reflection / personal learning</b>
<p>Professional roles of the nurse Updating myself Nurses are responsible for their own learning Take action to update learning from experience Critical thinking is an educational need to allow students to use independent judgement and evaluation. Questions may be asked.</p>	<p>Acting superior, arrogance Teaching to be a better nurse in the future</p>	<p>Highlight good and bad situations and their outcomes Could have dealt with the situation better Turned the situation round from a negative to a positive Take negative criticism, not like it, learn from it in a good way so something good can come out of it Evaluate self</p>
<b>Theory</b>		
<p>Theories can be taught.</p>		

### Story 9

<b>Reflection / personal learning</b>	<b>Communication / interaction</b>	<b>Practice</b>
<p>Not presenting myself as confident, garbled words Nurses are under pressure. Recognised my body language, ineffective / weakness in communications skills</p>	<p>Nurses doing something else when trying to communicate Not listening to what I was actually saying Verbal communication, no eye contact Barriers to communication Communication is core to care. Taking notes, can mean information is incorrectly passed on, plan and meet unstable patients needs Not listening to me as only a student How to get someone to listen to you</p>	<p>Opportunity to become competent Improving my confidence in a particular area of practice Learning to be more assertive – move to another room Delays affective patient care. Communication is the most valuable skill a nurse can have</p>
<b>Emotional</b>	<b>Learning from and with others</b>	<b>Management</b>
<p>Felt pleased with a learning opportunity <b>Feelings of inadequacy, inferior, foolish</b></p>	<p>Delegated a task to me I was up for the task and trusted to undertake this by my mentor. The significance of the action of others on performance of student</p>	<p>Knowing when to seek help when necessary Appropriate timing of actions</p>
<b>Teamwork</b>	<b>Hospital, community and government policy</b>	<b>Professional development / critical thinking</b>
<p>Support other health care professionals as much as possible Awareness of how inter-relate with members of care team</p>	<p>National standards agency, DoH does not advocate working from memory.</p>	<p>Need to improve communications skills Recognition of areas that need to be improved</p>

## Story 10

Theory	Communication	Ethical
<p>SVT, IHD, ECG continuous monitoring, cardiac monitoring, interpretation e.g. irregularities, interpretation of increased heart rate.</p> <p>Non sustained VT returned to SR</p> <p>Electrolyte analysis – these are dissolved in water become ions and generate an electrical charge beneficial for normal functioning of the heart.</p> <p>Ultrasound scan of the heart</p> <p>Read forms of literature to help understand patient's condition</p>	<p>Took telephone enquiries, explanation to the patient as to what was happening</p> <p>Calling the doctor to come to see patient informing of the patient's condition</p> <p>Asked to give verbal hand over to night staff</p> <p>Information forgotten regarding VT episode and subsequent interventions</p> <p>Talking to the patient about how he felt</p> <p>Documentation as a vital source of communication</p> <p>Communicate care to other members of staff</p> <p>Read patient's notes to help understand the patient's condition</p>	<p>Sought consent for procedures, drew curtains for privacy, maintained dignity</p> <p>Patient confidentiality</p> <p>When areas of documentation are forgotten it can affect the continuity of care being received by the patient.</p> <p>Documentation should include data about what was observed and must comply with professional standards and legal requirements.</p> <p>Avoiding omissions</p>
Learning from and with others	Management	Practice
<p>Care for a patient under the supervision of mentor</p> <p>Regularly consulted with my mentor</p> <p>Observation of my mentor taking a blood sample</p> <p>Observed by mentor, who was able to give the information I failed to give, this related to some prescribed medications (electrolytes) the patient had been prescribed</p> <p>Positive feedback from mentor regarding performance</p> <p>Support of mentor, patients of other staff who were patient and attentive</p> <p>Mentor taking over when necessary, when student knowledge can go no further.</p> <p>Wanted to observe the scan</p> <p>Was able to understand due to the explanation given to me by my mentor the relationship between VT and electrolyte imbalance e.g. potassium</p>	<p>Timing of care BGL and fluid balance for that hour were overdue and still needed to collect some of his medication from pharmacy</p> <p>Enthusiastic and confident that could manage patient's care</p> <p>There were so many things to do within specified periods of time and this put my time management skills to the test.</p> <p>Staff hierarchy</p> <p>Organisation of written documentation, forgetting details and information</p> <p>Forgetting information can be due to the busyness of the ward during certain periods</p> <p>Taking down short notes, as useful so things do not get forgotten</p> <p>Prioritise nursing care given to the patient.</p>	<p>Setting up e.g. alarms, connection of patient to a monitor</p> <p>Adhering to strict hand washing techniques</p> <p>Monitoring of fluid balance</p> <p>Administration of medication when they were due</p> <p>Knowing what to do when monitors alarm</p> <p>Taking a 12 Lead ECG</p> <p>Patient remained stable, continued monitoring his vital signs and administering care to him</p> <p>Completion of documentation in nursing notes ensuring accuracy of these</p> <p>To give information to a group of qualified professionals.</p> <p>Taking note of subsequent events</p> <p>Monitoring vital signs and documentation</p> <p>Communication is an integral part of the nurse's role</p> <p>Poor communication has a negative impact on care</p>
Professional development / critical thinking	Emotional	Reflection / personal learning
<p>NMC: nurses can identify accountability by documenting an event as soon as possible after its occurrence.</p> <p>Preserving professional integrity</p> <p>It has helped identify learning needs.</p> <p>Should be asking questions to mentor after he took over the care for a while</p>	<p>Enthusiastic and confident</p> <p>Overwhelmed and nervous</p> <p>Feelings of intimidation</p>	<p>It has helped develop my reflection skills and identify my learning needs.</p> <p>Change practice in the light of learning and experience</p> <p>Ask questions</p>
Teamwork	Hospital and community	
<p>Received information from members of the MDT about procedures regarding him</p> <p>Doctor confirming that the patient had a serious rhythm it was not sustained</p> <p>Effective communication between health care professionals is important.</p> <p>Communication plays an important part in the effectiveness of teamwork.</p>	<p>Hospital infection control policy was maintained, wearing protective clothing to protect myself from any contact with bodily fluids or blood and to prevent cross infection to him and others.</p> <p>Adhering to strict hand washing techniques</p>	

## Story 12

Theory	Communication	Practice
<p>Understanding specific terminology that relates to care e.g. liaison – recognised as a communication process between people or groups, with an emphasis on co-operation</p> <p>A CTPA scan and its value as an investigation is to diagnose a PE</p> <p>Did not seek clarity of decisions to ignore the CTPA, submitted because felt confused by the medical jargon and failed to understand the rationale for the lung function test. CTPA is not a definitive measure of PE and ventilation / perfusion (VQ) scan is a better predictor.</p> <p>Discovering deficit of medical knowledge</p>	<p>Not being able to hear conversations that go on and missing some important point</p> <p>Standing outside the main area of activity</p> <p>Non-verbal communication to others by standing back showed my subsidiary role and my dependency</p> <p>Being polite and well mannered e.g. excuse me</p> <p>Verbal interaction is a core social skill</p> <p>Judging communications well, not interrupting the flow and taking interpersonal cues</p> <p>Concerns that an interruption to communication routine may cause upset to the team</p> <p>Eye contact, communicating interest, silence, body language, displaying active listening skills</p> <p>The emphasis on poor communication and how this can impact on patient outcomes, treatment delayed or jeopardised if not spoken out</p> <p>Confidence and assertive skills and how these affect communication skills</p>	<p>Involved in the discussion of the patient's care on the ward round, assertive skills to put self forward</p> <p>Needed to plan the patient's care</p> <p>Gain respect from others through our involvement in the care of our patient</p> <p>Poor communication skills will affect the patient outcome.</p> <p>By being an effective practitioner with good interaction skills serves to gain respect from patients and colleagues</p> <p>Judging interventions well</p> <p>Preparation for a patient to go for a CTPA scan</p> <p>Not causing distress to patient</p> <p>Preparation for discharge planning and affect patient relatives and others</p> <p>Dealing with interpersonal conflict</p>
Emotional	Cultural awareness	Ethical
<p>Panic, fear of missing information, frustration, isolation, loneliness, being an outcast from the group, undervalued</p> <p>Defensiveness, negative feelings</p> <p>Insubordination and fear</p> <p>Feelings of empowerment due to acts of bravery</p> <p>Nervous at being shouted out or belittled when speaking out because of status</p>	<p>Ignoring the hierarchy determined by the culture of health care – break into the inner circle for the benefit of my patient</p> <p>Differing cultural values of nurses and doctors divide the medical and nursing profession</p> <p>Fear of speaking out due to status (determined through the culture of nursing, perpetuated in clinical practice, and through education)</p> <p>A realisation that some attitudes and stereotypes are ingrained and may pose a challenge to my career as a professional nurse</p> <p>Driven by my belief processes</p>	<p>Duty to care for a patient</p> <p>Breaking into the inner circle for the benefit of my patient to be a part of the decision making process</p> <p>A duty to pass on information when things have been forgotten e.g. the CTPA</p> <p>Standing up for the patient, being the patient's advocate e.g. when the CTPA was forgotten and put aside</p> <p>Contributions communicated with confidence my professional obligation as an advocate to ensure patient received safe nursing care</p> <p>Minimising the risk for confused message, verbal tone, not being passive when standing up for the needs of the patient</p>

<b>Teamwork</b>	<b>Reflection / personal learning</b>	<b>Professional learning / critical thinking</b>
<p>Involvement of the doctor in the care of patients            Sharing information with the MDT            The ward round an important event that transfers information amongst the MDT and to plan ongoing care            Others exercising their authority e.g. consultant            Inclusion is crucial to the functioning of a team and feeling of included            Power struggles that exist between HCP specifically doctor and nurse            By standing away from a group creates barriers to working as a team            Co-operation with others            Good communication also affects team work.            Concerns that an interruption to communication routine in a MDT may cause unwelcome upset and disruption to the team            Nervous at being shouted out or belittled when speaking out because of status. This emphasises the power struggle still going on in clinical practice.            Limited my input in the team</p>	<p>Needing to stand outside the situation            I feel reassured that my feelings of inferiority are shared amongst nurses, particularly during ward rounds owing to the dynamics of the MDT.            Rebellious but meaningful act of moving in closer to the consultant            Placing self in a position to question and challenge care when necessary to be patient advocate            Showing courage making a mental and physical effort to be involved e.g. a hero, brave?            More experience with ward rounds to understand communication cues            Lack confidence and assertive skills            Arranging a CTPA            Asserting self when patient decisions are being made to make presence known            Placing self in a position of authority on equal par to other members of the MDT – ignoring the hierarchy            The skill of the nurse to acknowledge the hierarchy and tailor the communication process accordingly            Self esteem</p>	<p>Fulfilling nursing role according to the NMC            Helps to inform future nursing practice            Wanting to know, understanding is a typical desire of a nurse – a passion for nursing?            Identification of future learning needs and skills that need to be developed            Placing self in a position to question and challenge care when necessary to be patient advocate            Showing courage making a mental and physical effort to be involved e.g. a hero, brave?            Questioning of practices when things have been forgotten            Questioning doctors, confidence in this practice ‘an ability to speak up within large interdisciplinary forums’            Take a more questioning role, missed opportunities to further question, as questioning a medical instruction is acceptable and common sense            Failing to question can lead to a missed learning and teaching opportunity.</p>
<b>Management</b>	<b>Learning from and with others</b>	
<p>Assumption about position in the hierarchy of other health care professionals e.g. behind the sister            Perceiving as a student to be at the very bottom of the health care hierarchy            Accepting the subordinate role therefore becoming accepted into many forums (only on this premise)            Standing outside a group prevents input and may be perceived as disregard for any involvement in the decisions made related to the patient            Communication for effective nursing management</p>	<p>Working under supervision</p>	

### Story 13

<b>Theory</b>	<b>Practice</b>	<b>Ethical</b>
<p>Leg ulcer, tiredness and thirst            Physiology behind heart failure, incidence in elderly people, complications of it, formation of oedema and development of leg ulcers.            Healing process            Doppler ultrasound to determine arterial blood supply:</p> <ul style="list-style-type: none"> <li>• Calculations of the ankle pressure index (API) and what this means (comparison between the highest ankle pressure in one leg and the higher of the two brachial pressures)</li> <li>• The range e.g. if API 0.8 or higher it is safe to apply high compression bandage (patient's was 0.94)</li> <li>• The significance of pedal pulses</li> </ul>	<p>Nutritional needs when patient's not eating or drinking            Food and liquid charts            Monitoring of food and liquid intake            Wound dressings aseptic technique            Assessment using a Doppler ultrasound            Calculations            Application of the use of compression therapy for arterial leg ulcers            Recording the information            Explanation of the situation to patient's is essential</p>	<p>Verbal consent to undertake the non-invasive procedure</p>
<b>Educating patients</b>	<b>Hospital, community and government policy</b>	<b>Management</b>
<p>Effects of illness on life style (health promotion)</p>	<p>Services available related to local support and therapy e.g. advice and non-cancer palliative care            National Service Framework (NSF) on heart failure</p>	<p>Economic burden of managing elderly patients with heart failure            Management of leg ulcers</p>

### Story 14

<b>Theory</b>	<b>Communication</b>	<b>Ethical</b>
Suffering from heart disease Cancer with liver metastasis Type II diabetic controlled with medication	Using non-verbal communication e.g. posture, gestures and keeping eye contact Listening to identify how the patient feels about her illness, telling her story in fighting the battle against her disease Communication as a therapeutic skill, which is deep The significance of accurate documentation in clinical settings	Discussion of dying, administration of doses of morphine, end of life issues Patient consent regarding records and obtaining information Maintaining patient confidentiality
<b>Professional development / critical thinking</b>	<b>Teamwork</b>	<b>Practice</b>
Following the NMC professional code of conduct in relation to confidentiality Identification of learning from the narrative and development Ineffective communication and record-keeping can influence the care given to patients within the community	Visited GP, GP secretary The importance of effective communication between HCP is essential The significance of inter and intra professional communications amongst health care professionals.	Palliative care / care of the dying Taking referrals from hospital in the community Patient assessment of clinical needs and plan care Visiting patients at home at their convenience Past medical history taking details, interviewing skills Appropriate assessment Importance of communication in care delivery In the assessment of patients effective listening skills and reassurance is therapeutic in communicating with palliative care patients
<b>Emotional</b>	<b>Cultural awareness</b>	<b>Management</b>
Expressing feelings of fear	Issues related to death and dying that are cultural and discussing these with the patient Visiting patients in their own home	Insufficient information to carry out a comprehensive assessment
<b>Learning from and with others</b>		
Mentor assigned me to a patient under her direct supervision		



### Story 15

<p><b>Theory</b></p> <p>Heart disease, cardiomyopathy          Pancreatic cancer with liver metastasis          pharmacology - morphine          Pancreatic cancer has a very high mortality          Knowledge of culture          Different types of pain management for these situations</p>	<p><b>Intuition</b></p> <p>Just knowing when things need to be told and shared with mentor or more senior members of the team, so further action can be taken.          Was able to spot something that was bothering patient</p>	<p><b>Ethical</b></p> <p>Maintaining confidentiality, but telling when things cannot be kept confidential and need to be shared, asking permission to do this from wife of patient          The patient's wishes, discussing these with HCP and relatives – facilitating this role</p>
<p><b>Communication</b></p> <p>Communication of difficulties with her husband to nurse.          Communicating with / challenge patients about difficult issues, use of skills helped the patient to disclose information and feelings          Communicating with colleagues          Appropriate and accurate language, so those colleagues understand my explanation.          Effective listening showing good verbal and non-verbal behaviour, body posture, gestures demonstrating concentration on conversation          Allowing the patient time to reveal concerns          Listening techniques such as nodding, signs of agreement to encourage the patient to talk          The use of voice e.g. tone and using simple language, making emphasis on aspects of the circumstances to facilitate understanding</p>	<p><b>Professional development / critical thinking</b></p> <p>Lack of counselling skills          Gives you the tools to improve          Knowledge of palliative care          More involvement in situations where nurses are advising and counselling patients          Improving communication skills          Asking appropriate questions</p>	<p><b>Practice</b></p> <p>Administration of medication          Informing others of things that have been communicated to you          Break through pain          High doses of medication can cause toxicity, excessive depression of the CNS and death          The amount of medication the patient is taking is worrying          Developing confidence in delivering correct information in an appropriate manner          Nurse's role within the family environment          Implementing the issues of culture into the care of the patient</p>
<p><b>Reflection / personal learning</b></p> <p>Limitations of counselling skills needed to share the wife's concerns with others</p>	<p><b>Emotional</b></p> <p>Emotional support          Concern for the patient's stress</p>	<p><b>Learning from and with others</b></p> <p>Informing the mentor of issues that relate directly to the patient's condition.          Shared with mentor or senior members of the team.</p>
<p><b>Cultural awareness</b></p> <p>Cultural issues related to the dying patient, facilitating this in clinical practice</p>	<p><b>Hospital and community</b></p> <p>The wide range of services available to families.</p>	<p><b>Management</b></p> <p>Realised how important it is to acquire experience to manage these situations satisfactorily</p>
<p><b>Teamwork</b></p> <p>The MDT is involved in the care of the dying patient e.g. GP, Macmillan nurse, hospice, pain nurse, social services etc.</p>		

**Story 16**

<b>Learning from and with others</b>	<b>Communication</b>	<b>Practice</b>
<p>Learning to work independently with less support from mentor            Assumptions about the role of the mentor and what s/he does e.g. give the handover every time / letting the student take the lead and undertake particular roles so they may practice            Need mentor to expose to relevant experiences            The mentor being there when the student feels unable to complete the task            Gives knowledge and backup, support and guidance needed for future development</p>	<p>Generally (the nursing handover) is one way communication whereby the nurse gives the relevant information and instructions to the nurses resuming their shift in the ward manager's office or nurses' station.            When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence.            Getting information mixed up</p>	<p>Gaining confidence            Two types of hand over, office / at the bedside the office being more intimidating than at the bedside            Writing down of information that needs to be conveyed, but need to understand it and not rely too heavily on it and just read out all that is written</p>
<b>Educating patients</b>	<b>Emotional</b>	<b>Reflection / personal learning</b>
<p>Support others to help them increase their knowledge</p>	<p>Concerns about not knowing enough, flustered, out of depth, frustrated and stressed.</p>	<p>Reflection on practice experiences needs to be improved to evaluate self</p>
<b>Professional development / critical thinking</b>	<b>Theory</b>	
<p>Learning through time, building up confidence            Reflection on practice experiences as an important step in professional development, support others and increase my knowledge of issues            The use of questioning to improve knowledge and understanding</p>	<p>Hypodermises what is it, the care required etc.            Look at various nursing journals            Models of hand over</p>	

**Story 18**

<b>Theory</b>	<b>Communication</b>	<b>Ethical</b>
<p>Not understanding the implications for a high blood pressure and an increase in heart rate or 'peculiar' and not normal heart rate                      Cardiomyopathy but did not know what it was                      Doing but not understanding what it means / significance                      Patient was in AF</p>	<p>Listening to relatives when they say they have never seen their relative has never seen him like this <i>before</i>. supporting your concerns                      The doctor listened to me because I had evidence, which I could not put into words but showed through the ECG.                      Observing the non-verbal expressions of the family and their saying they had never seen him this bad before</p>	<p>Did it to benefit my patient, did not care about how I was perceived or the repercussions of going straight to the doctor over the nurse who ignored me                      Responsibility for the patient, advocate especially in end of life issues, so the patient's wishes are facilitated.</p>
<b>Intuition</b>	<b>Learning from and with others</b>	<b>Practice</b>
<p>Felt something was wrong but could not put it into words                      Knew something was wrong so took a non-invasive interventions 12 Lead ECG                      Took all of the information and put it together, just knew something was wrong                      Not being afraid to develop intuition and use it in practice, if situation not understood but know something is not right</p>	<p>Informed nurse of concerns and suspicions about patient's conditions, informed will be there in a minute but never came                      If mentoring is insufficient in some situations the confidence to go elsewhere for the benefit of the patient</p>	<p>Immediate interventions, transfer to a resuscitation room for immediate care                      Being assertive in situations that require it                      Patient came to the A&amp;E department and thanked me for what I had done.</p>
<b>Emotional</b>	<b>Reflection / personal learning</b>	<b>Teamwork</b>
<p>Did not feel that I could be trusted                      Felt what I had to say was significant</p>	<p>Did not know what it all meant, process would help me to gain understanding and interpretation</p>	<p>Went directly to show the ECG to the doctor, as nurse not taken seriously, immediately knew what was wrong</p>

**Story 21**

<b>Theory</b>	<b>Practice</b>	<b>Educating patients</b>
Questioning theory, poly-pharmacy, 12 lead ECG, diabetic with high blood sugar, AF	Skills at interviewing patients to gain past medical history Assessment of BP, HR, RR and significance of them being high Caring for patients whose PMH is unclear and caring for them not knowing their precise history Old notes are not always available The skill of taking a 12 lead ECG	Patients cannot often identify the drugs they are taking, their names, the side effects of them Importance of diet and control of diabetes
<b>Reflection / personal learning</b>	<b>Professional development / critical thinking</b>	
Questioning of a patient about their past medical history and needing to be specific	Knowledge of PMH can help to care for the patient.	

**Story 23**

<b>Reflection / personal learning</b>	<b>Professional development / critical thinking</b>	<b>Learning from and with others</b>
<p>Finding it difficult to care for a patient or group of patients over a span of duty. This culminated in a situation whereby I lost contact with what was happening to my patient</p>	<p>I realised that I need to take responsibility for my own learning and state my own learning needs Inform all members of staff myself. Assertiveness in relation to my own learning needs</p>	<p>My mentor's role to facilitate this process and she was not able to fully relinquish the charge of the patients to me and just supervise or be there for me when I needed her. She did not confirm with other members of staff that I was managing this patient today. This invariably was leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice. my mentor took over Effective mentorship and supporting students learning and development in practice</p>

**Story 26**

<b>Cultural awareness</b>	<b>Communication</b>	<b>Practice</b>
<p>Non speaking English patients                      Husband translating for patient, did not notice the area was not private and carried on interpreting                      Barriers to communication in this was the language barrier</p>	<p>Speaking to patient  <i>Communication with patients who do not speak English</i>                      Non-verbal communication from patient e.g. facial expressions.                      Patient not comfortable with arrangements e.g. answering questions in an open trolley area                      Privacy may not matter to husband as his wife is being seen to  <i>Demonstrates how the environment is a barrier to effective communication</i></p>	<p>Patient assessment                      Even though the nurse was used to working in a busy area with patients around, did not have any concerns related to interviewing the patient in this type of area, but did not stop the nurse from recognising the patient's discomfort</p>
<b>Ethical</b>	<b>Theory</b>	<b>Intuition</b>
<p>Operation undertaken in a private hospital, gets an infection and comes to NHS hospital</p>	<p>Infected abdomen following lipo-suction</p>	<p>Privacy, difficult when only curtains separate from next patient. Interpreting non-verbal communication e.g. facial expressions. Taking cues from patient and moving to a quieter area</p>

**Story 27**

<p><b>Theory</b></p> <p>Inter-hospital transfer, palpable abdominal aortic aneurysm getting bigger          Consciousness and co-operative neurological assessment          The signs of shock, complications of AAA</p>	<p><b>Communication</b></p> <p>Met at the main door, directed straight towards theatre, all the way a member of staff was telling us the way so as not to get lost</p>	<p><b>Management</b></p> <p>The amazing communication, organisation, management and co-operation of all staff was very impressive</p>
<p><b>Learning from and with others</b></p> <p>Escorting a seriously ill patient with mentor, handing over the patient, directed to theatre a very useful learning opportunity was given to the student by the mentor</p>	<p><b>Ethical</b></p> <p>Getting a referral hospital to agree to take this patient, telling of the story was essential to get the seriousness across          Disappointment at not being able to follow patient up after the transfer, as if phoned no information would be able to be given due to confidentiality. The student would have to go to the hospital to find out any information related to the patient's condition.</p>	<p><b>Practice</b></p> <p>Organisation of an emergency transfer, entrusting a patient to another specialist, hospital equipment needed, notes, information, knowing the patient          Arranging everything that needed to be done          Travelling in an ambulance with a blue light flashing, consideration for the patient's needs at the same time, observing for any change in condition</p>
<p><b>Emotional</b></p>		
<p>Disappointment</p>		

### Story 33

<b>Theory</b>	<b>Practice</b>	<b>Ethical</b>
<p>On this ward learning about:            Cancer of the bladder with liver and lung metastases, cancer of the breast with brain metastases            Squamous cell cancer of the tongue and floor of the mouth, end stage renal failure, patients on strict fluid balance input and output            Hepatosplenomegaly, gross ascites, cancer of the lung, pneumonia, neutropenia, pancreatic carcinoma with jaundice post-chemotherapy, cancer of the oesophagus, non-hodgkins's disease, sickle cell episodes, multiple myeloma, cancer of the endometrium, astrocytoma of the frontal lobe, paralysis, seizures, COPD, atrial fibrillation, closed tuberculosis, cancer of the larynx with a total laryngectomy, patients with colostomies, cancer of the prostate, and cancer of the stomach.</p>	<p>Had to do vital sign observations for patients on blood transfusions, enteral medication and feeds, observe patients on chemotherapy, and a great deal of pain control with controlled drugs.            I learnt basic nursing skills which will always be useful to me in my nursing career.</p>	<p>I learnt much about their successes in life, about their families and also, sadly, about their worries about how it would all end.            The experience on this oncology ward was immense.            I was an incredible experience to be with these courageous people in their time of need.</p>
<b>Reflection / personal learning</b>	<b>Professional development / critical thinking</b>	<b>Learning from and with others</b>
<p>I learnt patience, compassion, adaptability.            Care, compassion and communication are the basic elements of nursing.            You have to be genuine</p>	<p>I believe that my experience on this oncology ward helped me to think critically and made an improvement in the care that I give to my patients.            The most important conclusion is that I feel that what I learnt in communicating with and assisting these very ill and often dying patients'            The skills gained on an oncology ward will be useful during my future ward placements.</p>	<p>After I had been to my first meeting with my clinical tutor and had attended my first weekly lecture on oncology I was able to consider these experiences in a more positive manner.</p>
<b>Emotional</b>	<b>Communication</b>	
<p>Being a part of the patient's journey, the sad times at the end. On occasion there were many tears.            Concerns about not knowing enough about the vast areas related to oncology and those who are severely ill because of it.</p>	<p>This specialised care of the oncology patients made me realise how important communication is with not only the patients but also their families, partners and friends.</p>	



### Story 36

<b>Learning from and with others</b>	<b>Practice</b>	<b>Professional development / critical thinking</b>
<p>My mentor used her initiative and visited the ward from which the patient had been transferred and questioned staff there what they had administered as Zomorph SR 40 mg, one purple table of 30 mg and one yellow tablet of 10 mg.</p> <p>My mentor then bleeped the doctor and advised her that some confusion had arisen because she had used the trade name of Zomorph instead of the generic name of Morphine sulphate.</p> <p>As this was a controlled drug my mentor wanted to ensure she was giving the right drug to her patient. It was an important learning curve for me to observe how my mentor took control of the situation and brought it to a successful conclusion diplomatically</p>	<p>We returned to our own ward and administered the Morphine Sulphate to the patient.</p> <p>The pharmacy had administered a packet labelled morphine sulphate. The doctor amended the prescription sheet and everyone was relieved to know that the right drug had been administered but no-one else had questioned the trade name being written up.</p>	<p>Writing down the story also helped with my thoughts and to clarify what my current state of thinking is about a subject.</p> <p>The story helped to resolve an issue that we may not have handled in the best possible manner at the time. By making us look at the situation, break it down into salient points and consider what would have been a better course of action to achieve a more positive outcome is personally therapeutic and professionally diligent.</p>
<b>Reflection / personal learning</b>	<b>Communication</b>	<b>Ethical</b>
<p>The best lesson learned was being proactive is the best way to deal with complaints or incidents and it forced me to face this uncomfortable facts about my workplace and myself and carrying with me the lessons learned from this story, especially communication between HCP, in a productive, professional manner to sort out the problem faced.</p>	<p>The involvement of the MDT e.g. doctor and pharmacist was implicated in the learning and how it is imperative to involve everyone, as it is not generally just one persons mistake, it is a collection of errors gone unchallenged and undetected. No one had sought clarification and speak directly to the prescriber.</p>	<p>Immediately who is to blame changing from 'all working together' to 'who is the individual to blame?'</p>
<b>Emotional</b>		
<p>How a simple prescription error can lead to the feeling that something serious had happened and fearful of the outcome</p>		

### Story 44

Communication	Practice	Professional development / critical thinking
<p>Mr S and I exchanged a couple of frank and honest conversations about his illness and state of mind. He had reached the stage where he simply wanted to die as soon as possible and verbalised his disappointment every morning that he hadn't passed away during the night.</p> <p>I was able to give him time to listen and express the views he had to shield from his wife as not to cause her more distress.</p> <p>I felt I had gained confidence in talking to patients about challenging and difficult issues, discussing their options and individualising my care to meet my patient's needs,</p>	<p>The patient not wanting to wash, or to be repositioned, but it was important to do this as cleaning his wounds and skin helps prevent infection and cross contamination</p> <p>He had cancer of the prostate that had spread to his spine and was now bedbound. The patient was aware that he had been admitted for end of life care. This is classified as caring for people who have an advanced, progressive and incurable illness so they can live as well as possible until they die. It is about providing support that meets the needs of both the person who is dying and the people close to them.</p>	<p>Trying to maintain the nurses professional obligations to these principles when they do not match the patient's, in all of this pain relief was essential</p> <p>I can transfer these specialist skills to other areas where I practice using it in future care and placements and throughout my career.</p>
Emotional	Theory	Ethical
<p>This story left me emotional fatigued with emotional and physical exhaustion that I felt this story had left behind in me, in was however both challenging and rewarding, I feared this would distance me from the suffering of patients in the future and disengage from the patients and families I cared for.</p> <p>Getting in touch with emotional situations and the problems this can pose to me as a nurse.</p>	<p>Pressure ulcers and the causes, dressings</p> <p>Pneumonia, immune suppressed and susceptible to infection</p>	<p>Informed consent, the need for privacy dignity, individuality and respect</p> <p>Mr S did not want his dressing changed and the ethical dilemma of leaving Mr S with his dressing unchanged and the difficult this posed in respect to Mr S's well-being against his decision, facing how conflicting moral issues, whilst</p> <p>Ensuring moral and ethical principles.</p>

### Story 50

Communication	Practice	Reflection / personal learning
<p>The importance of taking time to be with patients and just talking to them was so powerful. Other staff just seemed to dismiss it and other patients began to 'tut', saying that she was a nuisance and shout sit down and be quiet. It seemed that no one had the time or patients to listen to her.</p> <p>I asked her how she was now feeling and she replied that she was fine, almost unaware of why I was asking.</p> <p>Eileen enjoyed having her nails painted, introduce her to other patients, and as we spoke she would recall her family, she told me her husband John and how he had passed away shortly after they married, she seemed happiest at these times talking about her past. She mentioned her son, but he lived abroad and rarely rang to see how his mother was, let alone visit her.</p>	<p>I could see she felt lonely and wanted to help, however it seemed that whenever I tried to speak to her it angered her more. Eventually I realised that I was not going to make Eileen understand and there were other patients who needed help with their breakfast and washes. Therefore, I left her to calm down, and perhaps another member of staff would be able to calm her.</p> <p>Eileen was often found wandering the ward. Occasionally she could be found sitting on another patient's bed, especially those within the side rooms. Eileen would often become aggressive and loud sometimes, but I did find time to spend with her and at these times Eileen enjoyed.</p>	<p>This story has made it apparent to me that an individual may come across as aggressive or unfriendly, but this does not necessarily what they mean to do. The patient may feel scared and vulnerable or they may act in a certain way because of a condition. As I nurse I realise that nurses need to take into consideration all factors which may influence person's behaviour.</p>
Emotional	Theory	Ethical
<p>During the shift it became obvious to me that the comments Eileen had made to me were not personal. After a short while I returned to her and I was greeted with the same smile I saw initially, Coping alone at home that some patients have to face</p> <p>When the patient told me that I did not care for her I was distressed, but knew this what part of her condition, and this knowledge helped me to understand.</p> <p>I found the fact that I could not seem to calm her hard to deal with.</p>	<p>Vascular dementia – is the 2<sup>nd</sup> most common type of dementia, after Alzheimer's disease. It is due to a lack of blood supply to the brain, damaging cells. Certain symptoms are displayed when an area of the brain is damaged by certain diseases; they may have difficulties remembering or memory loss, solving problems or concentrating, acute confusion, getting lost and changes in behaviour, difficulty in showing their emotions.</p> <p>The patient may suffer from acute memory loss, confusion and feel lost all at the same time.</p> <p>Antibiotics</p>	<p>The whole ward was able to hear her screaming. Eileen told me that I did not care about her and that I was keeping her there until she died. This was very distressing for me, as it was far from the truth, and I did not want someone to think this about me. It was difficult to know what her needs were as she could not make them known to us and therefore it was difficult for staff to know what level of interventions is required. It was difficult to reason with her due to the confusions they may experience.</p>

**Story 54**

<b>Communication</b>	<b>Practice</b>	<b>Professional development / critical thinking</b>
<p>On arrival we were told there was a short wait but the patient will be seen within the next hour. After 3 hours the patient was still waiting becoming more and more nervous by the minute.</p> <p>Just a few simple words of care to tell them how long left to wait and maybe why it took so long to tell them everything is going to be OK was all it would have taken.</p> <p>The nurse in the department came over to help me reassure with telling the patient how long left to wait or just good old fashioned sympathy.</p> <p>Everyone was very cold, and when keep getting asked how long until this patients turn and quite rude.</p> <p>Although I was reassuring the patient as much as I could.</p>	<p>I took a patient to have a colonoscopy. This patient had previously had this treatment but unfortunately it was unsuccessful, so had to be performed again Therefore was becoming extremely agitated before the treatment. As a student nurse I went with the patient to endoscopy so I could watch one procedure.</p>	<p>From telling this story to other nurses, students, friends family I learned that even though professionals may do the same procedure treatment many times a day a patient only experiences it once or just a few times and may be very anxious or scared.</p> <p>Gaining others views on the situation lets you see other perspectives and helps you learn from all angles and not just from your own.</p>
<b>Emotional</b>	<b>Reflection / personal learning</b>	<b>Ethical</b>
<p>This patient became so nervous a mild panic attack overwhelmed him and he was put on oxygen encouraged to breathe deeply.</p>	<p>Out on placement I had many experiences that I learned from. Sharing these experiences with others not only made me realise that I'd learnt from it but also enlightened others on the lessons learned.</p>	<p>Treating each patient as an individual is important as in this story I believe this patient did not get the care they deserved.</p>

## 9.2 - 3<sup>rd</sup> year adult nurses categorical data analysis

### Story 17

Theory	Management	Ethical
<p>The doctor prescribed a nebuliser as predicted, but I did not know how these drugs worked, I knew they were often prescribed for difficulty in breathing e.g. COPD patients.</p> <p>He needed to have investigations to rule out the seriousness of his pain. This included:</p> <ul style="list-style-type: none"> <li>· A chest X-Ray</li> <li>· ECG</li> </ul>	<p>In all of this the other patient had been forgotten and his care could have been delegated to another.</p> <p>This oversight on my part as a student nurse in my role as trying to gain management experience in the care of two patients probably meant the patient with rib pain stayed in the A&amp;E longer than necessary as his investigations could have been done sooner.</p>	<p>I put a judgement on the priority of his care 'a time waster' in relation to his rib pain, not serious as opposed to asthma; despite I knew he could be serious.</p>
Practice	Teamwork	
<p>I wished I had asked the doctor to show me what he was listening for so I could have identified a wheeze again when I saw a patient with asthma.</p> <p>Check drugs</p> <p>Take a urine sample to the sluice</p> <p>Inform sister of a result</p> <p>It is sometimes difficult to learn about one particular thing as often practice is sometimes a mess and there is mayhem, and drawing learning from it is difficult</p>	<p>I was impressed by how fast the doctor came to see my patient after I told him the situation, maybe there was urgency in my manner or voice?</p>	

## Story 21

Theory	Emotional	Ethical
<p>Blood disorders such as sickle cell disease and human immunodeficiency virus (HIV), tuberculosis (TB), cancer and other infectious diseases like methicillin resistant staphylococcus aureus (MRSA), blood transfusion HIV is not transmittable through splashes of shower from the patient although effective measures like wearing of aprons and gloves should always be maintained.</p>	<p>I felt honest and professional. I felt very nervous and a bit scared about these because the staff I was dealing with were much more experienced and I felt my standard was poor compared to theirs.</p>	<p>Patients should be involved in their care, be encouraged to participate in order to improve the effective implementation of their care plans. Nurses should be emphatic, responsible and respect the dignity, wishes and emotions of their patients even though sometimes, some of the wishes are impossible to be granted.</p>
Reflection / personal learning	Communication / interactions	Practice
<p>Assisting my patients with their personal hygiene I was thinking about the HIV condition of Mr A and Mrs B although I was aware that HIV is transmitted through the blood of the patient and sexual intercourse. I was helping Mrs B with her full shower I was feeling uncomfortable because she asked me to hold the water over her while she washed her genital areas. The dirty water was splashing onto my trousers and I knew I had to wash my trousers with other clothes including underwear in my house. So I was worried about transmission of infection from the splashes of water on my trousers to my underwear. It is vital to be aware about what types of medications I am giving to my patients Reflecting on the above my mentor did not ask the functions and categories of the drugs for my patients. I felt very ashamed when she did and I could not tell her most of the drugs' functions. The good thing about the experience was that it forced me to familiarise myself with majority of the drugs used on the ward</p>	<p>I talked to her about how she was feeling, explained the state of her ulcers and gave her reassurance. I suggested she wiggled the toes to promote blood flow a range of other exercises such as deep breathing so her condition could get better.' I had to communicate and document all care given to my three patients verbally during handover to staff and as well written on their nursing notes. Communication is a complex process of sending and receiving verbal and non-verbal messages. Documentation is an essential and crucial part of nursing care because it ensures continuity of care by healthcare professionals. In the future I will contribute to improve effective communication between me and the staff. Nurses should listen to their patients and be aware that body language matters a lot to patients and even to other members of the team. It is important for nurses to focus on their roles and responsibilities as well as having good interpersonal skills with team members to produce good standard of care.</p>	<p>I started the shift by checking their vital signs. Mr A's Blood Pressure was 168/97 with a pulse rate of 84. The experience from Mr A proved the sense that emotional change can affect stability of vital signs. I assisted Mr A with slicing his bread and butter and placed his table at an easy access for him, as he could only manage with one hand. I assisted them to have a wash or a shower. This was followed by aiding him to sit up in the chairs, giving them their prescribed medications. The level of independence of my patients were different, I checked in the care plans of Mrs B for the type of dressings needed on her ulcers. I applied aseptic technique as required by the infection control policy. At this junction most of the nursing cares required by my three patients were done. I was alert of their ongoing needs elimination, frequent change of positions or having drinks in between meals. Observation and assessment forms the basis for nursing care and each patient should be nursed as an individual.</p>
Management	Teamwork	Professional development / critical thinking
<p>The reason was that the time allocated for personal hygiene and that of the dispensing and administration of drugs nearly overlapped. By planning and prioritising this way, I was able to manage the time efficiently. Management skills are vital and necessary for nurses in order to fulfil responsibilities. It is vital to be aware that planning ahead, prioritising, delegating and good time management help to maintain effective management of nursing care. I felt uneasy in delegating to senior staff; I was democratic because I explained why I needed them to undertake the activity.</p>	<p>I had to delegate some responsibilities to a staff nurse and another student. Mrs B had three episodes of vomiting during this shift. I needed to delegate. At lunch I had to ask the other student nurse to help Mr A with cutting of his food into smaller pieces which he asked for. The nurse should pass information about the patient to other staff in the ward and the multi-disciplinary team to help create a supportive network that will work together to better the health of patients.</p>	<p>My patients were happy that they had been attended professionally and they have been encouraged to take part in their care to enable better independence. I accept I should at least have the BNF with me. If this situation arises again I will check in the BNF to clarify doubts. I was thinking it was my responsibility to provide information. In the future I will stick to the democratic form of leadership and management skills since it allows team members to be secured, supportive and willing to give their best in most times. In the future I will care for infected patients like any other patients but I will always adhere to the infection control policy of the unit.</p>
Learning from and with others	Educating patients	
<p>I required supervision from my mentor with the administration of medications for my patients.</p>	<p>Through treatment, cooperation and exercise such as wiggling of the toes to promote blood flow and other range of exercises performed with the physiotherapists her condition could get better.</p>	

**Story 23**

<p><b>Professional development / critical thinking</b></p> <p>This story has made me more appreciative of the fact that one day I will be a fully qualified nurse and be able to do this kind of work every day which I would love to do. I would like one day to be able to work in the emergency department as this is what I think I would like to do, being on the front line and dealing with the patients first hand, saving lives which is the first and last thing I would want to do as I get great pleasure in helping others . Critical thinking plays the most important role in delivering a dependable high standard of nursing care.</p>	<p><b>Communication / interactions</b></p> <p>The communication of the team was brilliant during this time no one felt out of place everything was going according to plan, Communication is essential for all the team involved and clearly it was in this circumstance. I had managed to get her to open up to the doctors in telling her name and address, and that she was truly grateful for my help and even wrote me a letter of thanks. The patient appeared to be unconscious I had stayed with her the whole time and was reassuring her that everything was going to be ok by talking to her and generally given her my nursing care for example taking her neurological observations.</p>	<p><b>Ethical</b></p> <p>Wondered how her parents would be feeling, as I am a parent myself, I seemed to put her under my wing and took over as a mum, as she had no one with her and no way of contacting anyone as she was a unknown A few days after this event it had emerged that she was not under 16 years at all and that she was 23 years old and had played along with the fact that they had thought she was younger as she thought she would get a better time on the children's ward and the affection she craved. This tells me not to judge a book by its cover.</p>
<p><b>Emotional</b></p> <p>I had felt a bit out of my depth in the resuscitation room as this was for emergencies and I had not the knowledge or the experience to be in total management and care of this patient, but I had given it my best shot in the nursing care of her. I was a bit hesitant at first as I do not have the knowledge of children's nursing I feel there is a lot more to be learnt. I did feel very scared for the patient as she was under 16 years old. I did feel more at ease when I did this as things were coming to me a bit better instead of just standing by and watching I involved myself in her best welfare. I feel she was under the best possible team.</p>	<p><b>Teamwork</b></p> <p>I feel aided in helping me to increase my knowledge and understanding of the situation and the different ways of the interdisciplinary team work, the communication between the team was great.</p>	<p><b>Practice</b></p> <p>The doctors had taken the decision to intubate and insert a Tracheostomy. A catheter was inserted so they could get a urine sample to check what drugs she had taken. The patient had regained consciousness and would not let me go as she recalled the time in resuscitation that I had stayed with her throughout.</p>
<p><b>Reflection / personal learning</b></p> <p>I feel that I can deliver good nursing care to all my patients.</p>	<p><b>Theory</b></p> <p>The patient who at the time had taken an overdose of crack cocaine, This patient upon arrival was not conscious her Glasgow coma scale was 3/15.</p>	<p><b>Learning from and with others</b></p> <p>I was under the supervision of the other doctors and nurses there, and in the resuscitation room in an emergency the doctors mainly take over and the nurses do as the doctor's request.</p>

**Story 30**

Theory	Practice	Management
<p>The CN asked for volunteers to carry out a literature review examining the impact of 13.5 hour shifts. This was to inform the planning of rosters based on current evidence-based best practice and to ensure the optimal care of patients.</p> <p>The effects and challenges of 8-hour 'earlies', 'lates' and rotating night duties, and whether changes in shift patterns are beneficial</p> <p>Those who work night shifts experience more tiredness and disturbed sleep, a high accident and error rates in staff that worked an early shift after a late shift and concluded that this should be avoided at all costs</p> <p>The fewest problems and least amount of disruption for individuals were experienced on regular shift systems (for example, five 'earlies' one week followed by two days off; five 'lates' the next week, and never more than five consecutive days together).</p>	<p>Nursing needs coverage of shifts on a seamless 24-hour basis, and fatigue, which can negatively affect the quality of nurses' performance, is a feature of any shift work but not enough information exists on the effects of shift work on health care professionals, particularly due to their permanent contact with human suffering and death.</p> <p>The serious implications of ineffective information processing and psychomotor skills performance in shifts lasting over 12.5 hours</p> <p>The CN was particularly concerned about this aspect of the proposed change.</p> <p>The problems of mental and physical tiredness affecting the nurses' overall performance may be compounded by the cumulative effect of working several 12-hour shifts consecutively.</p> <p>12-hour shifts held benefits for patients and nurse satisfaction, because nurses follow patient care for longer periods throughout a single day and patients see fewer different faces (thus improving continuity of care).</p>	<p>The belief is that the more innovative and creative the strategies that individuals are able to use in their daily work, the more responsive they will be in the delivery of effective healthcare.</p> <p>Theory of change management has drawn on a number of social science disciplines and tradition. Change is an alteration in the status quo and is inevitable.</p> <p>Planned change theories provide theoretical concepts in order to achieve changes.</p> <p>Different models of change are appropriate in different situations.</p> <p>Classic theory of change is a three-stage process, others later proposed more detailed processes, planned change and innovation adoption were presented as adapted linear models and problem-solving approaches to managing change</p> <p>Change is integrated into personal experience because it explains attitudes and reactions towards change processes and because it links to clinical practice and the proposed change.</p> <p>Forces driving towards and restraining individuals from adopting a change must be identified.</p>
<p><b>Teamwork</b></p> <p>There is a close relationship between the working environment and the capability and capacity of teams and individuals to handle issues they encounter in an innovative and creative manner.</p>		



### Story 32

<b>Theory</b>	<b>Communication</b>	<b>Ethical</b>
<p>Writing things down, documentation Pain and redness in left eye due to acid / liquid injury Medical terminology Effects of delayed eye irrigation as allows further penetration of chemicals into the inner eye Functions of the eye, anatomy of the eye. Knowing that most of the damage would have happened immediately after exposure to the acid</p>	<p>Use of body language and written documentation English not being their first language is a barrier to communication. How mis-communication can lead to a delay in providing treatment The low pitch, submissive person, fiddling with hands, nervous smile contradicted the urgency of verbal message, explains why doctor might not have listened. Reading body language as a crucial part of communication as speech</p>	<p>Confidentiality must be maintained. Judgement made as to how his injury occurred as the patient could not speak English The debate around seriousness of somebody with an eye injury over someone who is having a cardiac arrest, severe disability or serious life threatening condition Misguided in relation to what is serious and the complications it can lead to if interventions are not given immediately Could have resulted in sustaining ocular damage which would have had profound effects on visual prognosis, lifestyle and self image</p>
<b>Emotional</b>	<b>Teamwork</b>	<b>Practice</b>
<p>Feelings of being out of depth, due to situation e.g. eye injury Apprehensive due to lack of confidence Intimidated by the doctor Feelings of nervousness about using medical terminology such as 'ophthalmic' and sounding stupid if pronounced wrongly Lack of respect, disappointment Expressing negative feelings to determine why the situation sticks in our mind</p>	<p>Hand over to doctors what has occurred, the interventions and treatment. Not listening to student but thanked student and took the notes When health care professionals do not listen to each other, mis-communication e.g. liquid or hydrochloric acid in the eye will change interventions and if delayed could lead to eye damage. Intimidation by doctors due to the unequal power relationship and the effects on teamwork and giving of and sharing information about patients Communicating with HCP outside of nursing Disrespected as a member of the care team Tension between nurses and doctors, typical submissive person fiddling with hands, nervous smile and speaking in a low pitch</p>	<p>Sharing of information with other healthcare provider Assertiveness Constantly facing unique situations which require more than carrying out routine and ritual Triage the patient's eye as high priority Lack of confidence in relation to using medical terminology Use of language such as short sentences to inform patient of what is going on The significance of communication to patient interventions and continuity of care</p>
<b>Reflection / personal learning</b>	<b>Hospital and community</b>	<b>Learning from and with others</b>
<p>By analysing and understanding their actions, nurses gain new knowledge about their practice. I felt disappointed in the outcome because I had jeopardised John's sight by giving an ineffective handover. I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship</p>	<p>Our role was to ensure that patient care was managed according to clinical priority as opposed to waiting time</p>	<p>Experiencing night duty with my mentor</p>
<b>Professional development / critical thinking</b>	<b>Cultural awareness</b>	<b>Management</b>
<p>Assumptions and presumptions Questioning of abilities as a student nurse</p>	<p>Polish patients, and difficulties with speaking and understanding English, unable to explain mechanisms of injury</p>	<p>Prioritising care e.g. is it serious e.g. in comparison to a cardiac arrest.</p>

