Registered Nurses' Perceptions of Reflection as a Process for Exploring Experience

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Candidate Declaration

I hereby declare that:

I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.

None of the material contained in the thesis has been used in any other submission for an academic award.

I am aware of and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted have been properly and fully acknowledged.

The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.

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Abstract

Reflection is required by Registered Nurses to maintain registration with the Nursing and Midwifery Council of the United Kingdom but the structured mechanisms through which this happens officially do not necessarily foster reflection in practice. This research aims to explore Registered Nurses' (RN) perceptions of reflection with a particular focus on exploring, learning from and sharing workplace experiences. Using an approach which combined an interpretative phenomenological approach with aspects of narrative methodology, it addresses three questions: How do RNs perceive reflection? What are the features of shared reflection? And how might opportunities for sharing experience provide contexts for reflection? A particular focus here was reflection as a collective, rather than an individualised, activity. The participants were 22 RNs with varying numbers of years and levels of work experience following registration.

Qualitative data were collected using audio recordings, field notes and memos from four focus groups, seven follow-up interviews and five individual interviews. The recordings were analysed using the double-listening method which led to constant comparative and iterations of narrative analysis to produce codes, categories and themes. Four overarching themes were identified: perceptions of reflection; the significance of emotions to reflection; confidence, self-deprecation and humour in RN's accounts and belonging.

The findings suggest that, contrary to common recommendations on reflection in nursing practice, it is possible for nurses to benefit from reflecting on each other's practice, rather than just their own. The findings also demonstrate an emotional, embodied component to reflection that can create and sustain a sense of belonging through sharing stories during reflective conversations. It is argued therefore that sharing stories can form part of the collective reflective practice of nursing, and that collective reflective practice has potential to sustain and develop communities of reflective nursing practice and shared confidence in practice.

These conclusions lead to two recommendations. First, experienced nurses should have opportunities to consider their perceptions of reflection as an

activity that supports the reflective practice of nursing. Secondly, registered nurses would benefit from sharing reflective stories about their practice to sustain and further develop collective reflective nursing practice.

Acknowledgements

I loved listening to the stories, I even told my own. I learned so many things about nursing practice and about myself from the RNs who were the participants in my study. I also learned about working, studying and research in adversity. Completing this study has been the most difficult and sustained effort I have ever undertaken and yet the condition of human kindness and the support and assistance I have had, has sustained me in a most unexpected and positive way. Many people, including my supervisors, family, friends and colleagues, have assisted me in practical and esoteric ways, in obvious and less obvious ways, and some of them will never know how much they have helped or how much I needed help at that specific time. I am tired and grateful (especially that this is the end!).

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Chapter 1: The context

1.1 Introduction

Foreword

My interest in the area of reflective practice developed from years of working as a Registered Nurse (RN) and in health care education, from personal educational opportunities and an appreciation of the tensions between theory and practice. In my experience, such tensions often become particularly apparent given the requirement to work within the confines and rules of a professional body which sometimes seem at odds with the complex and often messy process that is nursing practice.

Over the course of my career I have worked for many years in the NHS and universities and had many and varied opportunities for professional training and development. I am a Registered nurse (RN), a Registered nurse teacher (RNT) with the Nursing and Midwifery Council (NMC) and I am employed by a university as a senior lecturer in Nursing and Health Care. Because of my clinical experience and education, I teach multiple subjects at pre-registration and post-registration levels, supporting undergraduate and post-graduate health care professionals including nursing, management, education and research.

From a philosophical perspective, I consider myself to be a nurse who teaches and facilitates practice, with the aim of improving patient care as a result of multiple ways of facilitating, encouraging and role modelling care. I am passionate about nursing, about the humanity and the dignity of patient care. I follow the philosophy of Henderson (1966) believing that my role is to care for patients who cannot care for themselves and help them to make contributions to their own health and wellbeing. If this is not possible, I believe that it is my role to contribute to their peaceful death.

Since I started training and working as an RN, changes have taken place in the way that nurses are trained and work in practice. Previously, nurses were considered apprentices who learned the ‘trade’. Great importance was placed on speed of performance and technical competence (Macleod-Clark et al. 1997,

Kozier et al. 2007). Student nurses were attached to Schools of Nursing within specific hospitals and were expected to be loyal to the rules and culture of that hospital; nurses followed Doctor's Orders and were predominantly taught to do as they were told. There was a rigid hierarchy and nurses completed tasks without question; they were not encouraged to think. Within this context, the value of the knowledge passed from more experienced to less experienced nurses was crucial (Macleod-Clark et al. 1997, McGann and Mortimer, 2004, Kozier et al. 2007).

Leading up to and during the 1970s, changes in nurse training were proposed culminating in the Nurses, Midwives and Health Visitors Act (1979). This act created The United Kingdom Central Council (UKCC), which introduced 'Project 2000' to produce a new breed of nurses who would be "knowledgeable doers" (UKCC 1986). Schools of nursing that had been previously sited within and attached to hospitals became colleges of nursing and, as a result of the Judge report (RCN 1985), in 1995 they were subsumed into universities. Nurse training became nurse education, and, for the first time, academic credit was given. Any nurse working in higher education and contributing to the assessment of academic work was expected to hold a first degree and then a Master's degree.

The development in nurse education reflected a new movement, part of which reflected the growing literature and research being produced by nurses and attempts by the governing body (UKCC) and academic nurses to obtain ownership of nursing as a 'profession' (Trant and Usher 2010, NMC 2010, RCN 2012). A distinction was made between nursing and medical care, and nurses were required to document the nursing care that had been given (UKCC 1993). Within this new approach, during their training, student nurses were encouraged to consider evidence as a basis for their practice and were encouraged to question their own practice and that of others. To achieve this shift in emphasis away from only supporting medical care, the intention was that they would be taught predominantly by nurses who had undertaken academic studies, as opposed to predominantly doctors. The difference between medical and nursing care has been debated extensively (Carper 1978, Macleod-Clark et al.

1997, Burnard 2002, May and Fleming 1997, Naish and Maclaine 2006, Price et al. 2014) with opinion ranging from those who saw nursing as supporting the diagnostic and curative role of the doctor to those who saw the caring role of nurses as unique and separate, yet complementary to the medical role of doctors (Baumann et al.1998, Price et al. 2014).

