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Clinical Placement Reflection

This journal is to reflect on a situation that took place during my clinical placement at Bethesda Hospital, palliative care ward. This reflection is based on the Gibbs Reflective Cycle (1988) model. The Gibbs reflection model consists of six stages to complete one cycle, which facilitates in my ability to improve my nursing practice continuously and learning from the experiences for better practices in the future. The cycle starts with a description of the situation, analysis of my feelings towards the event, an evaluation of the experience, an analysis to make sense of the experience, a conclusion of what else could have been done and the final stage is an action plan to prepare if the situation arose again. Reflection is used to generate practice knowledge, assist an ability to adapt new situations, develop self-esteem, adding value and professionalizing practice. However, O’Connor (2007) explained that reflection is about gaining self-confidence, identifying when we need to improve our practice, learning from our own mistakes, looking at other perspectives, and improving the future by learning from the past experiences. Using a model of reflection enables me to explore and evaluate all previous clinical experiences. The model allows me to develop the skills to evaluate and navigate myself through the reflection process and identify areas of weakness or vulnerability as well as to, and a platform to upgrade skills to overcome these deficiencies. The cornerstone to the reflective process is the understanding of the Australian Nursing & Midwifery Council (AMNC) national competency standards for registered nurses. These are core competency standards by which a nurse’s performance is accessed in obtaining and retaining a license to practice. Linked together with evidence based theory and practice, reflection will assist me in my professional development towards becoming a more competent nurse.

Reflection

On an evening shift, a fellow student and I were advised by our preceptor to perform an observation round for all our allocated patients in our care, in order to prepare them for up coming five o’ clock dinner meal service. This process involved ensuring patients were comfortable, and in an upright position, and that dining trays were placed in the appropriate positions to eat and drink off. On approaching room number ten, I advised my colleague that the patient presenting was an eighty two year old male with terminal lung cancer. I had been monitoring him throughout my shift, as we were advised during the afternoon shift handover,
that the patient’s health had deteriorated gradually throughout the morning shift. On entering the patient’s room, greeting out his name, there was no patient reply. On further observation of the patient, my colleague and I both came to the realization that he was unconscious. I approached the patient, called out his name again, and gently tried to arouse him. It became evident immediately that he was not breathing and I began to palpate his radial artery, only to find no pulse. We looked at each other in dismay, confirmed with each other that the patient was deceased. I immediately took action and responded by alerted nursing staff, by depressing emergency room button. Within a few seconds a range of staff entered the room, in which we advised them on our findings. This was my first experience of a death of a patient, in palliative care.

On analysis of the event, I felt feelings of anger and frustration towards the nursing staff that entered and assisted us at time of patient’s death. On initial entry into the room, the attending nursing staff told me that that the action of depressing the emergency button was totally unnecessary and an inconvenience as all nursing staff were pulled away from there activities to attend to this emergency call. I was advised in future only to depress the patient room call button. I stood there in disbelief and immediately felt feelings of anger. I was under the impression and understanding, that in any clinical situation that involves a patient’s death, palliative or acute, required immediate emergency attention. As nursing students, and as part of ANMC standards professional code of conduct that we practice under, I believed my actions were responsible and accurate. My anger was also focused on the fact that at the moment of patient’s death, all communications around bedside by attending staff were focused on the emergency call button protocol, which I personally found very inappropriate, and showing very little respect to the deceased patient. As competent nursing students, we are bound by the ANMC competency standards, and it is our responsibility to provide nursing care that advocates for our patients rights in life and death, showing respect and dignity towards the patient. (ANMC Competency elements 1.1-3, 2.3 3.1-4, 4.2-4, 7.1-4, 8.1-3, 3.5, 9.1-3, 10.4)²,⁵