### Story 33

<p><b>Professional development / critical thinking</b></p> <p>The choices I made were the correct ones in relation to the effectiveness of my delivery and management of nursing care. In particular, it helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection</p> <p>One needs to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve life long learning.</p>	<p><b>Emotional</b></p> <p>What I was feeling and what made me feel that way (aesthetics), Initially, I was nervous because I had no experience of managing my own patients.</p> <p>I was pleased that the patient felt more comfortable due to my care.</p> <p>I was initially concerned about my lack of managerial experience. I did my best to make the patient comfortable and I connected with her. She told me that she knew her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear</p>	<p><b>Ethical</b></p> <p>I was 'available' and concerned for her care.</p> <p>The nurse-patient relationship is central to nursing and to nurses feeling fulfilled in their caring role.</p> <p>I tried to look at the situation through the patient's perspective and from the view that I shall soon be a staff nurse.</p> <p>I was able to support the patient by providing psychosocial needs and a supportive, encouraging and respectful therapeutic environment.</p> <p>Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind</p>
<p><b>Management</b></p> <p>This managerial duty made me nervous because the consultants, doctors, physiotherapist, occupational therapist and dietician came to me regarding the management of those patients. I had to prioritise their care, deal with input from various sources and to document everything.</p> <p>Time management point of view, this patient needed a great deal of care and her size made it very difficult</p> <p>By managing the care of this patient I realised that nurses are in a unique position to educate, care for, support and guide patients through major life-style changes.</p> <p>I gained experience in delegating duties to healthcare assistants, student nurses, and to ask for assistance from staff nurses when necessary. Regarding what others were feeling and why, the patient realised that her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope, fear. Experience comes from external factors such as actually managing and taking responsibility for the care of patients.</p> <p>The doctor asked me to administer methyl-thioninium chloride to ensure that there was no leakage in the gastric sleeve. She later told me that she felt confident of leaving me in charge. I believe that I gave managerial and personal support, guidance and after-care to this vulnerable patient in a respectful therapeutic relationship</p>	<p><b>Theory</b></p> <p>Aware of the common morbidities that accompany obesity, such as hypertension, type 2 diabetes mellitus, stroke, coronary heart disease, gallbladder disease, hypercholesterolaemia, osteoarthritis, respiratory problems and several cancers</p> <p>Bariatric surgery is just one of the treatments that can offer hope for obese patients.</p> <p>Obese patients are at high risk of wound dehiscence and slow wound healing because of poor blood supply to adipose tissue</p> <p>The knowledge that informed my decisions were my need to be aware of the possibility of gastrointestinal haemorrhage, wound infection, pneumonia, pulmonary embolus (because she could not wear TED stockings) and prolonged nausea or vomiting.</p>	<p><b>Practice</b></p> <p>In particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin.</p> <p>I assessed her vital signs and pain levels regularly and I used an appropriately sized blood pressure cuff in order to prevent false high readings.</p> <p>She had an indwelling catheter, a nasal gastric tube, patient controlled analgesia (PCA), a Robinson drain, and she was on intravenous fluids and antibiotics.</p> <p>She had clips, her dressings needed attention, and she needed to start a clear liquid diet.</p> <p>I washed the patient on her bed.</p> <p>The main problem was moving her from her bed to the chair (neither of which were of the correct size).</p> <p>The first step I took was to order an appropriate chair and bed.</p> <p>The patient was able to use a zimmer frame to walk into the bathroom to clean her teeth, and I was able to attend to the washing of her back and legs. I needed to ensure that her legs were dried completely and moisturised, in order to reduce cracks in the skin and to prevent the formation of lesions.</p> <p>After one hour, I was responsible for removing the patient's nasal gastric tube, Robinson drain (my first experience of removing a stitch) and catheter.</p>
<p><b>Reflection / personal learning</b></p> <p>Evaluation should also be the central part of a dynamic process of reflective learning and critical thinking.</p> <p>I believe that I responded to this situation effectively by ensuring that the bed was elevated 30-45 degrees in order to decrease abdominal pressure on the diaphragm and to maximise tidal volume.</p> <p>This experience has been beneficial in terms of developing and increasing my self-awareness</p>	<p><b>Teamwork</b></p> <p>Informed the multi-disciplinary team that I was managing the care of four particular patients.</p> <p>The multi-disciplinary team members were encouraging and appeared to perceive me as a good manager and a caring member of the team.</p>	<p><b>Learning from and with others</b></p> <p>The doctor also instructed me to discontinue the PCA, intravenous fluids and antibiotics (the staff nurse did these for me).</p> <p>She was supportive and encouraging and allowed me to learn through supervised practical experience.</p>
<p><b>Educating patients</b></p> <p>I encouraged the patient to exercise gently, discussed her nutritional regime, and aware of psychological adjustments.</p>		

### Story 34

Theory	Communication / interaction	Ethical
<p>A low heart rate (bradycardia) It is highlighted with the National Service Framework for coronary heart disease that maintaining heart health is important in the prevention of this disease and therefore in the wider social context, advising patients on the benefits of a healthy balanced diet is vital within the realms of health promotion.</p>	<p>Effective communication and documentation within nursing are vital and it is suggested the ability to communicate effectively is the most important area that requires expertise in order to manage patient care efficiently. Previous clinical experiences have encouraged me to improve on my communication skills.</p>	<p>Initially, my feelings were of concern for my patient as she had become clinically unstable. It is acknowledged when a registered nurse delegates tasks, the accountability remains with the nurse</p>
Professional development / critical thinking	Management	Practice
<p>Clinical judgement skills for the newly qualified nurse are difficult as accurate decision making skills are derived from experience. Considered the areas of health promotion not only for my patient, but also for patients in the wider social context Decision making is also an essential skill within nursing during the course of a day, many decisions are expected of a nurse and almost all of these centred on patient care. Provided a critical analysis of my care delivery for a patient whilst I was on clinical placement in an assessment unit within a local NHS trust</p>	<p>The need to prioritise my patient's care was of paramount importance nursing priorities change throughout the day as new events occur. When another patient asked me for a commode, I delegated the task to a health care assistant. This delegation of duty was not meant to offload work, but was done out of necessity in order to effectively manage my time and also to ensure that the task got done. When tasks are not prioritised or delegated, then duties that require urgent attention can get forgotten. This experience has had a huge effect on my own management skills. Time management and prioritisation are essential skills within nursing for successful, efficient and effective patient care. My nursing management skills require development for my future nursing practice and these include my time management, delegation and prioritisation skills, and therefore my action plan is to address these issues.</p>	<p>The patient had no relevant past medical history of heart problems. I took her vital signs. Regular ECGs were taken. My main objective was to try and reassure my patient with the intention of keeping her relaxed as not to increase oxygen demand as bradycardia results in a diminished oxygen supply to the body. The nurse should inform the patient to report if they feel dizzy or have episodes of fatigue. My patient did report episodes of tiredness and fatigue is believed to be a common side effect of chemotherapy. To differentiate between tiredness due to bradycardia and tiredness as a result of chemotherapy could prove difficult. By keeping my patient still and relaxed, there is an increased risk of developing a deep vein thrombosis and therefore in order to minimise this risk, anti embolism stockings were used.</p>
Emotional	Teamwork	Reflection / personal learning
<p>I felt nervous about requesting the help, but I now realise that it was necessary as it is impossible to accomplish all tasks by myself.</p>	<p>It is a difficult task in caring for a patient being family friendly and working well with colleagues. The decision to contact the cardiology team was the correct decision as my prompt action resulted in my patient being transferred to the specialist cardiology unit.</p>	<p>Effectiveness of my care delivery was adequate still needs improvement My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading.</p>

### Story 35

Theory	Communication / interaction	Ethical
<p><b>Respiratory failure</b>, due to excessive alcohol consumption. In addition, the ambulance crew advised that there was the possibility that she had taken an unspecified amount of medication.</p>	<p>I intermittently chatted to Sarah about the circumstances surrounding the day's events, whilst providing routine nursing care to other patients within the department. <i>The involvement of active listening</i></p>	<p>Students are taught the importance of establishing a caring relationship with the patient, and the need to respond with genuineness and empathy to promote trust and rapport. Building an open and trusting relationship with Sarah, and my effective collaboration among the team.</p>
Emotional	Teamwork	Practice
<p>First the situation appeared daunting I had mixed feelings when asked to assist in Sarah's care. I was excited, but also apprehensive about the task, not because it was outside my experience, but because of the environment in which it was being performed. I was daunted by how busy it was There is always a feeling that you need to prove yourself when starting a new placement, which is greatest when a third year. He was pleased with my professional approach and said I looked calm and 'in control', even though he knew I was nervous.</p>	<p>The resuscitation team were called immediately There were a number of healthcare professionals involved Sarah was surrounded by a team of healthcare professionals, each with their individual roles in treating her condition Team members performed their tasks calmly I truly wanted to feel part of that team by not letting them down on the tasks I had been asked to perform. These comments boosted by confidence and confirmed my sense of belonging to the team on that day This incident demonstrated the merits of collaborative practice The team, including myself, were supporting, motivating and encouraging each other throughout by positive feedback Considering the contributions made by other team members to be more significant than mine.</p>	<p>I was able to effectively demonstrate my inter-professional skills by the monitoring, recording and relaying of her observations, which were conducted every 2 minutes. She had been attached to a monitor, and I was asked to regularly record her observations, and relay this information to the team when required, when her condition stabilised, and before transferring her to the medical assessment unit, under their supervision, together with that of the casualty registrar, she was treated and given fluids and medication to stabilise her condition.</p>
Cultural awareness	Management	Learning from and with others
<p>It is debated whether dominant cultural practices within a hospital choose to discourage reflective learning, considering it of limited value to the nurse who they believe has restricted power within the organisation.</p>	<p>Throughout, I was able to demonstrate my prioritisation, time-management and delegation skills, thus ensuring the delivery of care was appropriate and effective, being the right of every patient in my charge.</p>	<p>During discussions with my mentor and the ward manager, I realised the importance of teamwork and shared vision. Talks with my mentor I performed on the day were carried out to the complete satisfaction of my mentor</p>
Professional development / critical thinking	Reflection / personal learning	
<p>This incident posed a greater challenge by extending my clinical practice contributing to my continued learning, a prerequisite for the provision of professional nursing This highlighted the involvement of my clinical judgement My decision-making skills, in particular and the ability to think on my feet are still evolving and will continue to improve with further experience The incident has, developed to some degree my creative problem solving skills, and expanded my clinical abilities to enhance the quality of care I deliver to future patients This situation availed me with valuable experience in the form of development of my interpersonal and inter-professional skills I can further expand my knowledge and skills base</p>	<p>It must be remembered that reflective frameworks can actually restrict the deeper exploration of practice, and suppress creativity and thinking, especially if the nurse is a novice, or is faced with incidents which exceed the scope of the questions posed within the framework. Indeed, engaging in reflection can in fact lead to self-doubt. This made me question the importance of my role In similar situations I should no longer doubt my ability I lacked experience relating to the advanced nursing practice conducted within that specialist area. I have discovered a greater awareness of my current nursing skills and highlighted those which need development. In hindsight I should not have doubted my ability so readily. It enabled me to put theory into practice, directed at a patient in need of my assistance</p>	

### Story 36

Emotional	Management	Professional development / critical thinking
<p>I know that the patient was glad that I was trying to get as much done for her as possible</p> <p>I think that the stress that I felt was probably sensed by the patient</p> <p>I have always found organisation difficult</p> <p>I also felt nervous about the care of this patient because I didn't have a grasp of part of the patient's condition during the shift.</p>	<p>Would have helped if I had called others to assist me</p> <p>Better organisation of my actions</p> <p>By regularly using a structured approach to patient care my nursing practice should begin to improve e.g. the nursing process model, which when used in conjunction can provide a useful tool in critical thinking.</p>	<p>After researching the disease processes, I now have a better understanding of the priorities for this type of patient care.</p> <p>The effective nurse needs to utilise all these skills for good patient care to be achieved.</p>
Reflection / personal learning	Communication	Practice
<p>When I consider my interventions in retrospect, I can see that the majority of my actions were reactive rather than proactive,</p> <p>By not having a firm understanding of the patient's condition and her needs I feel that I could not judge effectively the order of prioritisation.</p> <p>By not planning and sharing my workload, the patient's care suffered, and many tasks took longer to achieve than normal.</p> <p>Rather than feeling empowered by successfully taking charge of patient care, I actually felt constantly worried, and nervous about how much I had to do.</p> <p>I could have dealt with the above situation differently, resulting in better patient outcome.</p> <p>I should communicate when I don't feel able to cope with the level of care that has been assigned to me, because patient care is of primary importance.</p> <p>My initial problem of inadequate information could have been dealt with if I had been more assertive.</p> <p>Patients with conditions that are not understood by myself will continue to be a part of the experience of being a nurse.</p> <p>I am now trying to see each experience as learning opportunity, rather than a barrier to patient care.</p> <p>I believe that this experience has given me a practical insight</p> <p>Once the hand over was over and I was left alone, I mentally took a step back and realised that the patient had many aspects of care that needed to be considered.</p>	<p>The night nurse handed over that the patient had suffered diarrhoea which had led to her opening her bowels on several occasions. It was also handed over that the patient needed to be regularly turned because the polymyopathy had caused the patient to develop grade 2 pressure ulcers which; unless regularly monitored, would worsen.</p> <p>After reading notes</p> <p>The polymyopathy had left the patient with speech difficulties, which made communication difficult.</p> <p>I was forced to check care documentation which slowed my own planning down.</p> <p>By explaining that I needed further information, I would not have needed to spend valuable time hunting for patient care information.</p> <p>I now also realised, that as a student it is important to communicate with the nurse assigned to work with me when I find it difficult to cope with the workload.</p>	<p>Just from looking at the patient, I could see that the patient had a central line insitu, she was fed via a Nasal gastric (NG) tube, the patient was diabetic with a syringe driver of atrapid running, and was being given regular nebulisers to help her breathing.</p> <p>After 10 minutes I found another nurse to assist me with washing, changing sheets, applying cavalon cream and turning the patient.</p> <p>Medications needed to be given</p> <p>I found out that the patient's catheter bag needed emptying, and I had missed recording two hours of observations, which I quickly completed.</p> <p>I then noticed that the patient had a very dry mouth and damaged lips that needed mouth care.</p> <p>The patient once more opened her bowels.</p> <p>Several aspects of care for the patient, such as manual handling, giving medication, and administering fluids involves a need for a nurse to be with me, and became time consuming because staff were frequently busy elsewhere.</p>

### Story 37

Practice	Teamwork	Ethical
<p>Through the practice of such 'basic' nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, mobilised to and back from the bathroom, improved her confidence in walking with a stick, and had regained some of her appetite.</p> <p>It is critically important for Wendy to increase her mobility and sit up to eat.</p> <p>Along with mobility, a nutritionally sound diet will play an essential component in improving and maintaining Wendy's recovery.</p> <p>Over the shift, through the practice nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, transferring to and from bed safely, improved her confidence in mobilising and had regained some of her appetite.</p>	<p>A brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided to my patient, over a whole shift.</p> <p>I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients.</p> <p>I am aware of the importance of team-working.</p> <p>I am pleased that I worked closely with the physiotherapist to encourage Wendy to get out of bed and transfer safely to the chair.</p> <p>It would appear that to provide effective care, a nurse should co-operate with others within a team (including the patient).</p> <p>Wendy's situation has demonstrated to me the importance of team-working in providing enhanced care.</p> <p>I now view team working as more than just a theoretical concept that should be applied to nursing practice; rather it is an essential nursing skill that can lead to enhanced quality of care.</p> <p>I need to improve upon my team-working skills, to ensure the quality and effectiveness of care.</p>	<p>I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of a patient for a whole shift.</p> <p>The situation encompasses how I used the nurse-patient therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist. The patient will be named 'Wendy' to ensure that confidentiality is maintained.</p> <p>The nurse-patient relationship is a privileged relationship, based upon trust, empathy and a rapport with the patient.</p> <p>I feel that I should, as a matter of course, use other healthcare professionals to enhance quality of care.</p> <p>It could also be the case that Wendy might not want to move out of her bed. In this regard there is both an ethical and moral obligation on nurses to ensure that they gain consent for all decisions involving treatment, ensuring that the principle of patient autonomy is respected.</p>
<b>Professional development / critical thinking</b>	<b>Reflection / personal learning</b>	<b>Management</b>
<p>It would appear that the use of physiotherapist input could be used to better effect by the nursing profession as a whole</p> <p>Whenever I encounter a similar situation to Wendy's, I can use practice enforced by theory to improve my relationship with physiotherapists and other healthcare workers, using their skills and abilities to increase patient care.</p> <p>I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing.</p>	<p>Upon reflection, from the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice.</p> <p>I realise that in future I must use other healthcare professionals to better effect.</p>	<p>I see that my management of the patient, until the physiotherapy session, had concentrated upon nursing issues such as adequate analgesia, bowel output and recording vital observations.</p> <p>Managing my patient is more than just providing a range of nursing duties; it is to provide holistic care.</p> <p>I have been able to assess how I feel about my nursing delivery and management of care for a patient over a whole shift.</p> <p>I have found that I can adequately manage the nursing care of a patient.</p>
<b>Communication</b>	<b>Emotional</b>	
<p>In this respect, good communication is fundamental to good nursing practice.</p> <p>I communicated Wendy's mobility status at handover</p> <p>I am also pleased that I adequately communicated to the physiotherapist that I wanted to work with her to see how she assisted Wendy in safe mobility.</p>	<p>I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of the patient for the shift.</p>	

### Story 38

<b>Theory</b>	<b>Reflection / personal learning</b>	<b>Ethical</b>
<p>Repair of a ruptured abdominal aortic aneurysm.            A temporary tracheostomy was in place to assist breathing.            The patient was receiving BiPAP (bilevel positive airway pressure) ventilation via the tracheostomy.            The plan for this patient was to slowly wean him of BiPAP and eventually remove the tracheostomy tube.            The patient was able to self-ventilate via a tracheostomy mask, with 5 litres of oxygen.            Nursing care in the HDU is based on the Mead model, and using this model I also monitored renal, neurological, pain, nutrition, elimination, psychological and social aspects of the patient's care.</p>	<p>The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it.            I was able to analyse my clinical practice, this related to the development of a therapeutic nurse-patient relationship and the feelings of guilt I experienced for not giving the patient the level of care I felt he needed.            The demands of every day nursing can often prevent individualised care at a time when a person is most at risk of losing their independence.</p>	<p>During the time that I cared for this patient, we developed a trusting professional relationship.            Even though my relationship with him was short term, I considered it 'therapeutic' based on commitment and trust.            He trusted my abilities and judgement, and welcomed me warmly at the beginning of each shift.            Although our relationship was purely professional, I felt a personal responsibility for neglecting him.            As his nurse, my responsibilities included close monitoring of the patient's condition, on this occasion I allowed my attention to be diverted, my reactions had been quick and effective.            When action is based on desirable practice, it has the potential to empower both the practitioner and the patient.</p>
<b>Emotional</b>	<b>Professional development / critical thinking</b>	<b>Practice</b>
<p>My feelings of guilt were due in part to the realisation that I had not provided the patient with sufficient information about his own care.            I felt conflict between the person-centred care I wished to provide and the restrictions of operating within the contemporary health system.</p>	<p>I was prompted to use my nursing knowledge and skills in order to care for the patient.            I was aware of the need to react quickly to changes in the patient's condition. I tried to be proactive, to anticipate potential problems and act in a way which would avoid these problems arising.            This highlights the challenge for nurses to be sensitive to the dynamic and rapidly changing needs of all patients.            The Nursing and Midwifery Council (NMC) recognises that nurse's practice is a constantly changing environment, with new advances in treatment and care, reorganisation and redirection of resources.            Nurses are required to develop professional knowledge and competence to meet these demands and the complexities of modern professional practice through lifelong learning.            This demands an enquiring approach to nursing practice.</p>	<p>Observations were taken and recorded hourly throughout the shift.            Caring for the tracheostomy            The patient asked if he could wash and change his gown and I agreed to assist him.            I saw that he was struggling to breathe. I immediately repositioned the mask and re-attached the finger probe            Early recognition of potential and actual deterioration in a patient's condition is essential, and should be accompanied by an appropriate response for early intervention.            Nurses must be able to make decisions quickly and accurately, based on their nursing knowledge and patient cues.            To ensure that these goals were achieved, it was important to monitor his respiratory system and note the ease with which he was able to perform the activities of daily living.</p>
<b>Learning from and with others</b>	<b>Teamwork</b>	<b>Educating patients</b>
<p>My mentor allowed me to plan the patient's care, and was available for advice and assistance and to perform those tasks which I was unqualified to carry out myself (such as administering intravenous medication).</p>	<p>Working with others, including physiotherapists, speech and language therapists, pharmacists and doctors.            The patient's nurses had developed a plan of care which would enable the patient to be weaned off BiPAP therapy and have his tracheostomy removed.</p>	<p>Through health education and health promotion patients are empowered to make informed choices about their own well being.            Part of my responsibility to my patient was to educate him on his condition and how best to promote his rehabilitation.            I explained to the patient how important it is to maintain a good oxygen supply, and indicated the monitor which showed his saturated oxygen levels had fallen to an unsafe level.</p>

### Story 39

<p><b>Theory</b></p> <p>The patient had developed a cardiac arrhythmia characterised by a rapid but irregular pulse, the patients pulse had increased from within the normal range of 60 to 100 to over one hundred pulses per minute.</p> <p>The ECG suggested that the patient was in atrial fibrillation and so the patient was given medications and potassium</p>	<p><b>Intuition</b></p> <p>Instead of ignoring my own feelings about this situation I persisted with voicing my concerns and this led to the patient receiving the appropriate treatment.</p>	<p><b>Ethical</b></p> <p>I had given a lot more attention to the patient who had developed the cardiac arrhythmia than I had to the other patients. The quality of decisions as measured by the rate of error reduces when the nurse is under stress or is in a stressful environment. Thankfully the environment I was in was both supportive and stress free.</p>
<p><b>Emotional</b></p> <p>I recall being quite concerned about my observations, previous experience had taught me to be wary of cardiac arrhythmias and the irregular pulse I had observed coupled with the patient's report that the episode started with a painful sensation made me especially wary.</p> <p>I feel that the patient was eventually given medications in order to stabilise his heart rhythm as well as subsequently being transferred to a cardiac ward demonstrated that I wasn't over-reacting and that I had performed my duties well.</p> <p>I also felt that I had prioritised my care correctly</p>	<p><b>Communication</b></p> <p>While communicating with the patient I maintained a professional but friendly relationship and did not allow my concerns to panic the patient.</p> <p>In the case being examined here I rapidly accepted the alternative explanation as it was being put forward by a nurse who has greater experience and a greater knowledge base upon which to draw.</p> <p>It took over one hour before I raised my concerns with a doctor, this was in part due to the simple explanations for the cardiac arrhythmia presented</p>	<p><b>Practice</b></p> <p>I wanted to take an ECG and blood sample to attempt to locate the source of the arrhythmia, the nurse said that would be fine, but first we should inform the doctor.</p> <p>Every time I monitored the patient's pulse I also made sure I palpated it manually and did not just rely on the electronic equipment</p> <p>I continued to provide care to the other patients that were allocated to myself and the registered nurse and did not allow the situation to impact upon the quality of the care I was providing. The role I held was one of assessment, patient reassurance, patient education and liaison with other professionals and the patient's relatives. It was due to my assessment that sought the treatment of the patient.</p>
<p><b>Reflection / personal learning</b></p> <p>In the case of the described incident part of the decision to report the cardiac arrhythmia was based on knowledge.</p> <p>A previous placement on a cardiac care unit led me to read about cardiac care and provided me with a deeper insight into arrhythmias.</p> <p>It was the application of this knowledge that leads me to suspect that there was something more.</p>	<p><b>Educating patients</b></p> <p>The patient realised that something out of the ordinary was occurring and had questions that he wanted answers for, due to my previous experiences and knowledge I was able to provide him with answers and if I was unable to answer his question I was able to locate someone who could.</p> <p>If I had been more persistent in stressing the importance of the irregular heart beat the doctor may have been consulted sooner and the patient's condition treated quicker.</p>	<p><b>Learning from and with others</b></p> <p>Whilst on placement I was engaged in providing care under the direction supervision of a registered nurse to a group of post-surgery patients.</p>
<p><b>Professional development / critical thinking</b></p> <p>By remaining calm and acting professionally my role as liaison, both to other professionals and to the patient's relatives, was a productive and informative one.</p> <p>Assertiveness is a positive quality for a nurse to exhibit and I believe that a barrier to assertiveness is perceived lack of experience and knowledge.</p> <p>By maintaining my careful monitoring of the patient and acting in a relaxed professional manner I avoided alarming the patient and as such the patient remained calm and reassured that everything that could be done to rectify the situation was being done.</p>	<p><b>Teamwork</b></p> <p>When the doctor was consulted I felt relieved and even a little proud that the first tasks he asked us to perform were the tasks I wanted to perform as well.</p> <p>The nurse-physician relationship is one of collaboration when applied to clinical decision making.</p> <p>In this case the nursing staff, consisting of myself and the registered nurse I was working with, had already reached the decision that the patient's cardiac rhythm required further investigations, this was corroborated by the doctor.</p>	



## Story 40

<p><b>Learning from and with others</b></p> <p>My mentor was nearby to observe my nursing skills, communication skills and give me reassurance. My mentor administered the Naloxone intravenously, and a couple of minutes later, Mrs Smith's respiratory rate had increased and all her observations were in normal range. I reminded myself that I was not on my own and I could have full support from my mentor if I needed it. When I noticed the change in Mrs Smith's Oxygen saturation and respiratory rate, I almost panicked and wanted to handover to my mentor, but she reassured me and told me to check the drug chart for prescribed medication. I had relied upon some assistance from my mentor. My mentor contributed to this experience with psychological support and minimal verbal guidance.</p>	<p><b>Communication</b></p> <p>I also had to think about Mrs Smith's needs and communicate well with her and other healthcare professionals. Communication is the process of transmitting messages and interpreting meaning. As an important nursing skill, communication competency is acquired through study and application. Effective communication is an essential necessity for effective nurse-patient relationships as well as inter-professional relationships. If nurses are aware of their body language, for example, presenting closed posture or not making eye contact, this could have a negative impact or change the message received by the patient. I felt that I communicated well with other team members and with the patient verbally and non-verbally.</p>	<p><b>Ethical</b></p> <p>Problem-solving is part of decision-making, a systematic process of focuses on analyzing a difficult situation and problem solving always includes a decision-making step. Because decisions may have far-reaching consequences. I am aware that in nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems. I also knew that if it was not the right decision, my mentor would have corrected me.</p>
<p><b>Emotional</b></p> <p>I felt very excited and intrigued when my mentor told me that I was to look after the patient and give all the necessary care. I felt nervous and was unsure if I could manage the patient's care myself. I also felt confident assessing the patient and taking the laryngeal mask out. I took deep breaths and tried to stay as calm as possible as it helps to focus, however, I found it was not easy. I was relieved when the nurse came back, administered the medication and Mrs Smith's respiration stabilised. I felt tired after the event, but also very positive and confident that I managed the situation well. The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear, and uncertainty but finally confidence. I was very nervous and panicked at the task, which has the potential to make other people nervous, as well. I also acted hesitantly at times, down to a lack of confidence. I feel I did well and I found this experience positively contributed to my overall nursing skills.</p>	<p><b>Professional development / critical thinking</b></p> <p>This experience has shown me that I can achieve more than I initially thought I could. Nurses use their own judgement every day in practice and therefore they need to have the relevant background knowledge to do so. Nurses are expected to access, appraise, and incorporate research evidence into their professional judgement and clinical decision making. In this situation I had to use my interpersonal-problem-solving and prioritising skills, as well as making clinical decisions and delegating duties to other staff members. If this situation arose again, I would try to be more confident in myself and I would be more aware of my facial expressions to prevent anxiety for the patient. I started to believe in my own competency and I recalled a past experience in which a similar decision had been made.</p>	<p><b>Practice</b></p> <p>I took her laryngeal mask out. I kept observing her vital signs and especially her respiratory rate as she had had Morphine administered in theatre, and one side affect of Morphine is that it can depress the respiratory rate. I checked the wound site as part of the assessment, I noticed a small amount of blood on the dressing, which I decided to monitor closely, as blood loss can be potentially dangerous. I observed Mrs Smith's breathing further and noticed a prominent decrease in oxygen saturation and respiratory rate. I checked the drug chart to see if Naloxone was prescribed, a medication that reverses the action of Morphine in patients with respiratory depression. I asked the nurse to stop the dressing preparation and instead find the anaesthetic to prescribe Naloxone and an alternative analgesic for Mrs Smith's pain. I was able to safely check the wound and changed the dressing. Ensuring patient care and safety. As Mrs Smith was comfortable she returned to the ward.</p>
<p><b>Teamwork</b></p> <p>I knew that I had to learn to delegate duties to other team members.</p>	<p><b>Management</b></p> <p>I had to ask a recovery nurse to prepare everything for the dressing change. This made me feel uneasy. Priority setting is also an important skill in nursing. I was unsure of how to delegate</p>	<p><b>Reflection / personal learning</b></p> <p>Highlighted the need for me to improve my self-awareness. Only with acceptance of one's self, can a person begin to acknowledge another person's uniqueness. I have gained a new perspective on my practice. Using my clinical judgement, I decided that stabilising the patient had priority over the dressing change.</p>
<p><b>Theory</b></p> <p>A 71 year old woman who had had a left total knee replacement into the recovery room</p>		

### Story 44

<p><b>Theory</b></p> <p>Mr X was sedated since he was on a ventilator using continuous positive airway pressure. Unfortunately Mr X remained hypertensive despite having a glycerine trinitrate (GTN) infusion and some other medications administered via the naso-gastric (NG) tube. He had four intravenous infusions running; crystalloids, GTN, propofol and phosphates as well as an NG feed. Mr X also had a low GCS score of only 3 all night.</p>	<p><b>Emotional</b></p> <p>I found the intensive care setting a very hard place to work, for me I found the biomedical model of care incongruent with my ideals of nursing.</p> <p>I enjoy spending time with patients and their family giving holistic nursing care, as opposed to the intensive care environment where although communication with patients is essential the bulk of the work is intensive and involves careful monitoring of equipment and vital signs etc. but not necessary hands on patient care and care for the patient's family.</p> <p>Many patients died overnight, and I was expected to cope with my own emotions.</p>	<p><b>Educating patients</b></p> <p>This change in treatment needed to be explained to the next of kin of Mr X so that they could understand the medical decisions and also prepare themselves for the death of Mr X.</p> <p>It was decided that the doctors should along with the shift leader discuss the possibility of organ donation with the family as well. The family were shocked and distressed by the news that Mr X was not responding to treatment and that the doctors believed he was now dying.</p>
<p><b>Ethical</b></p> <p>Transferred to a side room to allow greater privacy for the family to have time with Mr X.</p> <p>We also ceased hourly monitoring so that the family would not become fixated on the values of the vital signs.</p> <p>That shift highlighted how hard it is for both staff and families to see the change from active highly intensive treatment to palliative care.</p> <p>How hard it is to deal with a sudden loss, Intensive intervention measures were removed and the focus changed from life prolonging / saving to comfort care measures ensuring that the patients family had some time to say goodbye and understand that their relative in all likelihood would die.</p> <p>In this environment palliative care is given poorly, because death is seen as a failure.</p>	<p><b>Professional development / critical thinking</b></p> <p>I was aware that the doctors were reluctant to spend time with the family as it was a reminder if their so-called failing.</p> <p>This was another experience which led to my decision to head into palliative care in my nursing career.</p> <p>I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably lead to me to quitting nursing.</p> <p>I think it is essential for all nurses to recognise their individual skills and passion and follow this into an area of nursing which embraces their core beliefs and values rather than opposing them.</p>	<p><b>Practice</b></p> <p>His airway was protected with a guedel airway.</p> <p>As well as ensuring that all of the necessary supportive equipment was available and working it was also necessary to check ventilator alarm settings and limits and that the patient was receiving the correct FiO<sub>2</sub>.</p> <p>Necessary to check the central venous pressure and arterial lines</p> <p>Record the readings and that the safety checks have been completed at the start of the shift.</p> <p>Hourly observations including the checking of wounds, drain sites, chest auscultation, and the neurological status using the Glasgow coma scale (GCS) and ensuring their comfort by carrying out mouth care and position changes.</p> <p>Due to raised intracranial pressure Mr X was required to be nursed with his head at a 30 degree angle.</p>
<p><b>Learning from and with others</b></p> <p>The senior nurse would oversee my nursing care and take responsibility for the administration of intravenous fluids and monitoring of arterial blood gas (ABG) analysis.</p> <p>We agreed that I would work within my limitations as a student and seek her advice or direction as required.</p> <p>I carried out the above checks under the supervision and with the assistance of the charge nurse supervising me.</p> <p>Then we planned the shift</p>	<p><b>Teamwork</b></p> <p>The Dr's were informed during their morning round and believed this could reflect a further bleed.</p> <p>They therefore decided he was no longer for active treatment, but for palliative care.</p> <p>They were also informed that we believed Mr X was no longer managing the NG feed because there were signs of regurgitation. They made a decision to stop the feed and all the infusions, apart from the GTN infusion.</p>	<p><b>Cultural awareness</b></p> <p>I made sure that the son knew the chaplaincy team, who had access to a member of their faith, would be available to talk with him and spend time with his father, however, they declined.</p>
<p><b>Intuition</b></p> <p>Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family, I respected this.</p>		

### Story 48

<p><b>Theory</b></p> <p>It is imperative the nurses know exactly what medication the patient has had. Some medications like morphine for example tend to depress the respiration rate of the patient and can make them a little dehydrated.</p>	<p><b>Communication</b></p> <p>I should have reassured, encouraged and communicated with the patients a little more. <i>Good communication also has a good impact on patient care</i></p> <p>This is why the nursing staff need to continually let the patient know that they are ok.</p>	<p><b>Ethical</b></p> <p>The opportunity to understand what the patient was going through (empathy) and thereby improving the quality of care I could have given to the patients.</p>
<p><b>Emotional</b></p> <p>I believe I could have become more actively involved in reassuring the patients and letting them know they were in good hands and they were being taken care of. Sometimes patients can be emotionally distressed by their experience in surgery. It can be very emotionally draining. Nurses cannot allow themselves to get too emotionally attached to the patients.</p>	<p><b>Professional development / critical thinking</b></p> <p>In the future this is an area I will have to work on. In future I will be more proactive in my dealings with the patients. In terms of reassuring patients, and being made aware of the level of knowledge needed to offer that care, I have consistently applied these practices since my visit to the recovery room by taking a more active role in learning why certain procedures are taken and being prepared to interact more with patients. It would also ensure I would learn a little more.</p>	<p><b>Practice</b></p> <p>While I was there I was actively encouraged to interact with the patients in terms of reassuring them and informing them of where they were. The effects of this medication need to be monitored closely immediately after the operation until the effects of the medication wear off. Patients in the recovery room receive a very high level of care (as a general rule there is one nurse for each patient).</p>
<p><b>Educating patients</b></p> <p>Offering them advice and support when they need it, in addition to asking patients what they need from the nursing staff</p>	<p><b>Reflection / personal learning</b></p> <p>I chose this area because I believe it is important to realise that exposing oneself to other areas can have very beneficial side effects.</p>	<p><b>Learning from and with others</b></p> <p>My mentor suggested I should spend some time in each area that our patients visit while in hospital as well as spending some time in the surgical ward itself. I was also (under supervision from the nursing staff) encouraged to perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient.</p>
<p><b>Teamwork</b></p> <p>I intend to seek advice and support from the multi-disciplinary team when appropriate. It is important to be able to communicate that to a doctor or another relevant member of the multi-disciplinary team if the nurse does not have the necessary skills or training to assist the patient.</p>		

**Story 51**

<p><b>Theory</b></p> <p>Patient had a total hip replacement operation. Post operative patients especially those where the bone had been operated on, the risk of infection entering the bone presented a serious threat to the patient with the risk of amputation or worse.</p>	<p><b>Reflection / personal learning</b></p> <p>If wounds are not dealt with in a timely manner infection can set in. The comment on speed caused me to assess myself and has definitely enhanced my practical ability as a nurse.</p>	<p><b>Ethical</b></p> <p>Adequate care and consideration to minimise patient distress caused by pain. The implications can be enormous for the patient; physically, psychologically and socially, there are knock-on effects for other patients waiting in line for treatment.</p>
<p><b>Professional development / critical thinking</b></p> <p>I have found that I am more aware of my actions when fulfilling my duties, constantly seeking to justify my actions and underpin these with theoretical knowledge. I spend more time reviewing my work practice to determine the not-so-obvious consequences of my actions. When I worked in theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again.</p>	<p><b>Learning from and with others</b></p> <p>The comments my mentor had made to me highlighted that there was a need in me to focus on the broader picture. My mentor was pleased with my work I carefully attended to the wound my mentor, who had been unobtrusively watching me, came over and suggested I speed up my actions and asked whether I knew why speed was essential. My mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality. Although the criterion highlighted by my mentor was my lack of speed, the greater and more important implication was the risk presented to the patient should the wound become infected and pathogens spread to and compromise bone tissue.</p>	<p><b>Practice</b></p> <p>The patient was on his third day post-operatively and needed his wound dressing changed. The wound had been closed using clips and covered with opsite dressings. I carefully removed the old dressing, using the aseptic technique; I cleaned the area adjacent to the wound using saline solution and sterile swabs. I also did not want to cause the patient any pain although pain was taken care of by medication. I prepared the trolley following hospital guidelines and attended to the wound in accordance with aseptic technique practice.</p>
<p><b>Emotional</b></p> <p>The comments my mentor has expressed made me conscious of my actions, causing me anxiety due to nervousness, and my initial feelings of confidence as I dressed the wound was eroded by the criticism levelled against my work. I felt inadequate as the unexpected feedback caused me initially some stress. The patient's smile which I viewed as reassurance eased my troubled feeling and reflected the rapport we shared.</p>		

**Story 52**

<b>Theory</b>	<b>Reflection / personal learning</b>	<b>Professional development / critical thinking</b>
<p>S has severe cerebral palsy with contractures. In addition to this, he was suffering from cancer of the tongue and had undergone a hemi-glossectomy, had a permanent tracheostomy in place, poor eyesight</p>	<p>S appeared to be exceptionally bright but trapped in his useless body. Everyone loved him as he seemed such a gently character.</p>	<p>Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us</p>
<b>Emotional</b>	<b>Communication</b>	<b>Practice</b>
<p>I tried to be as cheerful as possible but had begun to feel dreadfully sorry for this poor soul. This was no way to live a life. It must have been hell. eyes said it all and I couldn't believe that this poor man, who's suffering was so immense, was saying sorry to ME! Who was I? I touched his arm to reassure him and told him that it was what I chose to do and that the nurses all loved to look after him and he was not to worry. Then I left the room, ran to the toilet and cried uncontrollably. I will never every forget S's story Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own.</p>	<p>Communicated with an alphabet chart. Suddenly he looked upset and indicated he wanted to communicate so I fetched his alphabet chart. He spelt S O R R Y.</p>	<p>He was totally bed-bound and had been admitted to our ward awaiting re-insertion of his jejunostomy which had accidentally come out. He was nursed in a side room and was totally dependent on the nursing staff. I was assigned to S daily and within a few days felt a real bond had developed between us. We hoisted him daily into his specially adapted wheelchair which supported him and positioned him by the door so he could watch what was going on and read his bible. Arrived at work to find S suffering from severe diarrhoea. I washed him from head to toe, cleaned the bed and floor and changed his sheets. I cleaned S's glasses and combed his hair.</p>

### 9.3 - 3<sup>rd</sup> year child nurses categorical analysis

#### Story 1

<b>Theory</b>	<b>Communication</b>	<b>Ethical</b>
Admitted to the ward with severe hydrocephalus, this can be defined as excessive cerebrospinal fluid within the skull. This child's hydrocephalus was as a result of a congenital condition and was one problem amongst many that this child was suffering from.	I spent a large amount of time talking with the family about their child.	Admitted to the general paediatric ward for tender loving care following increased severity of congenital hydrocephalus I was unsure about how effectively I would be able to care for a terminally ill child, I was extremely grateful to have been given this opportunity.
<b>Emotional</b>	<b>Management</b>	<b>Practice</b>
<p>I was glad that the care of the child had been allocated to myself during this shift as I had previously handled his care and the family had requested that I care for their son.</p> <p>I was however nervous because we were all aware that the child was only on the ward for Tender Loving Care (TLC) and would therefore die on the ward, we did not however know how long before this happened.</p> <p>The lack of experience made me nervous</p> <p>I felt that I had handled the care of this child effectively and with respect and dignity on this shift.</p> <p>I feel that the support available whilst on this paediatric ward was extremely helpful and encouraged me to share my emotions and feelings with the team at the end of the shift.</p> <p>I feel that this child and his family received the best quality of care and was looked after with respect and dignity.</p>	<p>I was allocated to manage the care of a dying paediatric patient. The focus of my attention and care needed to be focused around this family and this child.</p> <p>I had to manage communication between various professionals' 'time management for the care of this child and others on the ward whose care I was participating in.</p> <p>Time management is extremely important when caring for any patient however when the patient is terminally ill it is extremely difficult to manage your time.</p> <p>If I was managing the care of a dying child in a similar situation to this one I would handle the care of this child in a similar way to the way that I handled the care of this child.</p> <p>I would continue to involve the family and the child, if appropriate in the management and delivery of care. I would also continue to seek support and guidance from fellow members of the team.</p>	<p>I found it extremely difficult to look after this child and undertake other ward duties including observations and ensuring that prescribed medication was given on time because I was required to give support to the child and his family.</p> <p>However handling the care of this child gave me an insight into a different type of nursing care than the one I had previously experienced and participated in.</p> <p>I felt that I lacked experience in caring for children who were dying, I had observed and minimally participated in caring for children in this situation before but never managed or delivered their care before.</p>
<b>Professional development / critical thinking</b>	<b>Teamwork</b>	<b>Learning from and with others</b>
<p>I had an established professional relationship with the child and his family.</p> <p>This meant that the child's family were able to approach me with any questions or queries that they had.</p> <p>On this shift I found that I spent a large amount of time with the child and his family supporting them, answering any questions that they had and generally talking with them about their son.</p>	<p>Communication between myself and the family and myself and other members of the care team was extremely effective in this situation.</p> <p>The communication and teamwork ensured that the best possible care was provided to the child and his family and that all necessary information was shared between the necessary; healthcare professionals to ensure safe practice for the patients on the ward.</p> <p>Communication and inter-professional working within a team are essential.</p> <p>I learnt how effective communication, team work and support are essential factors when caring for children with such complex needs.</p>	<p>I was allocated my own patients to manage with minimal supervision from my mentor.</p> <p>Support was available from my mentor as well as other members of staff.</p> <p>My mentor and the other members of staff made it clear to me that I could ask for their help and support at any time.</p>

## Story 2

<b>Theory</b>	<b>Communication</b>	<b>Management</b>
<p>Hypomelanosis is a condition that is distinguished by a lack of skin colour (hypopigmentation) effecting many areas of the body. The patient had severe epilepsy.</p> <p>Frequent, prolonged, uncontrollable seizures, which were being treated with a continuous infusion of Phenobarbitone (Phenobarbital).</p> <p>I need to expand my nursing knowledge on the care and health promotion of children with neurological conditions</p>	<p>I read the patient's medical notes in order to gain an in-depth history of the patient.</p> <p>I made sure I was present during the ward round in order to know of any changes the doctors made to the patient's treatment plan.</p> <p>The nurse will need to rely on careful observation and interpretation of the patient's communicative behaviour, clinical judgement and knowledge of the person during assessment.</p> <p>I communicated over the phone with the physiotherapist to arrange for the patient to have physiotherapy.</p>	<p>While caring for this patient I utilised management skills such as prioritisation, time management and delegation</p> <p>I had not previously managed the care of this patient and therefore I was unaware of what needed to be done. I therefore spoke to the nurse who was caring for her during the previous shift.</p> <p>I made sure the most important tasks were highlighted and given greater priority.</p>
<b>Reflection / personal development</b>	<b>Educating patients</b>	<b>Practice</b>
<p>I believe I could have managed this patient's care better if I had more medical knowledge</p> <p>My previous knowledge allowed me to learn as I went.</p> <p>I could have utilised the help of other members of the nursing team more for advice and support, while managing the care of this patient.</p> <p>I now realise that as a nurse you will be expected to look after patients like this but also look after other patients as well.</p> <p>This situation highlighted that in order to become more confident as a nurse I will need to actively seek out situations where I care for my own group of patients as a student.</p> <p>I aim to manage the care of a group of patients while on placement to become more confident in my nursing skills.</p> <p>I also recognise there are gaps in my knowledge of certain skills and theories, which are required when managing the care of patients.</p> <p>I used my previous knowledge of wounds to monitor the site of the gastrostomy for signs of infection.</p> <p>The theory side of nursing knowledge is good but I need to be more aware of it and utilise it in practice situations.</p> <p>This will help me gain experience, confidence and help me to improve my management skills.</p>	<p>While caring for this patient I contributed to the health improvement of the patient through health promotion by educating the patient's mother.</p> <p>I showed her the correct way to suction the patient, which was shown to me by the physiotherapist.</p> <p>I also explained to the patient's mother about the importance of positioning the patient in a manner that prevents a heavy build-up of mucus secretions.</p> <p>I also explained to the patient's mother about the importance of regularly turning the patient in order to prevent pressure sores.</p>	<p>The care the patient required was personal care such as oral mouth care, bed bath and frequent changes of the patient's pad. With the help of the patient's mother's I carried out the personal care needs of the patient in the morning.</p> <p>Due to the side effects of the Phenobarbitone the patient requires, hourly monitoring of pulse, respirations, oxygen saturations and blood pressure observations.</p> <p>I also recorded the type of seizures the patient was having.</p> <p>The patient has a femoral line, which she has numerous other medications.</p> <p>The patient required regular turning and repositioning.</p> <p>I also carried out the patient's feeds which were set out in a nutrition plan which was arranged for her by the dietician.</p> <p>The patient had all her feeds through a gastrostomy.</p> <p>The patient requires frequent suctioning and physiotherapy.</p> <p>The regular pain assessment tools for children were not useful; I relied on the patient's sounds and facial expressions, as well as the movements she was making to indicate to me whether she was in pain.</p> <p>I also need more practice in the management of patients.</p>
<b>Professional development / critical thinking</b>	<b>Emotional</b>	<b>Learning from and with others</b>
<p>The NMC code of professional conduct (2004) and the practice area's medicines policy state I can under direct supervision calculate and administer medicines by a variety of routes.</p> <p>I acknowledge that these shortcomings will need to be addressed and be worked through as nursing is a lifelong process of learning.</p> <p>I realise that I learnt a great deal about what is to be expected of me as a qualified nurse.</p>	<p>While looking after this patient I sometimes felt overwhelmed as she required constant care and attention.</p> <p>At times I felt stressed and by the end of the shift I was physically tired.</p> <p>The more time I spent with the patient the more attached I got to her and I felt a lot of empathy towards her mother</p> <p>At the time however, I feared that I may be criticised by the other nurses.</p>	<p>In order to maintain safe practice I had to delegate the administration of the patient medicines which she has through her femoral line to the registered nurse.</p> <p>Whilst managing the care of this patient I was indirectly supervised by a registered nurse.</p>