Since such developments, the gap between the education of nurses in universities and the technical efficiency and speed expected in many areas of nursing practice in hospitals has been discussed at length (Trant and Usher 2010, Benner 2001). Nurses are taught to consider the individual and their significant others in a holistic way, with the emphasis being on the quality of individualised nursing care to provide a safe and comfortable environment for patients (NMC 2018a, Benner 2001, Burnard 2000). Changes in nurse education and the challenging of the medical model arose in tandem with the 1960s and 70s wave of feminist challenges to the patriarchal structures in wider society. But this was also a time when the UK economy became increasingly vulnerable to domestic and global influences and associated problems (Sandbrook 2012, NHS, Next steps forward 2018). The first investigation into alleged inefficiencies in the NHS as a major user of public funds was published in 1956, and from the early 1970s all public-sector provision including the NHS was required to become more efficient. That trend has continued in many guises and the emphasis on productivity and throughput of patients, along with the need to audit care and demonstrate specific cost-effective ways of delivery can produce tensions when giving care and interacting with patients on a personal level, although the hope is that these can co-exist (The Health Foundation, The King's Fund and the Nuffield Trust 2018).

Against this background professional reflection has emerged as a key focus for nurse education (Benner 2001), as promoted by the NMC (2018), the trusts (NHS, HEE 2018) and the higher education institutions (NHS, HEA 2018). Through reflection, nurses are encouraged to examine their own practice, seek resolution for problems and demonstrate an evidence-based practice. As I explore in more depth in Chapter 2, reflection is a contested concept but is generally believed to be the internal consideration of issues and problems that

arise in professional practice leading to some sort of resolution (Mezirow 1988, Schön 1983, Brookfield 1983, Moon 1993). Reflective practice became - and has continued to be - an essential aspect of nurse education at all levels from pre-registration to post-registration and it is assessed in every academic assignment submitted by student nurses throughout the three years of their undergraduate training for registration (NMC 2018b). The NMC believe that reflection enables the nurse to make sense of a situation and how it affects them. They also state that reflection can help keep nurses up to date with new and emerging information about health care and that it will be useful when considering near misses or critical incidents (NMC 2018c).

Before expanding on the aims of this study in more depth, the next section provides further context on professional education for nurses in the UK. Following this I identify issues associated with continuing to practice as an RN in the UK. Next, I discuss approaches to reflection as a collaborative exercise and I end by summarising the rationale for this study along with the specific research questions I wish to ask.

1.2 Nurse Education in the UK and requirements for reflection

The NMC's stated purpose is to "act in the interests of patients and the public in contributing to safe and effective care, and upholding confidence in the professions and regulation." (NMC 2018c). To achieve this, they control and dictate all areas of registration, starting with initial education. The NMC monitors the Curriculum for entry to the register, which is regularly audited (NMC 2018b). Indeed, the NMC have recently produced new standards of proficiency for registered nurses (NMC 2018b). Students study and work for three years at a university, in hospitals and in the community on a university-based course that consists of 50% theory and 50% practice. Student nurses who complete this course successfully are awarded a Bachelor's degree with honours and are eligible for registration with the NMC. Individuals cannot work as registered nurses in the UK unless they are registered with the NMC (NMC 2018a) and to achieve this, student nurses have to meet Educational standards set and monitored by the NMC (2018b), more detail of which follows in the next paragraph. Importantly, reflection is a strong feature of both strands of training:

reflective practice must be demonstrated in every written assignment for the university-based course, and reflective practice is included within the standards of proficiency during practice. This early emphasis on reflection in nurse education is key to the start of a career where reflective practice is key to continued education and to registration and revalidation as a RN in the UK. Revalidation is a mandatory requirement to maintain registration and takes place at three yearly intervals. Revalidation requires the production of written evidence, a significant portion of which is reflection. I return to revalidation in more detail in section 1.3.

More recently, the NMC have revised the Educational Standards (NMC 2018b) and are in the process of approving institutions who wish to train and educate nursing associates who wish to complete an apprenticeship degree. Student nurses wishing to complete an apprenticeship degree will be employed in hospitals and the community and attend university as required by the NMC approved institution (NMC 2018b). The new standards include proficiencies associated with reflection and self-reflection and so the need to consider what reflection means and how nurses can reflect is relevant for the future (NMC 2018b). The NMC are also moving towards the registration of people who are trained outside the Higher Educations Institutions and not to degree level (NMC 2018b). This means that the NMC will be responsible for validating any programme where an individual wishes to join this part of the register and the NMC have indicated that any validation will include the necessity to reflect both in and on practice (NMC 2018d). Against this backdrop, experienced nurses are expected to continue to support and assess student nurses and student nurse apprentices in practice. As part of this support and assessment process, experienced RNs will be expected to role-model and then assess self-reflection, team reflection and supervision “to promote improvements in practice and services” (NMC 2018d, p. 20).

1.3 Requirements for continuing to practice as an RN in the UK

Currently, there are essential requirements if RNs wish to remain on the NMC register. RNs must abide by a code that dictates professional standards and behaviour (NMC 2018a) and fulfil other requirements. They must pay an annual

retention fee (NMC 2018d) and renew their registration every three years by revalidation (NMC 2018d). According to the NMC (2018d), “revalidation will encourage you to reflect on the role of the Code in your practice and demonstrate that you are 'living' the standards set out within it.” The components of revalidation include:, five pieces of practice-related feedback, five written reflective accounts and evidence of a reflective discussion (NMC 2018d).

1.4 Reflective practice as a requirement of revalidation.

In meeting the requirements for revalidation, RNs are typically expected to complete pieces of reflective writing, chosen from the myriad of clinical experiences they have had since qualification or the last time they re-validated, through which they are expected to demonstrate a changed perspective or changed practice. In the guidance provided by the NMC, it is unclear whether reflective writing should take place in the workplace whilst on duty or out of the workplace as an unpaid activity (NMC 2018d). The documents for completion and return contain no specific guidance on the form that this reflection should take or on the features of effective reflective practice. Lastly, no evidence is cited by the NMC, in the written revalidation information and documents, that illuminates whether or not reflective writing enhances direct patient care.

These issues become even more pressing given the tension between reflective practice and evidence-based practice. The Nurses, Midwives and Health Visitors Act (HMSO 1979) specified the creation of a national body for nurses that would monitor and govern RNs. Initially this body was the UKCC (United Kingdom Central Council) in 1983 but this was superseded by the NMC, created in 2002 as a result of the Nursing and Midwifery Order (HMSO 2001), which legislated for the NMC to become the statutory regulators of the profession. This law and subsequent requirement to register and re-register to keep a job as an RN in the UK have made the NMC very powerful as all RNs pay and continue to support them in the regulation of the profession. However, it may be that the very reflection that the NMC ostensibly aims to promote is being undermined by a top-down approach from the NMC that is imposed on all nurses. The NMC requirements focus on evidence (NMC 2018d) and

performativity (Ball 2003, Mäkelä 2018) and have generated very complex and opposing reactions. On the one hand, it has been argued that it is essential to regulate the profession (NMC 2018c, Francis 2013). On the other hand, some have argued that RNs risk losing their autonomy if they are held to account for every element of practice and this may distract from their ability to meet the needs of each individual patient and setting within which they work (Aveling et al. 2016). Evetts (2011), for example, supports a more individualistic approach and argues that the bureaucratic and litigious paradigm within which we are now working as professionals limits the exercise of discretion and disempowers workers. For RNs, the process of navigating competing requirements can be difficult. The literature suggests that reflection can be highly valuable in navigating this context, for example in constructing or uncovering tacit understandings (Benner 2001, Moon 2004), but that there is a need for guidance and models for reflective practice that accommodate this complexity. It is against this background that this thesis aims to contribute to debates about the role of reflection in nursing and does so through a focus on reflection as a collaborative activity.

