The nursing expert in clinical practice

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Summary
Reflection has long been used as a developmental tool within nursing education, however the benefits of structured reflection for qualified nurses does not receive the same emphasis within clinical practice despite its well documented benefit in terms of professional development. The aim of this paper is to examine a specific clinical experience through the process of structured reflection to demonstrate that nurses can learn through the process of reflection and re-evaluate their perception of expert care.

It was found that many nurses do not consider themselves to be expert in the areas in which they work; however, the use of structured reflection can assist nurses to identify areas of practice in which they operate in an expert manner and therefore enable themselves and others to value their work as expert professionals.

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Editor's comments
This thought provoking article surrounding a small but significant incident caused the author many moral and ethical dilemmas concerning the essence of expert practice in spinal cord injury nursing. The incident could equally have been approached from an evidence-based practice stance and uncover even more issues and dilemmas.

Introduction
This paper examines a specific clinical experience relating to the management of a patient with an acute spinal cord injury through structured reflections based on John’s (1994) model of reflection. A critical discussion of the experience is presented focusing on the characteristics of expert practice that were evident within the structured analysis. The reflective episode is further discussed in relation to expert practice, with particular focus on moral agency and skilled know-how.

The article assumes that reflection is a useful tool for professional development and that there are many facets of expertise which nurses demonstrate within daily practice. It shows that:

- Structured reflection can assist nurses to value themselves as possessing and utilising expertise on a daily basis.
Awareness of the different facets of expertise evident within practice enriches the nursing profession and assists in the development of practice.

**Experience**

J was a 25-year-old male who had been admitted to the high dependency area (HDA) within a regional spinal unit. J had sustained a fractured C5 vertebra following a road traffic collision in which he had been a front passenger. This injury had caused an acute spinal cord injury (ASCI), which, resulted in him becoming quadriplegic. His other injuries consisted of bruising and superficial lacerations.

My initial contact with J was approximately three hours after his transfer to the unit from a district accident and emergency (A&E) department. On transfer he was suffering from spinal shock and mild respiratory compromise, he was therefore being closely monitored within the HDA when this interaction occurred.

Following the shift hand over I went to J’s bedside to introduce myself and to perform a set of clinical observations. Whilst performing checks on the equipment at J’s bedside, I asked how he was feeling, and if there was anything that I could do for him. He responded hesitantly, mumbling that he was fine and that he ‘would manage one way or another’. From his response and body language I was not satisfied that he felt entirely comfortable with his new environment. I asked if J minded if I took his blood pressure reading, and he merely nodded his agreement.

As I began taking his blood pressure, I began to explain to him what I was doing, why it was necessary along with why I would be doing it half hourly over the next few hours. After taking this reading I began explaining what the other attachments were and their purpose during this acute period. J took the lead from my openness and started asking what was in the ‘drip’, and why was it necessary when he was willing to drink to prevent dehydration. Whilst I was happy to explain that the maintenance fluid was necessary due to his ‘nil by mouth’ status because of the risk of developing a paralytic ileus, I did not feel at ease justifying why J was also receiving a methylprednisolone infusion through one of his ‘drips’, as this is a highly contested practice within contemporary health care. I did, however, explain to J that the steroid infusion might improve his neurological function once spinal shock had passed and said that I would ask one of the medical team to come and discuss what we were trying to achieve in terms of the medical management of his injuries. He thanked me for explaining the equipment to him and for offering him the opportunity to speak with the medical team, however, declined at that moment in time, saying that he would think about it and perhaps think of some questions for when they next ‘did their rounds’.

**Structured reflection**

The process of reflection develops both insight and self-awareness (Gustafsson and Fagerberg, 2004), and is an essential component within nursing if satisfactory levels of care are to be maintained at a professional standard (Kuokkanen and Leino-Kilpi, 2000; Hargreaves, 1997). However, to ensure that reflection is used to its maximum learning potential, the use of reflective tools should be incorporated into reflective practice. This paper utilises Johns’ model of structured reflection (Johns, 1994) to facilitate an in-depth examination of the incident. The model has been adapted slightly for the purpose of this reflection, with the omission of some of the prompting questions that were not particularly relevant to the situation being examined.

**What essential factors contributed to the experience?**

J was being cared for in the HDA, in which he was being subjected to a barrage of invasive tests and procedures. On my initial meeting with him, it appeared that either due to lack of information from the staff, or his inability to absorb the information at the time of delivery, he did not understand what was happening to and around him. This resulted in J not being able to engage in his own care or medical management. Whilst this is not always totally achievable in the early stages following ASCI, encouraging active involvement is part of the rehabilitation philosophy advocated by the unit.