### Story 3

Theory	Communication	Ethical
<p>Reference made to The British Thoracic Society (2007) says any child with an oxygen saturation level of less than 92% requires immediate administration of oxygen either via nasal prongs or a mask.</p> <p>Reduced oxygen levels can cause cell death reduced respiratory drive, with the risk that the child will proceed to respiratory and subsequently cardiac arrest.</p> <p>Referred to statistics each year 600,000 children under the age of five have an accident as a result of neglect by parents or carers.</p>	<p>I received handover from the night staff and read the child's notes and felt well informed about her condition.</p> <p>Shared concerns with the mother</p> <p>Realised that the mother's English was limited</p> <p>I assumed she had understood me as she had smiled and nodded.</p> <p>This experience has demonstrated that interaction such as a smile and a nod is not an indication that patients / parents have understood my advice.</p> <p>I feel I have gained knowledge of communication realising my interpretation was not as they were meant.</p> <p>The communication difficulties produced a barrier</p>	<p>My clinical judgement was that the child needed to be attached to the monitor continuously.</p> <p>The need to work in partnership with the mother to identify goals and needs and act as an advocate in assisting the family</p> <p>The need to consider the other patients that I had responsibility for</p> <p>How ethnically I had a duty to promote family centred care based on evidence to the child and</p>
Emotional	Educating patients	Practice
<p>At this point I was feeling very frustrated and disappointed.</p> <p>I felt justified in involving the interpreter</p> <p>I felt I could have dealt with the situation better</p> <p>I felt I should have been advised of the language difficulties in handover that morning.</p> <p>Kept calm and spoke to the mother clearly</p> <p>Feeling under pressure as I had other patients to see</p> <p>The effort of attempting to communicate was such a slow, painstaking process</p>	<p>I explained to the child's mother the reasons for providing extra pillows and propping her up.</p> <p>I was also concerned regarding a safety issue, as with the child propped up mum had left the cot sides down and walked away.</p> <p>I again tried to explain to the other the need to keep the child upright and the cot sides up to maintain her safety.</p>	<p>The child was attached to an oxygen saturation monitor and required regular nebulizers throughout the day to stabilise her condition.</p> <p>I decided it would be best to prop the child up in the cot rather than her laying down flat, which would hopefully help her chest and make her saturations rise.</p>
Management	Intuition	Reflection / personal learning
<p>Prioritising can create tensions for nurses because the needs of one patient compete with those of another in terms of urgency</p> <p>Prioritise my time towards them whilst ensuring patient safely at all times</p>	<p><b>My intuition had told me to get an interpreter.</b></p> <p>On a previous occasion I had been advised that interpreters were only to be used in emergency situations due to the financial cost which had made me apprehensive regarding instructing one.</p>	<p>This experience has allowed me to consider personal feelings, how I would feel in the mother's situation.</p>
Professional development / critical thinking	Teamwork	Management
<p>Although students are not held professionally accountable, they are morally responsible for ensuring patients receive good standards of care.</p> <p>Increasing my empirical knowledge on guidelines and protocols before embarking on patient care will assist me in future clinical practice and will help me understand some of the problems that I may encounter.</p>	<p>I decided to contact the hospital interpreters to ask if one was available to interpret for me.</p> <p>It is essential to ask advice from other members of the multi-disciplinary team who may have input into the child's care.</p>	<p>Difficult situations are only opportunities which are an optimistic way of looking at managing a situation and give a positive approach to professional life.</p> <p>I need to be more confident in making decisions earlier on in the day and not to leave things until they become unmanageable.</p>



## Story 4

Theory	Communication / interaction	Ethical
<p>I followed the department's pre-printed care plans for suspected meningitis that has been created based on evidence based research.</p> <p>Referred to the UK rules with regard to meningitis, all clinically diagnosed cases of meningitis and meningococcal septicaemia must be reported to the local health doctor who then ensures anyone at risk is contacted and antibiotics may be given</p> <p>I ensured safety was maintained at all times by basing my care on evidence based practice.</p>	<p>Once I was satisfied that the patient was stable I took a detailed history of the patient's present illness, past illnesses and normal routine including diet and sleep patterns. This information was obtained from the parents.</p> <p>The end of my shift I handed over this patient to the night staff via tape recorder, conveying all information about the patient and the care I had provided.</p> <p><i>All professionals to communicate effectively</i></p>	<p>At times when my attention was required in more than one place, I had to prioritise the care based on what patient was more ill and what impact would there be on the patient that I would attend to second.</p> <p>I feel this was the right decision and considerations need to be made, as the parents may have researched the topic thoroughly before making their decision, and the parents' decision should be respected.</p>
Management	Educating patients	Practice
<p>Meningitis can progress very rapidly - time management and constant monitoring of any changes is an essential component for the care of this patient.</p> <p>Assessing the patient on admission able to identify the patient's needs and organise what care was required throughout the day</p> <p>Planning ahead and writing plans down is an efficient way to manage time and ensures important tasks are not overlooked.</p> <p>Helps in the management of prioritising patient care</p> <p>Worked the care of this patient around the care of two other patients that I was caring for</p> <p>Prioritising care is an important skill for all nurses in the management of patient care.</p> <p>I implemented structure to my day by organising in advance how I would use my time effectively.</p>	<p>Advice was then given to the parents about infection control, and limiting visitors until an official diagnosis had been provided.</p> <p>Answered any questions in my ability or found out the answer to any question I did not know the answer to</p> <p>Advised the family on universal precautions</p> <p>Educated them on why we would be barrier nursing the patient in an individual cubical and implemented limitations for visitors.</p> <p>The mother highlighted her guilt for not taking the patient to have her immunisations, I felt stuck in a situation of whether to offer support or educate about the benefits of having immunisations</p>	<p>I ensured the patient was barrier nursed to prevent the spread of infection to other patients.</p> <p>I reviewed the patient's condition by observing how the patient looked and taking a set of clinical observations</p> <p>The patient had a petechial rash to their lower limbs, which appeared to be slowly getting worse.</p> <p>All observations were within normal limits except for a high temperature</p> <p>The level of consciousness and neurological status was also assessed.</p> <p>I continued to monitor any deterioration in the patient</p> <p>These observations were recorded in the nursing notes along with a fluid balance chart</p> <p>Medication was also administered as per the drug chart.</p> <p>I also spent a lot of time <b>supporting and comforting the parents</b> who were very upset.</p>
Reflection / personal learning	Professional development / critical thinking	Learning from and with others
<p>By reflecting on this experience, I was able to identify the importance of managing my time for the benefit of the patient and learnt the significance of prioritising the care I provide.</p> <p>I believe this experience has highlighted my ability to manage my own patient load and has demonstrated that I am ready to make the transition from 'student nurse' to 'newly qualified nurse'.</p> <p>My clinical decisions throughout the day were based on what was best for the patient, whilst also ensuring I equally met the needs of my other patients and families.</p>	<p>From this experience I have learnt that I am capable of managing my own workload.</p> <p>This exercise has emphasised the importance of prioritising care, safe practice, working as part of the multi-professional team, providing needed health education and basing my work on evidence based research.</p>	<p>After the initial assessment, which was discussed and approved by my mentor</p> <p>There were limitations to my role that required input from my mentor</p> <p>My mentor was often busy with her own work load, I was required to find her and wait until she had finished the task she was currently completing.</p> <p>Intravenous antibiotics were administered by my mentor as I observed.</p>
Emotional	Teamwork	
<p>I felt guilty that they had decided against their child having any immunisations, which may have been able to prevent this outcome.</p>	<p>Working with the multi-professional team to ensure the care given was the best as can be</p> <p>Worked as part of the multi professional team and collaborated well with the relevant professionals</p> <p>Shared knowledge, skills and expertise with other members of the team for the benefit of the patients</p>	

## 9.4 - 3<sup>rd</sup> year mental health nurses categorical analysis

### Story 1

Theory	Communication / interaction	Ethical
<p>According to the Mental Health Act Code of Practice, the use of seclusion is neither for the purpose of meting any punishment nor suitable where the patient has any risk of suicide or self-harm.</p>	<p>This review was recorded in the patient's nursing record and seclusion documentation.                      During the hour, we made documented and signed records of what we observed at intervals of fifteen minutes and sometimes less when the need to do so was identified. Our observations were to note any changes in the patient's mental state, physical state, and dietary intake, his level of contrition, his level of hostility and his interaction with us.                      With part of the response team still holding the patient, and <i>all aspects of patient privacy and dignity being maintained</i>, the nurse- in-charge communicated with the patient and explained the actions that were being taken.</p>	<p>Other patients in the ward were given the necessary support and reassurance.                      In providing care to the patient in seclusion, the team respected and upheld the patient's dignity.                      Mental Health Act – protecting their human rights, legitimises seclusion others find restraint and seclusion a hindrance to innovative ways of dealing with violence in mental health care                      Nurses taking their various roles, working diligently, consequences could be dire as observed by other patients                      Legal cases referred to e.g. inquiry into David Bennett after prolonged restraint, and Munjaz court ruling of 2003 local health authorities had rights to formulate local policies that depart from the Mental Health Act (1983) in the best interests of the patient                      Additional rulings in 2005 further stated that the Code of Practice guidelines were not always legally binding.                      Improve clinical effectiveness and legal implications of restraint and seclusion as this may help in preventing litigation</p>
<p><b>Emotional</b>                      Caring for a secluded patient was emotionally draining.                      Nurses are expected to cope with their emotions and their patient's emotions.                      Human beings have diverse characteristics and emotional thresholds, some of which can stall the nurses' quest for excellent service.                      Student felt seclusion was morally indefensible as it defeated the essence of a therapeutic relationship</p>	<p><b>Reflection / personal learning</b>                      I have gained new perspectives to set myself personal goals that facilitate effective patient care that may eventually eliminate the use of seclusion.                      Personal change and growth                      Rigorously and systematically develop self and work in a manner that fosters a deep sense of obligation, commitment and moral purpose to the nursing profession</p>	<p><b>Practice</b>                      Continuous nursing observations were initiated with a qualified nurse taking charge during the first hour. It was at his point that I requested to shadow the continuous nursing observation. The nurse reminded me of the competencies I was expected to have before I could shadow him.</p>
<p><b>Professional development / critical thinking</b>                      Professional dilemmas that militate against prosecuting or claiming for damages from patients who may lack insight as it can damage the therapeutic relationship                      Prepared the student to face similar situations with confidence and professional maturity                      Increase in the nurse's abilities and a greater awareness of the complexity of nursing practice                      Improving and developing professional behaviour                      This will enhance knowledge, skills, values and attitudes necessary for safe and effective practice and also lay a foundation for continued professional development and lifelong learning.</p>	<p><b>Teamwork</b>                      A decision to seclude the patient was made by the nurse-in-charge in liaison with the nursing team and the ward doctor was informed of this decision.                      With the patient deemed safe in the seclusion room, a multidisciplinary team involving the ward doctor reviewed his immediate care plan.                      The process of seclusion requires teamwork and adherence to local restraint and seclusion policies,                      Response team flawlessly assembled without showing hostility to the patient, confidence level of the team, staff support in a crisis                      hallmark of safety, communication co-ordinating the whole element of care</p>	

## Story 2

<b>Management</b>	<b>Communication</b>	<b>Ethical</b>
<p>Planned how best I was going to achieve the objectives of the day, a crucial part of my strategy to ensure effective management</p> <p>Delegation is a requisite of good supervision as it supports trust and confidence in your subordinates as you are sharing responsibilities.</p> <p>Managed to distinguish my problem and that of the patient, detaching myself a little in order to get things into perspective, if cannot engage in distancing risk of being drawn into people's problems and can no longer help them</p> <p>Leadership and communications are inseparable.</p> <p>Learned how to manage and co-ordinate a group of patients during shift</p> <p>I should have been more democratic in delegating tasks staff a chance to choose</p>	<p>Soon after delegating duties I communicated days programme to the patients</p> <p>A patient asked me to look into his notes to see what the outcome of last week's clinical team meeting was. I took his notes and sat down in the office to look for the notes of which I did not see. I informed him that I could not find the entry, he did not take it kindly and he became angry.</p> <p>I then said to him, I did not think I was and he started wagging his middle finger at me. I asked him to stop but he then stated that no one tells him what not to do.</p> <p>He then shouted obscenities at me and I terminated the conversation at that point. He continued to shout abusive language such that other nurses had to intervene.</p>	<p>I employed some problem-solving techniques</p> <p>I was left with the final decision – but involved others including patients and colleagues, participative leadership, makes everyone feel valued</p> <p>I used my delegating duties, communication, decision-making and problems-solving to execute duties as a nurse in delivering and managing care of patients while at the same time achieving learning needs.</p>
<b>Emotional</b>	<b>Cultural awareness</b>	<b>Practice</b>
<p>I remained apprehensive</p>	<p>Conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures.</p>	<p>One morning I had the opportunity to coordinate a whole shift.</p>
<b>Professional development / critical thinking</b>	<b>Learning from and with others</b>	
<p>I have insight into dealing with a group of patients, be more assertive</p>	<p>Better supervision cannot do anything alone</p>	

### Story 3

<b>Theory</b>	<b>Emotional</b>	<b>Ethical</b>
<p>Alcohol makes depression worse helped to explore healthier ways of dealing with stress and difficult situation e.g. physical activity to relieve tension in a healthy non-destructive manner.</p> <p>Depressed patients have a potential for suicide, and suicide prevention was at the top of our agenda.</p> <p>Antidepressants are the first line of treatment for moderate to severe depression.</p>	<p>When the patient was crying I did not know what to do to defuse the situation.</p> <p>Trying to get the patient to express feelings can help identify accept and work through feelings even if these are difficult.</p> <p>I might have made him cry due to my inexperience and lack of confidence in my abilities, but was pleased when we went for a drive as I had proposed this activity making him feel relaxed.</p>	<p>The use of a problem-solving process to facilitate patient's confidence in the use of coping skills</p> <p>I learned that the patient was lonely and isolated, took him for a drive and went with him to the community day centre.</p>
<b>Teamwork</b>	<b>Reflection / personal learning</b>	<b>Practice</b>
<p>The previous day to the current visit police and the ambulance staff had to be called to his house to assist gain entrance into the house as staff from home treatment had failed to do so. Simon had overslept and our staff fearing for the worst summoned for assistance. This further lowered his mood and he thought the presence of the police had relayed a wrong message to his neighbours that he was a bad person.</p> <p>Referred to bereavement counselling loss of his grandmother</p> <p>Making referral to other agencies and professionals using an holistic approach to a patient's needs</p>	<p>I learned that I probably was expecting too much of myself without recognising the limitations of my abilities and knowledge and taking into consideration that I was still undergoing training.</p>	<p>When we arrived the patient was very low in mood, citing feelings of worthlessness and indicating that he was better off dead than continuing to live.</p> <p>He began to cry during the visit. He wept uncontrollably and could not be stopped or consoled. He declined to take his medication, which was part of his treatment citing that he did not need it anymore.</p> <p>Before the visit I had gained all of the necessary equipment and preparation required.</p> <p>Ongoing assessment of a patient with depression is one of the most fundamental functions and strengths of any competent nurse.</p> <p>Administering of medication and feedback about his progress following this.</p>
<b>Learning from and with others</b>		
<p>I could have utilised qualified staffs' knowledge better.</p>		

## Story 4

<p><b>Reflection / personal learning</b></p> <p>Increased self awareness and professional expertise, provided an opportunity to examine practice and identify new knowledge</p>	<p><b>Communication</b></p> <p>All require effective communication that facilitates progress in a nursing environment, Communication can breed anger, disagreement, uproar and confusion at the expense of health, promotion and education. Considered as a yard stick in nursing practice and if used in the de-escalation technique it is a concept that has a great impact on the management of violence It is important to document clearly and key issues</p>	<p><b>Ethical</b></p> <p>Clinical judgement was used as a clinical skill to determine whether James had calmed down so as to end the seclusion. Problem solving and decision-making skills are important to professional nursing practice I need to improve my clinical judgement skills read more about teamwork and partnership.</p>
<p><b>Emotional</b></p> <p>Conflict of feelings about physical restraining as a way of managing violence Caught in between a situation, in which patients and staff were perceived to be at risk of harm and the sense of duty to protect as well as the professional, legal and ethical responsibility to protect patients Considering the after effects of restraining in terms of personal and emotional impact of restraint. After the incident I felt relieved as it had been dealt with instantly, I felt safer with the patient locked up at the same time guilty about the need for secluding James. The restraining process is unfriendly, I dislike getting physical with patients and unsatisfied because alternative strategies such as de-escalation skills were not fully considered before restraining the patient The patient felt punished, and I felt it had damaged the therapeutic relationship with the patient. Made me want to critique the idea of seclusion</p>	<p><b>Management</b></p> <p>The situation involved a lot of management and leadership skills The shift leader delegated staff accordingly taking into consideration appointments, escorts, psychiatric response, medication, ward security and other activities that were going to take place that day.</p>	<p><b>Practice</b></p> <p>James had been presenting with command hallucinations and as a result, he became restless, agitated, aggressive and violent. His behaviour was so disturbed that the psychiatric restraining team had to be called. Physical intervention was exercised. Restraining management skills were then used. To avoid prolonged physical intervention, rapid tranquillisation together with seclusion was considered to help him calm down Observation is essential to help the patient and staff engage in a positive trusting way Before restraint is imposed other interventions should first be sought e.g. de-escalation skills, make use of the soft furniture room specifically designed for the purpose of reducing agitation.</p>
<p><b>Professional development / critical thinking</b></p> <p>Clinical governance involves self management skills of professionals such as professional developments in education, audit, guidelines, managing time, increasing confidence, developing self awareness, learning from errors.</p>	<p><b>Teamwork</b></p> <p>The restraining team demonstrated teamwork, inter-professional practice and record keeping as integral part of teamwork and help with violence management if the problem occurred again.</p>	

## 9.5 - Post graduate nurses categorical analysis

### Stories1-6

Theory	Communication	Ethical
<p>What is an ultrasound Doppler assessment why undertaken, non-invasive evaluating ulcerated limbs            Determination of the API systolic pressure in the ankle is divided by the systolic brachial pressure, resulting figure indicates the presence of either venous insufficiency or of arterial impairment            If API less than 1.0 it is unsafe to use compression bandaging as it indicates arterial impairment            Contraindicated in diabetes and rheumatoid arthritis            Read a report related to this on the use of wholemeal bread versus laxatives. The study showed that over a 4-month period of media marketing of brown bread, its sales went up by 60%, and the sales of laxatives went down by 60%. This method of promotion was proved to be more effective than patient education by doctors. It also states 'it is now well accepted that increased fibre in the diet is a better way of preventing constipation than the use of laxatives'. This information has been very useful for me when caring for elderly patients in the community</p>	<p>Primary health care team meeting to discuss results of the audit, which is known as significant event audit.            Good communication between agencies involved in patient discharge from hospital starts before the patient leaves hospital.            Continue to evaluate and improve services to patients and relatives when newly discharged from hospital.            Be alert to current literature and research on the subject</p>	<p>I began to recognise the detrimental effects of social isolation on the health of elderly individuals.            What it means to a person to be socially isolated, and the effect it can have on health            More alert to individual needs and can now provide necessary information to patients being barrier nursed in this way</p>
Professional development / critical thinking	Hospital and community	Practical
<p>Assessment of a patient who is constipated, medical history, daily bowel function            Current types of treatment for constipation available, their action, the effects of these different treatments            Suitability of diet and exercise to recommend to patients            A sensitive approach to the subject</p>	<p>Phoned the local benefits agency to ask for latest information on the attendance allowance in particular and other benefits in general            What benefit is, who qualifies, exceptions, rates of pay, method of payment, rates for special rules            Allowance can be used to improve life style of the sick person, enabling them to go out occasionally or have a sitter so that their carer can be given a regular break each week</p>	<p>Spent half an hour learning to use the new Doppler machine with colleagues,            Performed Doppler assessment with the G grade sister supervising on patient with ulcerated ankle, the API was 1.21 indicating venous impairment.            A compression bandage was applied.</p>
Teamwork		
<p>Other agencies that patients are referred to on a regular basis            Identifies the extent to which patients need help to achieve maximum independence and to maintain an acceptable quality of life.            The need to establish a good working relationship is required with all agencies            Regularly assess and evaluate the input from agencies and be aware of the changing needs of the patient and families            Began to function effectively in a team and participate in a multi-professional approach to the care of patients            The referral process to other agencies for patients to gain access to the correct agency for the needs of that particular individual</p>		

### Story 7

Emotional	Communication	Ethical
<p>I felt awkward asking such detailed information in front of Gloria's mother</p> <p>I remained uncomfortable about asking the necessary and pertinent questions required to obtain a detailed structured history of a sexual nature especially with a young adult / adolescent.</p> <p>My tendency to skim over details of a sexual nature was also found to be what makes many nurses feel uncomfortable,</p>	<p>Asking questions around Gloria's sexual history and was there any possibility that she could be pregnant. building a relationship</p> <p>Information was needed such as if she was on the pill or sexually active, the date and time of her last menstrual period, was pregnancy a possibility. All of this information is relevant for the prescription of drugs</p> <p>After the consultation she documented her actions.</p>	<p>It could be a breach of confidentiality as Gloria may not want her mother to know about her sex life.</p> <p>Concordance which is described as a joint and shared approach and equal partnership during consultation between patients and health care professionals in the decision making process, the interesting issue here was that did the young adult have the same advantage</p> <p>The legal age of consent to give permission to perform the operation was Gloria old enough and when is she deemed competent, she can give consent at 16 as long as she is deemed competent, which is automatically assumed when over the age of 18</p>
Theory	Practical	
<p>A right video-assisted thoracic surgery (VATS) and pleurodesis, as she had suffered two right sided pneumothoraces within the last 6 months.</p> <p>collecting data</p>	<p>Considering the difference between adults and adolescents and whether it is appropriate to use the same strategies of care and consultation</p>	

## Story 8

Professional development / critical thinking	Communication	Ethical
<p>Towards the end of the consultation the gentleman asked if the nurse would prescribe an asthma inhaler for his friend who was visiting him from abroad.</p> <p>Initially, apart from being impressed at the professionalism of the nurse practitioner I paid little attention to this consultation. However, after writing this story I realised the significance of this brief encounter seemed much more pertinent.</p> <p>It made me realise that up until this point I had not taken the potential areas of tension we had been warned about seriously. Despite being an experienced nurse used to facing dilemmas of various natures, I had not truly considered the areas of tension that may arise from being able to prescribe.</p>	<p>Seven steps to good prescribing:</p> <ul style="list-style-type: none"> <li>▪ Consider the patient</li> <li>▪ Consider strategy of treatment</li> <li>▪ Consider the choice of product</li> <li>▪ Negotiate a contract</li> <li>▪ Review the patient</li> <li>▪ Record keeping</li> <li>▪ Reflection</li> </ul>	<p>I felt it was representative of the type of ethical dilemmas that Nurse Practitioners may be faced with daily. Untreated asthma can ultimately lead to death, which have been prevented if the NP prescribed the inhaler. The NP could therefore not prescribe and could have been negligent.</p> <p>Yet nurses still may experience pressure from patients/carers colleagues and pharmaceutical companies</p>
Teamwork	Management	Practical
<p>The functions of a consultation</p> <p>She discussed this with the practice manager to confirm her position.</p>	<p>Agreeing a management plan with the patient</p> <p>A full appreciation of all implications is essential, and NP are accountable for all prescribing decisions they make including not to prescribe.</p>	<p>I learned about the importance of practising within protocols, guidelines, recommendations and the law, to not prescribe outside of this.</p> <p>Practising within the set guidelines though can sometimes be difficult, but the patient was not present, could not be assessed or examined or a complete history obtained.</p>



**Story 12**

<p><b>Theory</b></p> <p>15 week pregnant suffering from vaginal bleeding Miscarriage</p>	<p><b>Communication</b></p> <p>Explanation was made that bleeding was not a good sign, and could suggest a miscarriage, but it could not be confirmed until a doctor examined her.</p>	<p><b>Ethical</b></p> <p>The need for privacy and dignity for any women suffering from a miscarriage is one of the great importance</p>
<p><b>Professional development / critical thinking</b></p> <p>However, by acting as a professional rather than a sensitive human being and not showing any emotion, I did not show the depth of my understanding and empathy.</p>	<p><b>Hospital and community</b></p> <p>According to the A&amp;E guidelines, any women suffering from PV bleeding should be placed in a side room</p>	<p><b>Practical</b></p> <p>I learned that it is easy to incorporate the care of patient's physical needs but not so easy to consider their psychological and social needs as well. These were not met appropriately and they could have profound effects on her later.</p>
<p><b>Emotional</b></p> <p>Mrs Y was extremely anxious When I returned to Mrs Y to check on her she was hysterical. She was pointing towards her vagina and was passing the foetus. I called for the doctor. Mrs Y was holding onto me and crying. I tried to comfort her in the only way I knew how, by hugging her and talking to her. I learned how one particular story can have such a profound effect on me. I found I was struggling not to appear upset, holding back the tears, trying to act as a professional. I was sharing the experience with her, she was not alone, but I was not showing this to her, I felt it, but was held back by how I thought I should act which was professional</p>	<p><b>Reflection / personal learning</b></p> <p>I have gone away and researched miscarriages to enhance my knowledge and understanding I have tried to visualise myself in the patient's situation and asked what would I do, how would I feel? It has helped me to adapt the way in which I manage the psychological needs of a patient experiencing a miscarriage and improved my ability to manage future patients more effectively and holistically. My thoughts were, should she receive an explanation that she is probably miscarrying and possibly devastate her before a firm diagnosis has been made or should she be told everything would be OK, when it more than likely is not, just to reduce her anxiety.</p>	

**Story 13**

<b>Professional development / critical thinking</b>	<b>Reflection / personal learning</b>	<b>Practical</b>
<p>Although I had never used mefix on superficial burns before, I did not question the NP experience and knowledge, and as there are no guidelines for management of minor burns, I did as I was instructed and Mr V was discharged home that evening.</p> <p>The following 48 hours another staff nurse challenged me over the choices of dressings used on Mr V as she had redressed his wounds that day. She was appalled that I had used mefix on Mr V as when she took it off it had removed some skin with it. I explained that I had dressed his wound on instructed by the NP, but as I had little knowledge on minor burns dressing was unable to justify the choice.</p> <p>I felt irresponsible for the treatment I had given Mr V as I am accountable for my practice and in accordance with the code of professional conduct clause 6, nurse must maintain their 'professional knowledge and competence' with a responsibility to 'deliver care based on current evidence' and 'validated research when it is available'.</p>	<p>I have gone away and researched minor burns and their management extensively and there is little evidence on the most appropriate dressing</p> <p>The evidence that I found advocates the use of mefix in superficial minor burn management, but implied that it should not be removed for seven days, as it promotes a moist wound healing environment and should not be changed at least for the first 48 hours and very infrequently after that as frequent changes interrupts the wound healing process.</p>	<p>I did an initial assessment which involved the rule of nines to assess the extent of the burns, and noted that he had sustained a combination of superficial and partial thickness burns as some areas were red, and others had blistered. The NP instructed that the wounds should be dressed with Jelonet and mefix and was to return for review clinic and a review dressing within the next 48 hours.</p>
<p><b>Management</b></p> <p>I am hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries, to prevent confusion over the most appropriate dressing, and the importance of not changing the dressing to frequently.</p>	<p><b>Theory</b></p> <p>Sustained burns to his right hand and wrist from boiling water</p>	

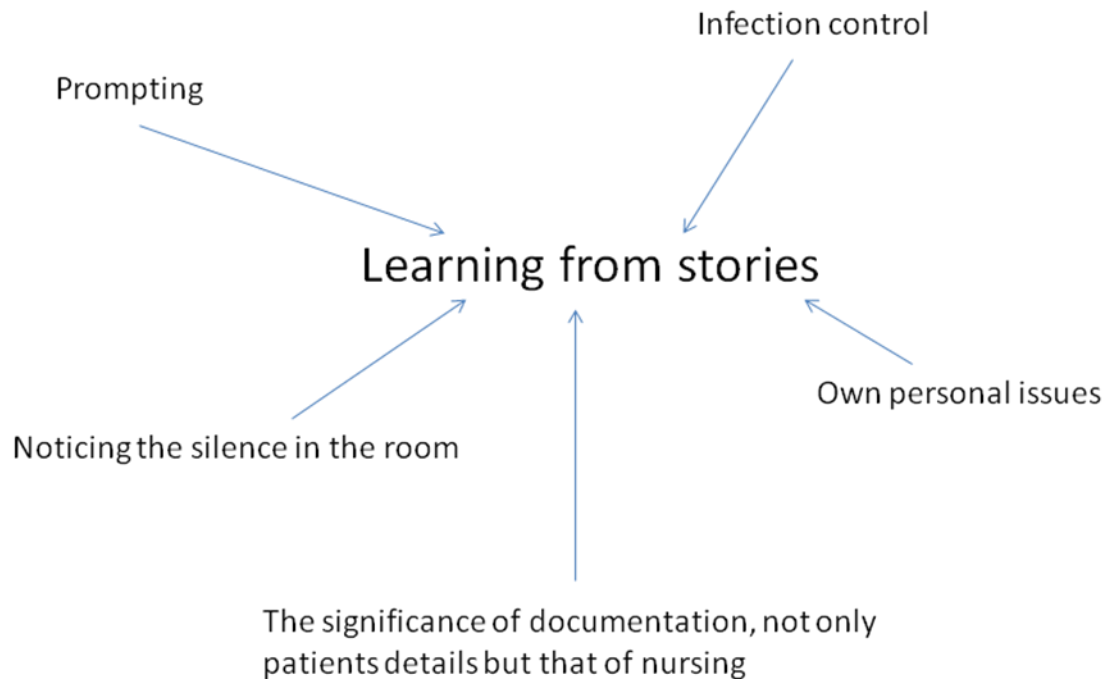
### Story 14

<b>Communication</b>	<b>Reflection / personal learning</b>	<b>Practical</b>
<p>Ms Z family did not speak English and therefore a history could not be obtained. From her notes I could see that she had attended A&amp;E the day before and asked reception to print off those notes. I was unable to get any information from the relatives due to the language barrier,</p>	<p>I had only seen two patients with these symptoms before, both of whom were reacting to metoclopramide. I knew that metoclopramide is contraindicated in under 20 year olds and therefore did not believe that it could have been due to this. I could not believe that metoclopramide had been prescribed to a 13 year old, as it is well documented and evidenced as to the extensive adverse reaction when given to children. I was shocked that it had been given and administered. Had I not previously remembered stories from my previous practice, I may not have recognised it.</p>	<p>As a trained staff nurse working in the resuscitation area, I looked after the patient from admission to discharge. Whilst waiting for the notes I carried out her vital signs which were all within normal limits. From my experience Ms Z appeared to be having an oculogyric crisis and lateral torticollis.</p>
<b>Teamwork</b>	<b>Emotional</b>	<b>Theory</b>
<p>A doctor joined me then to assess the patient and seemed as puzzled as I was and obtained IV access.</p>	<p>I felt frustrated due to the language barrier and concerned for Ms Z.</p>	<p>Dystonic symptoms</p>
<b>Management</b>	<b>Professional development / critical thinking</b>	
<p>Eventually the old notes came which highlighted that she had been administered metoclopramide the day before as a TTA, which meant it had been dispensed from us as pharmacy would not have been open at that time of night. We immediately administered procyclidine IV to treat the reaction, which was successful.</p>	<p>I have learned to question, if unsure, all prescribed medications to patients as we are accountable for our actions. As a result of this incident, guidelines have been introduced for prescribing anti-emetics for children.</p>	

## Appendix 10 – Focus group mind maps and researcher notes

### 10.1 - 3rd year adult student nurses

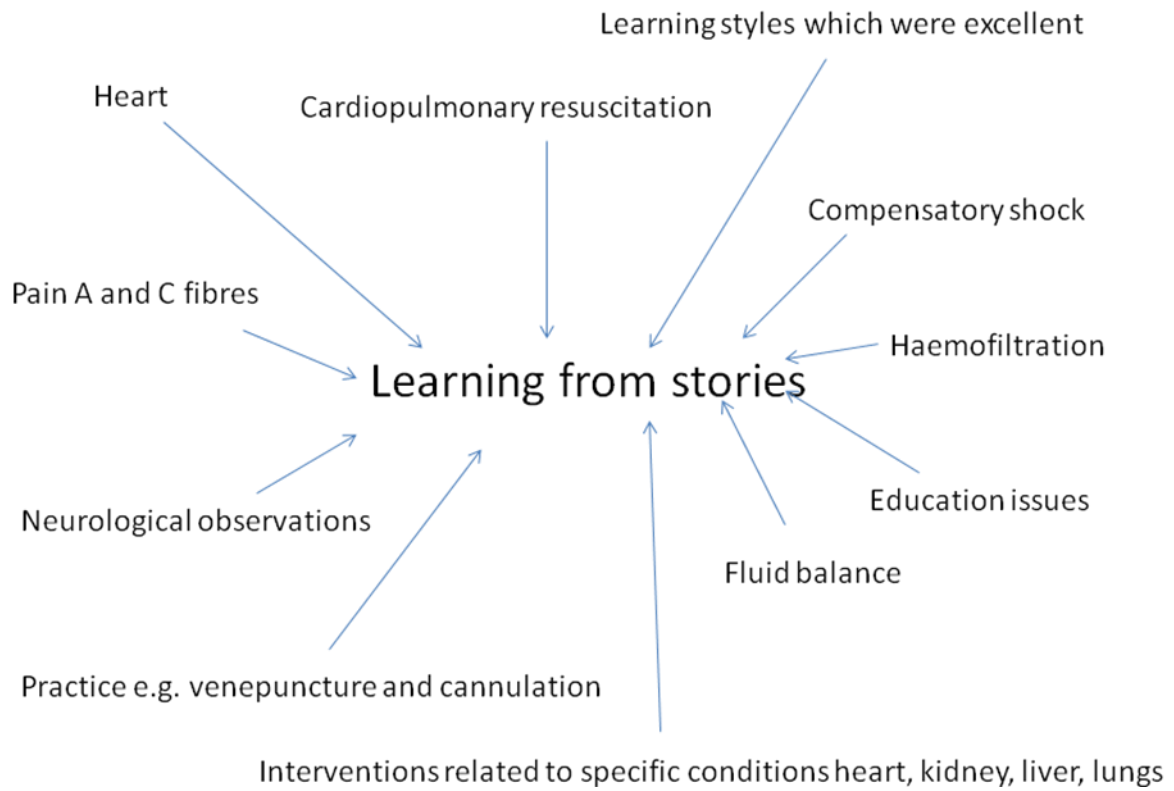
#### Focus group 1a



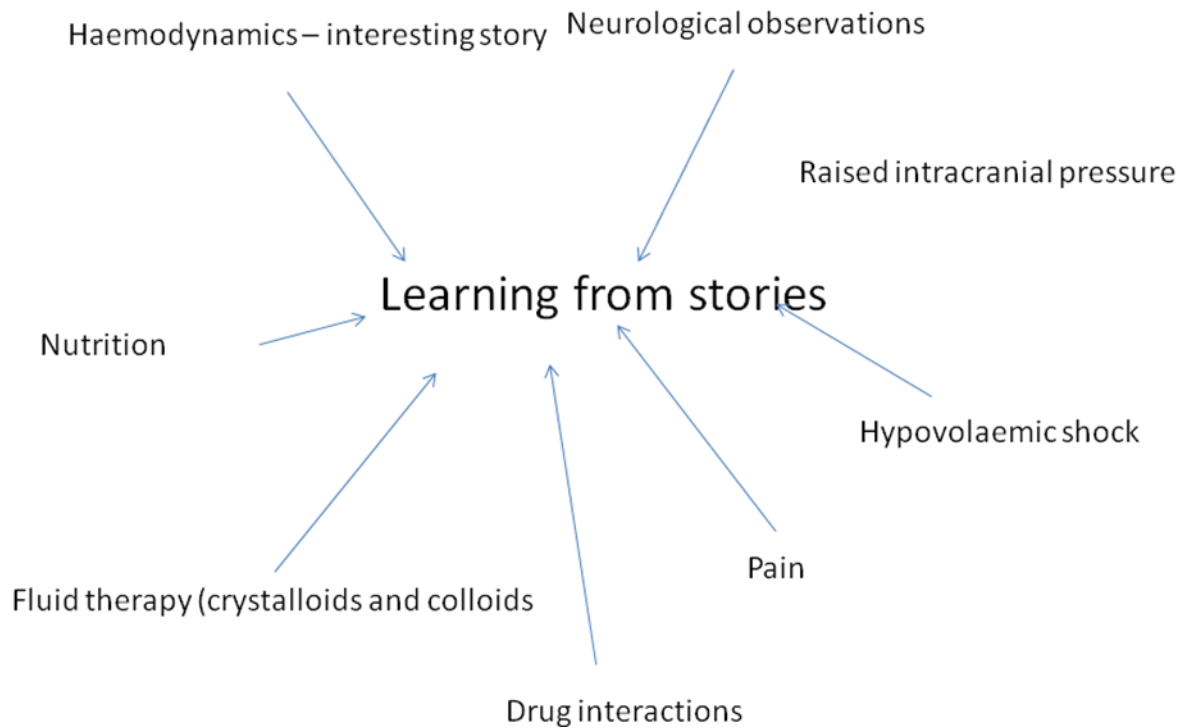
#### Focus group 1b



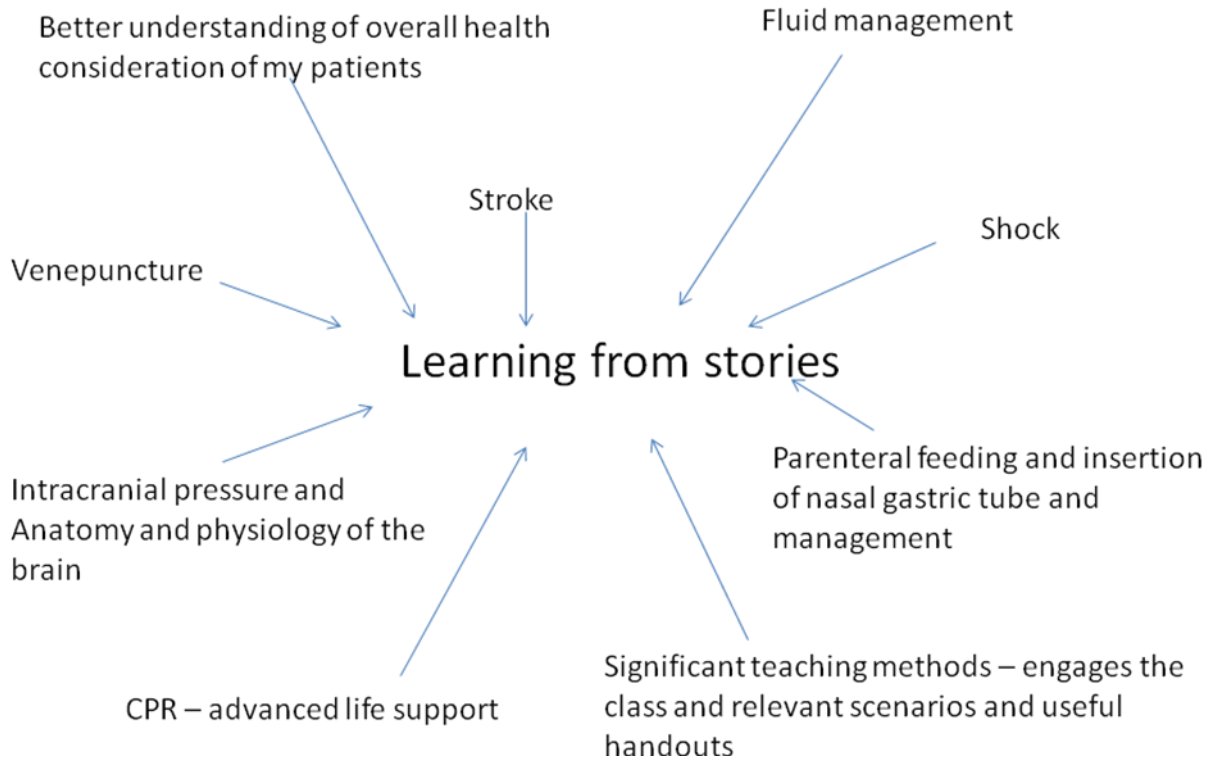
**Focus group 1c**



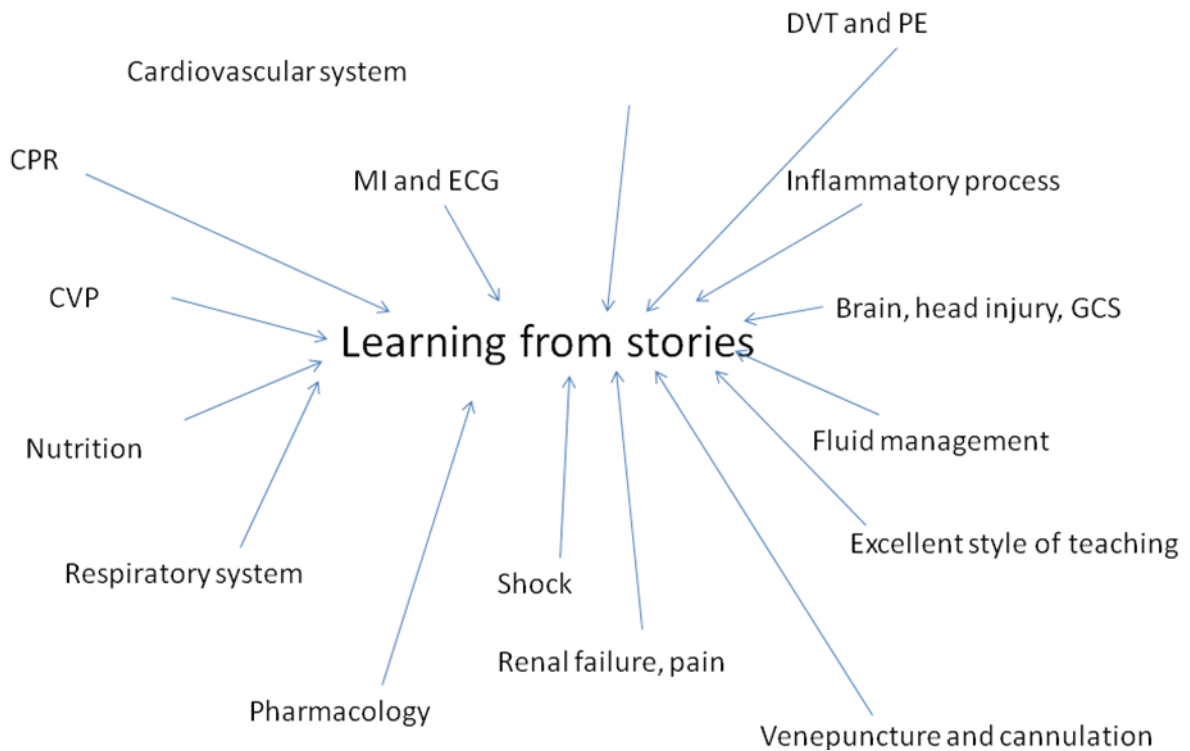
**Focus group 1d**



**Focus group 1e**



**Focus group 1f**



**10.2 – 2<sup>nd</sup> year adult student nurses**  
**Focus group 2a**



**Focus group 2b**



**Focus group 2c**



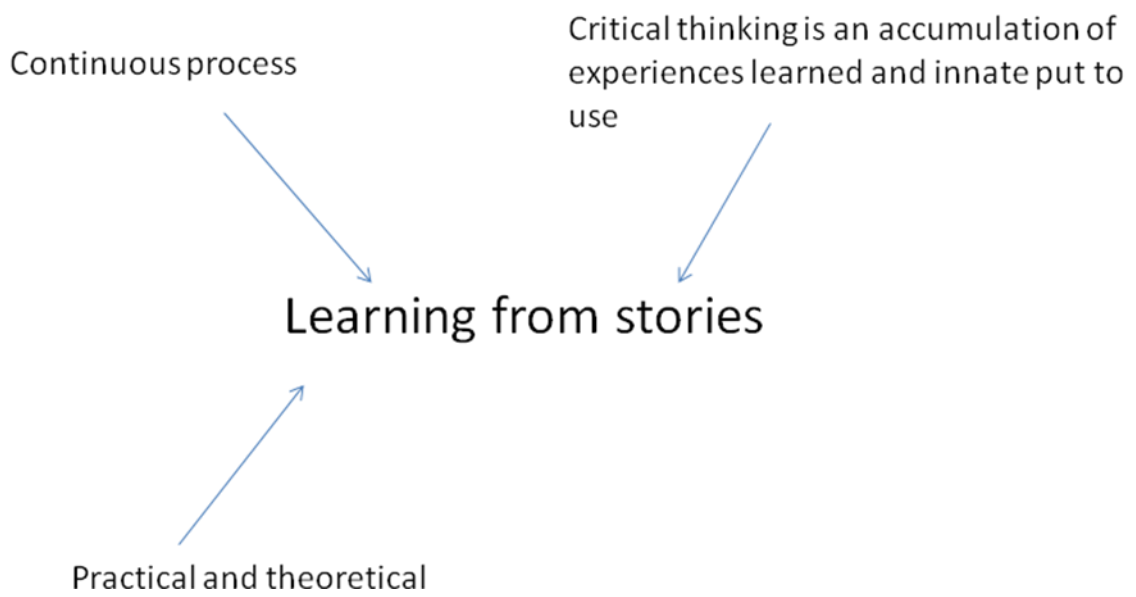
**10.3 – Qualified student nurses**

**Focus group 3a**

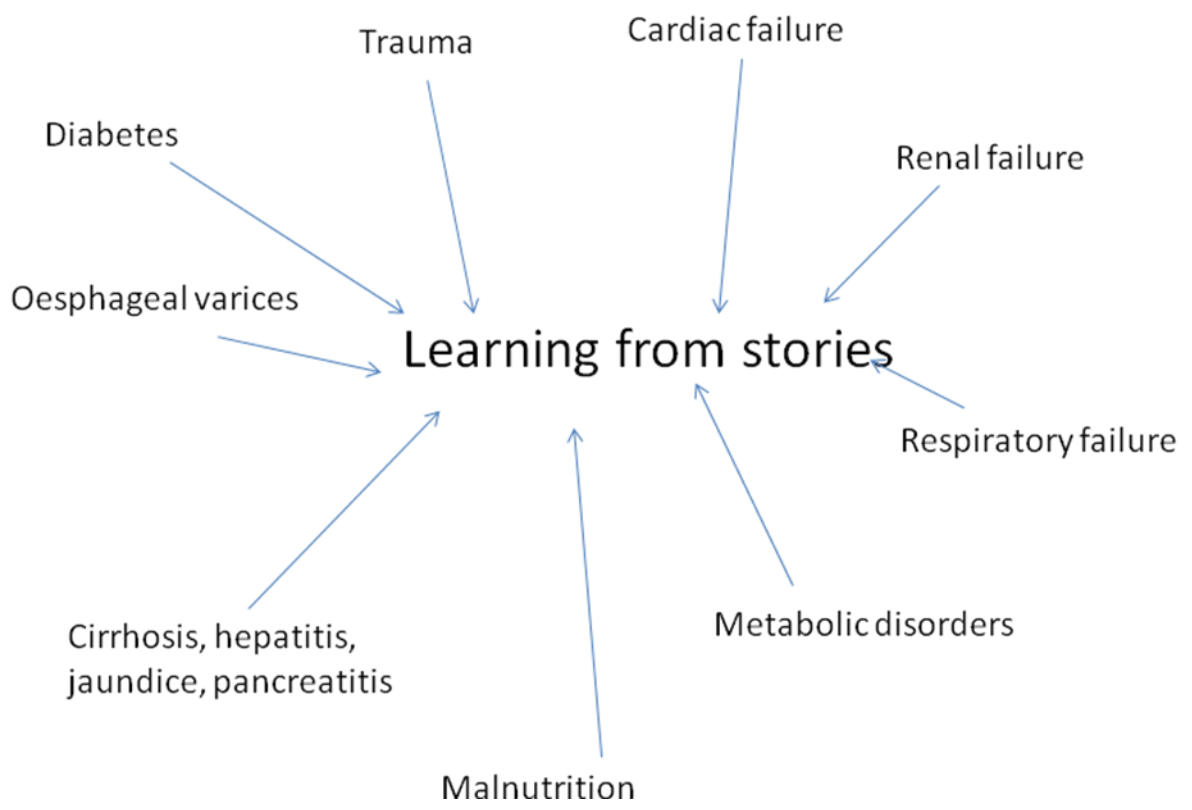




**Focus group 3b**



**Focus group 3c**



## 10.4 - Notes from focus groups

### 6.4.1 - 3rd year student focus group:

Notes from Focus groups 1d

Group 1d

A comment appears at the end of this group it reads – thank you for the reading materials, you were the only researcher who provided such. Your way of getting us involved and identifying to us the many uses of our practice stories was good, even though I was initially confused, but later realised their significance.