1.5 Investigating reflection as a collaborative exercise

The extensive literature on nurses and reflection predominantly presents reflection as an individual activity, often taking the form of writing for example, Boud (2001), Stevens and Cooper (2009) and Bolton (1999, 2014). However, we know from previous studies examining collaborative exercises that sharing perspectives can be highly productive because it encourages a rethinking and re-working of ideas about practice; it can create a sense of belonging and can promote problem solving activities that result in complementary and or alternative perspective and actions (Demissie 2012, Lave and Wenger 1991, Denborough 2006, Flanagan 1954). This thesis therefore starts from the premise that collaborative reflection might be a productive area for development, and more specifically may involve a form of reflection that builds on the collegiate practices that are so much part of RNs' professional lives.

Through this study, I therefore provided opportunities for RNs to reflect on the process of reflection alongside others and investigated what happened as they did so. In doing so I was interested both in how the RNs appeared to understand the purpose and value of reflection, and in the insights that this collaborative process itself suggested about what RNs might gain from reflecting together. The study addresses the following questions:-

1. How do nurses perceive reflection?
2. What are the features of shared reflection?
3. How might opportunities for sharing experience provide contexts for reflection?

In further contextualising the focus for this research, Chapter Two provides an in-depth literature review of research and thought linked to reflection, reflective practice and the professional. Chapter Three discusses the methodology and methods used in this study. Chapter Four presents the data analysis methods, Chapter Five and Six present the findings. Chapter Seven provides a discussion of these findings and Chapter Eight summarises the contributions of this thesis and considers implications and future directions for research and practice.

Chapter 2: Literature review

2.1 Introduction

This chapter evaluates and examines critically the relevant literature, with a particular focus on the body of knowledge on reflective practice. It is not exhaustive or definitive but focuses on sources that have been particularly influential in exploring relationships between nursing, professional practice and reflection, as well as highlighting some emerging trends in this area.

A number of detailed literature reviews have been conducted in this area, for example, Fook at al. (2006) and Moon (2004) who write within the adult education sphere, Mann et al (2007) who focus on health professionals, Mamede and Schmidt (2017) who write in medical education, Beauchamp (2015) and Jayatilleke and Mackie (2013) writing in the nursing and public health domain, and Heckemann et al. (2015) writing in nursing management journals. The reviews conclude that, while much has been written in this area, very little focuses on actual research into reflection in nursing or in other professional contexts and what little research there is tends to be inconclusive (Moon 2004, Fook et al 2006, Jayatilleke and Mackie 2013, Beauchamp 2015, Fook 2015, Edwards 2017). Reasons given for this scarcity of research focus on: the difficulty in defining reflection as a concept and learning tool and of building theory based on qualitative research (Smith et al. 2014, Knutsson et al. 2017, Wihlborg et al. 2017, Andersen et al 2018); the difficulty of measuring the direct effect of reflection on clinical practice (Tutticci et al. 2017, Meziane et al 2018); and also difficulties associated with demonstrating differences in practice as a result of reflection in longitudinal study (Embo et al. 2015, Goudreau et al 2015, Pai 2016).

In light of these issues associated with large amounts of literature and limited research, I begin this chapter by considering literature associated more broadly to reflection and professional learning, reviewing relevant research related to the practice of reflection, drawing on studies from the UK as well as those from other countries where reflection is viewed as a central part of nurse's

professional development. Such work contextualises approaches to developing reflection amongst nurses, with insights into how reflection is perceived and supported in other professions. It also highlights gaps in current thinking and research where further work may be beneficial.

In Section 2.2., I consider the wide and diverse background to reflection, which includes the origins of reflection in the early 20th century through to the resurgence of interest in this area in the 1980s, and more recent debates about the role of emotions. Specifically, I consider influences on nursing and reflective practice, including critical incident technique (CIT) and Benner's (1984) pioneering work on the development of nursing expertise through understanding experiences in nursing. Section 2.3. explores approaches to reflection and includes a review of espoused theory and theory in use and a consideration of where reflection takes place. Other approaches are discussed, ranging from individual reflection in and on practice to reflection before and beyond practice, along with consideration of formal and informal learning. Section 2.4. expands on the contested nature of the definition of reflection, distinguishing between noticing, mindfulness and critical reflection. Section 2.5 explores concerns about reflection and includes the positive and negative effects on the individual, including issues of privacy, consent and memory and the potential use of reflection as evidence. Section 2.6 explores recent and current thinking about reflection and moves away from the individual nature of reflection and towards more situated and shared reflections. Collective reflection is therefore considered, along with more recent iterations of reflection, in the form of productive reflection and including a focus on the use of storytelling in reflection.

2.2 Background to reflection

Many authors have highlighted that reflection is an ambiguous term, and that investigating reflection is highly complex (Fook et al. 2006, Moon 1999, 2004, Finlay 2008, Demissie 2015). Indeed Beauchamp (2015), in a literature review of studies associated with reflection in current teacher education, concludes that multiple definitions and a shifting terminology are common across all professions who use reflective practice as part of initial education and continuing professional development. Others claim that there is not enough

empirical evidence to either define reflection or assess its effect (Black and Plowright 2010, Edwards 2017, Jaystilleke and Mackie 2013, Belvis et al. 2013). Fook et al. (2006) are clear that there is little theoretical and empirical evidence to demonstrate that it is effective as a learning tool, which means that a clear definition is not possible. Nevertheless, given this study's focus on what RNs perceive as reflection, an investigation of different definitions within the literature is necessary in order to provide reference points for a further investigation into what RNs mean by reflection, ways in which reflection is perceived and the potential for sharing experiences.