On evaluation, themes and feelings of dread and terror, anxiety, feeling scared, helplessness, guilt, sadness, frustration and emotional breakdown are all part of providing care to patients in the dying period.⁶-⁹ Caring and treating dying patients is a major stressor in nursing practice.¹⁰,¹¹ Nurses experience and are confronted with death in every day work, and hence are exposed to many emotional aspects of grief.⁷,¹¹ Death and dying are an integral part of a palliative care environment. During research studies conducted by Kelly (1998) with female nursing students facing patient death for the first time, four major themes were evidenced.¹² These were namely
the uniqueness of the new experience of patient death, overwhelming sense of awe at moment of death, sadness due to patient death and reflection and evaluation of own personal beliefs with regards to death.\textsuperscript{12,13} Loftus (2004) evidenced that many people that grow up in a western society, are not exposed frequently to death, and in most cases are protected or shielded as children from experiencing death.\textsuperscript{11} Hospitals are viewed as institutions were patients only recover from illness, disregarding the reality that more patients die in hospitals than at home.\textsuperscript{11} This concept in itself makes for very little preparation or insight of young students facing realities of patient death.\textsuperscript{11,13} Within clinical practice; nurses spend more time with patients than any other medical profession. Part of a nurses role is to provide compassionate care, and dignity to patients. As nurses we need to be adequately prepared for patient death, and training to deal with death is vital element in student preparation for death.\textsuperscript{13} A solid base of training in this regard enables students to cope better and have a more positive outlook on dealing with dying patients.\textsuperscript{6,14} Personal development, continued education, promoting ethical care and patient advocacy are practices, as nurses, we are bound by, as stipulated by the ANMC professional code of conduct umbrella we practice under. (ANMC Competency elements 1.1-3, 2.3 3.1-4, 4.2-4, 3.5, 9.3, 10.4).\textsuperscript{2} Nurses repeated exposure to death and grief also leads to increased work stressors, and nursing burn out. Furthermore, this can lead to emotional care disengagement from dying patients, which has a serious impact of level and quality of care given to dying patients.\textsuperscript{7,13} As nursing students we are bound by the ANMC professional code of conduct, to provide to our patients the highest level of care, and source help and assistance in coping with stressors faced in the workplace, and not letting these affect patient healthcare outcomes. (ANMC Competency elements 1.1-3, 2.3 3.1-4, 4.2-4, 7-1-4, 3.5, 8.1-2,9.1-4, 10.1-4).\textsuperscript{2} Cooper and Barrett (2005) highlight the importance of nurse education in dealing with patient death.\textsuperscript{15} Education facilitates critical thinking and deeper reflection.\textsuperscript{14} Experiments preformed have shown that nursing students anxiety scores decreased significantly following patient death education.\textsuperscript{8,9} Reflection is a key element in nursing practice, Freshwater et all (2005) evidenced how reflective practice is a successful method used in nursing practice, and successfully can be integrated with nursing education.\textsuperscript{9,14-17} Student nurses need to reflect of their personal experiences throughout their practice, and this reflection process will enable student to earn from past experiences.\textsuperscript{11,18} Processes like storyboarding facilitate for deeper reflection and critical thinking.\textsuperscript{11,15} Storyboarding is the process that encourages clinicians to use the right side of the brain to formulate ideas, expressed in a group, and critical analysis of these thoughts and reflections.\textsuperscript{11,15,17}
In future, my action plan will reflect that I have come to the realization and understanding that patient death is an integral part of nursing practice in palliative care settings. I will also recognize that strong preceptor, mentors, and support from all members of the multidisciplinary team have positive implications for nursing students coping with stressors associated with patient death. On this placement I was fortunate to receive an extremely high level of support and education from my practitioner scholar, who assisted me throughout my clinical placement. Qualified nurses and experienced clinicians in a palliative care setting are able to offer support to inexperienced nursing students, using their life experiences with death, and transferring this experience and support to less experienced students. Beck (2002) evidenced that one of the most successful models of learning for nursing students is observing and emulating expert role models, who ultimately act as mentors and instructors to student nurses. Part of our professional practice is to embark on gaining further and additional education in palliative care, resource education that raises awareness to factors that affect terminally ill patients, developing appropriate skills to assist with the spiritual as well as physical needs of dying patients, adequately preparing me as a student nurse for entry into practice as a registered nurse. It is also important for me to take responsibility and make myself aware of hospital guidelines and procedures regarding patient death, especially in palliative care settings. In my future practice I will utilize continual reflection, trying to discover new ways of thinking about dying, focusing more on providing highest quality of patient comfort and care in their end of life journey. This will enable me to become a more professional and holistic nurse, delivering the highest level of quality care to my patients.

References
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