Students did not seem to realise at first what I wanted them to do and seemed to think I was doing some sort of evaluation. I thought by their conversations and discussion when I was circulating between the different groups the students did realise. They were evaluating not the teaching or the module, but what they gained from or could have gained from writing their stories and learning from them for me as part of their contribution to my research.

This group was large, and there were some students in this group which had not contributed a story but had seen the notice on blackboard and decided to come along. My allowing them to stay may have hindered the cohesiveness of the focus group and has maybe warped the information received as the mind maps refer mainly to topics that are in their 3<sup>rd</sup> year modules rather than from any story and learning from it they contributed to my research

An entry in my diary for the 28/09/07

I think I can see why I let the other students who had not contributed a story to my research to stay in the focus groups. I had missed the 3<sup>rd</sup> year students from the previous year and failed to contact them soon enough to attend a focus group and I was worried I would not get sufficient 3<sup>rd</sup> years to be a part of the focus groups. This is why I contacted the 2<sup>nd</sup> years early before they went into their 3<sup>rd</sup> year and forgotten they had ever contributed a story to my research.

### 6.4.2 - 2<sup>nd</sup> year adult student focus group

Written notes very sparse in fact nothing only details of the conversation between the students and me. Indeed the conversation though was really all that was needed between myself and the students because it was what inspirational no, equal between the students and myself possibly, a group coming together all with the same goals and aspirations to learn to care for patients better yes that's it.

The conversation went to my research, publishing questions about how much did I get, how do I find the time to do all of this work. They loved the idea of the written stories and using them in practice as most of them had experienced my teaching, and loved my stories and hoped I would be able to use theirs one day in the same way. I encouraged them to use their own with students they will be teaching in the future as a learning tool in practice, telling and sharing their stories. They loved it, so did I?

An entry from my diary 18/10/07

I noticed in my development in relation to my teaching that I seem to be able to be a teacher and researcher. I am managing maybe very amateurish that I can function as a teacher and researcher. The other day I combined the two together to gain / develop my focus groups. On the 2 occasions that I have done this it is the students' conversation that has been the most interesting rather than what they put down on the mind maps. The difficulty of tapping these would have required me to have 3-tap recorder at teach focus group. Another interesting development here was the dialogue between the students and myself as well. I was relating some of the information to my practice in the same way as I was 'does this mean that I am able to meet with them at their level of learning and interpret it' or 'am I just an old teacher reminiscing.

I was trying to get them to see things more deeply e.g. one group-mentioned understanding but could not at first elaborate. Through discussion and dialogue this developed and the group were able to identify what they meant. Learning through dialogue and questioning was an interesting concept to use during this time with the students.

The concept that I started with on the previous page of myself as a teacher/researcher was the difficulty of matching the two, as they seemed to clash. I was undertaking the focus groups and the difficulty arose for me going round to the student groups to identify areas of learning from their contribution of a story and learning from it to my research and trying to be a researcher and taking notes. How can the two best be met, rather than seen as disparate? May be that part of my research in relation to using narrative is that it is both a teaching and learning strategy and a research methodology, whereas that is not the case for some others and this is where practice / research / education can meet?

#### 6.4.3 - Post graduate student focus group

These notes resemble a concoction of the conversations that were going on with the students at the time. I am unsure whether they should be more about what I was feeling or doing at the time. I was walking around the groups listening to them and noted some of these down. They go like this:

Students found it very difficult to articulate learning from their stories in this instance. I was quite surprised, as these were all post-graduate students. They tried very hard and detailed things such as critical thinking is not just about criticism, used notes from what we had talked about previously in a teaching session though which I found disconcerting as I was unsure of this practice in a focus group and had not expected it. The students questioned me about the process of stories and my research as previous student groups attending the focus group had done and so I was prepared. But not from a teacher point of view but more as a researcher in this instance, but this time it was not as spontaneous or as free flowing as it had previously.

When we shared our stories there was an accumulation of experiences, which is continuous and contributes to being a good practitioner. It helps to facilitate the right things to learn. Unfortunately students are not taught to analyse their own stories or to use them effectively, but drilled into you not to trust yourself, just to take notes and

learn. As the group have become more experienced they have had to learn for themselves to trust their own self and value others opinions more now colleagues are more expert.

More able to participate through telling they're own stories and sharing with others. Nurses do not only respect their own value and trust themselves it can bread distrust in others and this is something that telling stories can teach us.

## Appendix 11 – The differing dimensions of the categories from all stories and learning accounts

This analysis is drawn from the category analysis in Appendix 9; the story number is given in brackets at the end of each excerpt.

### 11.1 – Theory

Differing dimensions	Excerpt from student story and learning account
Medical conditions	<p>DM – two types, treatment, complications. Stroke – blood vessels involved, what happens to cause a stroke (2A1)</p> <p>Suffering from heart disease. Cancer with liver metastasis. Type II diabetic controlled with medication (2A14)</p> <p>Heart disease, cardiomyopathy. Pancreatic cancer with liver metastasis. Pancreatic cancer has a very high mortality (2A15)</p> <p>Hypodermises what is it, the care required etc. (2A16)</p> <p>Cancer of the bladder with liver and lung metastases, cancer of the breast with brain metastases. Squamous cell cancer of the tongue and floor of the mouth, end stage renal failure. Hepatosplenomegaly, gross ascites, cancer of the lung, pneumonia, neutropenia, pancreatic carcinoma with jaundice post-chemotherapy, cancer of the oesophagus, non-hodgkins’s disease, sickle cell episodes, multiple myeloma, cancer of the endometrium, astrocytoma of the frontal lobe, paralysis, seizures, COPD, atrial fibrillation, closed tuberculosis, cancer of the larynx with a total laryngectomy, patients with colostomies, cancer of the prostate, and cancer of the stomach. (2A33)</p> <p>Alzheimer’s disease. It is due to a lack of blood supply to the brain, damaging cells. The patient may suffer from acute memory loss, confusion and feel lost all at the same time. (2A50)</p> <p>Blood disorders such as sickle cell disease and human immunodeficiency virus (HIV), tuberculosis (TB), cancer and other infectious diseases like methicillin resistant staphylococcus aureus (MRSA). (3A21)</p> <p>Repair of a ruptured abdominal aortic aneurysm. (3A38)</p> <p>Vascular dementia – is the 2<sup>nd</sup> most common type of dementia, after Sustained burns to his right hand and wrist from boiling water (PG13)</p>
Drugs pharmacology	<p>Different types of pain management for these situations. (2A15)</p> <p>Poly-pharmacy (2A21)</p> <p>Unfortunately Mr X remained hypertensive despite having a glycerine trinitrate (GTN) infusion and some other medications administered via the naso-gastric (NG) tube. He had four intravenous infusions running; crystalloids, GTN, propofol and phosphates as well as an NG feed.(3A44)</p> <p>It is imperative the nurses know exactly what medication the patient has had. Some medications like morphine for example tend to depress the respiration rate of the patient and can make them a little dehydrated. (3A48)</p> <p>Frequent, prolonged, uncontrollable seizures, which were being treated with a continuous infusion of Phenobarbitone (Phenobarbital).(3C2)</p> <p>Antidepressants are the first line of treatment for moderate to severe depression. (3MH3)</p>
Medical / surgical interventions	<p>Ultrasound scan of the heart (2A10)</p> <p>A CTPA scan and its value as an investigation is diagnose a PE (2A12)</p> <p>Doppler ultrasound to determine arterial blood supply. The significance of pedal pulses (2A13)</p> <p>He needed to have investigations to rule out the seriousness of his pain. This included a chest X-Ray (3A17)</p> <p>Bariatric surgery is just one of the treatments that can offer hope for obese patients. (3A33)</p>

	<p>Repair of a ruptured abdominal aortic aneurysm.(3A38)  A 71 year old woman who had a left total knee replacement into the recovery room. (3A40)  Patient had a total hip replacement operation.(3A51)  Patient had undergone a hemi-glossectomy, had a permanent tracheostomy in place, poor eyesight. (3A52)</p>
Patient symptoms	<p>Leg ulcer, tiredness and thirst (2A13)  Pain and redness in left eye due to acid / liquid injury (3A32)  Patient was in AF (2A18)  Palpable abdominal aortic aneurysm getting bigger. The signs of shock, complications of AAA (2A27)  Certain symptoms are displayed when an area of the brain is damaged by certain diseases; they may have difficulties remembering or memory loss, solving problems or concentrating, acute confusion, getting lost and changes in behaviour, difficulty in showing their emotions. (2A50)  The patient had developed a cardiac arrhythmia characterised by a rapid but irregular pulse, the patients pulse had increased form within the normal range of 60 to 100 to over 100 bpm. (3A39)</p>
Theoretical knowledge	<p>What is involved in good communication – listening, guiding, thinking, engaging, making sense of knowledge and information sharing (2A1)  Theories can be taught.(2A2)  SVT, IHD, ECG continuous monitoring, cardiac monitoring, interpretation e.g. irregularities, interpretation of increased heart rate. Non sustained VT returned to SR. Electrolyte analysis – these are dissolved in water become ions and generate an electrical charge beneficial for normal functioning of the heart.(2A10)  Knowledge of culture (2A15)  The CN asked for volunteers to carry out a literature review examining the impact of 13.5 hour shifts. (3A30)  Functions of the eye, anatomy of the eye. Knowing that most of the damage would have happened immediately after exposure to the acid. Effects of delayed eye irrigation as allow further penetration of chemicals into the inner eye. (3A32)  Admitted to the ward with severe hydrocephalus, this can be defined as excessive cerebrospinal fluid within the skull. (3C1)  I ensured safety was maintained at all times by basing my care on evidence based practice. (3C4)</p>
Theoretical nursing interventions	<p>Understanding specific terminology that relates to care e.g. liaison – recognised as a communication process between people or groups, with an emphasis on co-operation (2A12)  Different types of pain management for these situations (2A15)  Models of hand over (2A16)  Consciousness and co-operative neurological assessment. Inter-hospital transfer. Conscious and co-operative neurological assessment. (2A27)  12 lead ECG, diabetic with high blood sugar. (2A21)  Patients on strict fluid balance input and output (2A33)  Blood transfusion. HIV is not transmittable through splashes of shower from the patient although effective measures like wearing of aprons and gloves should always be maintained.(3A21)  The patient who at the time had taken an overdose of crack cocaine. This patient upon arrival was not conscious her Glasgow coma scale was 3/15.(3A23)  A temporary tracheostomy was in place to assist breathing. The patient was receiving BiPAP (bilevel positive airway pressure) ventilation via the tracheostomy. The plan for this patient was to slowly wean him of BiPAP and eventually remove the tracheostomy tube. The patient was able to self-</p>

	<p>ventilate via a tracheostomy mask, with 5 litres of oxygen. Nursing care in the HDU is based on the Mead model, and using this model I also monitored renal, neurological, pain, nutrition, elimination, psychological and social aspects of the patient's care.(3A38)</p> <p>The ECG suggested that the patient was in atrial fibrillation and so the patient was given medications and potassium. (3A39)</p> <p>Mr X was sedated since he was on a ventilator using continuous positive airway pressure. Mr X also had a low GCS score of only 3 all night.(3A44)</p> <p>Post operative patients especially those where the bone had been operated on, the risk of infection entering the bone presented a serious threat to the patient with the risk of amputation or worse. (3A51)</p>
Complications	<p>Infected abdomen following liposuction. (2A23)</p> <p>Aware of the common morbidities that accompany obesity, such as hypertension, type 2 diabetes mellitus, stroke, coronary heart disease, gallbladder disease, hypercholesterolaemia, osteoarthritis, respiratory problems and several cancers. Obese patients are at high risk of wound dehiscence and slow wound healing because of poor blood supply to adipose tissue (3A33)</p> <p>Respiratory failure, due to excessive alcohol consumption, overdose. (3A35)</p> <p>Pressure ulcers and the causes, dressings. Pneumonia, immune suppressed and susceptible to infection (2A44)</p> <p>15 week pregnant suffering from vaginal bleeding, having a miscarriage (PG12)</p>
Reference to reading / literature	<p>Read forms of literature to help understand patient's condition (2A10)</p> <p>Look at various nursing journals (2A16)</p> <p>The CN asked for volunteers to carry out a literature review examining the impact of 13.5 hour shifts. This was to inform the planning of rosters based on current evidence-based best practice and to ensure the optimal care of patients. (3A30)</p> <p>A slow heart rate (bradycardia) is highlighted with the National Service Framework for coronary heart disease that maintaining heart health is important in the prevention of this disease and therefore in the wider social context, advising patients on the benefits of a healthy balanced diet is vital within the realms of health promotion. (3A34)</p> <p>Reference made to The British Thoracic Society (2007) says any child with an oxygen saturation level of less than 92% requires immediate administration of oxygen either via nasal prongs or a mask. Referred to statistics each year 600,000 children under the age of five have an accident as a result of neglect by parents or carers. (3C3)</p> <p>Referred to the UK rules with regard to meningitis, all clinically diagnosed cases of meningitis and meningococcal septicaemia must be reported to the local health doctor who then ensures anyone at risk is contacted and antibiotics may be given (3C4)</p> <p>According to the Mental Health Act Code of Practice, the use of seclusion is neither for the purpose of meting any punishment nor suitable where the patient has any risk of suicide or self-harm.(3MH1)</p>
Developing understanding	<p>Did not seek clarity of decisions to ignore the CTPA, submitted because felt confused by the medical jargon and failed to understand the rationale for the lung function test. CPTA is not a definitive measure of PE and ventilation / perfusion (VQ) scan is a better predictor. Discovering deficit of medical knowledge (2A12)</p> <p>Physiology behind heart failure, incidence in elderly people, complications of it, formation of oedema and development of leg ulcers. (2A13)</p> <p>Not understanding the implications for a high blood pressure and an increase in heart rate or 'peculiar' and not normal heart rate. Cardiomyopathy but did not know what it was. Doing but not understanding what it means / significance (2A18)</p>

	<p>Questioning theory (2A21)</p> <p>The doctor prescribed a nebuliser as predicted, but I did not know how these drugs worked, I knew they were often prescribed for difficulty in breathing e.g. COPD patients. (3A17)</p> <p>The knowledge that informed my decisions were my need to be aware of the possibility of gastrointestinal haemorrhage, wound infection, pneumonia, pulmonary embolus (because she could not wear TED stockings) and prolonged nausea or vomiting. (3A33)</p> <p>Reduced oxygen levels can cause cell death reduced respiratory drive, with the risk that the child will proceed to respiratory and subsequently cardiac arrest.(3C3)</p> <p>Alcohol makes depression worse helped to explore healthier ways of dealing with stress and difficult situation e.g. physical activity to relieve tension in a healthy non-destructive manner. (3MH3)</p> <p>Depressed patients have a potential for suicide, and suicide prevention was at the top of our agenda.(3MH3)</p>
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## 11.2 - Practice

Differing dimensions	Student excerpt from story
Assessment	<p>Assessment using a Doppler ultrasound (2A13)</p> <p>Appropriate assessment. Patient assessment of clinical needs and plan care. In the assessment of patients effective listening skills and reassurance is therapeutic in (2A14)</p> <p>Assessment of BP, HR, RR and significance of them being high. (2A21)</p> <p>Patient assessment (2A26)</p> <p>I assessed her vital signs and pain levels regularly and I used an appropriately sized blood pressure cuff in order to prevent false high readings. (3A33)</p> <p>Ongoing assessment of a patient with depression is one of the most fundamental functions and strengths of any competent nurse.(3MH3)</p>
Planning	<p>Needed to plan the patient's care. Preparation for discharge planning and affect patient relatives and others. (2A12)</p> <p>It is critically important for Wendy to increase her mobility and sit up to eat. (3A37)</p> <p>Arranging everything that needed to be done (2A27)</p> <p>I prepared the trolley following hospital guidelines and attended to the wound in accordance with aseptic technique practice. (3A51)</p>
Monitoring	<p>Monitoring vital signs and documentation. Knowing what to do when monitors alarm. Taking a 12 Lead ECG, monitoring of fluid balance. Patient remained stable, continued monitoring his vital signs and administering care to him (2A10)</p> <p>Food and liquid charts. Monitoring of food and liquid intake (2A13)</p> <p>I started the shift by checking their vital signs. Mr A's Blood Pressure was 168/97 with a pulse rate of 84. The experience from Mr A proved the sense that emotional change can affect stability of vital signs. (3A21)</p> <p>Observations were taken and recorded hourly throughout the shift. (3A38)</p> <p>I kept observing her vital signs and especially her respiratory rate as she had had Morphine administered in theatre, and one side affect of Morphine is that it can depress the respiratory rate. (3A40)</p> <p>Hourly observations including the checking of wounds, drain sites, chest auscultation, and the neurological status using the Glasgow coma scale (GCS) and ensuring their comfort by carrying out mouth care and position changes. All observations were within normal limits except for a high temperature. (3A44)</p> <p>The level of consciousness and neurological status was also assessed. I continued to monitor any deterioration in the patient. (3C4)</p> <p>Every time I monitored the patient's pulse I also made sure I palpated it manually and did not just rely on the electronic equipment. (3A39)</p>
Keeping and reading notes	<p>Record keeping / documentation (2A1)</p> <p>Reading the patient's notes (2A2)</p> <p>Completion of documentation in nursing notes ensuring accuracy of these. To give information to a group of qualified professionals. Taking note of subsequent events (2A10)</p> <p>Recording the information (2A13)</p> <p>Past medical history taking details, interviewing skills (2A14)</p> <p>Writing down of information that needs to be conveyed, but need to understand it and not rely too heavily on it and just read out all that is written (2A16)</p> <p>Old notes are not always available (2A21)</p> <p>These observations were recorded in the nursing notes along with a fluid balance chart. (3C4)</p>

	Record the readings and that the safety checks have been completed at the start of the shift. (3A44)
Reporting and sharing information with other HCP	<p>Two types of hand over, office / at the bedside the office being more intimidating than at the bedside (2A16)</p> <p>Inform sister of a result (3A17)</p> <p>Sharing of information with other healthcare provider (3A32)</p> <p>The nurse should inform the patient to report if they feel dizzy or have episodes of fatigue. My patient did report episodes of tiredness and fatigue is believed to be a common side effect of chemotherapy. (3A34)</p> <p>She had been attached to a monitor, and I was asked to regularly record her observations, and relay this information to the team when required, when her condition stabilised, and before transferring her to the medical assessment unit, under their supervision, together with that of the casualty registrar, she was treated and given fluids and medication to stabilise her condition. (3A35)</p>
Medication	<p>Administration of medication when they were due. Administration of medication. Break through pain. High doses of medication can cause toxicity, excessive depression of the CNS and death. The amount of medication the patient is taking is worrying (2A15)</p> <p>Check drugs (3A17)</p> <p>This was followed by aiding him to sit up in the chairs, giving them their prescribed medications. (3A21)</p> <p>Medications needed to be given (3A36)</p> <p>I checked the drug chart to see if Naloxone was prescribed, a medication that reverses the action of Morphine in patients with respiratory depression. (3A40)</p> <p>The effects of this medication need to be monitored closely immediately after the operation until the effects of the medication wear off. (3A48)</p> <p>Medication was also administered as per the drug chart. (3C4)</p> <p>He declined to take his medication, which was part of his treatment citing that he did not need it anymore. (3MH3)</p> <p>We returned to our own ward and administered the Morphine Sulphate to the patient.(2A36)</p>
Nursing skills	<p>Importance of communication in care delivery (2A14)</p> <p>Informing others of things that have been communicated to you. Developing confidence in delivering correct information in an appropriate manner. (2A15)</p> <p>Gaining confidence (2A16)</p> <p>Being assertive in situations that require it (2A18)</p> <p>Skills at interviewing patients to gain past medical history. The skill of taking a 12 lead ECG (2A21)</p> <p>Taking cues from patient and moving to a quieter area (2A26)</p> <p>I learnt basic nursing skills which will always be useful to me in my nursing career. (2A33)</p> <p>He had cancer of the prostate that had spread to his spine and was now bedbound. (2A44)</p> <p>Take a urine sample to the sluice (3A17)</p> <p>I assisted Mr A with slicing his bread and butter and placed his table at an easy access for him, as he could only manage with one hand. I assisted them to have a wash or a shower. The level of independence of my patients was different. I checked in the care plans of Mrs B for the type of dressings needed on her ulcers. (3A21)</p> <p>A catheter was inserted so they could get a urine sample to check what drugs she had taken. (3A23)</p> <p>Assertiveness. Triaged the patient's eye as high priority (3A32)</p> <p>In particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin. She had an indwelling catheter, a nasal gastric tube, patient</p>

	<p>controlled analgesia (PCA), a Robinson drain, and she was on intravenous fluids and antibiotics. She had clips, her dressings needed attention, and she needed to start a clear liquid diet. I washed the patient on her bed. After one hour, I was responsible for removing the patient's nasal gastric tube, Robinson drain (my first experience of removing a stitch) and catheter. (3A33)</p> <p>The patient had no relevant past medical history of heart problems. I took her vital signs. Regular ECGs were taken. (3A34)</p> <p>I was able to effectively demonstrate my inter-professional skills by the monitoring, recording and relaying of her observations, which were conducted every 2 minutes. (3A35)</p> <p>The patient once more opened her bowels. (3A36)</p> <p>Caring for the tracheostomy The patient asked if he could wash and change his gown and I agreed to assist him. (3A38)</p> <p>His airway was protected with a guedel airway. (3A44)</p> <p>The care the patient required was personal care such as oral mouth care, bed bath and frequent changes of the patient's pad. With the help of the patient's mother's I carried out the personal care needs of the patient in the morning. I also recorded the type of seizures the patient was having. The patient has a femoral line, which she has numerous other medications. The patient required regular turning and repositioning. I also carried out the patient's feeds which were set out in a nutrition plan which was arranged for her by the dietician. The patient had all her feeds through a gastrostomy. The patient requires frequent suctioning and physiotherapy. (3C2)</p> <p>I took her laryngeal mask out. (3A40)</p> <p>Spent half an hour learning to use the new Doppler machine with colleagues, Performed Doppler assessment with the G grade sister supervising on patient with ulcerated ankle, the API was 1.21 indicating venous impairment. A compression bandage was applied. (PG1-6)</p>
<p>General nursing care issues</p>	<p>The care of stroke and DM. Improving patient care. Delivering patient focused care(2A1)</p> <p>Importance of knowing the procedure patient(s) are undergoing even if they are not your allocated patient (2A2)</p> <p>Setting up e.g. alarms, connection of patient to a monitor (2A10)</p> <p>Preparation for a patient to go for a CTPA scan. Not causing distress to patient. Dealing with interpersonal conflict (2A12)</p> <p>Nutritional needs when patient's not eating or drinking. Wound dressing aseptic technique. Application of the use of compression therapy for arterial leg ulcers (2A13)</p> <p>The patient was able to use a zimmer frame to walk into the bathroom to clean her teeth, and I was able to attend to the washing of her back and legs. I needed to ensure that her legs were dried completely and moisturised, in order to reduce cracks in the skin and to prevent the formation of lesions. (3A33)</p> <p>I was able to safely check the wound and changed the dressing. Ensuring patient care and safety. I checked the wound site as part of the assessment, I noticed a small amount of blood on the dressing, which I decided to monitor closely, as blood loss can be potentially dangerous. (3A40)</p> <p>As well as ensuring that all of the necessary supportive equipment was available and working it was also necessary to check ventilator alarm settings and limits and that the patient was receiving the correct FiO<sub>2</sub>. Necessary to check the central venous pressure and arterial lines. Record the readings and that the safety checks have been completed at the start of the shift. Due to raised intracranial pressure Mr X was required to be nursed with his head at a 30 degree angle. (3A44)</p> <p>The child was attached to an oxygen saturation monitor and required regular nebulizers throughout the day to stabilise her condition. I decided it would be best to prop the child up in the cot rather than her laying down flat, which would hopefully help her chest and make her saturations rise. (3C3)</p>

	<p>The patient was on his third day post-operatively and needed his wound dressing changed. The wound had been closed using clips and covered with opsite dressings. I carefully removed the old dressing, using the aseptic technique; I cleaned the area adjacent to the wound using saline solution and sterile swabs. I also did not want to cause the patient any pain although pain was taken care of by medication. (3A51)</p> <p>While I was there I was actively encouraged to interact with the patients in terms of reassuring them and informing them of where they were. Patients in the recovery room receive a very high level of care (as a general rule there is one nurse for each patient). (3A48)</p>
Evaluation	<p>At this junction most of the nursing care required by my three patients was done. I was alert of their ongoing needs elimination, frequent change of positions or having drinks in between meals.(3A21)</p> <p>The serious implications of ineffective information processing and psychomotor skills performance in shifts lasting over 12.5 hours. (3A30)</p> <p>Through the practice of such 'basic' nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, mobilised to and back from the bathroom, improved her confidence in walking with a stick, and had regained some of her appetite. Along with mobility, a nutritionally sound diet will play an essential component in improving and maintaining Wendy's recovery. (3A37)</p> <p>To ensure that these goals were achieved, it was important to monitor his respiratory system and note the ease with which he was able to perform the activities of daily living. (3A38)</p> <p>As Mrs Smith was comfortable she returned to the ward. (3A40)</p>
Caring in a variety of settings	<p>Patients going to theatre, the needs of a patient in theatre. (2A2)</p> <p>Palliative care / care of the dying. Taking referrals from hospital in the community. Visiting patients at home at their convenience. Communicating with palliative care patients. (2A14)</p> <p>Nurse's role within the family environment (2A15)</p> <p>Caring for patients whose PMH is unclear and caring for them not knowing their precise history. (2A21)</p> <p>Patient came to the A&amp;E department and thanked me for what I had done.(2A18)</p> <p>The patient was aware that he had been admitted for end of life care. This is classified as caring for people who have an advanced, progressive and incurable illness so they can live as well as possible until they die. It is about providing support that meets the needs of both the person who is dying and the people close to them.(2A44)</p>
Observation	<p>Had to do vital sign observations for patients on blood transfusions, enteral medication and feeds, observe patients on chemotherapy, and a great deal of pain control with controlled drugs. (2A33)</p> <p>Observations and assessment forms the basis for nursing care and each patient should be nursed as an individual. (3A21)</p> <p>Just from looking at the patient, I could see that the patient had a central line insitu, she was fed via a Nasal gastric (NG) tube, the patient was diabetic with a syringe driver of atrapid running, and was being given regular nebulisers to help her breathing. I then noticed that the patient had a very dry mouth and damaged lips that needed mouth care. I found out that the patient's catheter bag needed emptying, and I had missed recording two hours of observations, which I quickly completed. (3A36)</p> <p>I observed Mrs Smith's breathing further and noticed a prominent decrease in oxygen saturation and respiratory rate. (3A40)</p> <p>The patient had a petechial rash to their lower limbs, which appeared to be slowly getting worse. (3C4)</p> <p>When we arrived the patient was very low in mood, citing feelings of worthlessness and indicating that he was better off dead than continuing to live. (3MH3)</p>

	By keeping my patient still and relaxed, there is an increased risk of developing a deep vein thrombosis and therefore in order to minimise this risk, anti embolism stockings were used. (3A34)
Emergency interventions	<p>Immediate interventions, transfer to a resuscitation room for immediate care (2A18)</p> <p>The doctors had taken the decision to intubate and insert a Tracheostomy. The patient had regained consciousness and would not let me go as she recalled the time in resuscitation that I had stayed with her throughout.(3A23)</p> <p>The main problem was moving her from her bed to the chair (neither of which were of the correct size). (3A33)</p> <p>I saw that he was struggling to breathe. I immediately repositioned the mask and re-attached the finger probe. (3A38)</p>
Continuing care	<p>Quality of continuing nursing care (2A1)</p> <p>The significance of communication to patient interventions and continuity of care (3A32)</p>
Infection control	<p>Adhering to strict hand washing techniques (2A10)</p> <p>I ensured the patient was barrier nursed to prevent the spread of infection to other patients. (3C4)</p> <p>The patient not wanting to wash, or to be repositioned, but it was important to do this as cleaning his wounds and skin helps prevent infection and cross contamination. I applied aseptic technique as required by the infection control policy. (2A44)</p>
Developing a therapeutic relationship	<p>He was nursed in a side room and was totally dependent on the nursing staff. I was assigned to S daily and within a few days felt a real bond had developed between us. We hoisted him daily into his specially adapted wheelchair which supported him and positioned him by the door so he could watch what was going on and read his bible. Arrived at work to find S suffering from severe diarrhoea. I washed him from head to toe, cleaned the bed and floor and changed his sheets. I cleaned S's glasses and combed his hair. (3A52)</p>
Understanding nursing interventions	<p>More confident in dealing with situations, understanding what I am doing. Understanding of patient procedures they are having done (2A2)</p> <p>Improving my confidence in a particular area of practice (2A9)</p> <p>Judging interventions well (2A12)</p> <p>Organisation of an emergency transfer, entrusting a patient to another specialist, hospital equipment needed, notes, information, knowing the patient. Travelling in an ambulance with a blue light flashing, consideration for the patient's needs at the same time, observing for any change in condition (2A27)</p> <p>As a student nurse I went with the patient to endoscopy so I could watch one procedure. (2A54)</p> <p>I wished I had asked the doctor to show me what he was listening for so I could have identified a wheeze again when I saw a patient with asthma. (3A17)</p> <p>Constantly facing unique situations which require more than carrying out routine and ritual (3A32)</p> <p>My main objective was to try and reassure my patient with the intention of keeping her relaxed as not to increase oxygen demand as bradycardia results in a diminished oxygen supply to the body. Due to the side effects of the Phenobarbitone the patient requires, hourly monitoring of pulse, respirations, oxygen saturations and blood pressure observations. (3C2)</p> <p>From my experience Ms Z appeared to be having an oculogyric crisis and lateral torticollis.(PG14)</p>

<p>Insight into the complexities and limitations of care</p>	<p>Implementing the issues of culture into the care of the patient. (2A15)  I took a patient to have a colonoscopy. This patient had previously had this treatment but unfortunately it was unsuccessful, so had to be performed again. Therefore, was becoming extremely agitated before the treatment. (2A54)  It is sometimes difficult to learn about one particular thing as often practice is sometimes a mess and there is mayhem, and drawing learning from it is difficult (3A17)  I found it extremely difficult to look after this child and undertake other ward duties including observations and ensuring that prescribed medication was given on time because I was required to give support to the child and his family. However handling the care of this child gave me an insight into a different type of nursing care than the one I had previously experienced and participated in. I felt that I lacked experience in caring for children who were dying, I had observed and minimally participated in caring for children in this situation before but never managed or delivered their care before. (3C1)  The regular pain assessment tools for children were not useful; I relied on the patient's sounds and facial expressions, as well as the movements she was making to indicate to me whether she was in pain. (3C2)  She had been attached to a monitor, and I was asked to regularly record her observations, and relay this information to the team when required, when her condition stabilised, and before transferring her to the medical assessment unit, under their supervision, together with that of the casualty registrar, she was treated and given fluids and medication to stabilise her condition.  To differentiate between tiredness due to bradycardia and tiredness as a result of chemotherapy could prove difficult. (3A34)  Several aspects of care for the patient, such as manual handling, giving medication, and administering fluids involves a need for a nurse to be with me, and became time consuming because staff were frequently busy elsewhere. (3A36)  I continued to provide care to the other patients that were allocated to myself and the registered nurse did not allow the situation to impact upon the quality of the care I was providing. (3A39)  One morning I had the opportunity to co-ordinate a whole shift. (3MH2)  James had been presenting with command hallucinations and as a result, he became restless, agitated, aggressive and violent. His behaviour was so disturbed that the psychiatric restraining team had to be called. Physical intervention was exercised. Restraining management skills were then used. To avoid prolonged physical intervention, rapid tranquillisation together with seclusion was considered to help him calm down. Observation is essential to help the patient and staff engages in a positive trusting way. Before restraint is imposed other interventions should first be sought e.g. de-escalation skills, make use of the soft furniture room specifically designed for the purpose of reducing agitation. (3MH4)  I could see she felt lonely and wanted to help, however it seemed that whenever I tried to speak to her it angered her more. Eventually I realised that I was not going to make Eileen understand and there were other patients who needed help with their breakfast and washes. Therefore, I left her to calm down, and perhaps another member of staff would be able to calm her. Eileen was often found wandering the ward. Occasionally she could be found sitting on another patient's bed, especially those within the side rooms. Eileen would often become aggressive and loud sometimes, but I did find time to spend with her and at these times Eileen enjoyed. (2A50)  Practising within the set guidelines though can sometimes be difficult, but the patient was not present, could not be assessed or examined or a complete history obtained. (PG8)  I learned about the importance of practising within protocols, guidelines, recommendations and the law, to not prescribe outside of this. I learned that it is easy to incorporate the care of patient's physical needs but not so easy to consider their psychological and social needs as well. These were not met appropriately and they could have profound effects on her later. (PG12)</p>
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Initiating care	<p>The first practical step I took was to order an appropriate chair and bed. (3A33)</p> <p>Early recognition of potential and actual deterioration in a patient's condition is essential, and should be accompanied by an appropriate response for early intervention. Nurses must be able to make decisions quickly and accurately, based on their nursing knowledge and patient cues. (3A38)</p> <p>I wanted to take an ECG and blood sample to attempt to locate the source of the arrhythmia, the nurse said that would be fine, but first we should inform the doctor. The role I held was one of assessment, patient reassurance, patient education and liaison with other professionals and the patient's relatives. It was due to my assessment that sought the treatment of the patient. (3A39)</p> <p>I asked the nurse to stop the dressing preparation and instead find the anaesthetic to prescribe Naloxone and an alternative analgesic for Mrs Smith's pain. (3A40)</p>
Improving care provision	<p>I wished I had asked the doctor to show me what he was listening for so I could have identified a wheeze again when I saw a patient with asthma. (3A17)</p> <p>Nursing needs coverage of shifts on a seamless 24-hour basis, and fatigue, which can negatively affect the quality of nurses' performance, is a feature of any shift work but not enough information exists on the effects of shift work on health care professionals, particularly due to their permanent contact with human suffering and death.(3A30)</p> <p>The CN was particularly concerned about this aspect of the proposed change. The problems of mental and physical tiredness affecting the nurses' overall performance may be compounded by the cumulative effect of working several 12-hour shifts consecutively. 12-hour shifts held benefits for patients and nurse satisfaction, because nurses follow patient care for longer periods throughout a single day and patients see fewer different faces (thus improving continuity of care). (3A30)</p> <p>Considering the difference between adults and adolescents and whether it is appropriate to use the same strategies of care and consultation (PG7)</p>
Gaining respect	<p>Gain respect from others through our involvement in the care of our patient. By being an effective practitioner with good interaction skills serves to gain respect from patients and colleagues. (2A12)</p>

### 11.3 - Ethical issues

Differing dimensions	Student excerpt (story given in brackets)
Consent	<p>Sought consent for procedures, drew curtains for privacy and maintained dignity. (2A10)</p> <p>Verbal consent to undertake the non-invasive procedure. (2A13)</p> <p>Patient consent regarding records and obtaining information. (2A14)</p> <p>Consent</p> <p>Informed consent, the need for privacy dignity, individuality and respect. (2A44)</p>
Dealing with difficult issues	<p>Minimising the risk for confused message, verbal tone, not being passive when standing up for the needs of the patient. (2A12)</p> <p>Discussion of dying, administration of doses of morphine, end of life issues. (2A14)</p> <p>Getting a referral hospital to agree to take this patient, telling of the story was essential to get the seriousness across. (2A27)</p> <p>The whole ward was able to hear her screaming. Eileen told me that I did not care about her and that I was keeping her there until she died. This was very distressing for me, as it was far from the truth, and I did not want someone to think this about me. It was difficult to know what her needs were as she could not make them known to us and therefore it was difficult for staff to know what level of interventions is required. It was difficult to reason with her due to the confusions they may experience. (2A50)</p> <p>Mr S did not want his dressing changed and the ethical dilemma of leaving Mr S with his dressing unchanged and the difficult this posed in respect to Mr S's well-being against his decision, facing how conflicting moral issues, whilst ensuring moral and ethical principles. (2A44)</p> <p>Intensive intervention measures were removed and the focus changed from life prolonging / saving to comfort care measures ensuring that the patients family had some time to say goodbye and understand that their relative in all likelihood would die. (3A44)</p> <p>I had given a lot more attention to the patient who had developed the cardiac arrhythmia than I had to the other patients. (3A39)</p> <p>Admitted to the general paediatric ward for tender loving care following increased severity of congenital hydrocephalus. I was unsure about how effectively I would be able to care for a terminally ill child. I was extremely grateful to have been given this opportunity. (3C1)</p>
Advocacy	<p>Standing up for my patient, being the patient's advocate i.e. when the CTPA was forgotten and put aside. Contributions communicated with confidence my professional obligation as an advocate to ensure patient received safe nursing care. (2A12)</p> <p>The need to work in partnership with the mother to identify goals and needs and act as an advocate in assisting the family' (3C3)</p>
Autonomy	<p>The patient's wishes, discussing these with HCP and relatives – facilitating this role. (2A15)</p> <p>Treating each patient as an individual is important as in this story I believe this patient did not get the care they deserved. (2A54)</p> <p>Patients should be involved in their care, be encouraged to participate in order to improve the effective implementation of their care plans. (3A21)</p> <p>When action is based on desirable practice, it has the potential to empower both the practitioner and the patient (3A38)</p>
Developing a nurse-patient relationship, trust	<p>The nurse-patient relationship is central to nursing and to nurses feeling fulfilled in their caring role. (3A33)</p>



	<p>Building an open and trusting relationship with Sarah, and my effective collaboration among the team. (3A35)</p> <p>The nurse-patient relationship is a privileged relationship, based upon trust, empathy and rapport with the patient. (3A37)</p> <p>During the time that I cared for this patient, we developed a trusting professional relationship. Even though my relationship with him was short term, I considered it 'therapeutic' based on commitment and trust. He trusted my abilities and judgement, and welcomed me warmly at the beginning of each shift. (3A38)</p>
Respect and dignity	<p>In providing care to the patient in seclusion, the team respected and upheld the patient's dignity (3MH1)</p> <p>The need for privacy and dignity for any women suffering from a miscarriage is one of the great importance. (PG12)</p>
Non-judgemental	<p>Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind. (3A33)</p> <p>This tells me not to judge a book by its cover. (3A23)</p>
Confidentiality	<p>Patient confidentiality (2A10)</p> <p>Maintaining patient confidentiality. (2A14)</p> <p>Disappointment at not being able to follow patient up after the transfer, as if phoned no information would be able to be given due to confidentiality. (2A27)</p> <p>Maintaining patient confidentiality, but telling when things cannot be kept confidential and need to be shared, asking permission to do this from wife of patient (2A15)</p> <p>It could be a breach of confidentiality as Gloria may not want her mother to know about her sex life. (PG7)</p>
Responsibility	<p>Responsibility for the patient, advocate, especially in end of life issues, so the patient's wishes are facilitated. (2A18)</p> <p>Could have resulted in sustaining ocular damage which would have had profound effects on visual prognosis, lifestyle and self image (3A32)</p> <p>Although our relationship was purely professional, I felt a personal responsibility for neglecting him. As a nurse, my responsibilities included close monitoring of the patient's condition, on this occasion I allowed my attention to be diverted, my reactions had been quick and effective. (3A38).</p> <p>I also knew that if it was not the right decision, my mentor would have corrected me (3A40)</p> <p>The need to consider the other patients that I had responsibility for (3C3)</p> <p>Other patients in the ward were given the necessary support and reassurance. (3MH1)</p>
Accountability	<p>It is acknowledged when a registered nurse delegates tasks, the accountability remains with the nurse. (3A34)</p>
Political issues	<p>Operation undertaken in a private hospitals, get an infection and comes to NHS hospital. (2A26)</p> <p>The implications can be enormous for the patient; physically, psychologically and socially there are knock-on effects for other patients waiting in line for treatment. (3A51)</p> <p>I felt it was representative of the type of ethical dilemmas that Nurse Practitioners may be faced with daily. (PG8)</p>
Duty to care / legal issues	<p>How ethically I had a duty to promote family centred care based on evidence to the child (3C3)</p>

	<p>Mental health act – protecting their human rights, legitimises seclusion. Legal cases referred to e.g. inquiry into David Bennett after prolonged restraint, and Munjaz court ruling of 2003 local health authorities had rights to formulate local policies that depart from the Mental Health act (1983) in the best interests of the patient. Additional rulings in 2005 further stated that the Code of Practice guidelines were not always legally binding (3MH1)</p> <p>Documentation should include data about what was observed and must comply with professional standards and legal requirements. (2A10)</p> <p>The legal age of consent to give permission to perform the operation was Gloria old enough and when is she deemed competent, she can give consent at 16 as long as she is deemed competent, which is automatically assumed when over the age of 18 (PG7)</p>
Problem solving / Decision making	<p>Breaking into the inner circle for the benefit of my patient to be part of the decision making process. (2A12)</p> <p>Did it to benefit my patient, did not care about how I was perceived or the repercussions of going straight to the doctor over the nurse who ignored me. (2A18)</p> <p>The debate around seriousness of somebody with an eye injury over someone who is having a cardiac arrest, severe disability or serious life threatening condition (3A32)</p> <p>The quality of the decisions as measured by the rate of error reduces when the nurse is under stress or is in a stressful environment. (3A39)</p> <p>Problem solving is part of decision making, a systematic process of focuses on analysing a difficult situation and problem solving always includes a decision-making step. Because decisions may have far-reaching consequences. I am aware that in nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems (3A40)</p> <p>My clinical judgement was that the child needed to be attached to the monitor continuously (3C3)</p> <p>I employed some problem-solving techniques. (3MH2)</p> <p>The use of problem-solving processes to facilitate patient's confidence in the use of coping skills (3MH3)</p> <p>Problem solving and decision making skills are important to professional nursing practice (3MH4)</p>
Clinical judgement	<p>Not to make judgements, as judgements were made as to how his injury occurred as the patient could not speak English (3A32)</p> <p>I put a judgement on the priority of his care 'a time waster' in relation to his rib pain, not serious as opposed to asthma; despite I knew he could be serious. (3A17)</p> <p>Clinical judgement was used as a clinical skill to determine whether James had calmed down so as to end the seclusion' (3MH4)</p>
Empathy	<p>Wondered how her parents would be feeling, as I am a parent myself, I seemed to put her under my wing and took over as a mum, as she had no one with her and no way of contacting anyone as she was a unknown. (3A23)</p> <p>Students are taught the importance of establishing a caring relationship with the patient, and the need to respond with genuineness and empathy to promote trust and rapport. (3A35)</p> <p>'The opportunity to understand what the patient was going through (empathy) and thereby improving the quality of care I could have given to the patients' (3A48)</p> <p>'The implications can be enormous for the patient; physically, psychologically and socially, there are knock-on effects for other patients waiting in line for treatment' (3A51)</p>

	I tried to look at the situation through the patient's perspective and from the view that I shall soon be a staff nurse. (3A33)
Critique of care	Improve clinical effectiveness and legal implications of restraint and seclusion as this may help in preventing litigation (3MH1) Immediately who is to blame changing from 'all working together' to 'who is the individual to blame?' (2A36)
Take action	'I need to improve my clinical judgement skills read more about teamwork and partnership' (3MH4)
Compassion	I began to recognise the detrimental effects of social isolation on the health of elderly individuals (PG1-6) What it means to a person to be socially isolated, and the effect it can have on health (PG1-6) More alert to individual needs and can now provide necessary information to patients being barrier nursed in this way (PG1-6) I was 'available' and concerned for her care. (3A33) Initially, my feelings were of concern for my patient as she had become clinically unstable. (3A34) I learned much about their successes in life, about their families and also, sadly, about their worries about how it would all end. I was an incredible experience to be with these courageous people in their time of need' (2A33)
Linking concepts	In this regard there is both an ethical and moral obligation on nurses to ensure that they gain consent for all decisions involving treatment, ensuring that the principle of patient autonomy is respected (3A37) Students are taught the importance of establishing a caring relationship with the patient, and the need to respond with genuineness and empathy to promote trust and rapport (3A35) Nurses should be emphatic, responsible and respect the dignity, wishes and emotions of their patients even though sometimes, some of the wishes are impossible to be granted (3A21) I used my delegating duties, communication, decision-making and problem-solving to execute duties as a nurse in delivering and managing care of patients while at the same time achieving learning needs. (3MH2)

## 11.4 - Cultural awareness

Differing dimensions	Excerpt from students story and learning account
Awareness of differing cultures	<p>People communicate in different ways. People's mannerisms may come across as rude or arrogant' (2A2)</p> <p>Issues related to death and dying that are cultural and discussing these with the patient (2A14)</p> <p>Cultural issues related to the dying patient, facilitating this in clinical practice. (2A15)</p> <p>Conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures.' (3MH2)</p> <p>I made sure that the son knew the chaplaincy team, who had access to a member of their faith, would be available to talk with him and spend time with his father, however, they declined' (3A44).</p> <p>Conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures. (3MH2)</p>
Culture that poses a challenge	<p>Must be able to adapt to certain situations. (2A2)</p> <p>Visiting patients in their own home</p> <p>Non speaking English patients. Husband translating for patient, did not notice the area was not private and carried on interpreting.</p> <p>Barriers to communication in this was the language barrier (2A26)</p> <p>Polish patients, and difficulties with speaking and understanding English, unable to explain mechanisms of injury. (3A32)</p>
Different values	<p>Attitudes need to be experienced and lived. Should not be judgmental (2A2)</p> <p>A realisation that some attitudes and stereotypes are ingrained and may pose a challenge to my career as a professional nurse. Driven by my belief processes (2A12)</p>
Cultures of health professionals	<p>The use of experienced staff to support students' fundamental to professional socialisation. (2A1)</p> <p>Need to understand that working within health care environment you are going to come across certain people who are frustrated and stressed within their professional roles and peer pressure. (2A2)</p>
Culture of nursing	<p>It is debated whether dominant cultural practices within a hospital ..... consider it of limited value to the nurse who they believe has restricted power within the organisation (3A35)</p>
Power struggles	<p>Fear of speaking out due to status (determined through the culture of nursing, perpetuated in clinical practice, and through education).</p> <p>Differing cultural values of nurses and doctors divide the medical and nursing profession. (2A12)</p> <p>It is debated whether dominant cultural practices within a hospital choose to discourage reflective learning, considering it of limited value to the nurse who they believe has restricted power within the organisation. (3A35)</p>
Breaking through culture	<p>Ignoring the hierarchy determined by the culture of health care – break into the inner circle for the benefit of my patient. (2A12)</p>