2.2.1 Origins of reflection

The word 'reflection' originates from the Latin verb 'reflectere' which means bend or turn backwards. Reflection in learning is not a new idea, indeed it is akin to Aristotle's concept of deliberation (Bolton 2014). More recently, Boyd and Fales (1983) see reflective learning as emphasising the ipsative process of the self as the source of learning. By this they mean the monitoring of self as a way to learn and develop. They therefore argue that reflection is a natural process used spontaneously by many people and as such is not a new concept, but that its present significance lies in the emphasis on reflection as a 'paradigm shift' in professional learning from experience.

Dewey is generally regarded as the initial advocator of reflective practice in the 20th century. His definition is often cited and worthy of exploration. He claimed that reflective thought is the "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends" (Dewey 1933, p. 118) and saw this as a learning process. Schön (1983), in discussing the theory and practice of learning, argues that reflective practice could expand and enhance the craft and artistry of a profession. In nursing, reflective practice and Schön's notions of reflection have had a significant impact that is expected to remain fundamental to nursing practice for the foreseeable future (Hannigan 2001). Schön (1983) argued that the way in which individuals think and act in practice and reflect on

practice can lead to deeper understanding and can link the “high hard ground” of theory with the “swampy lowlands” of practice (Schön 1983, p.54). One of the aims of this study is to work within the remit of practice and develop the high hard ground of theory from the, often messy, lowlands of practice (Schön 1983)

Schön’s work is not without its dissenters, Smyth (1989) questioned the lack of a theoretical foundation for Schön’s claims, Eraut (2000) found Schön unclear and vague and Usher et al. (1997) found him unreflexive. Finlay (2008), however, gives a more balanced view of Schön’s work and echoes many in saying that despite the criticisms, which are to be expected, Schön’s work prompted the thinking of later scholars who have themselves become influential in adult and professional education (Moon et al. 2006, Beauchamp 2015, Edwards 2017).

2.2.2 The role of emotion in reflection

Over the last three decades a number of writers have explored the emotional dimension of reflection. While previous writers have emphasised the cognitive and philosophical dimensions of reflection (e.g. Bengtsson, 1995; van Manen, 1995), Boud et al. (1985) highlight the affective dimension of reflective practice. They argue that reflective practice is a standard phrase for new insight and awareness that arises from a cognitive and emotional exploration of experiences. In a later publication, they expand on these ideas (Boud and Walker 1998) and emphasise the affective aspects of learning along with a justification for how these may facilitate or hinder reflection. Feelings throughout any incident, they suggest, are of fundamental importance here because it is only by attending to feelings that one can fully understand and learn from experience. They state that the affective nature of learning is individual and so returning to the experience and attending to the emotional context of the ‘then’ and ‘now’ is crucial in evaluating those experiences and exposing something meaningful.

Later authors in the education and the nursing field also acknowledge the importance of attending to feelings as part of the reflective process and are very clear that reflection involves emotion (Fook et al. 2006, Dirkx 1997 and 2001, Edwards 2014, Heckemann et al 2015). However, the importance is tempered with the difficulty. Mahlanze and Sibiya (2017) investigate the use of reflective journals for clinical, personal, clinical and professional learning, using a small cohort for a quantitative, descriptive study. They find that student nurses feel uncomfortable writing personal feelings and are not clear about the benefits of reflective writing for clinical practice. In addition, Ruiz-López et al (2015) acknowledge the same issues associated with a lack of understanding about reflection and student nurses feeling exposed emotionally and therefore being uncomfortable sharing this unless supported by facilitators they know. The role of emotion in reflection is therefore evident in the literature but there is another dimension, that of the role of reflection in supporting emotional dimensions of practice.

In terms of the role of reflection as an emotional dimension of practice, Adamson and Dewar (2015) explore the way that guided reflection might assist student nurses with an appreciation of compassionate care that translates into practice. Their work is part of a three-year leadership in compassionate care in nursing project that uses action research to explore ways that students can learn to become more compassionate. Adamson and Dewar (2015) find that using reflection can encourage student nurses to be more compassionate but they indicate there is more to do in this area. Similarly, Meziane et al. (2018) conduct mixed method research where the aim is to establish whether a reflective practice intervention, carried out by individual experienced nurses, can alleviate his/her moral distress in end-of-life care. The results from the quantitative data are non-conclusive but the rationale and discussion from the qualitative data clearly cite reflective practice as attending to and being helpful with the emotional elements of caring for end-of-life patients in acute settings.

In examining relationships between emotion and reflection in nursing, Hochschild's (1983) notion of emotional labour is relevant. Hochschild conceived emotional labour as the ability to manage and regulate emotions and following this, much has since been written about emotional labour in nursing (Huynh at al. 2008, Mann and Cowburn 2005, Bolton 1999, 2014, Msiska et al. 2014). These emotional issues are directly addressed by Rees (2013) who phenomenologically investigates the role of reflection in coping with distressing emotional challenges. Her work with final year student nurses acknowledges the emotional labour of nursing (Hochschild 1989) and she tentatively proposes that reflection makes is easier for student nurses to manage their emotions. Subsequently, Schmidt and Diestal (2014), who report on a small, cross-sectional survey, see emotional labour as being at the heart of nursing practice and they distinguish between surface acting and deep acting. They argue that surface acting is the regulation of expressions to align with organisational expectations. Deep acting, on the other hand is associated with modified perceptions that change the felt emotion itself. This aligns with the work of Gross and Desteno who discuss reappraisal in the same way that these authors talk about deep acting. Gross and Destino (2013) suggest that emotion regulation is key to understanding how emotions are regulated in practice. They define this regulation as the ability to manage an emotional response which includes altering the magnitude of the emotion and the altering either the length of time the emotion is present or delaying the time of the emotion. Their process model identifies different types of emotional management, each with different elements and consequences. In short, if the emotion is supressed then this is considered unhealthy and carries inevitable consequences. If the individual can reappraise the situation, downplay their emotion and cognitively try to think about a way to alter the emotional response then this is a better management of emotions and is considered to contribute to emotional resilience (Traynor 2017 and 2018, Aburn et al. 2016, Fletcher and Sarkar 2013). This focus on managing emotions at different levels would seem to be relevant to discussions about nurses' reflection because, in sharing reflections, there

may be indications of ways that RNs are managing the emotional context if what they are discussing.