The use of high dose methylprednisolone is currently a controversial treatment in ASCI’s. The leading specialists within the field advocate that methylprednisolone should not be used based on research findings to date (BASCIS, 2005). I was concerned that the medical team (from the district A&E) had commenced J on this treatment without seemingly informing him of the risks associated with this treatment, and therefore, denying him the opportunity to give an informed consent for this controversial management strategy.
What was I trying to achieve?

I wanted to familiarise J with his immediate environment, so that he would feel at ease and able to engage in what was happening around him. By asking him if he would like to speak with the medical team I was intending to facilitate the opportunity for him to speak with medical personnel so that he could access information regarding the management of his injury and other issues that related to his prognosis and care. I did this as I felt that this information would increase J’s participation in the planning and delivery of care, and enable him to make appropriate decisions regarding his treatment.

Why did I intervene as I did?

I wanted J to possess knowledge about his current situation and therefore feel more relaxed in his current surroundings; similarly, he would be able to engage in his own care and medical management, which is a key part of the rehabilitation process (Harrison, 2000). As I did not feel entirely comfortable promoting the use methylprednisolone as part of his acute management I felt that this should be explained by the medical team. I, therefore, tried to facilitate a meeting with the medical team so that he could receive the appropriate information to make an informed decision regarding his management.

What were the consequences for myself?

I recognised that my awareness of the current research regarding the use of methylprednisolone in the management of ASCI’s placed me in a moral and ethical dilemma regarding J’s current care. Whilst I tried to facilitate a discussion with the doctors in which J could enquire about his current treatment, he declined the opportunity at that moment. This left me feeling frustrated and morally and ethically obliged to ensure that J was provided with the appropriate information to permit him to make an informed decision. This situation also forced me to consider my role as both patient advocate and an autonomous accountable practitioner.

What were the implications of my actions for the patient?

I believe that J felt more informed and at ease in his new surroundings after I had explained the immediate surroundings and occurrences. Although he thanked me for enlightening him about his current circumstances, which I interpreted as satisfaction with the information I had delivered, he did not appear to be ready to receive further information regarding his current care or condition at that time.

How did I feel about this experience when it was happening?

I was quite surprised when I received handover that J had been commenced on methylprednisolone in the district A&E despite the controversy surrounding its use in the management of ASCI. After discovering that he was seemingly unaware of the potential adverse effects following the use of high dose steroids, I was rather angry that he may not have been given the necessary information to consent to the use of such treatment. I also felt increasingly challenged with regards to how I would address this situation without undermining his confidence in the medical team either at the district hospital, or within the spinal unit.

How did the patient feel about it?

Although I did not specifically discuss J’s feelings in depth with him, he initially appeared anxious and withdrawn, not actively engaging with staff or seeking information. However, following our discussion, he appeared more relaxed and at peace with his environment, although not yet ready to receive information which may challenge his current state of mind, or force him to focus on issues which he did not feel ready to address.

What internal factors affected my decision making?

My personal philosophy advocates a facilitative role within healthcare where appropriate, although this may not always be possible when patients are as physically dependent as J. My clinical practice necessitates a combination of approaches to managing care, which need to be tailored to patients’ different stages within the rehabilitation process. Within the early stages of care this tends to focus on the twelve activities of living as described by Roper et al. (1996).

What external factors affected my decision making?

Up until approximately six years previously, methylprednisolone was administered within the Unit to all patients with ASCI as protocol. However, in light of...
the recent research debate regarding this treatment (Brohi, 1995), this practice is no longer followed.

Effective risk management should follow the ethical principles of beneficence, non-maleficence, and justice (Beauchamp and Childress, 2001) in order to provide the best possible care and outcome for the patient. The care delivered during this incident did not appear to adhere to basic moral and ethical principles as discussed by Beauchamp and Childress (Beauchamp and Childress, 2001) due to lack of supporting research in defence of the prescribed treatment regime and the deficiency of an informed consent from J himself. At that time, I felt that J could be exposed to undue risks due to the use of Methylprednisolone. These risks included: increased incidence and severity of pulmonary complications, increased risk of sepsis, and delayed healing (Hurlbert, 2001; Heary et al., 1997; Prendergast et al., 1994). Based on my current understanding of the potential adverse effects of methylprednisolone, and my intention to deliver care that was morally and ethically based, I encouraged J to discuss his care management with the medical team, so that he could give his informed consent if he wished to continue with a treatment which carries known risks.