## 11.5 – Management

Differing dimensions	Excerpt from students story and learning account
Managing patient care	<p>How situations are managed. (2A2)</p> <p>Enthusiastic and confident that could manage patient's care. Taking down short notes, as useful so things do not get forgotten. (2A10)</p> <p>Management of leg ulcers. (2A13)</p> <p>The belief is that the more innovative and creative the strategies that individuals are able to use in their daily work, the more responsive they will be in the delivery of effective healthcare. (3A30)</p> <p>By managing the care of this patient I realised that nurses are in a unique position to educate, care for, support and guide patients through major life-style changes. (3A33)</p> <p>I see that my management of the patient, until the physiotherapy session, had concentrated upon nursing issues such as adequate analgesia, bowel output and recording vital observations. I have found that I can adequately manage the nursing care of a patient. (3A37)</p> <p>I was allocated to manage the care of a dying paediatric patient. (3C1)</p> <p>Assessing the patient on admission able to identify the patient's needs and organise what care was required throughout the day</p> <p>I had not previously managed the care of this patient and therefore I was unaware of what needed to be done. I therefore spoke to the nurse who was caring for her during the previous shift. (3C2)</p> <p>Worked the care of this patient around the care of two other patients that I was caring for. (3C4)</p> <p>Managed to distinguish my problem and that of the patient, detaching myself a little in order to get things into perspective, if cannot engage in distancing risk of being drawn into people's problems and can no longer help them. (3MH2)</p>
Management theory	<p>Theory of change management has drawn on a number of social science disciplines and tradition. Change is an alteration in the status quo and is inevitable. Planned change theories provide theoretical concepts in order to achieve changes. Different models of change are appropriate in different situations. Classic theory of change is a three-stage process, others later proposed more detailed processes, planned change and innovation adoption were presented as adapted linear models and problem-solving approaches to managing change. (3A30)</p>
Approaches to care	<p>By regularly using a structured approach to patient care my nursing practice should begin to improve e.g. the nursing process model, which when used in conjunction can provide a useful tool in critical thinking. (3A36)</p> <p>Managing my patient is more than just providing a range of nursing duties; it is to provide holistic care. (3A37)</p> <p>I implemented structure to my day by organising in advance how I would use my time effectively. (3C4)</p> <p>Agreeing a management plan with the patient. (PG8)</p>
Gaining experience of management	<p>Realised how important it is to acquire experience to manage these situations satisfactorily. (2A15)</p> <p>This oversight on my part as a student nurse in my role as trying to gain management experience in the care of two patients probably meant the patient with rib pain stayed in the A&amp;E longer than necessary as his investigations could have been done sooner. (3A17)</p> <p>This experience has had a huge effect on my own management skills. (3A34)</p> <p>Experience comes from external factors such as actually managing and taking responsibility for the care of patients. She later told me that she felt confident of leaving me in charge. (3A33)</p>

Seeking help	<p>Knowing when to seek help when necessary. (2A9)  Student nurses, and to ask for assistance from staff nurses when necessary.  Would have helped if I had called others to assist me. Better organisation of my actions. (3A36)  I had to ask a recovery nurse to prepare everything for the dressing change. This made me feel uneasy. (3A40)</p>
Sorting out problems	<p>Sorting out of problems and differences in an amicable way that does not affect the patient. (2A2)  Eventually the old notes came which highlighted that she had been administered metoclopramide the day before as a TTA, which meant it had been dispensed from us as pharmacy would not have been open at that time of night. We immediately administered procyclidine IV to treat the reaction, which was successful. (PG14)</p>
Time management	<p>Effective time management (2A1)  Timing of care BGL and fluid balance for that hour were overdue and still needed to collect some of his medication from pharmacy. Organisation of written documentation, forgetting details and information. There were so many things to do within specified periods of time and this put my time management skills to the test. (2A10)  The reason was that the time allocated for personal hygiene and that of the dispensing and administration of drugs nearly overlapped. By planning and prioritising this way, I was able to manage the time efficiently. (3A21)  Time management is extremely important when caring for any patient however when the patient is terminally ill it is extremely difficult to manage your time. (3C1)  Meningitis can progress very rapidly - time management and constant monitoring of any changes is an essential component for the care of this patient. (3C4)</p>
Managing written documentation	<p>Taking down short notes, as useful so things do not get forgotten. (2A10)  Planning ahead and writing plans down is an efficient way to manage time and ensures important tasks are not overlooked. (3C4)</p>
Delegation	<p>In all of this the other patient had been forgotten and his care could have been delegated to another. (3A17)  I felt unease in delegating to senior staff; I was democratic because I explained why I needed them to undertake the activity. (3A21)  I gained experience in delegating duties to healthcare assistants. (3A33)  When another patient asked me for a commode, I delegated the task to a health care assistant. This delegation of duty was not meant to offload work, but was done out of necessity in order to effectively manage my time and also to ensure that the task got done. (3A34)  I was unsure of how to delegate. (3A40)  Delegation is a requisite of good supervision as it supports trust and confidence in your subordinates as you are sharing responsibilities. I should have been more democratic in delegating tasks staff a chance to choose. (3MH2)</p>
Managing hierarchy	<p>Staff hierarchy (2A10)  Assumption about position in the hierarchy of other health care professionals e.g. behind the sister. Perceiving as a student to be at the very bottom of the health care hierarchy. Accepting the subordinate role therefore becoming accepted into many forums (only on this premise).  Standing outside a group prevents input and may be perceived as disregard for any involvement in the decisions made related to the patient. (2A12)  This managerial duty made me nervous because the consultants, doctors,</p>

	<p>physiotherapist, occupational therapist and dietician came to me regarding the management of those patients. The doctor asked me to administer methyl-thioninium chloride to ensure that there was no leakage in the gastric sleeve. (3A33)</p>
Prioritising care	<p>Prioritise nursing care given to the patient. (2A10)          Prioritising care e.g. is it serious e.g. in comparison to a cardiac arrest. (3A32)          I had to prioritise their care, deal with input from various sources and to document everything. (3A33)          The need to prioritise my patient's care was of paramount importance nursing priorities change throughout the day as new events occur. (3A34)          Priority setting is also an important skill in nursing. (3A40)          I made sure the most important tasks were highlighted and given greater priority.          Prioritising can create tensions for nurses because the needs of one patient compete with those of another in terms of urgency. Prioritise my time towards them whilst ensuring patient safety at all times. (3C3)          Helps in the management of prioritising patient care. Prioritising care is an important skill for all nurses in the management of patient care. (3C4)</p>
Management of the family	<p>I would continue to involve the family and the child, if appropriate in the management and delivery of care. The focus of my attention and care needed to be focused around this family and this child. (3C1)          Learned how to manage and co-ordinate a group of patients during shift. (3C2)</p>
Barriers to good management	<p>Economic burden of managing elderly patients with heart failure. (2A13)          Dealing with situations better and not spoken to in front of the patient but in private. (2A2)          Forgetting information can be due to the busyness of the ward during certain periods. (2A10)          Communication for effective nursing management          Insufficient information to carry out a comprehensive assessment. (2A14)          When tasks are not prioritised or delegated, then duties that require urgent attention can get forgotten. (3A34)</p>
What is needed for effective management	<p>Communication for effective nursing management. (2A12)          The amazing communication, organisation, management and co-operation of all staff were very impressive. (2A27)          My nursing management skills require development for my future nursing practice and these include my time management, delegation and prioritisation skills, and therefore my action plan is to address these issues. (3A34)          I would also continue to seek support and guidance from fellow members of the team. (3C1)          Planned how best I was going to achieve the objectives of the day, a crucial part of my strategy to ensure effective management. (3MH2)          The situation involved a lot of management and leadership skills. The shift leader delegated staff accordingly taking into consideration appointments, escorts, psychiatric response, medication, ward security and other activities that were going to take place that day. (3MH4)          Leadership and communications are inseparable. (3MH2)</p>
Responsibility of all of this	<p>Management skills are vital and necessary for nurses in order to fulfil responsibilities. It is vital to be aware that planning ahead, prioritising, delegating and good time management help to maintain effective management of nursing care. (3A21)</p>

	A full appreciation of all implications is essential, and NPs are accountable for all prescribing decisions they make including not to prescribe. (PG8)
Insight and depth in the management role	<p>Regarding what others were feeling and why, the patient realised that her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear. I believe that I gave managerial and personal support, guidance and after-care to this vulnerable patient in a respectful therapeutic relationship. (3A33)</p> <p>I have been able to assess how I feel about my nursing delivery and management of care for a patient over a whole shift. (3A37)</p> <p>I had to manage communication between various professionals, time management for the care of this child and others on the ward whose care I was participating in. If I was managing the care of a dying child in a similar situation to this one I would handle the care of this child in a similar way to the way that I handled the care of this child. (3C1)</p> <p>I am hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries, to prevent confusion over the most appropriate dressing, and the importance of not changing the dressing to frequently. (PG13)</p>
Connecting a number of management issues together	<p>When tasks are not prioritised or delegated, then duties that require urgent attention can get forgotten. Time management and prioritisation are essential skills within nursing for successful, efficient and effective patient care. (3A34)</p> <p>Throughout, I was able to demonstrate my prioritisation, time-management and delegation skills, thus ensuring the delivery of care was appropriate and effective, being the right of every patient in my charge. (3A35)</p> <p>While caring for this patient I utilised management skills such as prioritisation, time management and delegation. (3C2)</p>



## 11.6 – Educating patients

Differing dimensions	Excerpt from student story and learning account
Giving information	<p>Information sharing (2A1)            Support others to help them increase their knowledge. (2A16)            Patients cannot often identify the drugs they are taking, their names, the side effects of them. Importance of diet and control of diabetes (2A21)</p>
Health education	<p>Through health education and health promotion patients are empowered to make informed choices about their own well being. (3A38)            This change in treatment needed to be explained to the next of kin of Mr X so that they could understand the medical decisions and also prepare themselves for the death of Mr X. It was decided that the doctors should along with the shift leader discuss the possibility of organ donation with the family as well. The family were shocked and distressed by the news that Mr X was not responding to treatment and that the doctors believed he was now dying. (3A44)            Offering them advice and support when they need it, in addition to asking patients what they need from the nursing staff. (3A48)            Educated them on why we would be barrier nursing the patient in an individual cubical and implemented limitations for visitors. The mother highlighted her guilt for not taking the patient to have her immunisations, I felt stuck in a situation of whether to offer support or educate about the benefits of having immunisations. (3C4)</p>
Increasing knowledge of the patient condition	<p>Part of my responsibility to my patient was to educate him on his condition and how best to promote his rehabilitation. I explained to the patient how important it is to maintain a good oxygen supply, and indicated the monitor which showed his saturated oxygen levels had fallen to an unsafe level. (3A38)            I showed her the correct way to suction the patient, which was shown to me by the physiotherapist. (3C2)            Advice was then given to the parents about infection control, and limiting visitors until an official diagnosis had been provided. Advised the family on universal precautions. (3C4)</p>
Answering the patients questions	<p>The patient realised that something out of the ordinary was occurring and had questions that he wanted answers for, due to my previous experiences and knowledge I was able to provide him with answers and if I was unable to answer his question I was able to locate someone who could. (3A39)            Answered any questions in my ability or found out the answer to any question I did not know the answer to. (3C4)</p>
Health promotion	<p>Effects of illness on life style (health promotion) (2A13)            While caring for this patient I contributed to the health improvement of the patient through health promotion by educating the patient's mother. (3C2)</p>
Preventing complications	<p>Through treatment, cooperation and exercise such as wiggling of the toes to promote blood flow and other range of exercises performed with the physiotherapists her condition could get better. (3A21)            I encouraged the patient to exercise gently, discussed her nutritional regime, and aware of psychological adjustments. (3A33)            If I had been more persistent in stressing the importance of the irregular heart beat the doctor may have been consulted sooner and the patient's condition treated quicker. (3A39)            I also explained to the patient's mother about the importance of positioning the patient in a manner that prevents a heavy build-up of mucus secretions. I also explained to the patient's mother about the importance of regularly turning the patient in order to prevent pressure sores. (3C2)</p>

	<p>I explained to the child's mother the reasons for providing extra pillows and propping her up. I was also concerned regarding a safety issue, as with the child propped up mum had left the cot sides down and walked away. I again tried to explain to the other the need to keep the child upright and the cot sides up to maintain her safety. (3C3)</p>
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## 11.7 - Hospital and community

<b>Differing dimensions</b>	<b>Excerpt from student story and learning account</b>
Following hospital policies	<p>Our role was to ensure that patient care was managed according to clinical priority as opposed to waiting time. (3A32)</p> <p>Hospital infection control policy was maintained, wearing protective clothing to protect myself from any contact with bodily fluids or blood and to prevent cross infection to him and others. Adhering to strict hand washing techniques. (2A10)</p> <p>According to the A&amp;E guidelines, any women suffering from PV bleeding should be placed in a side room. (PG12)</p>
Services available in the local community	<p>The wide range of services available to families.(2A15)</p> <p>Services available related to local support and therapy e.g. advice and non-cancer palliative care. (2A13)</p>
Benefits available	<p>Phoned the local benefits agency to ask for latest information on the attendance allowance in particular and other benefits in general. What benefit is, who qualifies, exceptions, rates of pay, method of payment, rates for special rules. Allowance can be used to improve life style of the sick person, enabling them to go out occasionally or have a sitter so that their carer can be given a regular break each week. (PG1-6)</p>

## 11.8 – Communication

Differing dimensions	Excerpt from students story and learning account
<p>Identification of what communication is;            Verbal (language, talking, verbal interactions, tone of voice)            Non-verbal (eye contact, listening, facial expressions, body language)            Written communication</p>	<p>Asked to give verbal hand over to night staff. Documentation as a vital source of communication. Read the patients notes to help understand the patient's condition. (2A10)            Eye contact, communicating interest, silence, body language, displaying active listening skills. (2A12)            The significance of accurate documentation in clinical settings. Using non-verbal communication e.g. posture, gestures and keeping eye contact. (2A14)            I read the patient's medical notes in order to gain an in-depth history of the patient. (3C2)            The uses of voice e.g. tone and using simple language, making emphasis on relevant aspects of the circumstances to facilitate absorption and understanding (2A15)            Generally (the nursing handover) is one way communication whereby the nurse gives the relevant information and instructions to the nurses resuming their shift in the ward manager's office or nurses' station. (2A16)            Observing the non-verbal expressions of the family and their saying they had never seen him this bad before. (2A18)            Speaking to patient. Non-verbal communication from patient e.g. facial expressions. (2A26)            The involvement of active listening (3A35)            Documentation is an essential and crucial part of nursing care (3A21)            Reading body language as a crucial part of communication as speech. Use of body language and written documentation. (3A32)            I read the patient's medical notes in order to gain an in-depth history of the patient. (3C2)            After the consultation she documented her actions. (PG7)            From her notes I could see that she had attended A&amp;E the day before and asked reception to print off those notes. (PG14)</p>
<p>Communication is core to nursing</p>	<p>The vital role of communication (2A1)            Communication is imperative in practice. (2A2)            Communication is core to care. (2A9)            Verbal communication is a core social skill. (2A12)            Good communication also has a good impact on patient care (A48)            All professionals to communicate effectively (C4)            All require effective communication that facilitates progress in a nursing environment. (MH4)            Considered as a yard stick in nursing practice (MH4)            ...the ability to communicate effectively is the most important area that requires expertise in order to manage patient care efficiently. (3A34)            Effective communication is an essential necessity for effective nurse-patient relationships as well as inter-professional relationships. (3A40)</p>
<p>Learning interpersonal relationships between patient, relatives, the nurse and other HCP</p>	<p>Effective hand over prepares and enables nurses to take over the care of patients and continue to deliver high quality care. Communicating well with colleagues and other. Communication depends on the nurse, client and other team members. (2A1)            Communication depends on the nurse, client and other team members' relationship. (2A2)            Calling the doctor to come to see patient informing of the patient's condition. Communicate care to other members of staff. (2A10)            Communicating with colleagues. (2A15)</p>

	<p>Listening to relatives when they have never seen their relative like this before. The doctor listened to me because I had evidence which I could not put into words but showed through the ECG. (2A18)</p> <p>...having good interpersonal skills with team members to produce good standard of care (3A21)</p> <p>Communication is essential for all the team involved and clearly it was in this circumstance. (3A23)</p> <p>I now also realised, that as a student it is important to communicate with the nurse assigned to work with me when I find it difficult to cope with the workload. (3A36)</p> <p>I communicated Wendy's mobility status at handover. I am also pleased that I adequately communicated to the physiotherapist that I wanted to work with her to see how she assisted Wendy in safe mobility. (3A37)</p> <p>I also had to think about Mrs Smith's needs and communicate well with her and other healthcare professionals. Effective communication is an essential necessity for effective nurse-patient relationships as well as inter-professional relationships. (3A40)</p> <p>I spent a large amount of time talking with the family about their child. (3C1)</p> <p>I made sure I was present during the ward round in order to know of any changes the doctors made to the patient's treatment. I communicated over the phone with the physiotherapist to arrange for the patient to have physiotherapy. (3C2)</p> <p>Primary health care team meeting to discuss results of the audit, which is known as significant event audit. Good communication between agencies involved in patient discharge from hospital starts before the patient leaves hospital. (PG1-6)</p> <p>The involvement of the MDT e.g. doctor and pharmacist was implicated in the learning and how it is imperative to involve everyone, as it is not generally just one persons mistake, it is a collection of errors gone unchallenged and undetected. (2A36)</p>
<p>Learning how to communicate involves talking to patients and listening to them</p>	<p>Talking to the patient about how he felt. (2A10)</p> <p>Explanation of the situation to patient's is essential (2A13)</p> <p>Listening to identify how the patient feels about her illness, telling her story in fighting the battle against her disease (2A14)</p> <p>Effective listening showing good verbal and non-verbal behaviour, body posture, noises and gestures of conformity, demonstrate concentration in conversation. Listening techniques such as nodding, signs of agreement to encourage the patient to talk. Allowing the patient to reveal concerns. (2A15)</p> <p>Nurses should listen to their patients and be aware that body language (A21)</p> <p>...how important communication is with not only the patients but also their families, partners and friends. (2A33)</p> <p>Mr S and I exchanged a couple of frank and honest conversations about his illness and state of mind. He had reached the stage where he simply wanted to die as soon as possible and verbalised his disappointment every morning that he hadn't passed away during the night. I was able to give him time to listen and express the views he had to shield from his wife as not to cause her more distress. I felt I had gained confidence in talking to patients about challenging and difficult issues, discussing their options and individualising my care to meet my patient's needs. (2A44)</p> <p>The importance of taking time to be with patients and just talking to them was so powerful. Other staff just seemed to dismiss it and other patients began to 'tut', saying that she was a nuisance and shout sit down and be quiet. It seemed that no one had the time or patients to listen to her. I asked her how she was now feeling and she replied that</p>

	<p>she was fine, almost unaware of why I was asking. (2A50)</p> <p>On arrival we were told there was a short wait but the patient will be seen within the next hour. After 3 hours the patient was still waiting becoming more and more nervous by the minute. Just a few simple words of care to tell them how long left to wait and maybe why it took so long to tell them everything is going to be OK was all it would have taken. The nurse in the department came over to help me reassure with telling the patient how long left to wait or just good old fashioned sympathy. (2A54)</p> <p>Nurses should listen to their patient and be aware that body language matters a lot to patients and even to other members of the team. (3A21)</p> <p>This is why nursing staff need to continually let the patient know that they are OK. (3A48)</p> <p>Communicated with an alphabet chart. Suddenly he looked upset and indicated he wanted to communicate so I fetched his alphabet chart. He spelt S O R R Y. (3A52)</p> <p>The nurse will need to rely on careful observation and interpretation of the patient's communication behaviour, clinical judgement and knowledge of the person during assessment. (3C2)</p> <p>With part of the response team still holding the patient, and all aspects of patient privacy and dignity being maintained, the nurse-in-charge communicated with the patient and explained the actions that were being taken. (3MH1)</p> <p>Asking questions around Gloria's sexual history and was there any possibility that she could be pregnant. Building a relationship. Information was needed such as if she was on the pill or sexually active, the date and time of her last menstrual period, was pregnancy a possibility. All of this information is relevant for the prescription of drugs. (PG7)</p> <p>Explanation was made that bleeding was not a good sign, and could suggest a miscarriage, but it could not be confirmed until a doctor examined her. (PG12)</p>
<p>Misunderstanding any form of communication can lead to problems</p>	<p>If the quality of the handover by the nurses who visited the patient the day before had been better the situation could have been prevented. (2A1)</p> <p>Information forgotten regarding VT episode and subsequent interventions. (2A10)</p> <p>Concerns that an interruption to communication routine may cause upset to the team (2A12)</p> <p>Getting information mixed up. (2A16)</p> <p>How mis-communication can lead to a delay in providing treatment. (3A32)</p> <p>I assumed she had understood me as she had smiled and nodded. This experience has demonstrated that interaction such as a smile and a nod is not an indication that patients / parents have understood my advice. (3C3)</p> <p>I informed him that I could not find the entry, he did not take it kindly and he became angry. (3MH2)</p> <p>Ms Z family did not speak English and therefore a history could not be obtained. (PG14)</p>
<p>The barriers to communication</p>	<p>Nurses doing something else when trying to communicate. Not listening to what I was actually saying. Verbal communication, no eye contact (2A9)</p> <p>Not being able to hear conversations that go on and missing some important point. Standing outside the main area of activity. (2A12)</p> <p>Communication with patients who do not speak English. Demonstrates how the environment is a barrier to effective communication' (2A26)</p>

	<p>English not being their first language is a barrier to communication. The low pitch, submissive person, fiddling with hands, nervous smile contradicted the urgency of verbal message, explains why doctor might not have listened.(3A32)</p> <p>...presenting closed posture or not making eye contact, this could have a negative impact or change the message received by the patient.’ (3A40)</p> <p>The communication difficulties produced a barrier (3C3)</p> <p>...he started wagging his middle finger at me..... he then shouted obscenities (3MH2)</p> <p>Communication can breed anger, disagreement, uproar and confusion at the expense of health, promotion and education. (3MH4)</p> <p>The polymyopathy had left the patient with speech difficulties, which made communication difficult. (3A36)</p> <p>Everyone was very cold, and when keep getting asked how long until this patients turn and quite rude. (2A54)</p> <p>I was unable to get any information from the relatives due to the language barrier. (PG14)</p>
Practices that enhance communication	<p>Being polite and well mannered e.g. excuse me. Judging communications well, not interrupting the flow and taking interpersonal cues. Confidence and assertive skills and how these affect communication skills (2A12)</p> <p>Listening to identify how the patient feels about her illness, telling her story in fighting the battle against her disease. (2A14)</p> <p>Met at the main door, directed straight towards theatre, all the way a member of staff was telling us the way so as not to get lost. (2A27)</p> <p>Previous clinical experiences have encouraged me to improve on my communication skills. (3A34)</p> <p>I intermittently chatted to Sarah about the circumstances surrounding the day’s events, whilst providing routine nursing care to other patients within the department. (3A35)</p> <p>Communication is the process of transmitting messages and interpreting meaning. As an important nursing skill, communication competency is acquired through study and application. (3A40)</p> <p>...all aspects of patient privacy and dignity being maintained (3MH1)</p> <p>Be alert to current literature and research on the subject (PG 1-6)</p> <p>Communication is a complex process of sending and receiving verbal and non-verbal messages. It is important for nurses to focus on their roles and responsibilities as well as having good interpersonal skills with team members to produce good standards of care. (3A21)</p> <p>Although I was reassuring the patient as much as I could. (2A54)</p>
Problems with getting themselves heard	<p>While communicating to the patient I maintained a professional but friendly relationship and did not allow my concerns to panic the patient. In the case being examined here I rapidly accepted the alternative explanation as it was being put forward by a nurse who has greater experience and a greater knowledge base upon which to draw. It took over one hour before I raised my concerns with a doctor. (3A39)</p> <p>Not being passive when standing up for the needs of the patient</p> <p>Not listening to what I was actually saying. Not listening to me as only a student. How to get someone to listen to you. (2A9)</p>
Communication used in a therapeutic way	<p>Talking to the patient about how he felt (2A10)</p> <p>Communication as a therapeutic skill, which is deep (2A14)</p> <p>Trying to get the patient to express feelings can help identify accept and work through feelings even if these are difficult. (3MH3)</p>
Communication can serve to gain respect from patients and colleagues	<p>I had managed to get her to open up to the doctors in telling her name and address, and that she was truly grateful for my help and even wrote me a letter of thanks. (3A23)</p>

<p>Interaction (communicating while undertaking an observation or intervention)</p>	<p>Eileen enjoyed having her nails painted, introduce her to other patients, and as we spoke she would recall her family, she told me her husband John and how he had passed away shortly after they married, she seemed happiest at these times talking about her past. She mentioned her son, but he lived abroad and rarely rang to see how his mother was, let alone visit her. (2A50)</p> <p>During the process I talked to her about how she was feeling, explained the state of her ulcers and gave her reassurance. I suggested she wiggled the toes to promote blood flow a range of other exercises such as deep breathing so her condition could get better (3A21)</p>
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## 11.9 - Teamwork

Differing dimensions	Excerpt from students story and learning account
Importance of teamwork	<p>The importance of MDT care. (2A1)</p> <p>Depends on team work. The importance of the MDT care. (2A2)</p> <p>This incident demonstrated the merits of collaborative practice. (3A35)</p> <p>I am aware of the importance of team-working. (3A37)</p> <p>When the doctor was consulted I felt relieved and even a little proud that the first tasks he asked us to perform were the tasks I wanted to perform as well. (3A39)</p> <p>The process of seclusion requires teamwork and adherence to local restraint and seclusion policies. (3MH1)</p>
Broad range of HCP	<p>There were a number of healthcare professionals involved. Team members performed their tasks calmly. (3A35)</p> <p>A brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided to my patient, over a whole shift. I am pleased that I worked closely with the physiotherapist to encourage Wendy to get out of bed and transfer safely to the chair. It would appear that to provide effective care, a nurse should co-operate with others within a team (including the patient). (3A37)</p> <p>Working with others, including physiotherapists, speech and language therapists, pharmacists and doctors. (3A38)</p> <p>I decided to contact the hospital interpreters to ask if one was available to interpret for me. (3C3)</p>
Professionals outside of hospital care	<p>Communicating with HCP outside of nursing. (3A32)</p> <p>Other agencies that patients are referred to on a regular basis</p> <p>Regularly assess and evaluate the input from agencies and be aware of the changing needs of the patient and families</p> <p>The previous day to the current visit police and the ambulance staff had to be called to his house to assist gain entrance into the house as staff from home treatment had failed to do so. The need to establish a good working relationship is required with all agencies. Referred to bereavement counselling loss of his grandmother. Making referral to other agencies and professionals using an holistic approach to a patient's needs. (3MH3)</p>
HCP needed when knowledge inadequate	<p>I had to delegate some responsibilities to a staff nurse and another student. Mrs B had three episodes of vomiting during this shift. I needed to delegate. (3A21)</p> <p>The resuscitation team were called immediately. Sarah was surrounded by a team of healthcare professionals, each with their individual roles in treating her condition. (3A35)</p> <p>I intend to seek advice and support from the multi-disciplinary team when appropriate. (3A48)</p> <p>It is important to be able to communicate that to a doctor or another relevant member of the multi-disciplinary team if the nurse does not have the necessary skills or training to assist the patient. (3A48)</p> <p>It is essential to ask advice from other members of the multi-disciplinary team who may have input into the child's care. (3C3)</p> <p>The referral process to other agencies for patients to gain access to the correct agency for the needs of that particular individual. (PG1-6)</p>

Communication between HCP	<p>Effective communication between health care professionals is important. Communication plays an important part in the effectiveness of teamwork.(2A10)</p> <p>Good communication also affects team work. Concerns that an interruption to communication routine in a MDT may cause unwelcome upset and disruption to the team. (2A12)</p> <p>The importance of effective communication between HCP is essential. The significance of inter and intra professional communications amongst health care professionals. (2A14)</p> <p>Communication between myself and the family and myself and other members of the care team was extremely effective in this situation. The communication and teamwork ensured that the best possible care was provided to the child and his family and that all necessary information was shared between the necessary; healthcare professionals to ensure safe practice for the patients on the ward. Communication and inter-professional working within a team are essential. I learnt how effective communication, team work and support are essential factors when caring for children with such complex needs. (3C1)</p>
Sharing information	<p>Received information from members of the MDT about procedures regarding him. Doctor confirming that the patient had a serious rhythm it was not sustained. (2A10)</p> <p>The nurse should pass information about the patient to other staff in the ward and the multi-disciplinary team to help create a supportive network that will work together to better the health of patients. (3A21)</p> <p>Sharing information with the MDT</p> <p>The patient's nurses had developed a plan of care which would enable the patient to be weaned off BiPAP therapy and have his tracheostomy removed. (3A38)</p> <p>A decision to seclude the patient was made by the nurse-in-charge in liaison with the nursing team and the ward doctor was informed of this decision. (3MH1)</p> <p>The ward round an important event that transfers information amongst the MDT and to plan ongoing care. (2A12)</p> <p>Informed the multi-disciplinary team that I was managing the care of four particular patients. (3A33)</p>
Not letting the team down	<p>Influences on other team members in the work place</p> <p>I truly wanted to feel part of that team by not letting them down on the tasks I had been asked to perform. (3A35)</p>
How student perceived by other HCP members	<p>Awareness of how inter-relate with members of care team. (2A9)</p> <p>The multi-disciplinary team members were encouraging and appeared to perceive me as a good manager and a caring member of the team. (3A33)</p> <p>Disrespected as a member of the care team. (3A32)</p> <p>These comments boosted by confidence and confirmed my sense of belonging to the team on that day. Considering the contributions made by other team members to be more significant than mine. (3A35)</p>
Sharing workload	<p>I knew that I had to learn to delegate duties to other team members. (3A40)</p>
Holistic approach all HCP needed	<p>The MDT is involved in the care of the dying patient e.g. GP, Macmillan nurse, hospice, pain nurse, social services etc. (2A15)</p> <p>There is a close relationship between the working environment and the capability and capacity of teams and individuals to handle</p>

	<p>issues they encounter in an innovative and creative manner. (3A30)</p> <p>The Dr's were informed during their morning round and believed this could reflect a further bleed. They therefore decided he was no longer for active treatment, but for palliative care. (3A44)</p> <p>With the patient deemed safe in the seclusion room, a multidisciplinary team involving the ward doctor reviewed his immediate care plan. Response team flawlessly assembled without showing hostility to the patient, confidence level of the team, staff support in a crisis hallmark of safety, communication co-ordinating the whole element of care. (3MH1)</p> <p>The restraining team demonstrated teamwork, inter-professional practice and record keeping as integral part of teamwork and help with violence management if the problem occurred again. (3MH4)</p>
<p>Working together to enhance quality of care</p>	<p>Support other health care professionals as much as possible</p> <p>Involvement of the doctor in the care of patients. (2A9)</p> <p>At lunch I had to ask the other student nurse to help Mr A with cutting of his food into smaller pieces which he asked for. (3A21)</p> <p>I feel aided in helping me to increase my knowledge and understanding of the situation and the different ways of the interdisciplinary team work, the communication between the team was great. (3A23)</p> <p>The decision to contact the cardiology team was the correct decision as my prompt action resulted in my patient being transferred to the specialist cardiology unit. (3A34)</p> <p>The team, including myself, were supporting, motivating and encouraging each other throughout by positive feedback. (3A35)</p> <p>I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients. (Wendy's situation has demonstrated to me the importance of team-working in providing enhanced care. I now view team working as more than just a theoretical concept that should be applied to nursing practice; rather it is an essential nursing skill that can lead to enhanced quality of care. I need to improve upon my team-working skills, to ensure the quality and effectiveness of care. (3A37)</p> <p>The nurse-physician relationship is one of collaboration when applied to clinical decision making. In this case the nursing staff, consisting of myself and the registered nurse I was working with, had already reached the decision that the patient's cardiac rhythm required further investigations, this was corroborated by the doctor. When the doctor was consulted I felt relieved and even a little proud that the first tasks he asked us to perform where the tasks I wanted to perform as well. (3A39)</p> <p>I intend to seek advice and support from the multidisciplinary team when appropriate. (3A48)</p> <p>Working with the multi-professional team to ensure the care given was the best as can be. Worked as part of the multi professional team and collaborated well with the relevant professionals</p> <p>Shared knowledge, skills and expertise with other members of the team for the benefit of the patients. (3C4)</p> <p>Began to function effectively in a team and participate in a multi-professional approach to the care of patients. (PG1-6)</p> <p>A doctor joined me then to assess the patient and seemed as puzzled as I was and obtained IV access. (PG14)</p> <p>The functions of a consultation. (PG8)</p> <p>She discussed this with the practice manager to confirm her position. (PG8)</p>

<p>Limitations of teamwork</p>	<p>Others exercising their authority e.g. consultant. Nervous at being shouted out or belittled when speaking out because of status. (2A12)  This emphasises the power struggle still going on in clinical practice.  Limited my input in the team  Hand over to doctors what has occurred, the interventions and treatment. Not listening to student but thanked student and took the notes. When health care professionals do not listen to each other, mis-communication e.g. liquid or hydrochloric acid in the eye will change interventions and if delayed could lead to eye damage. Intimidation by doctors due to the unequal power relationship and the effects on teamwork and giving of and sharing information about patients. (3A32)  It is a difficult task in caring for a patient being family friendly and working well with colleagues. (3A34)</p>
<p>Barriers to teamwork</p>	<p>Other staff members making sarcastic remarks about students not doing their job properly. (2A2)  Power struggles that exist between HCP specifically doctor and nurse. By standing away from a group creates barriers to working as a team. (2A12)  Tension between nurses and doctors, typical submissive person fiddling with hands, nervous smile and speaking in a low pitch. (3A32)</p>
<p>Breaking through hierarchy</p>	<p>Went directly to show the ECG to the doctor, as nurse not taken seriously, immediately knew what was wrong. (2A18)</p>
<p>Conveying the full story to other HCP</p>	<p>I was impressed by how fast the doctor came to see my patient after I told him the situation, maybe there was urgency in my manner or voice? (3A17)</p>

## 11.10– Learning from and with others

<b>Differing dimensions</b>	<b>Excerpt from students story and learning account</b>
Value of working with experienced HCP	<p>Skilful role models help discover knowledge embedded in clinical practice. Opportunity to work with experienced and knowledgeable practitioners and observe them providing care. (2A1)</p> <p>Effective mentorship and supporting students learning and development in practice. (2A23)</p> <p>Support of mentor, patients of other staff who were patient and attentive</p> <p>During discussions with my mentor and the ward manager, I realised the importance of teamwork and shared vision. Talks with my mentor. (3A35)</p> <p>My mentor was nearby to observe my nursing skills, communication skills and give me reassurance.</p> <p>My mentor administered the Naloxone intravenously, and a couple of minutes later, Mrs Smith's respiratory rate had increased and all her observations were in normal range. When I noticed the change in Mrs Smith's Oxygen saturation and respiratory rate, I almost panicked and wanted to handover to my mentor, but she reassured me and told me to check the drug chart for prescribed medication. (3A40)</p> <p>The senior nurse would oversee my nursing care and take responsibility for the administration of intravenous fluids and monitoring of arterial blood gas (ABG) analysis. We agreed that I would work within my limitations as a student and seek her advice or direction as required. Then we planned the shift. (3A44)</p> <p>My mentor used her initiative and visited the ward from which the patient had been transferred and questioned staff there what they had administered as Zomorph SR 40 mg. It was an important learning curve for me to observe how my mentor took control of the situation and brought it to a successful conclusion diplomatically (2A36)</p>
Under supervision	<p>I was also (under supervision from the nursing staff) encouraged to perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient. Care for a patient under the supervision of mentor. (2A10)</p> <p>Working under supervision (2A12)</p> <p>Mentor assigned me to a patient under her direct supervision. (2A14)</p> <p>Mentor assigned me to a patient under her direct supervision. I carried out the above checks under the supervision and with the assistance of the charge nurse supervising me. (3A44)</p> <p>I carefully attended to the wound my mentor, who had been unobtrusively watching me, came over and suggested I speed up my actions and asked whether I knew why speed was essential. (3A51)</p> <p>I was allocated my own patients to manage with minimal supervision from my mentor. (3C1)</p> <p>Whilst managing the care of this patient I was indirectly supervised by a registered nurse.</p> <p>After the initial assessment, which was discussed and approved by my mentor? (3C4)</p> <p>Whilst on placement I was engaged in providing care under the direction supervision of a registered nurse to a group of post-surgery patients. (3A39)</p>

Feedback	<p>Positive feedback from mentor regarding performance. (2A10)  The comments my mentor had made to me highlighted that there was a need in me to focus on the broader picture. My mentor was pleased with my work. My mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality. Although the criterion highlighted by my mentor was my lack of speed, the greater and more important implication was the risk presented to the patient should the wound become infected and pathogens spread to and compromise bone tissue. (3A51)</p>
Access to clinical skill development	<p>I carefully attended to the wound my mentor, who had been unobtrusively watching me, came over and suggested I speed up my actions and asked whether I knew why speed was essential. Delegated a task to me. I was up for the task and trusted to undertake this by my mentor. (2A9)  Observation of my mentor taking a blood sample. Observed by mentor, who was able to give the information I failed to give, this related to some prescribed medications (electrolytes) the patient had been prescribed. Wanted to observe the scan. (2A10)  Need mentor to expose to relevant experiences (2A16)  Escorting a seriously ill patient with mentor, handing over the patient, directed to theatre a very useful learning opportunity was given to the student by the mentor. (2A27)  Experiencing night duty with my mentor. (3A32)  My mentor suggested I should spend some time in each area that our patients visit while in hospital as well as spending some time in the surgical ward itself. (3A48)</p>
Support and help	<p>Support of mentor, who were patient and attentive. (2A10)  The mentor being there when the student feels unable to complete the task. Gives knowledge and backup, support and guidance needed for future development. Learning to work independently with less support from mentor. (2A16)  I had relied upon some assistance from my mentor. My mentor contributed to this experience with psychological support and minimal verbal guidance. (3A40)  Support was available from my mentor as well as other members of staff. My mentor and the other members of staff made it clear to me that I could ask for their help and support at any time. (3C1)  I reminded myself that I was not on my own and I could have full support from my mentor if I needed it.</p>
Reporting to mentor	<p>Shared with mentor or senior members of the team. Informing the mentor of issues that relate directly to the patient's condition. (2A15)  Regularly consulted with my mentor  Informed nurse of concerns and suspicions about patient's conditions, informed will be there in a minute but never came. (2A18)  My mentor allowed me to plan the patient's care, and was available for advice and assistance and to perform those tasks which I was unqualified to carry out myself (such as administering intravenous medication). (3A38)</p>
Authority within the HCT	<p>Acting superior, arrogance. (2A2)  I required supervision from my mentor with the administration of medications for my patients. (3A21)  I was under the supervision of the other doctors and nurses there, and in the resuscitation room in an emergency the doctors mainly</p>

	<p>take over and the nurses do as the doctor's request. (3A23)  The doctor also instructed me to discontinue the PCA, intravenous fluids and antibiotics (the staff nurse did these for me). (3A33)</p>
<p>Influence of mentors on students</p>	<p><b>Positive</b>  Skilful role models help discover knowledge embedded in clinical practice. (2A1)  Teaching to be a better nurse in the future. (2A2)  Positive feedback from mentor regarding performance  Was able to understand due to the explanation given to me by my mentor the relationship between VT and electrolyte imbalance e.g. potassium. (2A10)  After I had been to my first meeting with my clinical tutor and had attended my first weekly lecture on oncology I was able to consider these experiences in a more positive manner. (2A33)  She was supportive and encouraging and allowed me to learn through supervised practical experience. (3A33)  I performed on the day were carried out to the complete satisfaction of my mentor. (3A35)</p> <p><b>Negative</b>  The influence of mentors on student learning if not consistent throughout can impact on student learning. (2A1)  Mentor taking over when necessary, when student knowledge can go no further. (2A10)  My mentor took over (2A23)</p>
<p>Limitations of the mentor role</p>	<p>Limitation and observational form of learning – absorb their role model's qualities and skills  The significance of the action of others on performance of student. (2A9)  Assumptions about the role of the mentor and what s/he does e.g. give the handover every time / letting the student take the lead and undertake particular roles so they may practice. (2A16)  If mentoring is insufficient in some situations the confidence to go elsewhere for the benefit of the patient. (2A18)  My mentor's role to facilitate this process and she was not able to fully relinquish the charge of the patients to me and just supervise or be there for me when I needed her. She did not confirm with other members of staff that I was managing this patient today. This invariably was leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice. (2A23)  There were limitations to my role that required input from my mentor. My mentor was often busy with her own work load, I was required to find her and wait until she had finished the task she was currently completing. Intravenous antibiotics were administered by my mentor as I observed. (3C4)  Better supervision cannot do anything alone. (3MH2)  I could have utilised qualified staffs' knowledge better. (3MH3)</p>

## 11.11 – Emotional

Differing dimensions	Excerpt from students story and learning account
Types of emotions feelings (positive and negative)	<p><b>Positive</b></p> <p>Did not feel that I could be trusted (2A18)            I felt honest and professional. (3A21)            I feel there is a lot more to be learnt.            I feel she was under the best possible team.            Felt pleased with a learning opportunity. (2A9)            Enthusiastic and confident (2A10)            Feelings of empowerment due to acts of bravery (2A12)            I also felt that I had prioritised my care correctly. (3A39)            I felt justified in involving the interpreter. (3C3)            Kept calm and spoke to the mother clearly</p> <p><b>Negative</b></p> <p>Frustrated, stressed. (2A2)            Feelings of inadequacy, inferior, foolish. (2A9)            Overwhelmed and nervous. Feelings of intimidation (2A10)            Panic, fear of missing information, frustration, isolation, loneliness, being an outcast from the group, undervalued. Defensiveness, negative feelings            Insubordination and fear. Nervous at being shouted out or belittled when speaking out because of status. (2A12)            Expressing feelings of fear (2A14)            Concerns about not knowing enough, flustered, out of depth, frustrated and stressed. (2A16)            Felt what I had to say was significant. (2A18)            Disappointment (2A27)            I felt very nervous and a bit scared about these because the staff I was dealing with were much more experience and I felt my standard was poor compare to theirs. (3A21)            I was a bit hesitant at first as I do not have the knowledge of children's nursing            Feelings of being out of depth, due to situation e.g. eye injury.            Apprehensive due to lack of confidence. Intimidated by the doctor. Feelings of nervousness about using medical terminology such as "ophthalmic" and sounding stupid if pronounced wrongly. Lack of respect, disappointment. (3A32)            Failure to communicate effectively with someone can cause him or her concern, especially if vulnerable through illness.            First the situation appeared daunting. I was daunted by how busy it was. (3A35)            At the time however, I feared that I may be criticised by the other nurses.            At this point I was feeling very frustrated and disappointed. I felt I could have dealt with the situation better. I felt I should have been advised of the language difficulties in handover that morning. Feeling under pressure as I had other patients to see. The effort of attempting to communicate was such a slow, painstaking process. (3C3)            I remained apprehensive. (3MH2)            I felt frustrated due to the language barrier and concerned for Ms Z. (PG14)            I felt awkward asking such detailed information in front of Gloria's mother. (PG7)</p>
Reconciling the negative into positive	<p>Raising voices, angry expected in environments such as theatre. (2A2)            I had felt a bit out of my depth in the resuscitation room as this was for emergencies and I had not the knowledge or the experience to be in total management and care of this patient, but I had given it my best shot in the nursing care of her.</p>



	<p>I did feel more at ease when I did this as things were coming to me a bit better instead of just standing by and watching I involved myself in her best welfare. (3A23)</p> <p>Expressing negative feelings to determine why the situation sticks in our mind. (3A32)</p> <p>I felt nervous about requesting the help, but I now realise that it was necessary as it is impossible to accomplish all tasks by myself. (3A34)</p> <p>I was excited, but also apprehensive about the task. (3A35)</p> <p>During the shift it became obvious to me that the comments Eileen had made to me were not personal. After a short while I returned to her and I was greeted with the same smile I saw initially, Coping alone at home that some patients have to face. When the patient told me that I did not care for her I was distressed, but knew this what part of her condition, and this knowledge helped me to understand. (2A50)</p>
<p>Articulating their feelings of unease</p>	<p>Being a part of the patients' journey, the sad times at the end. On occasions there were many tears (2A33)</p> <p>'Instead of ignoring and put aside my own feelings and emotions about this situation I persisted with voicing my concerns and this led to the patient receiving the appropriate treatment.' (3A39)</p> <p>I felt tired after the event, but also very positive and confident that I managed the situation well (3A40)</p> <p>It can be very emotionally draining (3A48)</p> <p>I tried to be as cheerful as possible but had begun to feel dreadfully sorry for this poor soul. This was no way to live, it must have been hell. (3A52)</p>
<p>How well students' face emotional challenges (their own and the patients')</p>	<p><b>Their own emotional reactions</b></p> <p>I had mixed feelings when asked to assist in Sarah's care. I was excited, but also apprehensive about the task, not because it was outside my experience, but because of the environment in which it was being performed. There is always a feeling that you need to prove yourself when starting a new placement, which is greatest when a third year. He was pleased with my professional approach and said I looked calm and 'in control', even though he knew I was nervous. (3A35)</p> <p>While looking after this patient I sometimes felt overwhelmed as she required constant care and attention.</p> <p>At times I felt stressed and by the end of the shift I was physically tired.</p> <p>I felt very excited and intrigued when my mentor told me that I was to look after the patient and give all the necessary care. I felt nervous and was unsure if I could manage the patient's care myself. I also felt confident assessing the patient and taking the laryngeal mask out. I was relieved when the nurse came back, administered the medication and Mrs Smith's respiration stabilised. (3A40)</p> <p>The comments my mentor has expressed made me conscious of my actions, causing me anxiety due to nervousness, and y initial feelings of confidence as I dressed the wound was eroded by the criticism levelled against my work. (3A51)</p> <p>I was glad that the care of the child had been allocated to myself during this shift as I had previously handled his care and the family had requested that I care for their son. I was however nervous because we were all aware that the child was only on the ward for Tender Loving Care (TLC) and would therefore die on the ward, we did not however know how long before this happened. The lack of experience made me nervous. I felt that I had handled the care of this child effectively and with respect and dignity. (3C1)</p> <p>I believe I could have become more actively involved in reassuring the patients and letting them know they were in good hands and they were being taken care of.</p> <p>I have always found organisation difficult. I also felt nervous about the care of this patient because I didn't have a grasp of part of the patient's condition during the shift. (3A36)</p>

	<p>I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of the patient for the shift. My feelings of guilt were due in part to the realisation that I had not provided the patient with sufficient information about his own care. (3A38)</p> <p>I feel that this child and his family received the best quality of care and was looked after with respect and dignity.</p> <p>I felt guilty that they had decided against their child having any immunisations, which may have been able to prevent this outcome. (3C4)</p> <p>Caring for a secluded patient was emotionally draining. Student felt seclusion was morally indefensible as it defeated the essence of a therapeutic relationship. (3MH1)</p> <p>I learned how one particular story can have such a profound effect on me. I found I was struggling not to appear upset, holding back the tears, trying to act as a professional. (PG12)</p> <p>I remained uncomfortable about asking the necessary and pertinent questions required to obtain a detailed structured history of a sexual nature especially with a young adult / adolescent. (PG7)</p> <p>This was no way to live a life. It must have been hell.</p> <p><b>The patients emotional reactions</b></p> <p>Emotional support. Concern for the patient's stress (2A15)</p> <p>Sometimes patients can be emotionally distressed by their experience in surgery (3A48)</p> <p>I also spent a lot of time supporting and comforting the parents who were very upset.</p> <p>Sometimes patients can be emotionally distressed by their experience in surgery. (3A48)</p> <p>Considering the after effects of restraining in terms of personal and emotional impact of restraint. The patient felt punished, and I felt it had damaged the therapeutic relationship with the patient. (3MH4)</p> <p>Nurses are expected to cope with their emotions and their patient's emotions (3MH1)</p> <p>When the patient was crying I did not know what to do to defuse the situation. (MH3)</p> <p>Mrs Y was extremely anxious. When I returned to Mrs Y to check on her she was hysterical. She was pointing towards her vagina and was passing the foetus. I called for the doctor. Mrs Y was holding onto me and crying. I tried to comfort her in the only way I knew how, by hugging her and talking to her. (PG13)</p> <p>This patient became so nervous a mild panic attack overwhelmed him and he was put on oxygen encouraged to breathe deeply. (2A54)</p>
<p>Conflict and concern about becoming involved</p>	<p>I felt conflict between the person-centred care I wished to provide and the restrictions of operating within the contemporary health system (3A38)</p> <p>The more time I spent with the patient the more attached I got to her and I felt a lot of empathy towards her mother (3C2)</p> <p>Conflict of feelings about physical restraining as a way of managing violence. Caught in between a situation, in which patients and staff were perceived to be at risk of harm and the sense of duty to protect as well as the professional, legal and ethical responsibility to protect patients. (3MH4)</p> <p>I enjoy spending time with patients and their family giving holistic nursing care, as opposed to the intensive care environment where although communication with patients is essential the bulk of the work is intensive and involves careful monitoring of equipment and vital signs etc. but not necessary hands on patient care and care for the patient's family.</p> <p>Nurses cannot allow themselves to get too emotionally attached to the patients. (3A48)</p> <p>After the incident I felt relieved as it had been dealt with instantly, I felt safer with the patient locked up at the same time guilty about the need for</p>