2.2.3 Critical Incident Technique (CIT)

Over the past sixty years, a number of specific approaches have been used to support nurses' reflective practice (Bailey 1956, Butterfield et al. 2005). One of these is critical incident technique. Flanagan (1954) developed critical incident technique (CIT) as a way of gathering information in order to examine critical failures and near misses in the aviation industry. CIT enabled individuals and experts in the field to examine what went wrong and how they could improve techniques or procedures in the future, to prevent the incident from happening again (Butterfield et al. 2005). Building on the work of Flanagan (1954), a significant move in the development of nurses' reflective practice was the publication of Benner's 'From novice to expert: excellence and power in clinical nursing practice' in 1984. This book gained huge popularity throughout the nursing world as, for the first time, research into the way nurses develop knowledge was carried out. Benner's (1984) interpretive approach involved CIT in which experienced RNs were asked to share incidents from practice. Based on detailed phenomenological research with RNs at all levels, she developed a framework to explain the development of skills and expertise in patient care in nursing from novice (newly qualified RN) to expert (experienced RN).

As a result of Benner's publication, nurses and then physicians and other health professions working in critical care environments in hospitals, adapted CIT and started to use it to reflect individually on what they perceived to be failings in their practice (Johns 1995b, Wihlborg et al 2017). It then became common practice to use this technique in all areas of health care and in multidisciplinary case study meetings and CPD (Ghaye and Lillyman 2006, Butterfield et al. 2005). Given the retrospective and rational way CIT occurs, it is not difficult to see that this technique would also be useful in nursing or in any health care setting, where there is the potential for circumstances or individuals that might cause death or

injury, to prevent similar problems occurring in the future. Currently, CIT is used as a formal requirement when health care professionals formally debrief incidents that occur as part of risk assessment and reporting (NHS Risk assessment framework 2015). In relation to the literature on reflective practice both Mezirow (1981) and Brookfield (1995/2005) recommend using the critical incident technique as a starting point for reflective processes. Although they both make it clear that one can reflect on any type of incident, they also highlight that people tend to reflect on incidents where things have gone wrong. Current research supports this issue. Wihlborg et al. (2017) used the critical incident technique as a method in their qualitative research with ambulance nurses in Sweden and, based on the potential for negativity, were clear to ask participants to "Describe a positive event" (p. 21). While CIT is not a focus for this study, such work does suggest that focussing on negative issues may be a problem for RNs who have and are living in the NHS culture of risk aversion (NHS England 2017, 2018).

2.3 Approaches to reflection

Having explored the background to reflective practice and some influential work, in this section I consider approaches to reflection. I begin by outlining the distinction between espoused theory and theory in use, then consider different kinds of reflection as proposed by Schön (1983, 1987) and debated by other theorists, for example, Boud et al. (1985), Atkins and Murphy (1993), Bulman and Burns (2013) and Comer 2016), supporting this discussion with empirical sources where available.

2.3.1 Espoused theory and theory in use

As part of a discussion about reflection in and on practice, Argyris and Schön (1974) introduced the concept of espoused theory and theory in use. They argue that individuals might think they would act in a certain way and believe in certain things if placed in a certain situation (espoused theory) but then when they are in that situation they may act differently and demonstrate a different set of beliefs (theory-in-use). An example of this might be a nurse who believes that they wash their hands after every

encounter with a patient (espoused theory) but when in practice, does not do this and does not recognise that they are not doing this (theory-in-use). Fook (2007) acknowledges that in health care and indeed in other professions, rules espoused by professionals in theory do not necessarily translate into or are embedded in genuine actions in practice. This distinction between espoused theory and theory in use was relevant to this study as I was interested in how RNs understand and share reflection. I was interested in whether reflection highlighted any incongruity between espoused theory and theory in use, and whether participants recognised this when reflecting on their practice. In considering the potential for reflection to highlight such incongruity, it is helpful to consider different kinds of reflection. In the following sections I therefore distinguish between reflection-in-action, reflection on action, and reflection before and beyond action.

2.3.2 Reflection-in-action

Schön (1987), distinguishes between reflection-in-action and reflection on action as key elements of reflective practice. He writes that reflection-in-action is when we recognise an issue or situation whilst we are still acting, whilst we are still in the middle of it, and where we carry out “on the spot experimenting” (Comer 2016, p. 4) to solve problems and issues in practice. Schön writes that everyday action is carried out in a tacit, intuitive and spontaneous way by skilled practitioners. He calls this “knowing-in-action” (Schön 1983, p. 63) and sees it as artistry. He states that an uncertain, new, unique or conflicting situation produces an element of surprise and that this in turn prompts reflection-in-action. This notion of the element of surprise is supported by Mamede and Schmidt (2004, 2005) who carried out research with medical staff. It also resonates with the concept of cognitive dissonance, which is used to describe the – often uncomfortable situations – in which new learning conflicts with the cognitive structure (Festinger 1957). It may be that the individual partly recognises the conflict and checks out the new information by having an internal argument with themselves (Festinger 1957) or that if the individual has a more sophisticated idea of the structure of knowledge, they may be

more able to recognise and find ways of working with inconsistencies but will try and find ways to resolve the dissonance.
Aronson (1997) suggests that cognitive dissonance is about making sense of something and adds to cognitive dissonance theory by stating that a level of self-awareness is required to make changes in behaviour and beliefs, an idea that is similar to Boud et al.'s (1985) notion that self-awareness is a pre-requisite of reflection. More recently, Bulman and Burns (2013) write that keeping a reflective journal allows individuals to record dissonant moments and subsequent actions. So, the theory of cognitive dissonance may be compared with the element of surprise (Schön 1983) and the uncomfortable feeling (Atkins and Murphy 1993) that precedes or commences the process of reflection-in-action.

In response to Schön's ideas, Jarvis (1983, 1992) suggests that reflection-in-action is thoughtful practice, not reflective practice. He claims that thinking about what one is doing whilst one is doing it is a form of problem solving that does not necessarily lead to a transformation or a changed perspective. Further, Bengtsson (1995) argues that reflection-in-action does not occur. He states that Schön's examples of reflection-in-action may be related to incidents when action was interrupted or when it was just a reaction to the situation, and therefore might be more usefully seen as reflection after the event. Greenwood (1998) moved the debate about reflective practice forward in nursing by critiquing the work of Schön at a time when his work was, arguably, being applied unquestioningly (which is a paradox in itself). Greenwood claims that reflection-in-action is simply a means to an end, for example on-the-spot problem-solving, whereas "seriously reflective practice" (p. 1052) leads to appropriate as opposed to inappropriate nursing actions. For Greenwood, "seriously reflective practice" involves judging whether actions are appropriate in terms of social norms and values and therefore involves reflection on action. The counter argument to this is provided by Mamede and Schmidt (2004) whose qualitative research indicates that the more experienced one becomes the less one is surprised and the less dissonance is noticed. Mann et al. (2007) and Beauchamp (2015) states that there are other

factors involved such as routinised practice and familiarity. Consequently, reflection-in-action can be modified by experience that allows one to be thinking-in-action about more than the action itself. Bengtsson (1995, p .31) identifies this broader type of thinking as “apperception”. On a more practical level, Eraut (1997) questions Schön’s assertions about reflection-in-action, stating that in a busy and full classroom, it is difficult to see any evidence of reflection-in-action in an educational context. Such difficulties may also be evident in a busy ward, department or day in in the life of an RN.