What sources of knowledge influenced my decision making?

The use of skilled know-how and moral agency (RCN, 2000) greatly impacted upon my approach to this situation. Whilst these components affected my clinical practice and response to J’s situation, the existing research regarding methylprednisolone highlighted my awareness of the potential effects of methylprednisolone on individuals with ASCI’s (Nesathurai, 1998; Prendergast et al., 1994; Heary et al., 1997). The recommendations by BASCIS (BAS-CIS, 2005) not to give methylprednisolone in ASCI’s provided evidence of expert opinion, in which, I could raise my concerns with the medical team.

Could I have dealt better with the situation?

Potentially different strategies could have been implemented within this situation. Through openly challenging the doctor who re-prescribed the infusion of methylprednisolone, as this was not in accordance with how I interpreted the current research findings and recommendations. Suspending the infusion until the medical team had given J the appropriate information in terms of the associated risks and benefits of receiving high dose steroids was not an option even though it would allow him to make an informed decision regarding his management. Unless protocols are in place nurses are not allowed to prescribe or un-prescribe. The consequences of these would have been to place members of the medical team in a position where they could reconsider their colleagues’ decision regarding J’s management.

Whilst I tried to facilitate J gaining information from the medical team, he declined at that moment in time, and thus resulted in the treatment going unchallenged by him. On reflection, I could have pursued the matter further by informing him about some of the potential effects that high dose methylprednisolone may have on his recovery, and hope that it would enable him to challenge his medical management. However, it may similarly have undermined his confidence in his current health care providers, which could have been detrimental to his overall recovery. As a result of this situation I had to reconsider my role as a facilitator within a healthcare team contrasted to that of patient advocate.

How do I feel about this experience?

I still feel uncomfortable about this experience in that I have failed to ensure that J received justification of his treatment, or the opportunity to make an informed judgment regarding his treatment strategy. I feel that I failed to empower him with the opportunity to negotiate his management and maintain as much intellectual independence as possible, especially at a time when he was coming to terms with the loss of his physical independence.

What have I learned from this experience?

This situation has highlighted feelings of inadequacy when trying to empower individuals with information from the medical team in order to facilitate their involvement with their own care. My role as a facilitator on this occasion failed to provide J with the information he required in order to become an active participant with his care, and therefore, may have resulted in a detrimental effect on his immediate and future outcome. This provoked a preliminary emotional response of anger and frustration at the medical team for creating the initial situation, and other healthcare professionals for reinforcing this practice as being acceptable.

Commentary

This reflective episode has highlighted the frustration encountered when attempting to facilitate pa-
tients to access information that is central in determining their care management and potential outcomes. Within this commentary, the use of skilled know-how and moral agency will be examined in relation to expert practice. The emancipatory action research conducted by the RCN, "’Changing patients’ worlds through nursing practice expertise’," (2005), developed a conceptual framework identifying five key attributes required in practice expertise. These being:

- Holistic practice knowledge
- Knowing the patient
- Skilled know-how
- Moral agency
- Saliency

As described in the RCN’s Expertise in Practice project information pack, (2000), skilled know-how and moral agency are outlined within Table 1. Clinical expertise is the ability and confidence to use multiple forms of knowledge and the use of self in an appropriate and seamless manner, which is holistic, and individually tailored for each patient to promote individual patient choice and empowerment (Hardy et al., 2002). It is also characterised by high levels of clinical knowledge, assertive clinical leadership and patient focused involvement (Edwards, 1998) as well as professional artistry to ensure adept integration of such skills (RCN, 2005).

Knowing the patient is a key concept within therapeutic decision making (Radwin, 1996), as with the ability to understand and treat the patient as an individual (O’Callaghan, 1995). This involves not only finding out the patient’s perception and response to their situation, but the integration of knowledge surrounding specific treatments (Radwin, 1996). This reflective episode relates more to the clinical relationship and rapport with J, as opposed to knowing the patient as described by Jenny and Logan (1992), where time is considered to be essential in order to accumulate sufficient knowledge regarding the patient’s current condition and concerns. The development of good report in this situation was developed by working with J, as opposed to working for him (Hardy et al., 2002).

The ability to understand individuals through responding and appropriately interpreting non-verbal communication not only requires self-awareness and advanced communication skills (Stein-Parbury, 1993; Sanger, 1996), but the confidence to act differently to colleagues in order to provide care that is orientated around the individual’s requirements (Hardy et al., 2002). Expert practitioners are aware of the potential impact of their intentions on care and patient outcomes, as with the need to respond rapidly to a situation to ensure that interactions move the patient towards improved outcomes.