	<p>secluding James. The restraining process is unfriendly, I dislike getting physical with patients and unsatisfied because alternative strategies such as de-escalation skills were not fully considered before restraining the patient. (3MH4)</p> <p>I was sharing the experience with her, she was not alone, but I was not showing this to her, I felt it, but was held back by how I thought I should act which was professional. (PG12)</p>
Emotions getting in the way of care	<p>Human beings have diverse characteristics and emotional thresholds, some of which can stall the nurses' quest for excellent service (3MH1)</p> <p>My tendency to skim over details of a sexual nature was also found to be what makes many nurses feel uncomfortable. (PG7)</p> <p>Then I left the room, ran to the toilet and cried uncontrollably. I will never every forget S's story. (3A52)</p>
Patient concern for the student	<p>I know that the patient was glad that I was trying to get as much done for her as possible. I think that the stress that I felt was probably sensed by the patient (3A36)</p>
Frustration – wanting to do more	<p>Concerns about not knowing enough, and becoming flustered, out of my depth, frustrated and stressed (2A16)</p> <p>Apprehensive due to lack of confidence. Feelings of being out of depth, due to situation e.g. eye injury. (3A32)</p> <p>Concerns about not knowing enough about the vast areas related to oncology and those who are severely ill because of it (2A33)</p> <p>I feel there is a lot more to be learned. (3A23)</p>
Confronting emotions	<p>How a simple prescription error can lead to the feeling that something serious had happened and fearful of the outcome. (2A33)</p> <p>I felt out-of-my depth when John presented to us because I had never been involved in the care of an ophthalmic patient (3A32)</p> <p>Initially I was nervous because I had no experience of managing my own patients. (3A33)</p> <p>I was very nervous and panicked at the task, which has the potential to make other people nervous, as well. I also acted hesitantly at times, down to a lack of confidence. (3A40)</p> <p>I found the intensive care setting a very hard place to work, for me I found the biomedical model of care incongruent with my ideals of nursing. Many patients died over night, and I was expected to cope with my own emotions (3A44)</p> <p>I feel I did well and I found this experience positively contributed to my overall nursing skills.</p> <p>I feel that the support available whilst on this paediatric ward was extremely helpful and encouraged me to share my emotions and feelings with the team at the end of the shift.</p> <p>Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own. (3A52)</p> <p>I found the fact that I could not seem to calm her hard to deal with. (2A50)</p> <p>This story left me emotional fatigued with emotional and physical exhaustion that I felt this story had left behind in me, in was however both challenging and rewarding, I feared this would distance me from the suffering of patients in the future and disengage from the patients and families I cared for. Getting in touch with emotional situations and the problems this can pose to me as a nurse. (2A44)</p> <p>How a simple prescription error can lead to the feeling that something serious had happened and fearful of the outcome. (2A36)</p>
Looking from the patients perspective	<p>He began to cry during the visit. He wept uncontrollably and could not be stopped or consoled.</p>

	<p>I did feel very scared for the patient as she was under 16 years old. (3A23)</p> <p>His eyes said it all and I couldn't believe that this poor man, who's suffering was so immense, was saying sorry to ME! Who was I? I touched his arm to reassure him and told him that it was what I chose to do and that the nurses all loved to look after him and he was not to worry. (3A52)</p> <p>I know that the patient was glad that I was trying to get as much done for her as possible</p> <p>I think that the stress that I felt was probably sensed by the patient</p>
Action due to emotional learning	<p>Made me want to critique the idea of seclusion (3MH4)</p> <p>I feel that the patient was eventually given medications in order to stabilise his heart rhythm as well as subsequently being transferred to a cardiac ward demonstrated that I wasn't over- reacting and that I had performed my duties well. (3A39)</p>
Skilful ways to handle emotions	<p>I took deep breaths and tried to stay as calm as possible as it helps to focus, however, I found it was not easy (3A40)</p>
Growth and development as a result of emotions	<p>The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear, and uncertainty but finally confidence (3A40)</p> <p>I recall being quite concerned about my observations, previous experience had taught me to be wary of cardiac arrhythmias and the irregular pulse I had observed coupled with the patient's report that the episode started with a painful sensation made me especially wary. (3A39)</p>

## 11.12 – Engaging with reflection / Personal learning

Differing dimensions	Excerpt from student story and learning account
Evaluation of self	<p>Evaluate self. (2A2)</p> <p>Asserting self when patient decisions are being made to make presence known. Placing self in a position of authority on equal par to other members of the MDT – ignoring the hierarchy. (2A12)</p> <p>I feel that I can deliver good nursing care to all my patients. (3A23)</p> <p>Self esteem</p> <p>Highlighted the need for me to improve my self-awareness. Only with acceptance of one's self, can a person begin to acknowledge another person's uniqueness. (3A40)</p>
Learn more about the patient	<p>The role model observing mentors' enables students through the process of reflection, to internalise their mentor's behaviour and build on previous knowledge and experience. (2A1)</p> <p>Questioning of a patient about their past medical history and needing to be specific. (2A21)</p> <p>S appeared to be exceptionally bright but trapped in his useless body. Everyone loved him as he seemed such a gently character. (3A52)</p> <p>I have tried to visualise myself in the patient's situation and asked what would I do, how would I feel? (PG12)</p>
Dealing with the demands	<p>Nurses are under pressure. (2A9)</p> <p>Reflecting on the above my mentor did not ask the functions and categories of the drugs for my patients. I felt very ashamed when she did and I could not tell her most of the drugs' functions. The good thing about the experience was that it forced me to familiarise myself with majority of the drugs used on the ward. (3A21)</p> <p>Rather than feeling empowered by successfully taking charge of patient care, I actually felt constantly worried, and nervous about how much I had to do. Once the hand over was over and I was left alone, I mentally took a step back and realised that the patient had many aspects of care that needed to be considered. (3A36)</p> <p>The demands of every day nursing can often prevent individualised care at a time when a person is most at risk of losing their independence. (3A38)</p> <p>I should communicate when I don't feel able to cope with the level of care that has been assigned to me, because patient care is of primary importance.</p> <p>My thoughts were, should she receive an explanation that she is probably miscarrying and possibly devastate her before a firm diagnosis has been made or should she be told everything would be OK, when it more than likely is not, just to reduce her anxiety. (PG12)</p>
Identify gaps in their knowledge	<p>Highlight good and bad situations and their outcomes. Could have dealt with the situation better. (2A2)</p> <p>Did not know what it all meant, process would help me to gain understanding and interpretation. (2A18)</p> <p>My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading. (3A34)</p> <p>Patients with conditions that are not understood by myself will continue to be a part of the experience of being a nurse.</p> <p>The theory side of nursing knowledge is good but I need to be more aware of it and utilise it in practice situations. I also recognise there are gaps in my knowledge of certain skills and theories, which are required when managing the care of patients. I believe I could have managed this patient's care better if I had more medical knowledge. (3C2)</p>

	<p>I have gone away and researched miscarriages to enhance my knowledge and understanding. (PG12)</p> <p>I have gone away and researched minor burns and their management extensively and there is little evidence on the most appropriate dressing. The evidence that I found advocates the use of mefix in superficial minor burn management, but implied that it should not be removed for seven days, as it promotes a moist wound healing environment and should not be changed at least for the first 48 hours and very infrequently after that as frequent changes interrupts the wound healing process. (PG13)</p>
Looking inward	<p>Not listening to me as only a student. How to get someone to listen to you. Not presenting myself as confident, garbled words. (2A9)</p> <p>The skill of the nurse to acknowledge the hierarchy and tailor the communication process accordingly. (2A12)</p> <p>I learnt patience, compassion, adaptability. Care, compassion and communication are the basic elements of nursing. You have to be genuine. (2A33)</p> <p>I believe that I responded to this situation effectively by ensuring that the bed was elevated 30-45 degrees in order to decrease abdominal pressure on the diaphragm and to maximise tidal volume. (3A33)</p> <p>The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it. (3A38)</p> <p>I have gained a new perspective on my practice. (3A40)</p>
Self criticism	<p>Recognised my body language, ineffective / weakness in communications skills. (2A9)</p> <p>I feel reassured that my feelings of inferiority are shared amongst nurses, particularly during ward rounds owing to the dynamics of the MDT. Showing courage making a mental and physical effort to be involved e.g. a hero, brave? More experience with ward rounds to understand communication cues. Lack confidence and assertive skills. (2A12)</p> <p>Limitations of counselling skills needed to share the wife's concerns with others. (2A15)</p> <p>Reflection on practice experiences needs to be improved to evaluate self. (2A16)</p> <p>This culminated in a situation whereby I lost contact with what was happening to my patient. (2A23)</p> <p>It is vital to be aware about what types of medications I am giving to my patients</p> <p>I felt disappointed in the outcome because I had jeopardised John's sight by giving an ineffective handover. I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship. (3A32)</p> <p>Effectiveness of my care delivery was adequate still needs improvement. (3A34)</p> <p>Indeed, engaging in reflection can in fact lead to self-doubt. This made me question the importance of my role. I lacked experience relating to the advanced nursing practice conducted within that specialist area. (3A35)</p> <p>When I consider my interventions in retrospect, I can see that the majority of my actions were reactive rather than proactive. By not planning and sharing my workload, the patient's care suffered, and many tasks took longer to achieve than normal. My initial problem of inadequate information could have been dealt with if I had been more assertive. I could have dealt with the above situation differently, resulting in better patient outcome. (3A36)</p> <p>I realise that in future I must use other healthcare professionals to better effect. (3A37)</p>
Difficulties with care	<p>Finding it difficult to care for a patient or group of patients over a span of duty. (2A23)</p>

	<p>I had only seen two patients with these symptoms before, both of whom were reacting to metoclopramide. I knew that metoclopramide is contraindicated in under 20 year olds and therefore did not believe that it could have been due to this. I could not believe that metoclopramide had been prescribed to a 13 year old, as it is well documented and evidenced as to the extensive adverse reaction when given to children. I was shocked that it had been given and administered. Had I not previously remembered stories from my previous practice, I may not have recognised it. (PG14)</p>
Development	<p>It has helped develop my reflection skills and identify my learning needs. (2A10)</p> <p>I believe this experience has highlighted my ability to manage my own patient load and has demonstrated that I am ready to make the transition from 'student nurse' to 'newly qualified nurse'.</p> <p>In similar situations I should no longer doubt my ability</p> <p>I have discovered a greater awareness of my current nursing skills and highlighted those which need development. (3A35)</p> <p>Using my clinical judgement, I decided that stabilising the patient had priority over the dressing change. (3A40)</p> <p>The best lesson learned was being proactive is the best way to deal with complaints or incidents and it forced me to face this uncomfortable facts about my workplace and myself and carrying with me the lessons learned from this story, especially communication between HCP, in a productive, professional manner to sort out the problem faced. (2A36)</p> <p>I have gained new perspectives to set myself personal goals that facilitate effective patient care that may eventually eliminate the use of seclusion. (3MH1)</p> <p>Increased self-awareness and professional expertise, provided an opportunity to examine practice and identify new knowledge. (3MH4)</p> <p>It has helped me to adapt the way in which I manage the psychological needs of a patient experiencing a miscarriage and improved my ability to manage future patients more effectively and holistically. (PG12)</p>
Understanding	<p>It enabled me to put theory into practice, directed at a patient in need of my assistance. (3A35)</p> <p>By not having a firm understanding of the patient's condition and her needs I feel that I could not judge effectively the order of prioritisation.</p>
Change or growth	<p>Change practice in the light of learning and experience. (2A10)</p> <p>This story has made it apparent to me that an individual may come across as aggressive or unfriendly, but this does not necessarily what they mean to do. The patient may feel scared and vulnerable or they may act in a certain way because of a condition. (2A50)</p> <p>Increased self awareness and professional expertise, provided an opportunity to examine practice and identify new knowledge</p> <p>By analysing and understanding their actions, nurses gain new knowledge about their practice. (3A32)</p> <p>My clinical decisions throughout the day were based on what was best for the patient, whilst also ensuring I equally met the needs of my other patients and families.</p> <p>Upon reflection, from the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice. (3A37)</p> <p>Personal change and growth. (3MH1)</p> <p>Out on placement I had many experiences that I learned from. Sharing these experiences with others not only made me realise that I'd learnt from it but also enlightened others on the lessons learned. (2A54)</p>
A negative situation into a positive learning experience	<p>Turned the situation round from a negative to a positive. Take negative criticism, not like it, learn from it in a good way so something good can come out of it (2A2)</p>

	In hindsight I should not have doubted my ability so readily. (3A35) Change practice in the light of learning and experience
Restrictions of reflection	It must be remembered that reflective frameworks can actually restrict the deeper exploration of practice, and suppress creativity and thinking, especially if the nurse is a novice, or is faced with incidents which exceed the scope of the questions posed within the framework.
Insight into practice	<p>The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it. I believe that this experience has given me a practical insight Rigorously and systematically develop self and work in a manner that fosters a deep sense of obligation, commitment and moral purpose to the nursing profession. (3MH1)</p> <p>I was able to analyse my clinical practice, this related to the development of a therapeutic nurse-patient relationship and the feelings of guilt I experienced for not giving the patient the level of care I felt he needed. (3A38)</p> <p>The comment on speed caused me to assess myself and has definitely enhanced my practical ability as a nurse. (3A51)</p> <p>I now realise that as a nurse you will be expected to look after patients like this but also look after other patients as well. This situation highlighted that in order to become more confident as a nurse I will need to actively seek out situations where I care for my own group of patients as a student. This will help me gain experience, confidence and help me to improve my management skills. (3C2)</p> <p>I learned that I probably was expecting too much of myself without recognising the limitations of my abilities and knowledge and taking into consideration that I was still undergoing training. (3MH3)</p> <p>I chose this area because I believe it is important to realise that exposing oneself to other areas can have very beneficial side effects. (3A48)</p> <p>I have gained a new perspective on my practice. It was the application of this knowledge that leads me to suspect that there was something more. (3A39)</p> <p>This experience has allowed me to consider personal feelings, how I would feel in the mother's situation. By reflecting on this experience, I was able to identify the importance of managing my time for the benefit of the patient and learnt the significance of prioritising the care I provide. (3C4)</p> <p>I have gained new perspectives to set myself personal goals that facilitate effective patient care that may eventually eliminate the use of seclusion. As I nurse I realise that nurses need to take into consideration all factors which may influence person's behaviour. (2A50)</p>



## 11.13 – Professional development / critical thinking

### 11.13a - Intuition

<b>Differing dimensions</b>	<b>Excerpt from students story and learning account</b>
Engagement with intuition	Was able to spot something that was bothering patient. Just knowing when things need to be told and shared with mentor or more senior members of the team, so further action can be taken. (2A15)
Unaware of how they came to know or understand	Felt something was wrong but could not put it into words (2A18) Not being afraid to develop intuition and use it in practice, if situation not understood but know something is not right. (2A18)
Lacked confidence to use it	My intuition had told me to get an interpreter. On a previous occasion I had been advised that interpreters were only to be used in emergency situations due to the financial cost which had made me apprehensive regarding instructing one. (3C3)
Struggling to articulate feelings of unease	Instead of ignoring and put aside my own feelings and emotions about this situation I persisted with voicing my concerns and this led to the patient receiving the appropriate treatment. (3A39)
Putting information together	Took all of the information and put it together, just knew something was wrong. (2A18)
Acting on intuition	Knew something was wrong and had to take action so took a non-invasive intervention 12 Lead ECG. (2A18) Interpreting non-verbal communication e.g. facial expressions. Taking cues from patient and moving to a quieter area. (2A26) Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family, I respected this. (3A34)

### 11.13b - Professional development

<b>Differing dimensions</b>	<b>Excerpt from student story and learning account</b>
Codes of professional practice	NMC gives guidelines for professional practice. (2A1) NMC: nurses can identify accountability by documenting an event as soon as possible after its occurrence. (2A10) Fulfilling nursing role according to the NMC. (2A12) Following the NMC professional code of conduct in relation to confidentiality. (2A14) The NMC code of professional conduct (2004) and the practice area's medicines policy state I can under direct supervision calculate and administer medicines by a variety of routes. (3C2) The Nursing and Midwifery Council (NMC) recognises that nurse's practice is a constantly changing environment, with new advances in treatment and care, reorganisation and redirection of resources. (3A38) I felt irresponsible for the treatment I had given Mr V as I am accountable for my practice and in accordance with the code of professional conduct clause 6, nurse must maintain their 'professional knowledge and competence' with a responsibility to 'deliver care based on current evidence' and 'validated research when it is available. (PG13)

<p>Responsibility for own learning</p>	<p>Student responsible for their own learning needs and must be actively involved. (2A1)          Updating myself. Nurses are responsible for their own learning. Take action to update learning from experience. (2A2)          Need to improve communication skills. Recognition of areas that need to be improved. (2A9)          It has helped identify learning needs.(2A10)          I realised that I need to take responsibility for my own learning and state my own learning needs Inform all members of staff myself. (2A23)</p>
<p>Present yourself to others / behaviour</p>	<p>By remaining calm and acting professionally my role as liaison, both to other professionals and to the patient's relatives, was a productive and informative one. By maintaining my careful monitoring of the patient and acting in a relaxed professional manner I avoided alarming the patient and as such the patient remained calm and reassured that everything that could be done to rectify the situation was being done. (3A39)          Improving and developing professional behaviour. (3MH1)</p>
<p>Anticipate interventions</p>	<p>I was prompted to use my nursing knowledge and skills in order to care for the patient. I was aware of the need to react quickly to changes in the patient's condition. I tried to be proactive, to anticipate potential problems and act in a way which would avoid these problems arising. This highlights the challenge for nurses to be sensitive to the dynamic and rapidly changing needs of all patients. (3A38)          I had an established professional relationship with the child and his family. (3C1)</p>
<p>Lifelong learning</p>	<p>Reinforces the professional status of the nurse. Lifelong learning. (2A1)          Identification of future learning needs and skills that need to be developed Helps to inform future nursing practice. (2A12)          In the future I will care for infected patients like any other patients but I will always adhere to the infection control policy of the unit. (3A21)          This incident posted a greater challenge by extending my clinical practice contributing to my continued learning, a prerequisite for the provision of professional learning. (3A35)          I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing. (3A37)          Nurses are required to develop professional knowledge and competence to meet these demands and the complexities of modern professional practice through lifelong learning. (3A38)          This was another experience which led to my decision to head into palliative care in my nursing career. (3A44)          In the future this is an area I will have to work on. In future I will be more proactive in my dealings with the patients. In terms of reassuring patients, and being made aware of the level of knowledge needed to offer that care. (3A48)          Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us. (3A52)          I acknowledge that these shortcomings will need to be addressed and be worked through as nursing is a lifelong process of learning. (3C2)          This will enhance knowledge, skills, values and attitudes necessary for safe and effective practice and also lay a foundation for continued professional development and lifelong learning. (3MH1)</p>
<p>Wider professional issues</p>	<p>One needs to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve lifelong learning. In particular, it helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection. (3A33)</p>

	<p>My patients were happy that they had been attended professionally and they have been encouraged to take part in their care to enable better independence. (3A21)</p> <p>Wanting to know, understanding is a typical desire of a nurse – a passion for nursing?</p> <p>Showing courage making a mental and physical effort to be involved e.g. a hero, brave?</p> <p>interdisciplinary forums'</p> <p>I think it is essential for all nurses to recognise their individual skills and passion and follow this into an area of nursing which embraces their core beliefs and values rather than opposing them. I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably lead to me to quitting nursing. (3A44)</p> <p>Considered the areas of health promotion not only for my patient, but also for patients in the wider social context. (3A34)</p> <p>It would appear that the use of physiotherapist input could be used to better effect by the nursing profession as a whole. (3A37)</p> <p>Reflection on practice experiences as an important step in professional development, support others and increase my knowledge of issues. (2A16)</p> <p>This meant that the child's family were able to approach me with any questions or queries that they had. On this shift I found that I spent a large amount of time with the child and his family supporting them, answering any questions that they had and generally talking with them about their son. (3C1)</p> <p>I realise that I learnt a great deal about what is to be expected of me as a qualified nurse. (3C2)</p> <p>Clinical governance involves self management skills of professionals such as professional developments in education, audit, guidelines, managing time, increasing confidence, developing self awareness, learning from errors.</p> <p>From this experience I have learnt that I am capable of managing my own workload. This exercise has emphasised the importance of prioritising care, safe practice, working as part of the multi-professional team, providing needed health education and basing my work on evidence based research. (3C4)</p>
Updating knowledge	<p>Increasing my empirical knowledge on guidelines and protocols before embarking on patient care will assist me in future clinical practice and will help me understand some of the problems that I may encounter. (3C3)</p> <p>I accept I should at least have the BNF with me. If this situation arises again I will check in the BNF to clarify doubts. (3A21)</p>
Obtaining additional knowledge	<p>After researching the disease processes, I now have a better understanding of the priorities for this type of patient care. (3A36)</p> <p>This incident posed a greater challenge by extending my clinical practice contributing to my continued learning, a prerequisite for the provision of professional nursing</p> <p>This situation availed me with valuable experience in the form of development of my interpersonal and inter-professional skills</p> <p>I can further expand my knowledge and skills base</p> <p>I have found that I am more aware of my actions when fulfilling my duties, constantly seeking to justify my actions and underpin these with theoretical knowledge.</p> <p>Assertiveness in relation to my own learning needs</p> <p>Learning through time, building up confidence (2A16)</p> <p>Assertiveness is a positive quality for a nurse to exhibit and I believe that a barrier to assertiveness is perceived lack of experience and knowledge. (3A39)</p>

	From telling this story to other nurses, students, friends family I learned that even though professionals may do the same procedure treatment many times a day a patient only experiences it once or just a few times and may be very anxious or scared. (2A54)
Ethical principles, legal issues	Professional dilemmas that militate against prosecuting or claiming for damages from patients who may lack insight as it can damage the therapeutic relationship Although students are not held professionally accountable, they are morally responsible for ensuring patients receive good standards of care. (3C3) Trying to maintain the nurses professional obligations to these principles when they do not match the patient's, in all of this pain relief was essential. (2A44) However, by acting as a professional rather than a sensitive human being and not showing any emotion, I did not show the depth of my understanding and empathy. (PG12)
Transferability	The skills gained on an oncology are invaluable and will be useful during future ward placements (2A33) I can transfer these specialist skills to other areas where I practice using it in future care and placements and throughout my career. (2A44) If this situation arose again, I would try to be ore confident in myself and I would be more aware of my facial expressions to prevent anxiety for the patient. (3A40) I have consistently applied these practise since my visit to the recovery room by taking a more active role in learning why certain procedures are taken and being prepared to interact more with patients. (3A48)

### 11.13c - Critical thinking

Differing dimensions	Excerpt from student story and learning account
Clinical judgement	Critical thinking is an educational need to allow students to use independent judgement and evaluation. (2A2) I believe that my experience on this oncology ward helped me to think critically and made an improvement in the care that I give to my patients. (2A33) Clinical judgement skills for the newly qualified nurse are difficult as accurate decision making skills are derived from experience. Provided a critical analysis of my care delivery for a patient whilst I was on clinical placement in an assessment unit within a local NHS trust. (3A34) Critical thinking plays the most important role in delivering a dependable high standard of nursing care. (3A23) This highlighted the involvement of my clinical judgement. (3A35) The choices I made were the correct ones in relation to the effectiveness of my delivery and management of nursing care. (3A33) Nurses use their own judgement every day in practice and therefore they need to have the relevant background knowledge to do so. (3A40) Towards the end of the consultation the gentleman asked if the nurse would prescribe an asthma inhaler for his friend who was visiting him from abroad. Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us. (3A52)
Questioning	Questions may be asked. (2A2) Should be asking questions to mentor after he took over the care for a while. (2A10)

	<p>Questioning of practices when things have been forgotten. Questioning doctors, confidence in this practice ‘an ability to speak up within large Take a more questioning role, missed opportunities to further question, as questioning a medical instruction is acceptable and common sense. Failing to question can lead to a missed learning and teaching opportunity. Placing self in a position to question and challenge care when necessary to be patient advocate. (2A12)</p> <p>The use of questioning to improve knowledge and understanding. (2A16)</p> <p>Questioning of abilities as a student nurse. (3A32)</p> <p>Asking appropriate questions</p> <p>This demands an enquiring approach to nursing practice. (3A38)</p> <p>I have learned to question, if unsure, all prescribed medications to patients as we are accountable for our actions. As a result of this incident, guidelines have been introduced for prescribing anti-emetics for children</p> <p>Although I had never used mefix on superficial burns before, I did not question the NP experience and knowledge, and as there are no guidelines for management of minor burns, I did as I was instructed and Mr V was discharged home that evening. (PG14)</p> <p>The following 48 hours another staff nurse challenged me over the choices of dressings used on Mr V as she had redressed his wounds that day. (PG13)</p>
Decision making	<p>Decision making is also an essential skill within nursing during the course of a day, many decisions are expected of a nurse and almost all of these centred on patient care. (3A34)</p> <p>My decision-making skills, in particular and the ability to think on my feet are still evolving and will continue to improve with further experience. The incident has, developed to some degree my creative problem solving skills, and expanded my clinical abilities to enhance the quality of care I deliver to future patients. (3A35)</p> <p>Nurses are expected to access, appraise and incorporate research evidence into their professional judgement and clinical decision making. (3A40)</p>
Analysis of an issue	<p>The story helped to resolve an issue that we may not have handled in the best possible manner at the time. By making us look at the situation, break it down into salient points and consider what would have been a better course of action to achieve a more positive outcome is personally therapeutic and professionally diligent. (2A36)</p> <p>Initially, apart from being impressed at the professionalism of the nurse practitioner I paid little attention to this consultation. However, after writing this story I realised the significance of this brief encounter seemed much more pertinent. It made me realise that up until this point I had not taken the potential areas of tension we had been warned about seriously.</p> <p>Despite being an experienced nurse used to facing dilemmas of various natures, I had not truly considered the areas of tension that may arise from being able to prescribe. (PG8)</p> <p>Writing down the story also helped with my thoughts and to clarify what my current state of thinking is about a subject.</p>
Gaining others' views	<p>Gaining others views on the situation lets you see other perspectives and helps you learn from all angles and not just from your own. (2A54)</p>

## Appendix 12 – Additional patterns found in the learning accounts

The excerpts from the student learning accounts (given in brackets) can be cross referenced to the data given in Appendix 6.

### 12.1 – 2<sup>nd</sup> year adult patterns

The categories presented as patterns	Student excerpt related to the pattern
Personal learning / management	Communication depends on the nurse, client and other team members' relationship. (A2)
Theoretical / cultural / personal learning	Theories can be taught and attitudes need to be experienced and lived (A2)
Personal learning / cultural awareness	Students have to overcome many barriers to learning, nurses are responsible for their own learning and must be able to adapt to certain situations. (A2)
Emotional / professional development	Need to understand that working within health care environment you are going to come across certain people who are frustrated and stressed within their professional roles and peer pressure. (A2)
Personal learning / practice / theory	National standards agency, DoH does not advocate working from memory not taking notes can mean information is incorrectly passed on and needed to be passed on, plan and meet unstable patients needs (A9)
Personal learning / practice	Communications is core to care and one of the most valuable skills a nurse can have. (A9)
Personal learning / professional development / teamwork / management	Weakness in communication, need to improve future communication and support other health care professionals as much as possible, seeking help when necessary (A9)
Theory / practice / hospital policy and community	Hospital infection control policy was maintained, wearing protective clothing to protect myself from any contact with bodily fluids or blood and to prevent cross infection to him and others. (A10)
Theory / practice / personal learning / teamwork / learning from and with others	Monitored and documented his blood pressure, heart rate, respiration rate and oxygen saturation hourly, his temperature four hourly and his blood glucose levels two hourly. His fluid balance was also monitored hourly and administered his oral medication whenever they were due. I also took telephone enquiries and received information from members of the MDT about procedures regarding him, to the best of my knowledge and ability while regularly consulting with my mentor. (A10)
Theory / practice	Recording a 12 Lead ECG in order to record the electrical activity of his heart. (A10)
Theory / practice / teamwork	Mentor took a blood sample to send off to the laboratory. Electrolyte analysis – these are dissolved in water become ions and generate an electrical charge beneficial for normal functioning of the heart. (A10)
Theory / personal learning / patient education	Patient scheduled to have an ultrasound scan of the heart and wanted to observe. (A10)

Professional development / ethical / practice	NMC nurses can identify their accountability by documenting an event as soon as possible after its occurrence. (A10)
Teamwork / personal learning / professional development	The ward round is considered an important event to transfer information amongst the MDT and to plan ongoing care. This should help inform my future nursing practice. (A12)
Emotional / teamwork / cultural awareness	Frustration also met with a feeling of isolation and loneliness, being an outcast from the group and feeling of being undervalued. Feelings of inadequacy driven by belief systems, allowing consultant to exercise his authority and cause defensiveness. (A12)
Emotional / personal learning / management / professional development / cultural awareness / teamwork / emotional	Plagued by thoughts of insubordination and fear, decided to assert self and make presence known. Ignoring the hierarchy excused self, squeezing through the inner circle and standing beside the registrar. Courage to break into a circle requires great mental and physical effort (breaking the cultural norms). Felt empowered as realisation that inclusion is crucial to function as a team and feel included. Refusing to accept the power of doctors for the benefit of the patient.(A12)
Theory / educating patients / management	Leg ulcers, healing process, effects on lifestyle, management of leg ulcers, economic burden of managing these patients (A13)
Theory / practice	Application of compression therapy for arterial leg ulcers (A13)
Personal learning / ethical	Recording the information and explanation of the situation to patients is essential. (A13)
Professional development / ethical communication / educating patients / emotional	Proper process following NMC code of professional conduct maintaining patient confidentiality. In the assessment of patients effective listening skills and reassurance is therapeutic in communicating with palliative care patients. Listening to identify how the patient feels about her illness, telling her story in fighting the battle against their disease, expressing her feelings of fear (A14)
Theory / practice / ethical	Pain received diamorphine through syringe driver revised on a daily basis, 4 Fentanyl lollypops a day, a potent opioid analgesic chemically related to pethidine (80-100 times stronger than morphine) commonly used for break through cancer pain. High doses of medication can create toxicity, excessive depression of the CNS and death. (A15)
Theory / practice / personal learning / learning from and with others	Lack of counselling skills, needed to tell and share this information with more experienced colleagues. I asked patients permission if I could do this. When explained to colleagues used posture, appropriate accurate and appropriate language, I wanted to ensure I my colleagues fully understood my explanation. (A15)
Practice / personal learning / local hospital and community	Imperative role of the nurse within the family environment, the wide range of services available to families to cope with these situations to provide the best quality of life possible (A15)
Communication / personal learning / professional development / ethical / management / learning from and with others	Need to get more involved in situations where nurses are advising and counselling patients as I have realised how important it is to acquire experience to satisfactorily manage these situations. (A15)

Professional development / critical thinking / personal learning / reflection theory	Reflection on practice experiences as an important step in professional development, support others and increase my knowledge or issues (A16)
Professional development / theory	The use of questioning to improve knowledge and understanding (A16)
Emotional / learning from and with others	I panicked and got information mixed up, became flustered unclear as I was out of my depth mentor took over. (A16)
Personal development / practice / ethical / cultural awareness	The barriers to communication were environmental and language, which the patient did not feel comfortable and adequately able to communicate, effective communication was blocked. (A26)
Practice / management / hospital and community	Our role was to ensure that patient care was managed according to clinical priority as opposed to waiting time (A32)
Teamwork / communication / professional development	The involvement of the MDT e.g. doctor and pharmacist was implicated in the learning and how it is imperative to involve everyone, as it is not generally just one persons mistake, it is a collection of errors gone unchallenged and undetected. No one had sought clarification and speak directly to the prescriber (A36).
Teamworking / ethical / practice / communication	The involvement of the MDT e.g. doctor and pharmacist was implicated in the learning and how it is imperative to involve everyone, as it is not generally just one persons mistake, it is a collection of errors gone unchallenged and undetected. No one had sought clarification and speak directly to the prescriber (A36).
Critical thinking / professional	The story helped to resolve an issue that we may not have handled in the best possible manner at the time. By making us look at the situation, break it down into salient points and consider what would have been a better course of action to achieve a more positive outcome is personally therapeutic and professionally diligent (A36).
Reflection / emotional / communication / teamwork / professional development	The best lesson learned was being proactive is the best way to deal with complaints or incidents and it forced me to face this uncomfortable facts about my workplace and myself and carrying with me the lessons learned from this story, especially communication between HCP, in a productive, professional manner to sort out the problem faced (A36)
Practice / theory / ethical / professional development	Pressure ulcers and the causes, dressings Mr S did not want his dressing changed and the ethical dilemma of leaving Mr S with his dressing unchanged and the difficult this posed in respect to Mr S's well-being against his decision, facing how conflicting moral issues, whilst trying to maintain the nurses professional obligations to these principles when they do not match the patient's, in all of this pain relief was essential (A44)
Communication / ethical / theory	When the patient told me that I did not care for her I was distressed, but knew this what part of her condition, and this knowledge helped me to understand (A50).



## 12.2 – 3<sup>rd</sup> year adult patterns

The categories presented as patterns	Student excerpt related to the pattern
Practical / management / theory	The level of independence of my patients were different, I began the personal hygiene of Mr A and Mrs B who required more time and assistance. The reason was that the time allocated for personal hygiene and that of the dispensing and administration of drugs nearly overlapped. By planning and prioritising this way (A21)
Practical / teamwork / communication	The nurse should pass information about the patient to other staff in the ward and the multi-disciplinary team to help create a supportive network that will work together to better the health of patients. (A21)
Teamwork / practice / theory	I was involved in the care of a patient brought in by the police from the Samaritans where she had been found, there was no name of the patient and the police could not at the time find a name for her, she had taken an overdose of what was thought to of been crack cocaine, this patient upon arrival was not conscious her Glasgow coma scale was 3/15. (A23)
Learning from and with others / personal learning / reflection / teamwork / communication	I feel aided in helping me to increase my knowledge and understanding of the situation and the different ways of the interdisciplinary team work, the communication between the team was great and I feel she was under the best possible team. (A23)
Communication / theory	The notes detailed both care provided and care required and were written in short sentences which should, theoretically, have made the passage easy to understand. (A32)
Communication / professional development	I am now aware that I need to be more assertive when handing over patients in future and ensure my body language coincides with what I say. (A32)
Practice / communication / emotional	I did my best to make the patient comfortable and I connected with her. She told me that she knew her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear. (A33)
Theory / practice / educating patients	It is highlighted with the National Service Framework (NSF) for coronary heart disease that maintaining heart health is important in the prevention of this disease and therefore in the wider social context, advising patients on the benefits of a healthy balanced diet is vital within the realms of health promotion (A34)
Learning from and with others / teamwork / management / practice	During discussions with my mentor and the ward manager, I realised the importance of teamwork and shared vision, essential for the smooth running of the department and contributing to patient care. (A35)
Reflection / practice / management / teamwork	When I consider my interventions in retrospect, I can see that the majority of my actions were reactive rather than proactive, and little if any planning was given in the patient's care. By not having a firm understanding of the patient's condition and her needs I feel that I could not judge effectively the order of prioritisation. By not planning and sharing my workload, the patient's care suffered, and many tasks took longer to achieve than normal. (A36)

Practice / theory / critical thinking	Assessments such as these fit in well to the nursing process model, which when used in conjunction can provide a useful tool in critical thinking. (A36)
Management / teamwork / practice / theory	I see that my management of the patient, until the physiotherapy session, had concentrated upon nursing issues such as adequate analgesia, bowel output and recording vital observations. (A37)
Teamwork / professional development / ethical	It would appear that the use of physiotherapy input could be used to better effect by the nursing profession as a whole.....In this regard there is both an ethical and moral obligation on nurses to ensure that they gain consent for all decisions involving treatment, ensuring that the principle of patient autonomy is respected. (A37)
Reflection / professional development / theory / communication / practice	Whenever I encounter a similar situation to Wendy's, I can use practice enforced by theory to improve my relationship with Physiotherapists and other healthcare workers, using their skills and abilities to increase patient care. I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing. (A37)
Practice / communication / ethical / emotional / reflection	I was able to analyse my clinical practice, this related to the development of a therapeutic nurse-patient relationship and the feelings of guilt I experienced for not giving the patient the level of care I felt he needed. (A38)
Educating patients / ethical	Through health education and health promotion patients are empowered to make informed choices about their own well being. (A38)
Emotional / theory / practice / professional development	I feel that the patient was eventually given medications in order to stabilise his heart rhythm as well as subsequently being transferred to a cardiac ward demonstrated that I wasn't over reacting and that I had performed my duties well. (A39)
Theory / practice / communication / learning from and with others	When I noticed the change in Mrs Smith's oxygen saturation and respiratory rate, I almost panicked and wanted to handover to my mentor, but she reassured me and told me to check the drug chart for prescribed medication. (A40)
Personal learning / theory / practice	I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably lead to me to quitting nursing. (A44)
Reflection / communication / ethical / teamwork	In future I will be more proactive in my dealings with the patients. Offering them advice and support when they need it, in addition to asking patients what they need from the nursing staff. I also intend to seek advice and support from the multi-disciplinary team when appropriate. (A48)
Learning from and with others / emotional / personal learning / professional development / theory / practice	The comments my mentor has expressed made me conscious of my actions, causing me anxiety due to nervousness, and my initial feelings of confidence as I dressed the wound was eroded by the criticism levelled against my work. I felt inadequate as the unexpected feedback caused me initially some stress. (A51)

Critical thinking / patient education / theory / practice	Speedily dressing a wound is not often highlighted as a contentious issue nor one that lends itself to health promotion, however, when it is associated with the transmission of infection it became a healthcare issue. (A51)
Emotional / practice / communication /	The following week, I arrived at work to find S suffering from severe diarrhoea. I washed him from head to toe, cleaned the bed and floor and changed his sheets. I tried to be as cheerful as possible but had begun to feel dreadfully sorry for this poor soul. This was no way to live a life. It must have been hell (A52).

### 12.3 – 3<sup>rd</sup> year child patterns

The categories presented as patterns	Student excerpt related to the pattern
Communication / patient education / ethics / management / teamwork	The focus of my attention and care needed to be focused around this family and this child, however, this meant that I had to manage communication between various professionals' time management for the care of this child and others on the ward whose care I was participating in. (C1)
Reflection / learning from and with others / practice	The lack of experience made me nervous however my mentor and the other members of staff made it clear to me that I could ask for their help and support at any time. (C1)
Emotional / practice / ethical	I felt that I had handled the care of this child effectively and with respect and dignity on this shift, although I was unsure about how effectively I would be able to care for a terminally ill child I was extremely grateful to have this given the opportunity. (C1)
Theory / communication / practice	The patient is neurologically impaired and cannot communicate, therefore, I did not rely on the vital signs alone, I also used a pain assessment tool. Because the patient cannot communicate, the regular pain assessment tools for children were not useful; I relied on the patient's sounds and facial expressions, as well as the movements she was making to indicate to me whether she was in pain. (C2)
Teamwork / communication / patient education / hospital and community	Contacted a health visitor for her as they deal with public health issues including parenting education, health advice information. They would visit her home with an interpreter to look at safety within the home and see if we could be of any further help regarding communication issues within the community. The mother was extremely pleased that she was being offered some support. (C3)
Management / professional development / ethical / practice	At times when my attention was required in more than one place, I had to prioritise the care based on what patient was more sick and what impact would there be on the patient that I would attend to second. Prioritising care is an important skill for all nurses in the management of patient care. (C4)

## 12.4 – 3<sup>rd</sup> year mental health patterns

The categories presented as patterns	Student excerpt related to the pattern
Professional development, emotional / communication / ethical	Professional dilemmas that militate against prosecuting or claiming for damages from patients who may lack insight as it can damage the therapeutic relationship. (MH1)
Teamwork / hospital and community / communication / practice	The process of seclusion requires teamwork and adherence to local restraint and seclusion policies, response team flawlessly assembled without showing hostility to the patient, confidence level of the team, staff support in a crisis hallmark of safety, communication co-ordinating the whole element of care. (MH1)
Emotional / cultural awareness / communication	I remained apprehensive as I was conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures. (MH2)
Reflection / professional development / theory / practice	I learned that I probably was expecting too much of myself without recognising the limitations of my abilities and knowledge and taking into consideration that I was still undergoing training. (MH3)
Professional development / personal learning / critical thinking	The restraining process is unfriendly, I dislike getting physical with patients and unsatisfied because alternative strategies such as de-escalation skills were not fully considered before restraining the patient. (MH4)

## 12.5 – Post graduate patterns

The categories presented as patterns	Student excerpt related to the pattern
Theory / practice	Important for nurses to recognise the differences when implementing a new piece of equipment, research is important on the use of Doppler as an assessment tool. (PG1)
Teamwork / patient education / communications	Regularly assess and evaluate the input from agencies and be aware of the changing needs of the patient and families. (PG2)
Communication / educating patients / hospital and community	Good communication between agencies involved in patient discharge from hospital starts before the patient leaves hospital. (PG3)
Practice / emotional / reflection / hospital and community	I began to recognise the detrimental effects of social isolation on the health of elderly individuals. (PG4)
Hospital and community / educating patients / reflection	How extra money can improve quality of life for a person who is sick or disabled. It may ease the burden on a spouse who may have been struggling to care for their loved one, and whose own health may have been put in jeopardy. (PG5)
Practice / theory / communication	Assessment of a patient who is constipated, medical history, daily bowel function. Current types of treatment for constipation available, their action, the effects of these different treatments. (PG6)
Communication / management / theory	The functions of a consultation – building a relationship, collecting data and agreeing a management plan with the patient (PG7)

Reflection / emotional / communication / theory / practice	A tendency to skim over details of a sexual nature was also found to be what makes many nurses feel uncomfortable, but information was needed such as if she was on the pill or sexually active, the date and time of her last menstrual period, was pregnancy a possibility. All of this information is relevant for the prescription of drugs (PG7)
Emotional / communication / theory / ethical	My thoughts were, should she receive an explanation that she is probably miscarrying and possibly devastate her before a firm diagnosis has been made or should she be told everything would be OK, when it more than likely is not, just to reduce her anxiety (PG12).
Emotional / professional development / reflection	I learned how one particular story can have such a profound effect on me. I found I was struggling not to appear upset, holding back the tears, trying to act as a professional. However, by acting as a professional rather than a sensitive human being and not showing any emotion, I did not show the depth of my understanding and empathy. I was sharing the experience with her, she was not alone, but I was not showing this to her, I felt it, but was held back by how I thought I should act which was professional (PG12)
Reflection / theory / practice	I had limited knowledge on burn injuries and was able to assess Mr V. I did an initial assessment which involved the rule of nines to assess the extent of the burns, and noted that he had sustained a combination of superficial and partial thickness burns as some areas were red, and others had blistered. (PG13)
Reflection / practice / professional development	The NP instructed that the wounds should be dressed with Jelonet and mefix and was to return for review clinic and a review dressing within the next 48 hours. Although I had never used mefix on superficial burns before, I did not question the NP experience and knowledge, and as there are no guidelines for management of minor burns, I did as I was instructed and Mr V was discharged home that evening. (PG13)
Ethical / practice / professional development / theory	I felt irresponsible for the treatment I had given Mr V as I am accountable for my practice and in accordance with the code of professional conduct clause 6, nurse must maintain their 'professional knowledge and competence' with a responsibility to 'deliver care based on current evidence' and 'validated research when it is available'. (PG13)
Management / practice / reflection	I am hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries, to prevent confusion over the most appropriate dressing, and the importance of not changing the dressing too frequently (PG13).
Practice / communication / theory	I felt frustrated due to the language barrier and concerned for Ms Z. Eventually the old notes came which highlighted that she had been administered metoclopramide the day before as a TTA, which meant it had been dispensed from us as pharmacy would not have been open at that time of night. We immediately administered procyclidine IV to treat the reaction, which was successful (PG14)

## Appendix 13 - Individual student learning and researcher commentary

I selected seven students' stories and learning accounts (3A33, 37, 38, 40, 44, 48 and 51) and analyse them as a whole. Selection was on the basis of the richness of the data I felt they provided. What I was hoping to achieve here was the preservation of the story and learning accounts in their entirety and understand each one as a complete entity. For example the individual learning gained from the story that is special to the student.

### 13.1 - Story 3A33

#### Story 33

The patient had been a senior Theatre Sister and was now a Complementary Medicine Practitioner. She was well aware of the common morbidities that accompany obesity, such as hypertension, type 2 diabetes mellitus, stroke, coronary heart disease, gallbladder disease, hypercholesterolemia, osteoarthritis, respiratory problems and several cancers and wished to alleviate these as far as she could. Whilst her daily physical activity has declined significantly, caloric consumption has increased steadily.

Bariatric surgery is just one of the treatments that can offer hope for obese patients and is not the only panacea. The patient had an elective Laparoscopic Gastric Sleeve Resection due to obesity. She weighed 161 kg and had a Body Mass Index of 61.

#### Learning account excerpt

- This managerial duty made me nervous because the consultants, doctors, physiotherapist, occupational therapist and dietician came to me regarding the management of those patients.
- Obese patients are at high risk of wound dehiscence and slow wound healing because of poor blood supply to adipose tissue.
- I had to deal with the practical and physical problems caring for this patient, in particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin
- I did my best to make the patient comfortable and I connected with her. She told me that she knew her size made it hard to care for her and expressed mixed feelings of shame, embarrassment, hope and fear.
- By managing the care of this patient I realised that nurses are in a unique position to educate, care for, support and guide patients through major life-style changes.
- The first practical step I took was to order an appropriate chair and bed.
- The patient was able to use a zimmer frame to walk into the bathroom to clean her teeth, and I was able to attend to the washing of her back and legs. I needed to ensure that her legs were dried completely and moisturised, in order to reduce cracks in the skin and to prevent the formation of lesions.
- I was 'available' and concerned for her care.
- The nurse-patient relationship is central to nursing and to nurses feeling fulfilled in their caring role.
- I tried to look at the situation through the patient's perspective and from the view that I shall soon be a staff nurse.
- I was able to support the patient by providing psychosocial needs and a supportive, encouraging and respectful therapeutic environment.
- Others described the patient as a 'pain' and difficult to manage due to her size. Disregarding what others were feeling I brushed off the negative comments and met the patient with an open mind
- The multi-disciplinary team members were encouraging and appeared to perceive me as a good manager and a caring member of the team.
- I encouraged the patient to exercise gently, discussed her nutritional regime with her, and made her aware of psychological adjustments.
- This story has been beneficial in terms of developing and increasing my self-awareness regarding managerial care.

- This story writing experience helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection.
- One need is to link practice to wider professional goals, social issues, ethical and political concerns, and to own one's learning needs in order to achieve lifelong learning.

#### Researcher commentary

The student through this story was able to achieve desirable practice and learn to integrate compassion, adaptability to empathy and psychosocial needs, support, analytical skills, communication and interpersonal skills.

*For example*, the student maintained a respectful, non judgemental and caring attitude, and delivered and provided integrated, equitable and effective care and *management*. Most importantly developed *managerial skills* for when s/he become a staff nurse, such as the management of time, the necessity for the delegation of duties, and reporting relevant information to other *multidisciplinary team* (MDT) members. The caring acts delivered here could be *intuitively* surrounded by empathetic *interactions* and bodily presence. The student supported the patient by providing psychosocial needs and a supportive, encouraging and respectful therapeutic environment.