From a nursing point of view, Benner (1984) argues that it is futile to attempt to reflect in action as “if experts are made to attend to the particulars or to a formal model or rule, their performance actually deteriorates” (Benner, 1984, p. 37). This is supported by Gardner (2012) who, in reviewing Benner (1984) in terms of “big ideas” (p. 339) in nursing, asserts that, at the very least, according to Benner’s theory, experts would regress to novices, rule follow and, at worst, reflecting in action could be “downright dangerous” (Gardner 2012). Benner et al. later defend this stance and call reflection-in-action “engaged thinking-in-action” (Benner et al. 2011, p. 10), where, rather than making up new rules at the time, which is what Schön claims is happening, the expert nurse is using tacit knowledge from deep-seated, contextual, prior experiences. The key to the difference, as Benner et al. see it, is that original and dynamic ways of thinking continue to occur in practice. Nevertheless, they acknowledge that reflection-in-action can occur as well, maybe even in a complementary way (Benner et al. 2011).

Edwards (2017), on the other hand, takes issue with nurse education for the wholesale implementation of reflection on action as an assessment strategy and in an attempt to theorise nursing, which, she says, means that reflection-in-action has largely been ignored (Edwards 2017). Mann et al. (2009) and Fook et al. (2006) concur and, in their separate and independent literature reviews, claim that only a few practising professionals have studied reflection-in-action, for example, Pinsky et al.

(1998), Teekman (2000) and Stockhausen 2005). For the most part, Mann et al. (2009) found that studies involve methods of data collection not carried out in actual practice or with “authentic experiences” (p. 613) as does Fook et al. (2006) and more recently Jayatilleke and Mackie (2013).

As can be seen, much debate has been stimulated about whether reflection-in-action is praxis (informed action) or whether it can indeed be possible to reflect in the middle of acting (Greenwood 1993, Atkins and Murphy 1993, Wellington and Austin 1996, Bulman and Schutz 2008, Lestander et al. 2016). Considering these assertions and criticisms, I was interested in what would emerge from the data about the RNs perceptions of reflection-in-action, if indeed they recognised it as such.

2.3.3 Reflection on action

Schön (1983) writes that the difference between reflection in and reflection on action is as an important distinction in reflective practice and that is why it is addressed here. More specifically, reflection on action is seen as a way to uncover knowledge used in a particular situation by looking back and analysing and interpreting what happened (Queirós 2015). In other words, it is thinking about what you have done after the event.

Alternatively, in terms of reflection on action, Benner (1984) argues that intuitive, expert practice is atheoretical and so therefore cannot be reflected upon and related to theory. She also states that every situation is unique and so to attempt to theorise and generalise would be inappropriate and futile. In later publications, she moderates these ideas, seeing clinical wisdom as combining practice and theory (Benner et al. 2011). Greenwood also writes about reflection on action as a “cognitive post-mortem” (Greenwood 1993, p. 1185) and essentially unsound. However, Atkinson (2012) states that reflection on action is deliberate and considered and Fook et al. (2006) writes that it is associated with a change process. Indeed, most authors write that reflection on action is associated with a deeper, more critical examination of actions than reflection-in-action, and that this that can lead to agency (Fook 2010),

emancipatory action (Mezirow 1981), theory deconstruction and reconstruction (Fook et al. 2006), and knowledge construction (Belvis et al 2013).

Recently there have been a number of studies that have set out to correlate reflection and effectiveness. Several procedures for measuring this have been developed for example, Asselin and Fain (2013), in their pilot study with post-registration nurses who are continuing their education, use a mixed method design to ascertain whether reflection can be measured. They focus on testing an instrument to see if this is possible and conclude that the instrument has potential but that there is a need for further testing on larger samples (Asselin and Fain 2013). Similarly, a number of attempts have been made to test the effectiveness of different approaches to reflection for example, Lavoie et al (2013) test a teaching intervention with novice RNs combining high fidelity simulation with reflective debriefing. Again, their conclusions are tentative but they state that novice RNs can learn from their experiences and therefore enhance their clinical judgement if this combined teaching intervention is used. Other studies focus on linking reflection with enhanced clinical decision making (Razieh et al (2018) and testing technology that can assess eye movement to check whether different methods of reflection influence what is observed and what clinical judgements are made as a result of this (Nishimura 2017). However, although the studies discussed have potential, they all state that this kind of testing is exploratory and inferences cannot yet be made until further research is carried out.

2.3.4 Reflection before and beyond action

In critiquing Schön's two-dimensional model, Greenwood (1993) takes issue with Schön's omission of reflection before action. This is supported by Edwards (2014) who proposes two further dimensions: reflection before action and reflection beyond action. This focus on reflection before and beyond action seems to reflect Dewey's (1933) argument that action is continuous and connected (Elkjaer 2009). He states that it is human nature to look forward and even to think about future actions whilst

reflecting on current or previous actions. In a similar way, if much later, van Manen (1991) proposes an additional type of reflection - anticipatory reflection. He describes, for example, how teachers may consider ways of approaching their teaching differently whilst reflecting on practice and, at the same time, think forward to future actions should the same or something similar happen again. A number of authors have suggested that anticipatory reflection can also play a role in reflecting on nursing practice (e.g. Greenwood 1993, Fook et al. 2006, Mann et al. 2009, Raelin 2001, Beauchamp 2015). Other authors however have highlighted the role of reflection *beyond* action, which connects with the cyclical or iterative nature of reflection (Elkjaer 2009). More specifically, Edwards (2017) describes how reflection beyond action may involve practitioners in re-thinking previous reflection in the light of more experience or more knowledge.

Two recent studies have examined the effect of reflection on nursing practice. Embo et al (2015) report on a cross-sectional, retrospective, longitudinal, study with midwifery students where they examined and scored post-clinical placement, written reflective pieces against clinical performance indicators. Essentially, they were examining the effect of reflection on action. They conclude that there is a statistically significant relationship between reflective ability and clinical competence. This view is supported by Pai (2016) in another correlational, longitudinal study. Although the sample size in both studies is not generalisable and the claims not necessarily substantiated by the detail of the study, Pai (2016) who tests the effects of reflection on simulation as well as actual clinical practice, finds that reflective ability (reflection on action) can ease anxiety and therefore improve clinical performance. In considering approaches to reflection, there is little if any recent research into reflection-in-action in nursing, therefore more research should be done to explore the effects and role of different kinds of reflection.