Working as a nurse within the HDA necessitates a variety of skills, which may often go unrecognised and unexplored in terms of being expert as detailed in the RCN expertise in practice project, (2000).

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### Table 1 Skilled know-how and moral agency (RCN, 2000)

**Skilled know-how**

- The use of all available resources
- Utilizing all ways of Knowing (Carper, 1978) and all types of evidence in the organisation and delivery of care, including interpersonal and technical skills
- The capacity to respond to individual people and situations in an appropriate, seamless and holistic manner
- Seamless combination of technical and interpersonal skills demonstrating artistry in the delivery
- Demonstration of timing and pacing which is suited to the patient and their situation
- Continual reflection on, and reflection in practice, and modification of practice as a result of reflection
- Facilitating others through the use of knowledge and skills
- Acknowledgement and appreciation of the difference in skills and knowledge base required within different areas of specialism

**Moral agency**

- Openness
- Working in partnership, displaying warmth and being genuine
- Providing choice and enabling involvement
- Providing information that will facilitate people to problem solve and enhance their ability to make decisions for themselves
- Respecting the individual’s right to make his or her own choices, and not be paternalistic
- Advocating for the patient when they are unable to do this themselves
- Knowing one’s own values and beliefs, but not enforcing them on others, or being judgmental of their values and beliefs
- Promote and respect others dignity and individuality
- Providing comfort and maintaining integrity within the relationship

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However, with reflective models such as John’s (1994), it is possible to verbalise professional judgement and clinical decisions through a process of structured, conscious and rational thought (Mantzoukas and Jasper, 2004). This clinical episode challenged me to utilise advanced knowledge and skills within the realms of practice expertise, especially in terms of evidence-based practice and facilitating the delivery of information.

During our initial meeting, J appeared to be suffering from a high state of anxiety (Speilberger, 1983) relating to his immediate situation, as opposed to a high trait anxiety, which would indicate an anxious character. Whilst I was aware that this subjective emotional reaction might serve as a motivating factor (Martin, 1996) for many aspects of J’s care (for example, performing deep breathing exercises), I was aware that it might also be causing excessive caution in activities such as regular position changes, due to the perceived threat of J’s care (for example, performing deep breathing exercises), I was aware that it might also be causing excessive caution in activities such as regular position changes, due to the perceived threat to well-being (Atkinson, 1993).

Larzarus and Folkman (1984) suggest that J would have made an initial appraisal of the importance of the situation and the resources that were available to him to deal with this. They also suggest that stress may occur if J viewed the situation as being important and that his resources/knowledge were insufficient to deal with the situation. My primary assessment of the situation suggested J had not been adequately orientated to his immediate surroundings or his current situation and did not possess the resources to make sense of what was occurring to or around him. This consequently invoked stress and anxiety, which may have been avoided or reduced through health care staff integrating interpersonal skills and technical abilities.

The timing and pacing of information required consideration of its relevance to J, as with the provision of appropriate resources, which would enable him to reframe his perception of what was happening. This application of knowledge required expert use of the RCN’s (2000) realms of clinical practise, not only in the use of empirics, aesthetics, ethics and personal ways of knowing, but in their skilled integration into holistic patient care.

My initial aim within our interaction was to orientate J and to familiarise him with what he could expect to happen in the immediate future, so that he could anticipate what would be happening around him, and therefore, reduce some of the stress and anxiety that he was experiencing at that time.

Kelly’s (1955) personal construct theory views people as dynamic, evolving individuals who continuously modify their perception of the world in light of what has transpired (Burnard, 1996). Therefore, the provision of information would help create a sense of normality and security and may consequentially assist J to participate and prepare adequately for the forthcoming procedures (Salmon, 1993). The use of moral agency involved the protection of J’s personhood in moments of vulnerability. Expertise was therefore required to help him feel safe in his unfamiliar environment. It was essential that these attempts did not become paternalistic in their approach or delivery ensuring the focus remained on facilitating involvement with care and the decision-making process and enabling choice over care options (RCN, 2000).

Whilst I tried to impart information, which I thought J would find useful at this stage in his rehabilitation journey, I could not anticipate how his own perceptions and previous experiences would affect how he would interpret his current and future situations related to his ASCI. The use of effective nurse—patient communication was therefore essential to ensure satisfactory transmission of information (Sheppard, 1993) and transmission and recognition of feelings (McCabe, 2004) to invite and encourage his participation in his care and negotiated decision making (Langewitz et al., 1998).