This story also details how sometimes students are burdened with a patient's emotions, feelings about being obese and how the patient searched for ways to describe her current experience and difficulties, in an attempt to get the student to understand her pain. The ceaseless physical and psychological nature of being obese expressed to the student is a lot to take in for a relatively novice nurse. The apprehension the patient was feeling as a result of this experience of hospitalisation may potentially in other instances be distressing.

Furthermore, the story helps the student to focus on thoughts and *emotions* and acted for the best in tune with his/her *beliefs*. This student was able to link practice to wider professional goals, *social issues*; *ethical* and *political* concerns, emotions and his/her own learning needs in order to achieve lifelong learning. The student in this story does not appear to have remained unchanged by learning from this story.

#### 13.2 - Story 3A37

The ability for students to learn from written stories of practice shifts teachers' focus from the interventions or outcomes expected to be completed in practice to exploring links between the categories explored in this research and the integration into caring for the patient. It helps students to find meaning in the practice experience for students. It is easy to overlook the importance of the student nurse's account of learning from nursing practice experience. By interpreting a small part of this written story and the learning from it using the categories drawn from earlier analysis, highlights the important individual learning from student nurses' practice that combines with caring for patients.

##### Story 37

The patient involved is an 85-year old lady with left buttock pain and lumbar stenosis. The patient will be called 'Wendy' to ensure confidentiality is maintained. When I first nursed Wendy, she was reluctant to leave her bed, and although had good physiotherapy input, lacked confidence in walking. The pain in her left buttock exacerbated the situation. Wendy felt hesitant to move from lying fairly immobile on her back (defined as a

“comfortable position”) to either side (“painful positions”). The pain in her buttock had also led to a loss of appetite.

The health improvements for the patient at this stage were to encourage mobility and to ensure maximised independence and improve food and fluid intake. I introduced myself and talked to her to find out why she was upset. She said she felt like she had been in hospital forever, and would never get out. She felt like she could do nothing for herself and resented people coming in and forcing her to do things, even when she was so tired. I thought about what she was saying and realised that some of these problems could be handled by a change in her care. Over the shift, working with my mentor we spoke briefly to the physiotherapist and worked out how Wendy could benefit from altering the times of therapy and being exhausted by everything being done in the morning, as by 10 a.m. she had had a bath, breakfast, physiotherapy and walked to the toilet and stairs, a doctor visit. This was all too overwhelming for her. So her schedule was changed and some of these activities were moved to the afternoon.’

Over the shift, I encouraged Wendy to leave her bed with minimal assistance, practicing the safe transfer in and out of bed. I also encouraged Wendy to transfer to and from the lavatory with a stick. Encouraging Wendy to sit in her chair also enabled her to feel more inclined to eat and drink.

Through the practice of such ‘basic’ nursing care, a range of holistic caring needs had been met. Wendy had moved from her bed, mobilised to and back from the bathroom, improved her confidence in walking with a stick, and had regained some of her appetite. I feel that the nurse-patient relationship had assisted me in helping the delivery and management of the nursing care of a patient for a whole shift. Upon reflection, from the care provided to Wendy, I feel that I have learnt more about myself and my nursing practice.

#### Learning account excerpt

- A brief and unplanned team-working session with a physiotherapist made all the difference to the care I provided to my patient, over a whole shift.
- I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients.
- The situation encompasses how I used the nurse-patient therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist.
- When I first nursed Wendy, she was reluctant to leave her bed and lacked confidence in transferring from bed to chair. Wendy felt hesitant to move from lying fairly immobile on her back (a ‘comfortable’ position) to either side (‘painful positions’). The pain in her buttock exasperated her loss of appetite; pain can reduce a patient’s desire to eat.
- I am aware of the importance of team-working. I am also aware of tendency, of healthcare professionals to remain within the safety of their own specialist area.
- It is critically important for Wendy to increase her mobility and sit up to eat.
- Along with mobility, a nutritionally sound diet will play an essential component in improving and maintaining Wendy’s recovery.
- I am pleased that I worked closely with the physiotherapist to encourage Wendy to get out of bed and transfer safely to the chair.
- I am also pleased that I adequately communicated to the physiotherapist that I wanted to work with her to see how she assisted Wendy in safe mobility.
- I now view team-working as more than just a theoretical concept that should be applied to nursing practice; rather it is an essential nursing skill that can lead to enhanced quality of care.
- I intend to use the learning from this story as part of a strategy to enhance my future approach to nursing.

#### Researcher commentary

The student’s learning seems to identify that initially he is disappointed in other nurses’ inability to have an effect on this patient’s organisation of care. The student seems to read the situation that other members of the multi-disciplinary team needed to be involved. The situation reveals to the student that a new way



of approaching Wendy's care was necessary. In her learning the student had recognised the skills of other healthcare professionals to assist her in the management and delivery of the best care for Wendy. By working as a team and negotiating with other health care practitioners team-working really influenced the delivery of care for Wendy. The brief and unplanned team-working session with a physiotherapist made all the difference to the care provided to this patient, over a whole shift.

Interestingly though this student describes his/her learning mainly in terms of 'I', which is interesting as the team working identified in the story, seems relevant. The student interacted and negotiated with the physiotherapist yet this action was given limited attention, the student nurses sole focus was on the patient alone. Dewey (1934/2005) would explain this as the strong feeling in the nurse, a desire to improve this patient's care allowed some features of the story to stand out and others to fade away. The interaction with the physiotherapist is less significant and this is related to the students own immersion in caring for the patient.

The student had incorporated elements of communication, the development of a therapeutic relationship in combination with team-working skills, in the form of assistance by a physiotherapist. In addition, the student had made reference to theory, was guided by her own professional status as a student nurse and all the time critically thinking about what could be done about it.

*For example*, the student began her account by describing the patient's condition and giving some brief insight into what this condition entailed using *theory*. She continued to *interact* with the patient recognising Wendy's non verbal as the student noticed she was upset, she listened to Wendy's account of her hospitalisation, while at the same time *critically thinking* about the meaning and significance. By being open to Wendy's account the nurse interprets Wendy's concerns and realises that some of her problems could be handled by negotiating with the physiotherapist to *work together as a team* to change her care. This culminated in the student nurse using her *practical skills* to assist Wendy's transfer in and out of bed and to walk to and from the lavatory with a stick. But more importantly Wendy was no longer upset, and the student had gained *personal* insight into herself as a nurse. This visible symbol of caring is what should be celebrated as the difference we can make as nurses.

### 13.3 - Story 3A38

How well do teachers know the day-to-day experiences of students in contemporary practice education? Can places be created within practice courses for students to share their stories of experience and develop new models of practice learning? Research that investigates students' stories of practice is one place to begin developing student centred approaches that are more compelling and responsive to contemporary contexts in which students learn to practice. Do teachers and clinicians underestimate students' contributions and abilities to show their own learning? The student wrote:

Story 38 excerpt

While on placement in a surgical High Dependency Unit (HDU) I was given responsibility for the care of a male patient for an entire shift. My mentor allowed me to plan the patient's care, and was available for advice and assistance and to perform those tasks

which I was unqualified to carry out myself (such as administering intravenous medication).

Frank had been admitted into hospital for surgery to repair a ruptured abdominal aortic aneurysm. Due to complications following surgery, Frank had remained in the Intensive Care Unit for two months and had been receiving respiratory support. A temporary tracheostomy was in place to assist breathing. On transfer to HDU the patient was receiving BiPAP (bilevel positive airway pressure) ventilation via the tracheostomy, the plan for this patient was to wean him slowly off BiPAP, and eventually remove the tracheostomy tube. Frank was able to self-ventilate via a tracheostomy mask, with 5 litres of oxygen.

During the shift, Frank was constantly monitored with any changes in respiration and cardiac function. Nursing care in the HDU I monitored renal, neurological, pain, nutrition, elimination, psychological and social aspects of the patient's care. Observations were taken and recorded hourly throughout the shift. In addition, I attempted to use what I learned previously and my nursing skills in order to care for the patient. I was aware of the need to react quickly to changes in the patient's condition. I tried to be proactive, to anticipate potential problems and act in a way which would avoid these problems arising.

Frank asked if he could wash and change his gown and I agreed to assist him. Because I wanted to encourage his independence, I prepared the washing items for him and allowed him to wash himself. My attention was distracted and I failed to notice that he had removed his oximeter finger probe and had accidentally moved his oxygen mask so that he was no longer receiving the full amount of oxygen supplied. When I turned to Frank, I saw that he was struggling to breathe. I immediately repositioned the mask and re-attached the finger probe. I explained to the patient how important it is to maintain a good oxygen supply, and indicated the monitor which showed his saturated oxygen levels had fallen to an unsafe level.

Learning account excerpt

- The story has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it.
- I felt conflict between the person-centred care I wished to provide and the restrictions of operating within the contemporary health system.
- The demands of every day nursing can often prevent individualised care at a time when a person is most at risk of losing their independence.
- During the time that I cared for this patient, we developed a trusting professional relationship.
- My understanding of the patient came from knowledge of his symptoms and how he coped with them.
- I attempted to use my knowledge to support the patient in his rehabilitation. Even though my relationship with him was short term, I considered it 'therapeutic' based on commitment and trust.
- He trusted my abilities and judgement, and welcomed me warmly at the beginning of each shift.
- Although our relationship was purely professional, I felt a personal responsibility for neglecting him.
- Feelings of guilt I experienced for not giving the patient the level of care I felt he needed
- Early recognition of potential and actual deterioration in a patient's condition is essential, and should be accompanied by an appropriate response for early intervention.
- My feelings of guilt were due in part to the realisation that I had not provided the patient with sufficient information about his own care.
- Learned to share my emotions and expectations in care, to be sensitive to the dynamic and rapidly changing needs of all patients and helped clarify and resolve my original feelings of guilt and doubt.
- Through health education and health promotion patients are empowered to make informed choices about their own well being.

- Part of my responsibility to my patient was to educate him on his condition and how best to promote his rehabilitation. This included the need for continuous monitoring and the importance of maintaining an adequate supply of oxygen.
- After I had explained this to the patient, he understood the need for keeping his oxygen mask in place, and apologised for causing alarm.
- The Nursing and Midwifery Council (NMC) recognises that nurses' practice is a constantly changing environment, with new advances in treatment and care, reorganisation and redirection of resources.
- Nurses are required to develop professional knowledge and competence to meet the demands and the complexities of modern professional practice through lifelong learning.
- This demands an enquiring approach to nursing practice.

### Researcher commentary

Frank was receiving respiratory care. The experience is enabling the student to explore the meaning and significance of his / her clinical practice and to recognise the complexities within it. A number of issues have been raised, with regard to the organisation of work schedules in which student nurses provide care to patients such as Frank.

The student recognised the need for Frank to maintain hygiene and independence while being severely ill. By attending to his essential needs the student nurse's account draws attention to the importance of students acknowledging conflicts in care, in this instance between the person-centred care the student nurse wished to provide and the demands of every day nursing, which can often prevent individualised care at a time when a person is most at risk of losing their independence. This highlights the challenge for student nurses gaining clinical practice experience in a variety of ward settings, as students have to have a high level of competency, skill and knowledge to meet the demands of operating within the contemporary health care system. There is also a need to allow the patient time to share their emotions and expectations with a trusted partner in care.

Practices are becoming increasingly difficult it would have been easy for the student nurse, to focus only on completing the prescribed interventions required of vital signs in the form of physiological measures and structured assessments, accumulating data related to this complex patient. Yet instead, by ensuring the patient did not become dependent, the nurse made time to work with the patient to be involved in washing himself, the student nurse could have just worked and completed the tasks by doing the wash for the patient, it might have been safer to do so. As the student nurse's story unfolds, it is through responding to the call of the patient through interaction that the student attempted to understand the patient's need for independence and so improve the patients care and how best to promote his rehabilitation.

*For example*, when the student was confronted with a situation in which optimal patient care was not being delivered in the event the oxygen became disconnected, the student nurse acted promptly, gathered *previous learning*, stopped what was being done with the patient, cultivated her *thinking*, promoted reassurance to the patient by *talking* to Frank calmly and explaining the need for the patient to keep the oxygen mask and probe attached, while washing. This included the need for the *practice* of continuous monitoring and the importance of maintaining an adequate supply of oxygen, upholding the principles of student involvement in *health education*. Through the process of mutual collaboration in care Frank trusted the student's abilities and judgement, to deal with the situation

when it occurred. The student was able to *make decisions* quickly and accurately, based on *previous learning* and patient cues.

This student's story reminds me as a teacher of how students are learning in clinical settings. Interpreting students' experiences provides teachers with insight into students individual learning, regardless of what is intended. In other words, when students interpret their own stories, they can explore new possibilities for learning from practice, despite the pressures and contingencies of the contemporary health care system.

A student nurse's practice is constantly changing, with new advances in treatment and care, reorganisation and redirection of resources. Nurses are required to develop professional learning and competence to meet these demands and the complexities of modern professional practice through lifelong learning. This demands an enquiring approach to nursing practice, an increased understanding of professional issues to improve standards of care. Perhaps students learning for themselves are an unacknowledged, untapped resource in hectic practice environments. The conventional approaches to learning from and in practice are challenged.

#### 13.4 - Story 3A40

Another student developed the notion of learning more about his / herself further by suggesting it facilitates the understanding of others individuality. At the same time the student may be paying attention to learning how to become a nurse and find meaning in the care s/he gave.

##### Story 40 excerpt

During the first week of my clinical placement in theatre, I was placed at the recovery room to experience the care of patients post-operatively. On my third day my mentor asked me to look after a patient and deliver all care necessary with indirect supervision. The Anaesthetist and the Operating Department Practitioner (ODP) brought Mrs Smith a 71 year old woman who had had a left total knee replacement into the recovery room and handed the patient over to me. I stood at the head of the bed to have a clear view of the patient, observing the patient's breathing pattern, chest movement and vital signs. As soon as Mrs Smith had awoken from her anaesthetic, I took her Laryngeal mask off. I kept observing her vital signs and especially her respiratory rate as she had had morphine administered in theatre, and one side affect of morphine is that it can depress the respiratory rate. My mentor was nearby to observe my nursing skills, communication skills and give me reassurance.

As I checked the wound site as part of the assessment, I noticed a small amount of blood on the dressing, which I decided to monitor closely, as blood loss can be potentially dangerous. A few minutes later I thought that the dressing should be removed to see why it was bleeding further. I delegated the duty of preparing the dressing trolley to the recovery nurse, as I had to stay with my patient. I observed Mrs Smith's breathing further and noticed a prominent decrease in oxygen saturation and respiratory rate. I checked the drug chart to see if naloxone was prescribed, a medication that reverses the action of Morphine in patients with respiratory depression. As I found that it was not prescribed, I asked the nurse to stop the dressing preparation and instead find the anaesthetist to prescribe naloxone and an alternative analgesic for Mrs Smith's pain. Using my clinical judgement, I decided that stabilising the patient had priority over the dressing change. I elevated Mrs Smith's headrest to aid her breathing and reassured her verbally and held her hand until the nurse came back with the prescribed medication. My mentor administered the naloxone intravenously, and a couple of minutes later, Mrs Smith's respiratory rate had increased and all her observations were in normal range, therefore, I

was able to safely check the wound and changed the dressing, ensuring patient care and safety. As Mrs Smith was comfortable she returned to the ward.

*Learning account excerpt*

- I started to believe in my own competency and I recalled a past experience in which a similar decision had been made. I also knew that if it was not the right decision, my mentor would have corrected me. I feel I did well and I found this experience positively contributed to my overall nursing skills.
- Problem-solving is part of decision-making, a systematic process of focuses on analyzing a difficult situation and problem solving always includes a decision-making step.
- Decisions may have far-reaching consequences.
- I am aware that in nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems.
- I feel that I had solved Mrs Smith's acute emergency situation accurately, but I am aware that I had relied upon some assistance from my mentor. My mentor contributed to this experience with psychological support and minimal verbal guidance.
- Priority setting is also an important skill in nursing, and a skill deficit can have serious consequences for patients, factors that might impact on priority setting include: the experience of the nurse, the patient's condition, the availability of resources, ward settings, and cognitive strategies.
- I believed I had managed this emergency situation well, this experience was very stressful for me, and it has highlighted the need for me to improve my self-awareness.
- Only with acceptance of one's self, can a person begin to acknowledge another person's uniqueness and build upon this to provide holistic care.
- If this situation arose again, I would try to be more confident in myself and I would be more aware of my facial expressions to prevent anxiety for the patient.
- I have gained a new perspective on my practice which is to set myself personal goals in facilitating effective communication between the patient and myself.

Researcher commentary

The student seems to have no problems in relating her feelings to story in a positive way. The student concentrates on herself and the patient and does not mention any other person, s/he seems to be in harmony with caring for the patient in the hospital environment. According to the student it is a great feeling when the patient's emergency condition is dealt with promptly, despite being stressful. The student's focus on the story and the quality of care s/he delivers appears to have a positive aspect. The student's learning strategy as it appears in the story – seems to be about her own competency, staying calm in an emergency, her emotions s/he has gone through, problem solving skills the situation demanded, the possible consequences for the patient and the new insight into her / himself.

13.5 - Story 3A44

There is a challenge for nursing schools to provide practice education experiences. When securing clinical placements, higher education institutes are often concerned that students may be placed in areas that are short staffed and, thus, students may witness varying levels of quality in the nursing care provided. Clinical time is at a premium as clinical sites are limited, making the conventional model of practice education difficult to sustain (Kelley 2002). One place to begin reforming practice education is with explicating the common experiences of nursing students in the practice environment.

Story 44 excerpt

It was agreed that I would work with a senior nurse and look after a fifty six year old gentleman who had suffered a subarachnoid haemorrhage (SAH). Due to raised intracranial pressure Mr X was required to be nursed with his head at a 30 degree angle, thus reducing the risk of further damage being caused by a raise in pressure.

Unfortunately Mr X remained hypertensive despite having a glycerine tri-nitrate (GTN) infusion and some other medications administered via the naso-gastric (NG) tube. When we took over the nursing care of Mr X he had four intravenous infusions running; crystalloids, GTN, Propofol and phosphates as well as an NG feed. Mr X also had a low GCS score of only 3 all night. During our initial assessment it became clear that Mr X's pupils had become fixed and dilated. The Doctors were informed during their morning round and believed this could reflect a further bleed. Mr X did not even respond to deep suctioning. They therefore decided he was no longer for active treatment, but for palliative care.

This change in treatment needed to be explained to the next of kin of Mr X. The family were shocked and distressed by the news that Mr X was not responding to treatment and that the doctors believed he was now dying. The family met with the transplant co-ordinator, but they were not in favour of this. While the family discussed the option of organ donation Mr X was kept on the ventilator, however, when they decided against donation the doctors decided to extubate Mr X and make him comfortable with a Diamorphine infusion and oxygen delivered via Hudson mask. It was also decided that Mr X would be transferred to a side room to allow greater privacy for the family to have time with Mr X. We also ceased hourly monitoring so that the family would not become fixed on the values of the vital signs.

Mr X's immediate next of kin was a young boy around eighteen years old; unfortunately Mr X's wife was out of the country. During the shift I made sure that the son knew the chaplaincy team, who had access to a member of their faith, would be available to talk with him and spend time with his father, however, they declined.

Whenever I went into the family room I got the impression that they wanted to be left alone to deal with their situation as a family. The shift ended with Mr X maintaining his own airway and breathing unaided, his GCS remained at 3 and pupils were fixed and dilated. He appeared comfortable and showed no signs of agitation or distress. Later that night he died.

#### Learning account excerpt

- For me the shift highlighted how hard it is for both staff and families to see the change from active highly intensive treatment to palliative care.
- It also highlighted how hard it is to deal with a sudden loss, Mr X had been fine up until the evening of the haemorrhage where he developed a blinding headache and vomited, collapsed unconscious and was rushed to hospital.
- In this environment palliative care was given poorly, because death is seen as a failure and therefore the focus is on making people well, the environment is not family friendly and the focus of care is of a technical nature so that skills in palliative care are often lacking, and other priorities prevail.
- I was aware that the doctors were reluctant to spend time with the family as it was a reminder of their so-called failing.
- This experience led to my decision to head into palliative care in my nursing career.
- I knew it was where I would be most successful because it matched my ideals, whilst an environment which was clearly biomedical in structure would cause me to lose my passion and probably to me to quitting nursing.

#### Researcher commentary

In this story the student has recognised that in twelve and a half hours a patient went from being intensively nursed and cared for with lots of medical intervention in a busy intensive care setting through to being nursed for in a palliative manner. The intensive intervention measures were removed and the focus changed from life prolonging / saving to comfort care measures, in all likelihood the patient would die. Perhaps what can be seen here is when nurses are told that a patient is going to die, such descriptions can deeply influence how nurses respond. It can sometimes, especially in critical care, be by distancing and non-engagement. The removal of intensive interventions can be seen as a failure to provide a cure

and reflects the pervasive scientific perspective of health care in which human experiences of illness are reduced to diseases and their treatments.

*For example*, the student recognised through this experience her own individual skills and passion and decided in the *future* to follow it in an area of nursing which matches his / her own core beliefs and values rather than opposing them. In a sense it highlights the influences of our past and the potential this offers our future, it fuses learning from story with the individual, which is applied to the student's possible future. This student's story, written here, is shown to be ongoing and his / her career choice only perceivable through *time*, as is learning from story.

More to the point, this student was not happy with the predominance of values of technical competence in the health care system and his/her own personal values rooted in the ethic to care. What appears to emerge here is the human aspect of dealing with patients and their families as individuals. Yet, despite the tension s/he felt this nurse though personally challenged by critical care, as it depersonalises the patient the student overcame it. The student was able to put aside her *personal* reactions and comfort the relatives, it is a response to learning about something that is not liked but still care is generously given. The nurse had seen the family grapple with the complex technologies used in an attempt to save Mr X and then it all just stopped. The student had to deal with tensions in this experience s/he did not like and perhaps would have avoided if given the choice, to one in which s/he freely accompanies the *mentor* into the relatives and does her best to provide comfort. The student story shows how students are able to respond to *situations*, while putting aside *personal* reactions to provide care.

Clearly, there is an important place in these interpretations for critiquing the many failures of the contemporary health care system and for exploring how students experience these challenges in nursing practice. Perhaps only focusing on the failures in the system covers over important aspects of nursing practice within this student's story.

*For example*, what the student clearly details here is how s/he learned to use his / her *intuition* by stating 'I got the impression they wanted to be left alone.' In this way the nurse had connected with the family, by being open to *intuition* and acting upon it and in so doing refocuses the care to meet her own values of what makes nursing successful.

### 13.6 - Story 3A48

#### Story 48 excerpt

Whilst on placement I was working in a surgical ward. My mentor suggested I should spend some time in each area that our patients visit while in hospital as well as spending some time in the surgical ward itself. A typical patient's journey involves the following areas: the pre-assessment area, the surgical ward, the operating room, the recovery and then return to the ward. I gained some valuable experience in each of these areas and I learned while I was there, explain the importance of the recovery room and summarise what is involved in the smooth and efficient running of the recovery room.

I got the permission of the charge sister of the recovery room, the charge sister in charge of the surgical ward and also my mentor to go to the recovery room for a day; I also informed all the other staff on the surgical ward of my whereabouts. When I reached the

recovery room, I was introduced to all staff members and was asked to “shadow” one particular nurse for the duration of my stay there.

While I was there I was actively encouraged to interact with the patients in terms of reassuring them and informing them of where they were. I was also (under supervision from the nursing staff) encouraged to perform minor tasks for the patients for example taking a BM (testing the blood sugar level) test for a diabetic patient.

While I was there I observed quite a number of differences between the treatment patients receive in the recovery room and the treatment received in the ward. First, patients are on quite a lot of medication when undergoing surgery; the effects of this medication needed to be monitored closely immediately after the operation until the effects of the medication wore off. Patients for example can sometimes wake up from an anaesthetic shivering. Some argue this is a reaction to the anaesthetic, others disagree. The treatment for this is to encourage the patient to breathe deeply while on oxygen therapy. Second, I learned that the emotions of the patient may vary quite a bit after an operation. One patient for example, woke up crying after an operation on her foot. In this case it was important to continuously reassure the patient and let her know that she was in safe hands and that she will be ok.

Patients are usually stable within a half an hour after surgery (although some patients with underlying conditions such as diabetes may have to stay longer) after which they are sent back to the ward. Some patients do not remember all of their time in recovery and find gaps in their memory. This can be very worrying for some patients as they feel they should remember everything. This is why it is very important to continuously reassure the patient in every way possible in this situation. Once the patient returns to the ward their nursing care continues until their eventual discharge.

It can be very emotionally draining from the point of view of giving emotion. The main downside is, however, nurses cannot allow themselves to get too emotionally attached to the patients. Because the patient moves from one area to another very quickly it can feel more like “assembly line medicine” rather than taking care of the patient as a whole.

Learning account excerpt

- I mean I should have reassured and encouraged and communicated with the patients a little more than I actually did.
- This would have given me the opportunity to understand what the patient was going through and thereby improving the quality of care I could have given to the patients. It would also ensure I would learn a little more.
- I believe I got to see some of the best practices a nurse can offer a patient.
- In terms of reassuring patients, and being made aware of the level of knowledge needed to offer that care, I have consistently applied these practices since my visit to the recovery room by taking a more active role in learning why certain procedures are taken and being prepared to interact more with patients.
- I chose this area because I believe it is important to realise that exposing oneself to other areas can have very beneficial side effects.
- This is especially true when it comes to learning how other wards work and how the two wards have an impact on each other. Sometimes this gets forgotten to the detriment of patient care.
- I did not interact with the patients as much as I should have, reassured, encouraged and communicated with the patient a little more.
- This is something the qualified nurses did not actively do on an ongoing basis with each patient.
- This I believe would have given me the opportunity to understand what the patient was going through, I would learn a little more, taking a more active role in learning to interact more with patients’.
- Sometimes patients can be emotionally distressed by their experience in surgery. This is why the nursing staff needs to continually let the patient know that they are ok.
- In future I will be more proactive in my dealings with the patients. Offering them advice and support when they need it, in addition to asking patients what they need from the nursing staff. .



### Researcher commentary

In this story and the excerpt of learning the student recognised that what was needed for the effective running of a recovery room is communication between the different disciplines working in them. Good personal interaction also has a good impact on patient care for example if a problem develops shortly after the operation it is important to be able to communicate that to a doctor or another relevant member of the multi-disciplinary team if the nurse does not have the necessary skills or training to assist the patient.

*For example*, a patient just arrived into the recovery room it is imperative the nurse knows exactly what medication the patient has had. Some medications like morphine tend to depress the respiration rate of the patient and can make them a little dehydrated and can affect their memory. The student was unclear about why a patient came back from theatre cold and shivering, this can be easily explained, theatres are very cold environment, together with patient exposure contributes to a reduced temperature, when the patient comes round, the body shivers to produce heat to help the body warm up. All of this contributes to learning about *theory* in relation to *practice*. To be able to do this the student needs a certain level of understanding to offer this connected care. Yet this type of *theoretical* learning from this *practice* experience applied helps students to interpret the symptoms they observe in patients conditions. From this perspective nursing becomes more than just doing for patients, applying a blanket because a patient is cold, the practices are understood and justified through this type of learning.

The student outlined how the patient had surgery and tended to get more intensive care in the recovery room than they otherwise would on the ward. This might contribute to the level of *interaction* with the patients and would have given the student more opportunity to understand what the patient was going through. Even though the nurse seemed to have had a good experience and offered the patient, in terms of reassurance this may have been influenced by the type of environment s/he was working in. The student identified how the recovery room could be very *emotionally* draining, as nurses cannot allow themselves to get too attached to the patients, because the patients move from one area to another very quickly and can feel more like an “assembly line medicine” rather than taking care of the patient as a whole. This could also contribute to the amount of reassurance given in this environment.

### 13.7 - Story 3A51

#### Story 51 excerpt

One of the patients I had been assigned to care for is a patient who had a total hip replacement operation. The patient was on his third day post-operatively and needed his wound dressing changed. The wound had been closed using clips and covered with oposite dressings. I carefully removed the old dressing, using the aseptic technique; I cleaned the area adjacent to the wound using saline solution and sterile swabs. As I wiped the area close to the wound my mentor suggested I carry out the procedure more speedily which I did. He asked if I knew why and replied that it was to minimise exposure of the wound to the surrounding environment and thus minimise the risk of the patient developing a wound infection. I looked at the patient, and he smiled at me.

He explained it again to me stating that with post –operative patients especially those where the bone had been operated on, the risk of infection entering the bone presented a serious threat to the patient with the risk of amputation or worse. When I worked in

theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again.

Although these were both important, of greater importance was the long term risk to the patient, infection setting in and compromising bone tissue and the whole system, this was not immediately apparent. Also highlighted was the fact that I have the knowledge, however, having the knowledge is of no use if it is not applied. In effect, I was being told to think as I worked. The comment on speed caused me to assess myself and has definitely enhanced my practical ability as a nurse.

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He explained it again to me stating that with post-operative patients especially those where the bone had been operated on, the risk of infection entering the bone presented a serious threat to the patient with the risk of amputation or worse. When I worked in theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again.

Whilst dressing the wound, I had taken care not to get the swab caught up in the clips and one clip was not fully homed and presented a risk of getting pulled and opening the wound. I also did not want to cause the patient any pain although pain was taken care of by medication. The comments my mentor had made to me highlighted that there was a need in me to focus on the broader picture. I had focused on what I could see, the wound, and had anticipated the patient's pain.

Although these were both important, of greater importance was the long term risk to the patient, infection setting in and compromising bone tissue and the whole system, this was not immediately apparent. Also highlighted was the fact that I have the knowledge, however, having the knowledge is of no use if it is not applied. In effect, I was being told to think as I worked. My mentor was pleased with my work and qualified his comment on speed by stating that speed develops with practice and at times haste causes errors which can have dire consequences. The comment on speed caused me to assess myself and has definitely enhanced my practical ability as a nurse.

#### Learning account excerpt

- The individual learning and surgical site infection and its far reaching effects highlight how a seemingly innocuous act such as not speedily dressing a wound can have grave consequences.
- I carefully attended to the wound my mentor, who had been unobtrusively watching me, came over and suggested I speed up my actions and asked whether I knew why speed was essential.
- I replied that it reduced exposure time to infections micro-organisms. The patient smiled. I completed the dressing as speedily as possible, taking care to prevent causing the patient pain and contaminating the wound or dressings.
- This was executed to my mentor's and my satisfaction.
- I noted my immediate response was to increase the pace at which I worked and rather than simply focusing on dressing the wound, I became very conscious of its significance
- The comments my mentor has expressed made me conscious of my actions, causing me anxiety due to nervousness, and my initial feelings of confidence as I dressed the wound was eroded by the criticism levelled against my work. I felt inadequate as the unexpected feedback caused me initially some stress.
- The patient's smile which I viewed as reassurance eased my troubled feeling and reflected the rapport we shared..

- My mentor reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality.
- Since the wound-dressing incident I have found that I am more aware of my actions when fulfilling my duties, constantly seeking to justify my actions and underpin these with theoretical knowledge. I spend more time reviewing my work practice to determine the not-so-obvious consequences of my actions.

#### Researcher commentary

The individual student learning here is about practical learning, developed through understanding given by the mentor by increasing speed at a surgical wound site and its effect on the development of infection and how it can have far reaching effects. This highlights how a seemingly innocuous act such as not speedily dressing a wound can have grave consequences.

*For example*, the comments the *mentor* had made alerted the student to be conscious of his/her actions. The erosion of the confidence due to the criticism levelled against the student's work can lead to *feelings* and *emotions* such as anxiety due to nervousness, inadequacy and due to the unexpected nature of the feedback may cause stress. This can lead to a loss of concentration and poor performance perpetuating further anxiety. Yet, due to the conduct of a good *mentor* the student learned to be responsible thus enhancing the student's ability to direct actions *professionally* and confidently. The *mentor* reinforced important issues by emphasising how infection to bone tissue was difficult to cure and increased the patient's prospects of morbidity and mortality.

The patient's smile given in the story also contributed to the student not losing confidence in their own abilities, as the question from the mentor was given correctly and was viewed as reassurance, which eased any troubled feelings the student may have. It also showed a rapport between the *patient* and the student which they shared at that moment. The fact that the student had given the patient adequate care and consideration to minimise distress that may be caused by pain during the dressing procedure was demonstrated.

In this story there are learning processes that are imprecise and at different stages of a larger progression in the students accumulation of learning through time, which they are all embedded in the many other student's stories yet unwritten. This student's story of their individual learning implicitly captures aspects of the learning that has taken place, but what it also shows is how the story can be expanded to reveal more.

*For example*, the student described that if the *practice* of wound dressings was not dealt with in a timely manner infection could set in. By undertaking the dressing a hospital acquired infection (HAI) was prevented, if MRSA sets in, the patient may require an extended hospital stay, occupying much needed hospital beds. By adhering to the hospital *infection control policy* a source of infection to careers and other patients is avoided. The *mentor* influenced student's practice and showed how support of clinical staff is vital, by giving a rationale, using *theory*, emphasising how 'this sort of infection in a limb if it is allowed access can lead to amputation'. This too will necessitate prolonged hospital care and if mobility is compromised pressure wounds could set in compromising and distressing the patient further.

In addition, the story reveals greater meaning and significance for the patient for amputation will influence their *social*, work and home life; specifically *family* dependants of the patient who may be devastated if the infection resulted in the patient's death. There is the significance of potential *legal* costs to the hospital if found to be negligent increasing the financial burden on the NHS trust's funds resulting in *political* influences such as reduced or loss of services, staff or even hospital closure.

The student connected with the patient through her *previous experience*, the patient trusting his or her ability to undertake the dressing and in his or her knowledge of *theory* when s/he answered the mentors question correctly. It is through the *practical* interventions we undertake for patients and interactions because if it that we come to provide what matters to patients. When thought of in this way, conceivably it is the *interactions* with patients in practice that sustains students as they learn and enter nursing practice.

## Appendix 14 – Descriptions of analysis through time

Through time elements	Interpretations of learning through time
Past	If the student detailed accounts in their story or learning account about published documents, research, literature, policies I put it here. If the past tense was used e.g. 'when I worked', 'past experience' or 'previous knowledge', 'I recalled', 'I have encountered', 'past incidences' or 'previous placement'. In addition, if the student was looking at a patient's past medical history.
Present	If the story or learning account detailed areas that were happening now e.g. 'at the time ', 'when the story took place', 'I was', 'I felt, 'knew the signs of' or 'with the help of' I put it here.
Future	If the student detailed how their learning would influence 'future care' or used terms such as 'in the future' or 'do further' 'expanded', 'if the situation arises again', 'I need to gain', 'I realised' or 'similar concepts I put it here.

## Appendix 15 – Temporal analysis: learning through time

The excerpts from the student stories and learning accounts (given in brackets) can be cross referenced to the data given in Appendix 4 (given in italics).

### 15.1 - Analysis through time 2<sup>nd</sup> year adult

Temporal element	Student learning account excerpt
Looking backward	<ul style="list-style-type: none"> <li>• I realise also that my actions e.g. body language and ineffective communication skills may have contributed to what happened in this situation. (A9)</li> <li>• Unprepared to give the next shift a nursing hand over, assumed mentor would do it as my previous shifts, asked me to do it last minute (A16)</li> <li>• How PMH and knowledge of it can affect nursing interventions. Questioning in practice to patients to obtain a history needs to be at a level they can understand (A21)</li> <li>• ....and as we spoke she would recall her family, she told me her husband John and how he had passed away shortly after they married, she seemed happiest at these times talking about her past. (A50)</li> <li>• Out on placement I had many experiences that I learned from. (A54)</li> </ul>
Present	<ul style="list-style-type: none"> <li>• This patient was not one of my allocated group of patients, but I could see the nurse who had been allocated was busy with another patient, so I agreed to escort the patient. I checked to make sure all the documentation was present and proceeded to theatres. Students have to overcome many barriers to learning, nurses are responsible for their own learning and must be able to adapt to certain situations (A2)</li> <li>• Whilst on placement in A&amp;E I had the opportunity to transfer a patient I had been looking after to the ward nurse. The nurse not listening to my hand over made me feel inadequate and they did not want to listen to me because I was a student nurse. The nurse not listening to me made me fumble around with the notes, I felt quite foolish, did not present myself as confident and garbled my words (A9)</li> <li>• My direct involvement in clinical practice has given me a clearer view of the importance of documentation as a form of communication and as a basis for verbal handover reports to ensure effective continuity of nursing care (A10)</li> <li>• I was courageous to break into this circle, as a great physical and mental effort was involved. My feelings are symptomatic of the power-struggle that exists between doctors and nurses (A12).</li> <li>• What is heart failure physiology behind it, incidence in elderly people, complications of it and the formation of leg oedema and its relationship to the development of leg ulcers? Leg ulcers, healing process, effects on lifestyle, management of leg ulcers, economic burden of managing these patients (A13)</li> <li>• Obtaining information / records from elsewhere when not available and gaining patient consent to do this (A14).</li> <li>• Beginning to work independently within a supervised environment. I panicked and got information mixed up, became flustered clear I was out of my depth, my mentor took over (A16).</li> <li>• The use of the ECG was non-invasive do no harm only good. Can be assertive in situations that require it. Learning to take cues of others who know the person better (A18).</li> <li>• In some clinical areas such as A&amp;E the students are caring for patient go in blind as a PMH cannot always be available and difficult to care and priorities in these situations (A21).</li> <li>• I was initially quite concerned that I did not know enough about cancer and that most of these patients were severely ill. I learnt much about their successes in</li> </ul>

	<p>life, about their families and also, sadly, about their worries about how it would all end (A33).</p> <ul style="list-style-type: none"> <li>• I learnt patience, compassion, adaptability and communication skills. (A33)</li> <li>• This story left me emotional fatigued with emotional and physical exhaustion that I felt this story had left behind in me, in was however both challenging and rewarding (A44)</li> <li>• I asked her how she was now feeling and she replied that she was fine, almost unaware of why I was asking. Eileen enjoyed having her nails painted. When the patient told me that I did not care for her I was distressed, but knew this was part of her condition, and this knowledge helped me to understand. (A50)</li> <li>• After 3 hours the patient was still waiting becoming more and more nervous by the minute. Everyone was very cold, and when I asked how long until this patients turn and quite rude. Although I was reassuring the patient as much as I could. (A54)</li> </ul>
Looking forward	<ul style="list-style-type: none"> <li>• Taking the whole experience on board to ensure it did not happen again, updating myself with regards to patients going to theatre, read patients notes before taking a patient to theatre, so I had a better and broader understanding of the procedure they are having done. That I can take negative criticism and not like it but that I can learn from it in a positive way and something good can come out of it. Should not be judgmental in how the nurse managed the situation, he was trying to teach me to become a better nurse for the future. Evaluate self, take further action to update learning from the experience (A2)</li> <li>• My weaknesses in communication, I need to improve future communication and support other health care professionals as much as possible, seeking help when necessary (A9)</li> <li>• If the situation arose again, my action would be to document care provided as soon as possible after its provision to avoid omissions and therefore be able to communicate it to other members of staff. I would also ensure to ask questions and read patients' notes and other forms of literature that would help me understand the patients' condition and consequently prioritise the nursing care I would give to them. (A10)</li> <li>• I feel I have learned from this experience; discovering my deficit of medical knowledge which limited my input in the team. This has enabled me to reassess my learning needs. (A12)</li> <li>• I need to gain confidence in verbal office hand over, look at various nursing journals, plan how to give hand over, write down all the information I want to convey, yet this can lead to a heavy reliance on my notes and just reading them out. To learn I need the back up of nurses with useful experiences to provide me with support and guidance for the future, knowledge and back up of a qualified member of staff. (A16)</li> <li>• Patient contacted me 2 days later and thanked me for the care she received (A18)</li> <li>• I realised that I need to take responsibility for my own learning and state my own learning needs clearly and inform all members of staff myself. Assertiveness in relation to my own learning needs (A23)</li> <li>• Not being able to follow up the patient and find out how he did due to confidentiality and too far for me to travel into London to enquire (A27)</li> <li>• I learnt basic nursing skills which will always be useful to me in my nursing career. The most important conclusion is that I feel that what I learnt in communicating with and assisting these very ill and often dying patients will be invaluablely useful to me during my future ward placements. (A33)</li> <li>• I feared this would distance me from the suffering of patients in the future and disengage from the patients and families I cared for. I can transfer these specialist skills to other areas where I practice using it in future care and placements and throughout my career (A44).</li> <li>• This story has made it apparent to me that an individual may come across as aggressive or unfriendly, but this does not necessarily what they mean to do. The patient may be scared and vulnerable or they may act in certain way</li> </ul>

	<ul style="list-style-type: none"> <li>• because of a condition. As I nurse I realise that nurses need to take into consideration all factors which may influence a person's behaviour. (A50)</li> <li>• Sharing these experiences with others not only made me realise that I'd learnt from it but also enlightened others on the lessons learned. (A54)</li> </ul>
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## 15.2 - Analysis through time 3<sup>rd</sup> year adult

Temporal element	Student learning account excerpt
Looking backward	<ul style="list-style-type: none"> <li>• I looked back at the literature and found that HIV is not transmittable through splashes of shower from the patient although effective measures like wearing of aprons and gloves should always be maintained. (A21)</li> <li>• Some kind of recollection of a person similar to her, a year previous who had done the same thing (A23)</li> <li>• The knowledge that informed my decisions were my need to be aware of the possibility of gastrointestinal haemorrhage, wound infection, pneumonia, pulmonary embolus (because she could not wear TED stockings) and prolonged nausea or vomiting. (A33)</li> <li>• Offering her support and reassurance by utilising the interpersonal skills I had mastered during my training (A34)</li> <li>• A previous placement on a cardiac care unit had given me some understanding of cardiac rhythms and I was concerned that this symptom could have stemmed from electrolyte imbalances and was entirely treatable. (A39)</li> <li>• Looking back and analysing the situation made me realise that managing patient care is more complicated than I thought. There was so much to consider, as patients should always be seen as a whole and healthcare professionals should not just concentrate on one issue. (A40)</li> <li>• When I worked in theatre, this risk had been accentuated and the need for aseptic techniques in carrying out procedures was stressed over and over again (A51)</li> <li>• S had severe cerebral palsy with contractures. (A52)</li> </ul>
Present	<ul style="list-style-type: none"> <li>• I was caring for two patients as part of my management 3<sup>rd</sup> year module. The doctor prescribed a nebuliser as predicted, but I did not know how these drugs worked, I knew they were often prescribed for difficulty in breathing e.g. COPD patients (A17).</li> <li>• Being a third year student, I was allocated with three patients to manage their nursing care for the entire shift although I was supervised by my mentor. Being responsible for the nursing care management of the above three patients, I started the shift by checking their vital signs (A21).</li> <li>• I was pleased that the patient felt more comfortable due to my care (A33).</li> <li>• My prompt action resulted in my patient being transferred to the specialist cardiology unit (A34).</li> <li>• This incident posed a greater challenge by extending my clinical practice beyond its normal confines, contributing to my continued learning (A35)</li> <li>• He was totally bed-bound and had been admitted to our ward awaiting reinsertion of his jejunostomy which had accidentally come out. (A52)</li> </ul>
Looking forward	<ul style="list-style-type: none"> <li>• I wished I had asked the doctor to show me what he was listening for so I could have identified a wheeze again when I saw a patient with asthma (A17).</li> <li>• In the future I will care for infected patients like any other patients but I will always adhere to the infection control policy of the unit. If this situation arises again I will check in the BNF to clarify doubts. (A21)</li> </ul>



	<ul style="list-style-type: none"> <li>• I would like one day to be able to work in the emergency department as this is what I think I would like to do (A23)</li> <li>• It was important the doctor was told he had possibly splashed acid in his eye because delayed irrigation allows further penetration of the chemical. This could have resulted in John sustaining ocular damage, which would have had profound effects on his visual prognosis, lifestyle and self image, yet most damage caused by acids happens immediately after exposure. Identified learning needs: <ul style="list-style-type: none"> <li>○ Develop confidence in own abilities</li> <li>○ Become familiar with medical terminology surrounding ophthalmic</li> <li>○ Gain experience in handing over patients to other members of the care team</li> <li>○ Become more assertive</li> <li>○ Develop body language skills (A32)</li> </ul> </li> <li>• Obese patients are at high risk of wound dehiscence and slow wound healing because of poor blood supply to adipose tissue. Helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development (33)</li> <li>• My limited knowledge of bradycardia and the causes of it have encouraged me to do further reading (A34)</li> <li>• This experience has had a huge effect on my own management skills (A34).</li> <li>• The incident has, however, developed to some degree my creative problem solving skills, allowing me to transfer those new skills to similar situations, and expanded my clinical abilities to enhance the quality of care I deliver to future patients. In similar situations I should no longer doubt my ability, but consider the aspects of my nursing abilities and complement those tasks performed by my colleagues (A35).</li> <li>• If this situation arose again, I would try to be more confident in myself and I would be more aware of my facial expressions to prevent anxiety for the patient. I have gained a new perspective on my practice which is to set myself personal goals in facilitating effective communication between the patient and myself (A40).</li> <li>• This was another experience which led to my decision to head into palliative care in my nursing career. (A44)</li> <li>• Having this knowledge will enhance my confidence enabling me to work faster and more professionally. (A51)</li> <li>• Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own.</li> </ul>
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### 15.3 - Analysis through time 3<sup>rd</sup> year child

<b>Temporal element</b>	<b>Student learning account excerpt</b>
Looking backward	<ul style="list-style-type: none"> <li>• The child had been previously admitted with severe hydrocephalus, this could be defined as excessive cerebrospinal fluid within the skull. Resulted from a congenital condition and was one problem amongst many that this child was suffering from. It had already been decided that the child's condition was terminal. The child was a frequent patient on the ward and the family was well known by all members of staff on the ward including myself. (C1)</li> <li>• The child had profound learning difficulties and hypomelanosis of Ito a severe neurological impairment, which is a condition that is distinguished by a lack of skin colour (hypopigmentation) effecting many areas of the body. The child had severe epilepsy and was admitted to the ward for frequent, prolonged, uncontrollable seizures, treated with an infusion of Phenobarbitone via a</li> </ul>

	<p>subcutaneous infusion line. I used my previous knowledge of wounds to monitor the site of the gastrostomy. Previous knowledge influences care. (C2)</p> <ul style="list-style-type: none"> <li>• Look after a 10-month-old baby who had been admitted the previous evening with a chest infection. Reference made to The British Thoracic Society (2007) - any child with an oxygen saturation level of less than 92% requires immediate administration of oxygen either via nasal prongs or a mask. Referred to statistics each year 600,000 children under the age of five have an accident as a result of neglect by parents or carers. Referred to The Department of Health National Service Framework for children 3.5 (DoH 2003) acknowledges that children and their parents can only participate fully as partners in care if they have access to accurate information that is valid, relevant, up to date, timely, understandable and developmentally, ethically and culturally appropriate. (C3)</li> <li>• Once I was satisfied that the patient was stable I took a detailed history of the patient's present illness, past illnesses and normal routine including diet and sleep patterns. (C4)</li> </ul>
Present	<ul style="list-style-type: none"> <li>• Time management is extremely important when caring for any patient however; when the patient is terminally ill it is extremely difficult to manage your time. (C1)</li> <li>• With the help of the patient's mother I carried out the personal care needs of the patient in the morning. The patient was completely dependent on the care of her mother who stays with her on the ward during most of the day.</li> <li>• Hourly monitoring of pulse, respiration, oxygen saturation and blood pressure, record of seizures and type the child was having. Because of knowledge in the past knew the signs for infection fever, redness, swelling or hardening around the site. (C2)</li> <li>• The need to consider the other patients that I had responsibility for and prioritise my time towards them whilst ensuring patient safety at all times. (C3)</li> <li>• I ensured safety was maintained at all times by basing my care on evidence based practice. My clinical decisions throughout the day were based on what was best for the patient, whilst also ensuring I equally met the needs of my other patients and families. (C4)</li> </ul>
Looking forward	<ul style="list-style-type: none"> <li>• We did not know how long the child would live for. (C1)</li> <li>• If I was managing the care of a dying child in a similar situation to this one I would handle the care of this child in a similar way to the way that I handled the care of this child. I would continue to involve the family and the child, if appropriate in the management and delivery of care. I would also continue to seek support and guidance from fellow members of the team. (C1)</li> <li>• Reduced oxygen levels can cause cell death, with the risk that the child will proceed to respiratory and subsequently cardiac arrest – by knowing this prevented it from happening. (C3)</li> <li>• From this experience I have learned that I am capable of managing my own workload. This exercise has emphasised the importance of prioritising care, safe practice, working as part of the multi-professional team, providing needed health education. (C4)</li> </ul>