2.3.5 Formal versus informal/non-formal learning

In exploring reflection in, on and beyond action and considering where those reflections might take place, a distinction is often made between formal and informal learning in the workplace (Naidoo and Mtshali 2017, Edwards 2017). Broadly speaking, formal learning is regarded as learning which takes place in a formal learning institution where the content is pre-set by others and where intentional learning takes place. Whereas informal learning, sometimes referred to as non-formal (Eraut 2000), is that which takes place in the workplace and 'on the job' but which is often unplanned and not specifically intentional. Cheetham and Chivers (1996, 2001) report on their research into informal learning in adult education and produce a model of professional learning and professional competence acquisition, which includes reflection. It is interesting to note that Chivers (2003) later identifies that when discussing reflection with the participants, who are all professionals or aspiring professionals, many were doing well at work, oblivious to the need to reflect regularly on practice and getting on "without any overt attempt to follow any recipes for learning from reflection on practice" (Chivers 2003, p. 2), This does not necessarily mean they were not reflecting, merely that if they are, they may have been unaware of it and this illustrates that professional learning can involve a mix of tacit and explicit learning opportunities, some formally taught and some learned in practice, and which may or may not involve conscious reflection. Other, more recent studies, with student nurses focus on perceptions of reflection on action. Anderson et al (2018), for example, investigates the reluctance of student nurses to attend reflective seminars after they had completed a period of clinical practice. In their randomised, crossover research, they conclude that students have a negative attitude to the requirement to attend these seminars and arrived with the intent to stay silent (Anderson et al 2018). In the same way, Adamson and Dewar (2014), who explore on-line reflection using stories, find there is a reluctance to participate but they highlight that the student nurses claim it is useful to listen to the stories. In light of these issues, it seems that consideration of where and how reflection takes place in terms of exploring less formal approaches to reflection should be explored.

2.4 Levels of reflection

As explored in the previous section, relationships between reflection and practice have been conceived in a variety of ways. West (2010), for example, claims that “despite the pervasive mantra of reflective practice as being essential” (p. 66) in health care and elsewhere, professionals can be cynical and compliant, paying little attention to deeper and more critical forms of reflection. This raises questions about whether reflection is brief and pragmatically driven or whether it is lengthy and resulting in a changed perspective or social action. A further complication is that there is a large volume of literature that debates differences in the level of criticality and reflection (Jarvis 1992, Mackintosh 1998, Fook et al. 2006, Moon 2004, Ghaye and Lillyman 2006, Brookfield 2017, Edwards 2017). In this section, I consider various ways in which different *levels* of reflection have been discussed. I begin with noticing and mindful practice, then I discuss critical reflection and then I end by describing a number of models of reflective practice that have been influential in nursing.

2.4.1 Noticing and Mindful practice

Moon (1999) suggested that the first step in the process of reflecting on practice is noticing and Benner et al. (2011) identify noticing as crucial to clinical decision making and a feature of clinical wisdom. By noticing these authors refer to the act of distinguishing an event or feeling as being different to, or similar to, previous experiences. Boud and Walker (1998) also claim that reflective practice involves ‘noticing’ and this, they argue is the act of being aware of yourself, of others and of the environment. This noticing and being aware, Boud, Keough and Walker (1998) argue, is crucial to reflective practice because it is the preliminary step in the analysis and subsequent evaluation of an experience. Later research by Bussard (2015) supports the notion of noticing in her study about reflection and the development of clinical judgement in student nurses. She uses Tanner’s (2006) model of clinical judgement, the first step of which is noticing. Although Bussard’s (2015) research was carried out following high-fidelity simulation rather than authentic practice, she concludes that students demonstrate evidence of noticing in journals produced post-

simulation training, indeed more comments relate to noticing than any other element of clinical judgement. Conversely, Padden (2013) conducted a pilot study to assess the validity and reliability of assessing written reflection on action in student nurses and uses clinical judgement as one of the indicators.

In a similar vein, Epstein (1999, 2003a) refers to “mindful practice” as essential to reflective practice and suggests that habits of mindfulness lead to being reflective. By the same token, Boud, Keogh and Walker (1985) identify that there are prerequisites to reflection such as self-awareness. They contend that if one were not self-aware, one could not be reflective. Likewise, Stuart (2000) writes that reflective practice, as a process, can only commence if one demonstrates self-awareness. Further, Epstein (1999) sees mindfulness as involving a conscious attempt to stop and place oneself in a calm, considered state of mind to think about one’s own state of mind, that of others and to be present in the environment and situation. In this way he writes that clinicians, in particular physicians, can relate better to themselves and others and become more effective in their practice. Similarly, and much later, Caley et al. (2017) carry out mixed method but predominantly quantitative research exploring group reflective practice sessions with researchers in a clinical oncology setting. Their results are inconclusive but it is interesting that they use the Mindful Attention Awareness Scale with RNs and researchers in an oncology setting, in an attempt to discover whether mindfulness can improve healthcare provision. Their tentative findings are that mindfulness, as part of group reflection, can assist in thinking about the environment and in feeling supported professionally.

2.4.2 Critical Reflection

Critical reflection is a subject of much debate. Put concisely, reflection is deemed by many authors to concern questions arising from practice and in practice and how they can be solved (Schön 1983, Moon 2007, Fook 2015), whereas critical reflection is deemed to be a deeper and broader interrogation of oneself, the organisation, the political or social arena

(Hatton and Smith 1995, Swan 2008, Brookfield 2017, McDrury and Alterio 2001, Walker et al. 2013, Edwards 2017).

One particular approach to critical reflection involves single- and double-loop learning as proposed by Argyris and Schön (1974). Single loop learning refers to the unthinking actions of learned behaviour whereas double loop learning refers to thinking that does not just search for alternative actions but is also considerate of the values and social structures affected by those actions (Argyris and Schön 1974). Tashiro et al (2013) who also published a concept analysis of reflection in nursing, use the example of a second-year student nurse who struggles to communicate effectively as a team member. She sees this as a normal part of the process of orientation and makes various unthinking attempts to solve the problem (single loop learning) but does little about it until prompted to reflect. She then, with encouragement, learns to communicate more effectively and as a result becomes more confident and more insightful about her need to be pro-active in her learning and believes that this will assist her in future orientation to different clinical settings (double loop learning) (Tashiro et al. 2013).