Research regarding methylprednisolone highlights increased incidence of and severity of pulmonary complications, infection and septic conditions, increased risk of pancreatitis and gastrointestinal haemorrhage in patients with ASCI’s (Hurlbert, 2001). Hence, I would have felt happier if J had continued to discuss his medical treatment with the medical team. I respected J’s individual right to make his own choice, despite my paternalistic feelings. I did, however, feel some satisfaction in that I had provided him with choices to make from the information that he had already accessed. I had, therefore, facilitated him to become actively involved in his own care, even though it was not at a level at which I would have liked. Expertise in this situation recognises and respects the patient’s dignity, values and beliefs, acknowledging that these will play a part in how they interpret what is happening to, and around them.

Openness is a key attribute of expert practice (RCN, 2005), therefore, I feel that I could possibly have been more open about the adverse effects of high dose methylprednisolone as opposed to trying to facilitate the discussion with the medical team. When J declined to access further information regarding his medical management I was obliged to respect his right to make his own choice regarding the information that he accessed. I found this difficult due to my own values and beliefs surrounding the use of methylprednisolone, however I...
did act in accordance with moral agency (RCN, 2005, p. 50).

It is not only the quantity of the information that is important, but also the quality of the information that is important. Egbert et al. (1968) noted that patients’ ability to comprehend and retain information was dependent on the communication skills and experience of the person delivering the information. However, Anderson et al. (1979) also identified that patients receiving purely verbal information, could only remember 40% of this at a later stage. These factors may have been attributable to J’s apparent lack of knowledge regarding the medical management of his ASCI. Similarly, the stress and anxiety that he experienced at the time of admission to A&E may have affected his ability to focus on the information being delivered, or indeed his ability to absorb such information. It was therefore difficult to ascertain at the time of interaction whether J had received any information regarding the use of methylprednisolone at the commencement of the infusion, or whether he had not been given the information to enable informed consent. Due to his inability to recall any information that he may have been given regarding the methylprednisolone infusion, I assumed that he was not able to provide an appropriate informed consent for his current treatment. I therefore believed that this apparent lack of understanding surrounding this contentious treatment options necessitated action in order to facilitate his increase in knowledge.

Whilst the research regarding the use of methylprednisolone in ASCI’s is easily accessible within journals and through the internet, nursing colleagues were only vaguely aware of the literature surrounding this contentious treatment. Furthermore, they appeared reluctant to develop their knowledge so that they could improve standards of care. Rycroft-Malone et al. (2004) have identified four potential barriers that may deter nurses from utilising research within clinical decision making, these being:

- Problems interpreting and using research which may be seen by some as too complex, academic, or statistical.
- Lack of organisational support to implement current research findings.
- A perception that research products lack appropriate clinical direction.
- A lack of skills and motivation to implement the research themselves, therefore, relying on others to inform them of things of relevance.

Knowledge of key research, as with other types of knowledge, requires skilled know-how to ensure its appropriate application to situations to meet the patient’s actual or potential needs.

I was surprised by my colleagues’ lack of seamless and appropriate response to J. Particularly, as in today’s clinical culture communication is viewed as a valid method in which the quality of the health care can be judged (Price, 2004), and which may transform the patient’s experience of healthcare. In terms of benefit to the patient, good communication potentially lessens the impact of potentially painful, difficult or anxiety provoking situations (Cortis and Lacey, 1996), and therefore should be viewed as a central component of moral agency and excellent care.

On reflection, I should have utilised the opportunity to arrange study sessions for colleagues on the use of methylprednisolone in ASCI’s to facilitate their empowerment to act in the future. Unfortunately, it was not until using John’s (1994) structured reflective tool to develop my own self-insight and self-awareness surrounding my own clinical expertise that this solution became apparent.

Conclusion

Structured reflection is thought provoking and challenging. The process of reading and reflective thinking has demonstrated the use of skilled know-how and moral agency (RCN, 2000) within the management of patients with ASCI’s. The use of relevant research and its implementation to practice in an appropriate and seamless manner can demonstrate an artistry, which, without the use of structured reflection would go unrecognised. Therefore, within my own practice, expert practice signifies not only expert knowledge required for the care of individuals with ASCI’s, but the expert integration and implementation of other knowledge sources such as technical and interpersonal skills.

References