#### 15.4 - Analysis through time 3<sup>rd</sup> year mental health

Temporal element	Student learning account excerpt
Looking backward	<ul style="list-style-type: none"> <li>• Mental Health Act Code of Practice (MH1)</li> <li>• Zero tolerance towards violence in all health care settings (MH1)</li> <li>• Past incidences e.g. David Bennett 2003 ruled that local authorities had rights to formulate local policies in best interest of patient (MH1)</li> </ul>

	<ul style="list-style-type: none"> <li>• Reference made to the zero tolerance campaign influenced this patient's care in the present and others in the future. (MH1)</li> <li>• NHS crisis resolution teams were set up following the NHS plan in 2000 to offer immediate response to mental health crisis. A crisis resolution means responding rapidly to and supporting adults, who are experiencing a severe mental health problem that might lead to hospital admission. The primary function is to maintain the service user's community tenure, through home focused assessment, support and short-term treatment and therefore avoiding unnecessary hospital admissions. (MH3)</li> <li>• The background information related to restraint is that it requires at least 3 members of staff, believed to restrict diaphragm motility in obese patients and contributes to deaths during restraint. (MH4)</li> </ul>
Present	<ul style="list-style-type: none"> <li>• According to the Mental Health Act Code of Practice, the use of seclusion is neither for the purpose of meting any punishment nor suitable where the patient has any risk of suicide or self-harm. (MH1)</li> <li>• Past influences the present practice in restraint (MH1)</li> <li>• Planned to keep a journal to record incidents that evoke soul searching reflection (MH1)</li> <li>• Patient thought I was messing it up for him and I should stop smirking at him. (MH2)</li> <li>• Patients under home treatment care are visited at their homes throughout the day. Depending on the need they may be visited once or twice a day. The frequency of visits is determined by the severity of the illness or crisis. (MH3)</li> <li>• Police and ambulance staff had to be called to assist to gain entry into patient's house as staff from home treatment had failed to gain access. Assistance had to be summoned. (MH3)</li> <li>• Patient declined to take his medication, which was part of his treatment stating that he did not mean it (MH3)</li> <li>• Depressed patients have a potential for suicide, and suicide prevention was at the top of our agenda. (MH3)</li> <li>• Continuous observations from outside the seclusion room. Every 2 hours nursing staff reviewed whether James had calmed down enough to end the seclusion. (MH4)</li> </ul>
Looking forward	<ul style="list-style-type: none"> <li>• Improving and developing professional behaviour. (MH1)</li> <li>• Increase in my abilities and a greater awareness of the complexity of nursing practice (MH1)</li> <li>• Eliminate the use of seclusion in the future (MH4)</li> <li>• Challenging the process of restraint in practice and the idea of seclusion (MH4)</li> <li>• Physical intervention should be avoided in the future. (MH4)</li> <li>• Help with violence management if the problem occurred again. (MH4)</li> <li>• Using de-escalation as the preferred method of managing violence (MH4)</li> <li>• Need to improve clinical judgement skills read more about teamwork and partnership</li> </ul>

### 15.5 - Analysis through time post graduate students

Temporal element	Student learning account excerpt
Looking backward	<ul style="list-style-type: none"> <li>• What is an ultrasound Doppler assessment why undertaken, non-invasive evaluating ulcerated limbs (PG1)</li> <li>• Determination of the API systolic pressure in the ankle is divided by the systolic brachial pressure, resulting figure indicates the presence of either venous insufficiency or of arterial impairment (PG1)</li> </ul>

	<ul style="list-style-type: none"> <li>• If ABI less than 1.0 it is unsafe to use compression bandaging as it indicates arterial impairment (PG1)</li> <li>• RCN continuing education articles on arterial and venous ulcers (PG1)</li> <li>• I read a chapter on social isolation, which is defined in the nursing literature as 'aloneness experienced by the individual and perceived as imposed by others as a negative or threatening state'. The chapter refers to social isolation of the elderly contributing to worsening health, leading to further isolation, unless this can be relieved (PG4).</li> <li>• Read a report related to this on the use of wholemeal bread versus laxatives. The study showed that over a 4-month period of media marketing of brown bread, its sales went up by 60%, and the sales of laxatives went down by 60%. This method of promotion was proved to be more effective than patient education by doctors. It also states 'it is now well accepted that increased fibre in the diet is a better way of preventing constipation than the use of laxatives' (PG6)</li> <li>• Eventually the old notes came which highlighted that she had been administered metoclopramide the day before as a TTA, which meant it had been dispensed from us as pharmacy would not have been open at that time of night (PG14).</li> <li>• Had I not previously remembered stories from my previous practice, I may not have recognised it (PG14).</li> </ul>
Present	<ul style="list-style-type: none"> <li>• Spent half an hour learning to use the new Doppler machine with colleagues, looked up and read the history of the Doppler and advances in the present day use in the following: <ul style="list-style-type: none"> <li>○ Leg ulcers – incorporated a practical guide to management</li> <li>○ Assessment of the lower limb (PG1)</li> </ul> </li> <li>• Performed Doppler assessment with the G grade sister supervising on patient with ulcerated ankle, the ABI was 1.21 indicating venous impairment. A compression bandage was applied. (PG1)</li> <li>• Contraindicated in diabetes and rheumatoid arthritis (PG1)</li> <li>• Conflicting problems when testing leg ulcers, each case as individual (PG1)</li> <li>• Other agencies that patients are referred to on a regular basis (PG2)</li> <li>• Identifies the extent to which patients need help to achieve maximum independence and to maintain an acceptable quality of life. (PG2)</li> <li>• More alert to individual needs and can now provide necessary information to patients being barrier nursed in this way (PG4).</li> <li>• What benefit is, who qualifies, exceptions, rates of pay, method of payment, rates for special rules (PG5)</li> <li>• This is not a means tested allowance and so people can apply even if they are well off and are available to everyone over 65 who need help and personal care (PG5)</li> <li>• A sensitive approach to the subject (PG6)</li> <li>• I learned about the importance of practising within protocols, guidelines, recommendations and the law, to not prescribe outside of this (PG7).</li> </ul>
Looking forward	<ul style="list-style-type: none"> <li>• Doppler is used on a variety of patients and new equipment and advanced equipment continue to be developed (PG1)</li> <li>• Continue to evaluate and improve services to patients and relatives when newly discharged from hospital (PG3).</li> <li>• What it means to a person to be socially isolated, and the effect it can have on health (PG4)</li> <li>• How extra money can improve quality of life for a person who is sick or disabled. It may ease the burden on a spouse who may have been struggling to care for their loved one, and whose own health may have been put in jeopardy (PG5).</li> <li>• It has helped me to adapt the way in which I manage the psychological needs of a patient experiencing a miscarriage and improved my ability to manage future patients more effectively and holistically (PG12)</li> </ul>

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|  | <ul style="list-style-type: none"><li>• I am hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries, to prevent confusion over the most appropriate dressing, and the importance of not changing the dressing too frequently (PG13).</li></ul> |
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**Appendix 16 – The descriptions used for the inclusion of the process of learning**

<b>Continuity</b>	<b>Interpretation</b>
Pre-narrative	The story itself
Remembering	Importance or significance of the story to the individual, appreciate the story for some reason.
Writing / recording	Documentation of the story, or communication of the patient's condition or interaction, recording.
Sharing	Working well together, quality, reflection, emotions
Learning from story	An intention, consequence, a resolution / end or resolve, improvement, guidance.

## Appendix 17 - The process of learning analysis

### 17.1 – The process of learning analysis 2<sup>nd</sup> year adult

The process of learning from story	Student learning accounts
Pre-narrative	<ul style="list-style-type: none"> <li>• A member of staff asked me about the procedure the patient was undergoing, I replied I was not sure and went to check the patient's notes. He then said in a sarcastic manner that as a student nurse I should know what the patient is going to theatre for and the type of procedure to be performed (A2).</li> <li>• This is an incident that I was involved in during my clinical placement at a nursing home. A 95 year-old lady came in with a leg ulcer in her leg. The patient was complaining of tiredness and thirst. She did not eat much or drink. During her stay at the nursing home I was assigned with the help of the staff nurse to draw up a food and liquid chart and monitor it to check on her food and liquid intake (A13)</li> <li>• I felt it was my mentor role to facilitate this process and she was not able to fully relinquish the charge of the patients to me and just supervise or be there for me when I needed her. She did not confirm with other members of staff that I was managing this patient today. This was invariably leading to confusion with other staff who continued to give me tasks to do while I was trying to learn holistic practice. This culminated in a situation whereby I lost contact with what was happening to my patient and so my mentor took over. This could have been avoided (A23).</li> <li>• I was travelling in a blue light ambulance through the centre of London and it was exciting (A27)</li> </ul>
Remembering	<ul style="list-style-type: none"> <li>• Other nurse acting superior, excuses for his arrogance. Should not be judgmental in how the nurse managed the situation. A member of staff asked me about the procedure the patient was undergoing, I replied I was not sure and went to check the patient's notes. He then said in a sarcastic manner that as a student nurse I should know what the patient is going to theatre for and the type of procedure to be performed. (A2)</li> <li>• Ineffective / weakness in communications skills (A9)</li> <li>• On reflection I believe this frustration was also met with a feeling of isolation and loneliness, being outcast from the group and feeling undervalued. I feel reassured that my feelings of inferiority are shared amongst nurses, particularly during ward rounds owing to the dynamics of the MDT (A12).</li> <li>• When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence. (A16)</li> </ul>
Writing / recording	<ul style="list-style-type: none"> <li>• Taking notes, can mean information is incorrectly passed on (A9)</li> <li>• Documentation as a vital source of communication. Organisation of written documentation, forgetting details and information (A10)</li> <li>• The significance of accurate documentation in clinical settings (A14)</li> <li>• Writing down the story also helped with my thoughts and to clarify what my current state of thinking is about a subject (A36).</li> </ul>
Sharing	<ul style="list-style-type: none"> <li>• Credit my action; implying I was courageous to break into this circle, suggesting a great physical and mental effort being involved. Retrospectively I felt empowered (A12)</li> <li>• Sharing these experiences with others not only made me realise that I'd learnt from it but also enlightened others on the lessons learned. Gaining others views on the situation lets you see other perspectives and helps you learn from all angles and not just from your own. (A54)</li> </ul>

Learning from story	<ul style="list-style-type: none"> <li>• Critical thinking is an educational need to allow students to use independent judgement and evaluation. Evaluate self take further action to update learning from the experience (A2).</li> <li>• It seems my negative feelings were affecting my self-esteem. My inclusion is crucial to function as the team and 'feel included'. The power-struggle that exists between doctors and nurses (A12).</li> <li>• To learn I need the back up of nurses with useful experiences to provide me with support and guidance for the future, knowledge and back up of a qualified member of staff. Improved my ability to reflect on practice experiences as an important step in professional development, support others and increase my knowledge of issues surrounding patient hand over. The use of questioning to improve my knowledge and understanding (A16)</li> <li>• The best lesson learned was being proactive is the best way to deal with complaints or incidents and it forced me to face this uncomfortable facts about my workplace and myself and carrying with me the lessons learned from this story, especially communication between HCP, in a productive, professional manner to sort out the problem faced. It was an important learning curve for me to observe how my mentor took control of the situation and brought it to a successful conclusion diplomatically (A36).</li> </ul>
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## 17.2 – The process of learning analysis 3<sup>rd</sup> year adult

The process of learning from story	Student learning analysis
Pre-narrative	<ul style="list-style-type: none"> <li>• I was involved in the care of a patient brought in by the police from the Samaritans where she had been found, there was no name of the patient and the police could not at the time find a name for her, she had taken an overdose thought to be crack cocaine, this patient upon arrival was not conscious her Glasgow coma scale was 3/15 (A23)</li> <li>• Most of the nurses wanted to change from working 8-hour 'earlies' and 'lates' to 13.5-hour shifts (A30).</li> <li>• A 43 year old lady brought in by ambulance with respiratory failure, due to excessive alcohol consumption. The ambulance crew advised that there was the possibility she had taken an unspecified amount of sleeping tablets (A35).</li> <li>• Once the hand over was completed I was left alone, I mentally took a step back and realised the patient had many aspects of care that needed to be considered. Just from looking at the patient, I could see that the patient had a CVP, and central line, she was fed via a naso-gastic (NG) tube, the patient was diabetic with a syringe driver of Actrapid insulin running, and was being given regular nebulisers to help her breathing (A36).</li> </ul>
Remembering stories	<ul style="list-style-type: none"> <li>• The clinical area where this learning experience took place is an adult ward, a haematology unit that cares for patients with blood disorders (A21).</li> <li>• Although the patient appeared to be unconscious I had stayed with her the whole time and was reassuring her that everything was going to be OK by talking to her and generally given her nursing care for example taking her neurological observations. I had felt a bit out of my depth in the resuscitation room. Wondered how her parents would be feeling, as I am a parent myself (A23).</li> <li>• It then became apparent that there had been some serious miscommunication on my part. I felt out-of-my depth when John presented to us because I had never been involved in the care of an ophthalmic patient. I felt apprehensive, I lacked confidence in myself and felt intimidated by the doctor due to our unequal power relationship, I felt nervous about using medical terminology such as 'ophthalmic' because I thought I would sound stupid if I pronounced them</li> </ul>



	<p>wrong. I find it difficult to look back at the incident without questioning my abilities as a student nurse, but this encourages expression of such negative feelings because this determines why the situation sticks in our mind (A32).</p> <ul style="list-style-type: none"> <li>• I was 'available' and concerned for her care, the nurse-patient relationship is central to nursing; I was initially concerned about my lack of managerial experience (A33).</li> <li>• My feelings were of concern for my patient as she had become clinically unstable (A34).</li> <li>• I had mixed feelings when asked to assist in Sarah's care. This being my second day in that department, I was unfamiliar with its staff and procedures. I was excited, but also apprehensive about the task, not because it was outside of my experience. I was daunted by how busy it was and although team members performed their tasks calmly, it was extremely noisy. Helping Sarah identify her excessive alcohol consumption was a contributing factor to the day's events. I obviously lacked experience relating to the advanced nursing practice conducted within that specialist area. This impacted on my decision-making skills and made me doubt my own ability, even though the tasks were well within my clinical experience. Engaging in reflection can in fact lead to self-doubt. (A35)</li> <li>• My feelings of guilt (A38)</li> <li>• I felt relieved and even a little proud (A39).</li> <li>• I felt very excited and intrigued when my mentor told me that I was to look after the patient and give all the necessary care. At that point I had observed and assisted my mentor for two days, my mentor felt confident that I was competent to care for this patient. When I received the handover I was surprised at how much of the information I understood and could relate to, which gave me confidence. I also felt confident assessing the patient and taking the Laryngeal mask out, as I had previously had opportunities to practice these skills. The emotions I had gone through in this particular situation ranged from excitement, nervousness, fear, and uncertainty but finally confidence. This experience has shown me that I can achieve more than I initially thought I could (A40).</li> <li>• Since the wound dressing incident I have found that I am more aware of my actions when fulfilling my duties. (A51)</li> </ul>
Writing / recording stories	<ul style="list-style-type: none"> <li>• Documentation and communication I was thinking it was my responsibility to provide information (A21).</li> <li>• Supervision helps others maintain a safe and effective quality care (A23).</li> <li>• This situation availed me with valuable experience in the form of development of my interpersonal and inter-professional skills (A35).</li> <li>• While writing this I have been able to re-examine my story thoroughly (A40).</li> <li>• I carefully removed the old dressing, using the aseptic technique; I cleaned the area adjacent to the wound using saline solution and sterile swabs. As I wiped the area close to the wound my mentor, who had been unobtrusively watching me, suggested I carry out the procedure more speedily which I did. (A51)</li> </ul>
Sharing	<ul style="list-style-type: none"> <li>• It is sometimes difficult to learn about one particular thing as often practice is sometimes a mess and there is mayhem, and drawing learning from it is difficult (A17).</li> <li>• The nurse should pass information about the patient to other staff in the ward and the multi-disciplinary team to help create a supportive network that will work together to better the health of patients (A21).</li> <li>• The communication of the team was brilliant during this time no one felt out of place everything was going according to plan, communication is essential for all the team involved and clearly it was in this circumstance (A23).</li> <li>• I then took the notes to minor injuries and gave a verbal hand-over to the on-call doctor (A32).</li> <li>• Practitioners can come together to identify solutions to problems, increase understanding of professional issues and, most importantly, to improve standards of care (A38).</li> </ul>

	<ul style="list-style-type: none"> <li>• Afterwards, I discussed the situation with my mentor and told her about my thoughts and feelings that I had whilst managing Mrs Smith's patient care (A40).</li> <li>• I felt that I communicated well with other team members and with the patient verbally and non-verbally, and that I had reassured Mrs Smith successfully (A40).</li> <li>• Whenever I feel down or when something bad happens in my life, I think about S lying in a bed somewhere, and then see that life for some really can be a whole lot worse and it makes me feel better about my own. Nurses are not encouraged to respect value or trust our own stories and this is something that telling stories can teach us (A52).</li> </ul>
Learning from stories	<ul style="list-style-type: none"> <li>• Who has the priority in this situation – the rib pain patient could collapse as his condition could be very serious, whereas the asthma was equally distressed and needed interventions. I put a judgement on the priority of his care 'a time waster' in relation to his rib pain, not serious as opposed to asthma; despite I knew he could be serious (A17).</li> <li>• The management of patients does not take place in a vacuum as many things continue to go on around as you try to organise / arrange for the care of particular patients. My knowledge about dressings has improved. This aided me in helping me to increase my knowledge and understanding of the situation and the different ways of the interdisciplinary team work (A21).</li> <li>• I feel there is a lot more to be learnt. Wondered how her parents would be feeling, as I am a parent myself (A23)</li> <li>• She (mentor) was supportive and encouraging and allowed me to learn through supervised practical experience. This experience has been beneficial in terms of developing and increasing my self-awareness. I had to deal with the practical and physical problems caring for this patient, in particular moving and handling, the placement of her catheter (due to her enormous legs), and ensuring that sweat did not accumulate in the folds of her skin. This story writing experience helped me to focus on my thoughts and emotions during and after the experience and to ensure continual professional development through critical reflection. (A33)</li> <li>• I felt nervous about requesting the help, but I now realise that it was necessary as it is impossible to accomplish all tasks by myself (A34).</li> <li>• Students are taught the importance of establishing a caring relationship with the patient, the involvement of active listening and the need to respond with genuineness and empathy to promote trust and rapport. I realised the importance of teamwork and shared vision, essential for the smooth running of the department and contributing to patient care. This facilitates individual self-worth and value which are central needs in the workplace. Expert nurses, often base their decisions on experience and intuition, in addition to evidence-based practice. These additional dimensions enhance outcome and is beneficial to the patient (A35).</li> <li>• I have always found organisation difficult, and because of this, I try to over compensate for my difficulties by rigidly sticking to activities at set times (A36).</li> <li>• I feel that I have learnt more about myself and my nursing practice, the importance of team-working in providing enhanced care. I will ensure that I always use the skills of other healthcare professionals to assist me in the management and delivery of the best care for my patients. (A37)</li> <li>• The experience has enabled me to explore the meaning and significance of my clinical practice and to recognise the complexities within it. This experience prompted me to use my nursing knowledge and skills in order to care for the patient' (A38)</li> <li>• Assertiveness is a positive quality for a nurse to exhibit, a barrier to assertiveness is perceived lack of experience and knowledge (A39).</li> <li>• Nurses use their own judgement every day in practice and therefore they need to have the relevant background knowledge to do so. I was aware that nurses make important decisions every day and these have an effect on the patient's health care and the actions of the healthcare professionals. I am aware that in</li> </ul>

	<p>nursing practice, patient problems constantly arise and it is therefore important that nurses are able to solve clinical problems. My ability to priorities is also an important skill in nursing, and a skill deficit can have serious consequences for patients (A40).</p> <ul style="list-style-type: none"> <li>• My learning is that if wounds are not dealt with in a timely manner infection can set in; therefore, I as a practitioner would fail in my duty of care to the patient. If a hospital acquired infection (HAI) sets in, such as MRSA, the patient may require an extended hospital stay. The patient's social, work and home life will be affected; specifically dependants of the patient who may be devastated if that infection resulted in the patient's death. If I as the nurse or the hospital were found to be negligent the patient or patient's family could take legal action and seek recompense. The increased financial burden for the extra care, materials etc. or defending legal action can seriously affect the trust's funds resulting in reduced or loss of services, staff or hospital closure. The comments my mentor had made to me highlighted a need for me to focus on the broader picture. Since the wound-dressing incident I have found that I am more aware of my actions when fulfilling my duties. (A51)</li> </ul>
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### 17.3 – The process of learning analysis 3<sup>rd</sup> year child

<b>The process of learning from story</b>	<b>Student learning accounts</b>
Pre-narrative	<ul style="list-style-type: none"> <li>• Admitted to the ward with severe hydrocephalus (C1)</li> <li>• The patient had severe epilepsy (C2)</li> <li>• I was working on a children's ward and had been asked to look after a 10 month-old baby who had been admitted the previous evening with a chest infection. (C3)</li> <li>• I undertook the admission of a patient with suspected bacterial meningitis. I then proceeded to care for this patient throughout the remainder of the day. (C4)</li> </ul>
Remembering	<ul style="list-style-type: none"> <li>• Admitted to the general paediatric ward for tender loving care following increased severity of congenital hydrocephalus ..... caring for a terminally ill child. (C1)</li> <li>• Frequent, prolonged, uncontrollable seizures, which were being treated with a continuous infusion of Phenobarbitone. (C2)</li> <li>• The child was attached to an oxygen saturation monitor and required regular nebulisers throughout the day. As the child's saturation was quite low I decided it would be best to prop the child up in the cot..... I explained to the child's mother the reasons..... The child's mother's English was limited, but as soon as I left the child the mother removed the pillows. (C3)</li> <li>• Worked the care of this patient around the care of two other patients that I was caring for. I believe my role was very important in the assessment, treatment and monitoring of the patients and also in supporting the family. (C4)</li> </ul>
Writing / recording	<ul style="list-style-type: none"> <li>• .....read the child's notes and felt well informed about her condition. (C3)</li> <li>• The end of my shift I handed over this patient to the night staff via tape recorder, conveying all information about the patient and the care I had provided. Planning ahead and writing plans down is an efficient way to manage time and ensures important tasks are not overlooked. (C4)</li> </ul>
Sharing	<ul style="list-style-type: none"> <li>• The communication and teamwork ensured that the best possible care was provided to the child and his family and that all necessary information was shared between the necessary healthcare professionals to ensure safe practice for the patients on the ward. (C1)</li> </ul>

	<ul style="list-style-type: none"> <li>• I feel the support available whilst on this paediatric ward was extremely helpful and encouraged me to share my emotions and feelings with the team at the end of the shift. (C1)</li> <li>• It is essential to ask advice from other members of the multi-disciplinary team who may have input into the child's care. Shared concerns with the mother. (C3)</li> <li>• This experience has allowed me to consider personal feelings, how I would feel in the mother's situation. (C3)</li> <li>• Shared knowledge, skills and expertise with other members of the team for the benefit of the patient. (C4)</li> </ul>
Learning from story	<ul style="list-style-type: none"> <li>• Handling the care of this child gave me an insight into a different type of nursing care than the one I had previously experienced and participated in (C1)</li> <li>• I realise that I learnt a great deal about what is to be expected of me as a qualified nurse. (C2)</li> <li>• This will help me gain experience, confidence and help me to improve my management skills. (C2)</li> <li>• I feel I had gained knowledge of communication realising my interpretation was not as they were meant. (C3)</li> <li>• From this experience I have learnt that I am capable of managing my own workload. I believe this experience has highlighted my ability to manage my own patient load and has demonstrated that I am ready to make the transition from student nurse to newly qualified nurse. (C4)</li> </ul>

#### 17.4 – The process of learning analysis 3<sup>rd</sup> year mental health

<b>The process of learning from story</b>	<b>Student learning accounts</b>
Pre-narrative	<ul style="list-style-type: none"> <li>• Seclusion and containment of a patient. (MH1)</li> <li>• One morning I had the opportunity to coordinate a whole shift. (MH2)</li> <li>• I was attached to a crisis resolution and home treatment community mental health team. (MH3)</li> <li>• An area of practice experience that involved managing one patient for a whole shift on a forensic adolescent unit. (MH4)</li> </ul>
Remembering	<ul style="list-style-type: none"> <li>• The alarm sounded and a broadcast on the two-way radio system requested for assistance at one of the wards in the psychiatric unit. I had to hurry along to the distressed caller's ward. On arrival we found one of the nurses writhing in pain as he had been punched and kicked several times by one of the patients. Part of the members of the response team attended to the injured member of staff whilst the rest of the team promptly restrained the assailant in a well-rehearsed move. Student felt seclusion was morally indefensible as it defeated the essence of a therapeutic relationship. (MH1)</li> <li>• A patient asked me to look into his notes to see what the outcome of last week's clinical team meeting was. I took his notes and sat down in the office to look for the notes of which I did not see. I informed hi that I could not find the entry, he did not take it kindly and he became angry stating I was messing it up for him and I should stop smirking at him. I then said to him, I did not think I was and he started wagging his middle finger at me. I asked him to stop but he then stated that no one tells him what not to do. He then shouted obscenities at me and I terminated the conversation at that point. He continued to shout abusive language such that other nurses had to intervene. The nursing team agreed to send him to his room as his behaviour was distressing other service users. (MH2)</li> </ul>

	<ul style="list-style-type: none"> <li>• I was allocated a patient who had recently presented at A&amp;E having taken an overdose triggered by social stressors and recent bereavement (the loss of his grandmother). When we arrived Simon was very low in mood, stating feelings of worthlessness and indicating that he was better off dead than continuing to live. He began to cry during the visit. He wept uncontrollably and could not be stopped or consoled. He declined to take his medication, which was part of his treatment citing that he did not need it anymore. (MH3)</li> <li>• James had been presenting with command hallucinations and as a result, he became restless, agitated, aggressive and violent. His behaviour was so disturbed that the psychiatric restraining team had to be called. Physical intervention was exercised. Restraining management skills were then used. To avoid prolonged physical intervention, rapid tranquillisation together with seclusion was considered to help him calm down. A staff member was then allocated to carry out continuous observations from outside the seclusion room. (MH4)</li> </ul>
Writing / recording	<ul style="list-style-type: none"> <li>• This review was recorded in the patient's nursing record and seclusion documented. During the hour, we made documented and signed records of what we observed at intervals of fifteen minutes and sometimes less when the need to do so was identified. (MH1)</li> <li>▪ The restraining team demonstrated teamwork, inter-professional practice and record keeping as integral part of teamwork and help with violence management if the problem occurred again. It is important to document clearly the key issues. (MH4)</li> </ul>
Sharing	<ul style="list-style-type: none"> <li>• Trying to get the patient to express feelings can help identify accept and work through feelings even if these are difficult. (MH3)</li> </ul>
Learning from story	<ul style="list-style-type: none"> <li>• Prepared the student to face similar situations with confidence and professional maturity. Increase in the nurse's abilities and a greater awareness of the complexity of nursing practice. This will enhance knowledge, skills, values and attitudes necessary for safe and effective practice and also lay a foundation for continued professional development and lifelong learning. I have gained new perspectives to set myself personal goals that facilitate effective patient care that my eventually eliminate the use of seclusion. (MH1)</li> <li>• Increase the nurse's abilities and a greater awareness of the complexity of nursing practice. (MH1)</li> <li>• Conscious of the differing cultural background to mine, the different meanings gestures and intonation might have in different cultures. (MH2)</li> <li>• I learned that I probably was expecting too much of myself without recognising the limitations of my abilities and knowledge and taking into consideration that I was still undergoing training. I learned that the patient was lonely and isolated, took him for a drive and went with him to the community day centre. (MH3)</li> <li>• Made me want to critique the idea of seclusion. Eliminate the use of seclusion in the future. Increased self awareness and professional expertise provided an opportunity to examine practice and identify new knowledge. (MH4)</li> </ul>

### 17.5 – The process of learning analysis post graduate

<b>The process of learning from story</b>	<b>Student learning accounts</b>
Pre-narrative	<ul style="list-style-type: none"> <li>• I cared for a 75 year old woman who had her hernia repaired, after spending 3 days on the ward contracted MRSA in her wound and had to be placed in a side room for barrier nursing. (PG4)</li> <li>• Phoned the local benefits agency to ask for latest information on the</li> </ul>

	attendance allowance in particular and other benefits in general and since then I have become more aware of the disability living allowance for those who are aged under 65, who are ill or disabled as we have several patients who fall into this category. (PG5)
Remembering	<ul style="list-style-type: none"> <li>Spent half an hour learning to use the new Doppler machine with colleagues, looked up and read the history of the Doppler and advances in the present day use. (PG1)</li> <li>Assessment of a patient who is constipated, medical history, daily bowel function (PG6)</li> <li>A 15 week pregnant woman suffering from vaginal bleeding, suffering a miscarriage (PG12)</li> </ul>
Writing / recording	<ul style="list-style-type: none"> <li>Primary health care team meeting to discuss results of the audit, which is known as significant event audit. (PG3)</li> <li>I was hoping because of this story to be involved in the production of guidelines in our department for the management of minor burns injuries (PG13)</li> <li>After the consultation she documented her actions (PG7)</li> </ul>
Sharing	<ul style="list-style-type: none"> <li>Good communication between agencies involved in patient discharge from hospital starts before the patient leaves hospital.</li> <li>Continue to evaluate and improve services to patients and relatives when newly discharged from hospital. (PG3)</li> <li>I was sharing the experience with her, she was not alone, but I was not showing this to her. (PG12)</li> </ul>
Learning from story	<ul style="list-style-type: none"> <li>What is an ultrasound Doppler assessment why undertaken, non-invasive evaluating ulcerated limbs. Determination of the ABI systolic pressure in the ankle is divided by the systolic brachial pressure, resulting figure indicates the presence of either venous insufficiency or of arterial impairment (PG1)</li> <li>Other agencies that patients are referred to on a regular basis. The extent to which patients need help to achieve maximum independence and to maintain an acceptable quality of life. Began to function effectively in a team and participate in a multi-professional approach to the care of patients. The referral process to other agencies for patients to gain access to the correct agency for the needs of that particular individual (PG2)</li> <li>Be alert to current literature and research on the subject (PG3)</li> <li>What benefit is, who qualifies, exceptions, rates of pay, method of payment, rates for special rules. Allowance can be used to improve life style of the sick person, enabling them to go out occasionally or have a sitter so that their carer can be given a regular break each week (PG5)</li> <li>I learned how one particular story can have such a profound effect on me. I found I was struggling not to appear upset, holding back the tears, trying to act as a professional. However, by acting as a professional rather than a sensitive human being and not showing any emotion, I did not show the depth of my understanding and empathy. I learned it is not easy to incorporate the care of patient's physical needs but not so easy to consider their psychological and social needs as well. (PG12).</li> <li>I have gone away and researched minor burns and their management extensively and there is little evidence on the most appropriate dressing. The evidence that I found advocates the use of mefix in superficial minor burn management, but implied that it should not be removed for seven days, as it promotes a moist wound healing environment and should not be changed at least for the first 48 hours and very infrequently after that as frequent changes interrupts the wound healing process (PG13).</li> <li>I have learned to question, if unsure, all prescribed medications to patients as we are accountable for our actions. As a result of this incident, guidelines have been introduced for prescribing anti-emetics for children (PG14).</li> </ul>



## Glossary of Terms and Abbreviations

Term	Interpretation
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### A

Abdominal aortic aneurysm (AAA)	A balloon like swelling in the wall of an artery, which occurs in the abdominal aorta.
Accident and Emergency (A&E)	A specialist area of care that deals with life threatening conditions that require immediate medical attention.
Actrapid infusion	Actrapid is an artificial insulin, an infusion is given in uncontrolled diabetes
Adipose tissue	Cells of the body that contain fat.
Alzheimer's disease	A form of dementia, caused by a variety of disorders, most commonly structural brain disease.
Amputation	Surgical removal of a limb (arm, leg) or finger or toe
Anaesthetist	A specialist doctor who oversees respiratory function during an operation.
Analgesia	Broad term given to the group of drugs that relieve pain
Ankle pressure index	A measure obtained via a Doppler to determine patients' at risk of developing arterial leg ulcers.
Arterial blood gases (ABG)	Blood taken from an artery to determine a patient's acid base and so determine severity of a particular medical condition e.g. asthma, diabetes
Aseptic technique	A wound dressing that is performed in a sterile manner to prevent infection.
Ascites	An accumulation of fluid in the abdominal cavity, causing abdominal swelling. Usually observed in liver failure.
Asthma	Narrowing of the bronchial airways leading to difficulty in breathing and wheezing, precipitated by exposure to a wide range of stimuli.
Astrocytoma	Slow growing tumour of the glial tissue of the brain and spinal cord – a glioma
Atrial fibrillation (AF)	Fast chaotic irregular heart rhythm

### B

BiLevel positive airways pressure (BiPAP)	Non invasive ventilation, which requires external mask attachment.
Blood glucose level (BGL)	Blood glucose level – the measure of glucose (sugar) in blood to determine diabetes (high). Can be an indication of malnutrition or dieting if low.
Blood pressure (BP)	Blood pressure – the pressure in blood that ensures circulation throughout the body from the right side of the heart to the left.
Blood products	These are administered in hospital or emergency situation via the intravenous route to maintain blood pressure and body circulation.



## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Blood results	The blood contains a normal level of many of the body's waste products, electrolytes, proteins, haemoglobin, glucose required for normal body function. These can be measured and contribute to a personal diagnosis.
Blood transfusion	The introduction of blood into a blood vessel, replacement of lost or destroyed blood by compatible human blood.
BM Stix	A thin stick - when a small amount of blood is placed on it a reading will be given which reflects blood glucose level (see above).
Body Mass Index (BMI)	A measure using the formula $\text{weight}/\text{height}^2$ to determine a patient's propensity towards obesity or under nutrition
Brain stem dead	The brain stem is situated at the top of the spine and at the base of the skull, in serious brain injury if this fails to function the patient is termed brain stem dead.
Bradycardia	Slow heart rate, resulting in a slow pulse rate
British National Formulary (BNF)	A book giving all up-to-date information regarding drugs e.g. names, doses, side effects.

### C

Cancer	Any malignant tumour. It arises from the abnormal and uncontrolled division of cells that then invade and destroy the surrounding tissues.
Cardiac arrest	A state whereby the person's heart stops beating or fails to supply the rest of the body with blood.
Cardiomyopathy	Congenital disease of the heart not caused by a defect or hypertension, generally degenerative and can lead to serious arrhythmia
Cardiopulmonary resuscitation	Maintaining external cardiac and respiratory function through cardiac massage and artificial breathing.
Catheter / catheterisation	Insertion of thin tube into the bladder to facilitate patients to pass urine or to measure urine output.
Central venous pressure (CVP)	A measure obtained by placing a small catheter through a neck vein down into the right atrium of the heart.
Chemotherapy	Use of chemical agents to prevent the growth and spread a tumour. Related to the treatment of cancer.
Chest X-Ray (CXR)	Radiographic picture of the lungs
Chest pain	Type of severe pain between the ribs that generally radiates down the left arm – sign of a heart attack
Chronic obstructive pulmonary disease (COPD)	A chronic respiratory condition generally brought on by smoking. Includes two conditions chronic bronchitis and emphysema.

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Clotting factors	Manufactured by the liver and form a clot when blood loss is threatened.
Colonoscopy	Visual examination of the large bowel using a scope, to determine abnormalities of the lower intestines.
Colostomy	A surgical operation in which a part of the colon is brought through the abdominal wall and opened in order to drain the intestine. May be temporary or permanent.
Computerised tomography pulmonary angiography (CTPA)	Computerised tomography pulmonary angiograph – used to determine pulmonary embolism.
Confusion	A mental state whereby a patient may not know where or who they are, the time or date or recognise family or friends.
Congenital condition	A baby is born with a condition or disease either genetically acquired or damage occurred while in the mother's womb.
Coronary care unit (CCU)	A specialist area of nursing, caring for patients with potential or after having a heart attack.
Crystalloids	Intravenous fluid that contains electrolytes

### D

Deep vein thrombosis (DVT)	Deep vein thrombosis – a blood clot in the vein in the calf of the leg.
Diabetes mellitus (DM) types I & II	Diabetes mellitus – an inability of the pancreas to release insulin. Type I is generally congenital and requires insulin injections and diet control. Type II is generally of late onset and requires oral drugs and diet control and possibly insulin
Diamorphine	Drug used for severe pain
Difficulty in breathing	Breathlessness, unable to effectively move air into the lungs
Dysphagia	Disorder of swallowing
Dysphasic / aphasia	Disorder of language following brain damage.
Dystonic	Lack of tone in any body tissue

### E

Electrocardiograph (ECG)	Electrocardiograph – a measure of the electrical impulses running through the heart at regular intervals. There are generally 12 leads, which look at the heart from all angles.
Endotracheal tube (ETT)	Oral or nasal tube passed into the lungs on patients who can no longer maintain their own airway e.g. when unconscious
Extubated	When a breathing tube is removed from a patient who has been unable to maintain their own airway or breath for themselves due to major illness.

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

### F

Fentanyl	Drug used for moderate to severe pain
Fractured neck of femur	A break in the continuity of a bone in the hip joint.

### G

Gastrostomy	A tube passed from the surface of the skin through the abdominal wall into the stomach; usually for artificial feeding.
General practitioner (GP)	Community based doctor
Glasgow coma scale (GCS)	A quick and easy measure to determine mental state of an unconscious patient.
Glycerine trinitrate (GTN)	A drug that dilates blood vessels, used mainly for chest pain
Guedel airway	A thick plastic tube passed into the mouth when a patient is unconscious and unable to maintain their own airway

### H

Haematology	The study of disorders of the blood
Health care practitioner (HCP)	Used to refer to a professional that works in health
Hemodynamic	A state of the body e.g. stable or unstable; generally refers to cardiovascular status e.g. blood pressure, heart rate, respiratory rate, urinary output and temperature.
Heart disease	A broad term given to any disease that effects the heart.
Heart failure	This is when the heart fails as a pump generally due to a heart attack or some other cardiac condition.
Heart rate (HR)	Heart rate - is the rhythmic beat of the heart. It can be counted at various points around the body where an artery flows over a bone, measured in beats per min (bpm).
Hemiglossectomy	Surgical removal of one-half of the tongue.
Hepatosplenomegaly	Enlargement of the liver and spleen
High Dependency Unit (HDU)	A specialist area of nursing whereby patients are acutely ill and require moderate invasive therapies.
Hospital acquired infection (HAI)	An infection that acquired while the patient was in hospital
Human immunodeficiency virus (HIV)	A virus carried by humans if infected that leads to auto immune deficiency syndrome (AIDS)
Hydrocephalus	A congenital condition determined by an excess of cerebral spinal fluid (CSF) inside the skull due to an obstruction to normal CSF circulation
Hypothermia	A body temperature below 35.5°C

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Hypovolaemia	When a person's blood loss is so great the body homeostatic mechanisms can no longer maintain blood circulation.
Hypoxia	When all cells or a part of the body is starved of oxygen e.g. as in a stroke.

### I

Infection control	A list of general principles that prevent infection from transferring from one patient to another in hospital e.g. hand washing, use of antiseptic hand gel
Inflammatory immune response (IIR)	Inflammatory immune response – is the body's normal defence mechanism against infection following injury.
Insulin	A pancreatic hormone that regulates glucose in the blood can be given artificially by injection in diabetes.
Intensive Therapy Unit (ITU)	A specialist area of nursing whereby patients are critically ill and require high technological invasive therapies.
Intubated, intubation	A act of passing a into the trachea to initiate artificial breathing (ventilation), involves the use of an ETT (see above).
Ischaemic heart disease (IHD)	Ischaemic heart disease – is when an artery in the heart is blocked due to fat or blood clot leading to areas of the heart starved of oxygen.

### J

Jejunostomy	The surgical formation of a stoma or opening onto the surface of the abdomen into the small intestine to allow excretion of faeces
Jaundice	Associated with liver failure and gall stones, when bile cannot drain out of the liver via the bile duct and excess bile is taken up by the tissues and the patient appears yellow in colour.

### L

Laparoscopic gastric sleeve resection	Stapling of the stomach to reduce it in size.
Laryngectomy	Surgical removal of the larynx.
Last offices	A procedure that takes place by a nurse for a patient following their death
Liver failure	A failure of the liver to function adequately, affecting all other body functions.

### M

Medical assessment unit (MAU)	An area of accident and emergency that initially assesses patients prior to admission to hospital.
Melanoma	A tumour arising from the deep cells in the skin

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Metoclopramide	An anti-emetic drug, given to stop or prevent vomiting
Metastasis	The distant spread of disease, especially a malignant tumour from its site of origin.
Monitoring	A variety of equipment for continuous measurement of heart rate, blood pressure, temperature, respiratory rate and oxygen saturation.
Multi-disciplinary team (MDT)	All health care professionals involved in patient care e.g. GP, pharmacist, consultant, nurse, physiotherapist, occupational therapist, specialist nurse (pain, wound).
Multi-resistant staphylococcus aureus (MRSA)	A strain of bacteria that is resistant to most of the current antibiotic therapies.
Multiple myeloma	More than one tumour occurring in bone tissue
Myocardial infarction (MI)	Medical term for a heart attack.

### N

Naloxone	An antidote drug to overdose to morphine derivative drugs.
Nasal gastric tube	An artificial tube passed through the nose into the stomach, used for artificial feeding.
Nebulisers	Drugs given through oxygen or air under pressure for certain lung conditions e.g. asthma, chronic obstructive pulmonary disease.
Neurological assessment	A set of criteria that determines neurological deterioration.
Neutropenia	Reduction in neutrophils (specialist white blood cells involved in fighting infection – part of immunity)
Nursing Midwifery Council	The professional registration body for nurses.
Nurse practitioner (NP)	An independent practising nurse.

### O

Oedema	Excessive accumulation of fluid in the body tissues.
Oncology	The medical study of tumours
Oculogyric	Rolling of the eyeballs
Ophthalmology	The study of the eye
Opsite	A clear film wound dressing
Operating department practitioner	A person who assists anaesthetists in the operating theatre.
Oesophageal varices	Related to liver failure and alcohol abuse, bleeding occurs in the upper gastro-intestinal tract due to back pressure from the damaged liver.
Oxygen saturation	The measure of the molecules of oxygen attached to haemoglobin in the blood.

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

### P

Pain A and C fibres	The two pain pathways up to the brain
Palliative care	Care delivered to the dying person.
Pancreatic cancer	A tumour growth in the pancreas
Paralysis	Complete or incomplete loss of nervous function to a part of the body.
Past medical history (PMH)	Enquiring into the medical history of a patient.
Patient controlled analgesia (PCA)	Pain relief that is controlled and self administered by the patient
Per vagina (PV) bleeding	Bleeding occurring from the vagina, often seen prior to miscarriage of a foetus.
Petechia	Small haemorrhagic (bruise like) spots generally found on the skin
Pethadine	Drug used for severe pain
Pharmacology	The study of drugs and their effects on the body.
Phenobarbitone	A barbiturate used as a general sedative and in epilepsy.
Physiotherapist	A practitioner who specialises in rehabilitation using manipulation, therapeutic exercises and helping patients to gain independence.
Pleurisy	Inflammation of the pleural tissue lining of the lungs
Pleurodesis	The creation of a fibrous adhesion between the visceral and parietal layers of the lung pleura, obliterating the pleural cavity, undertaken for repeat occurrence of spontaneous pneumothorax.
Pneumonia	Infection of lung tissue by the <i>pneumococcal</i> bacteria
Pneumothorax	Collapsed lung due to collection of air between the pleura of the lungs seen in trauma
Polymyopathy	Inflammation of the muscles
Post-operative care	Care and management of a patient following surgery
Propofol	A short acting sedative
Pulmonary embolism (PE)	A clot occurring in the one of the major arteries (blood vessel) of the lungs. Generally occurs following long haul flights abroad.
Pulse oximeter	A monitor that is placed on the finger to measure oxygen saturation of blood

### R

Renal failure	Failure of kidneys to function
Respiratory failure	The lungs fail to work, this may require intubation and artificial ventilation
Respiratory rate	Respiratory rate – the rate of breathing, the lungs should expand symmetrically.
Resuscitation	A term used to indicate the administration of invasive therapy when a patient's condition is deteriorating.

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Robinson drain	A small tube inserted into a wound following surgery to remove excess fluid that may collect internally.
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### S

Semi-conscious	A mental state whereby the person is not fully aware of their surroundings, there are varying degrees of this state.
Shock	A condition associated with circulatory collapse, when the blood pressure is too low to maintain an adequate supply of blood to the tissues.
Sickle cell disease	A hereditary blood disease that mainly affects people of African ancestry. It occurs when the sickle cell gene has been inherited from both parents. Characterised by an abnormal production of haemoglobin.
Sinus rhythm (SR)	The normal electrical rhythm of the heart shown on an ECG.
Sjogren-Larsson syndrome	Genetically determined congenital mental sub-normality
Squamous cell carcinoma	A type of cancer that emerges from squamous cells - a specialist type of body tissue that covers external body surfaces.
Stroke / Cerebral vascular accident (CVA)	An area of the brain suffers a period of hypoxia due to a bleed or clot (fat or blood).
Subarachnoid haemorrhage (SAH)	Rupture of an artery in the brain leading to a stroke.
Supra-ventricular tachycardia (SVT)	A very fast heart rate that is regular but with abnormal electrical complexes
Systemic lupus erythematosus (SLE)	An autoimmune process that effects all organs of the body.

### T

TED stockings	White elasticised stockings that create pressure on the outside of the legs to prevent oedema and deep vein thrombosis (DVT) formation.
Tender loving care (TLC)	A term used when a patient is dying and requires all nursing care to alleviate suffering and pain.
Terminally ill	A patient who will not recover and eventually will die.
Tidal volume	The amount of air which passes in and out of the lungs in normal quiet breathing.
Torticollis	A spasmodic contraction of the muscles in the neck; the head is drawn to one side and usually rotated so that the chin point to the other side.
Total parenteral nutrition (TPN)	Nutrition is administered intravenously via a central venous line (CVP)
Tracheostomy	Opening in the neck into the trachea to allow breathing

## Appendix 18 – Glossary of medical and nursing terms and abbreviations

Tuberculosis (TB)	An infectious disease caused by the bacteria tuberculosis.
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### U

Ulcer	A break in the skin or in the mucous membrane lining the alimentary tract that fails to heal and is often accompanied by inflammation.
Ultrasound	Sound waves of extremely high frequency inaudible to the human ear. Can be used to examine the structure of the inside of the body and can be used to break up stones and cataracts.
Unstable angina	A clot in the heart that has become unstable and the person feels chest pain.
Urinary tract infection (UTI)	Infection in urine

### V

Ventilation / ventilator	Artificial respiration.
Ventricular tachycardia (VT)	A fast undefined heart rate, that is life threatening.
Ventilation / perfusion (V/Q scanning)	Two different isotopes are used, one inhaled to examine lung ventilation and one injected, to examine lung perfusion. Used to detect pulmonary embolism.
Vital signs	Includes blood pressure (BP), heart rate (HR), respiratory rate (RR) and temperature (temp).
Vitamin K	This is manufactured by the liver and is required for the body to produce clotting factors.

### W

Wound care	Caring for an opening in the skin either from surgery or trauma, uses aseptic technique and a variety of assessment tools, wound dressings and techniques.
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