Whilst Argyris and Schön (1974) use the distinction between single and double loop learning to consider the relationship between individual actions and organisational aims and goals, Greenwood (1993) argues that a defining element of reflective as opposed to thoughtful practice is the use of double loop learning that takes account of the values and beliefs of the individual and those working closely with them. Greenwood (1993) is supported in this by Wellington and Austin (1996), who state that what reflective people write about when they are reflecting on action is dependent on what they think is practical and that what they think is practical is based on their values and beliefs. More recently, Tosey et al (2011) explore the idea of triple loop learning in their critical review and concept analysis but express concern about uncritical application of theories associated with “higher level learning” (p. 303). Despite these

arguments about the level and nature of critical reflection, there are few examples in recent research in nursing.

Other work exploring the quality of reflection includes that which has argued that reflection is part of deep as opposed to surface learning (e.g. Hounsell et al. 1997, Entwistle 1981). Marton and Säljö (1976) first conceived the notion of deep and surface learning and write that surface learning consists of seeing learning as an objective task of memorising and recalling information without necessarily understanding what it is about. Deep learning, on the other hand, involves engaging with the information, trying to understand it in different contexts and thinking beyond the initial information, which could be related to double loop learning as discussed before. Biggs (2003) however argues that no learner is either a surface or deep learner and that the depth of learning varies according to context. He also states that, even within any one context, learners could flip from surface to deep and back again depending on their motivation, which could be internally or externally driven.

These debates about the relationship between deep thinking and reflection continue. Indeed Brookfield (2009) contends that reflection, reflexivity and critical reflection are unclear and ambiguous concepts and that the depth of reflection generated in any one context would vary according to the individual's perspective. Brookfield (1995) has long asserted that reflection is an everyday process, whereas critical reflection is not so commonplace and is about understanding power and how it can be used to expand or restrict our working practice (Fook et al. 2006). Mann et al. (2009) refer to this difference as a vertical dimension, in that a more surface reflection is seen as descriptive and problem solving but deeper critical reflection is more analytical, more difficult to achieve and less easily demonstrated.

The influential work of Mezirow (1981) focusses on critical reflection as a means of achieving perspective transformation, whereby through a critically reflective process, either a change in beliefs or values or a

change in behaviour takes place. He also writes that perspective transformation is about looking into oneself and being pro-active in making decisions, judgements and being empowered to change conditions and circumstances (Mezirow 1981). Mezirow (1981) highlights the importance of instrumental and communicative learning in achieving such transformation, which involves examining our own point of view and habits of mind. Such an approach, he argues, involves problematising situations that would otherwise appear taken for granted and questioning the validity of those assumptions (Mezirow 1998). Brookfield (1995), another respected thinker and writer in the field of adult education, was influenced by Mezirow and further develops the theory of critical reflection. Brookfield's (1995) work is considered instrumental in finding ways to become more critically reflective by "hunting assumptions" and considering incidents in practice from different perspectives (p. 21) (Cranton 2011).

In attempting to explain his concept of reflective practice, Johns (1995b) developed a structured model of reflection involving very specific questions, which invited nurses to consider the influencing factors of an incident in terms of their learning that included the empirical, personal, ethical and aesthetic elements of the incident. These elements are deemed by Carper (1978) to be fundamental ways of knowing in nursing. This questioning model is often used with student nurses during their first forays into reflective practice in nursing (Moon 2006, Fook et al. 2006 Edwards 2014). Johns further developed this structured set of questions to guide reflection in 2006, amending it to acknowledge more global and spiritual conceptions of reflection and mindfulness. Johns' model (1993, 2006) has also been used in recent research into reflective practice in nursing. Meziane et al. (2018) used Johns' model of structured reflection as the intervention in a pre-test/post-test feasibility pilot study (19 RNs) to discover whether a reflective practice intervention decreased moral distress in acute care RNs working with end-of-life patients. Their conclusions were that using Johns model as an intervention was perceived by the RNs to be feasible and acceptable but that, predictably,

as there was no significant statistical differences pre and post-test, other studies would need to be conducted to demonstrate its efficacy.

2.4.3 Models of reflection

Many authors have attempted to explain the reflective practice process in terms of a process or model and there is a profusion of models which are generally a result of theoretical critique, conceptual analysis or research, for example those developed by Mezirow (1981), Brookfield (1995, 2017) and Bass et al. (2017). Where there is research into reflective practice, attempts to explore definitions and perceptions of reflection or to seek a causal effect between reflection and action have resulted in the production of yet more models of reflection, either in the process of data collection (Lestander et al. 2016) or as an attempt to explain findings (Gustafsson and Fagerberg 2004, Caley et al. 2017).

Ghaye and Lillyman (2006, p. 20) identify different categories of models, including those which are structured (Johns 1995), hierarchical (Mezirow 1981), iterative (Kolb 1984 and 2015, Gibbs 1988, Atkins and Murphy 1993), and holistic (Bass et al 2017). Hierarchical models (e.g. Mezirow 1981, Caley et al. 2017) propose that the '*depth*' of critical reflection is achieved by reaching '*higher*' levels of critical and emancipatory actions. Iterative models are cyclical in nature, with the intention that the user reaches deeper and different understandings on each round of reflection. Kolb (1984, 2015) and Gibbs (1988) are the most commonly cited of the iterative models and are claimed to be the most commonly used in undergraduate nursing programmes in the UK (Rees 2013, Bulman et al. 2016, Tashiro et al. 2017). According to Bass et al (2017), in their theorical paper introducing a holistic model of reflection for midwives, holistic models are derived from philosophical underpinnings and relate to more inclusive, evolving forms of reflection where diversity and borrowings from other cultures and disciplines are encouraged. Johns later model of reflection focussing on spiritual and mindful ways of reflecting is an example of these later iterations (Johns 2006).

As can be seen in the previous discussion, the amount and variety of models that attempt to explain or use reflection as a tool for learning are myriad and complex. The difficulty is that no one model is likely to work for every incident, situation or feeling that one might wish to reflect upon, nor does everyone find the same model useful (Palmer et al.1994, Bulman et al. 2016). Another difficulty is that, by providing a structure for reflection, these models may invite practitioners to follow prescribed formats to reflect on their practice which can mean that they do so unreflectively. As such, models could reproduce the technical rational approach so passionately argued against by Dewey and Schön to name but a few. Indeed Boud (2010, p. 25) stated that these models seem to reproduce "excessively instrumental approaches to their use". Although he acknowledges that models of reflection have been useful in providing frameworks that help in the conceptualisation of adult learning processes, Boud (2010) also argues that reflection should be situated firmly in practice. Rather than working to develop a model, or indeed to build on existing models, this study therefore sought to explore the process of reflection amongst practitioners in more depth to discover how they perceive reflection and how they might or might not use it in or on practice.

2.5 Concerns about reflective practice

While much of the literature highlights positive aspects of reflective practice, it is also important to acknowledge issues and problems that might arise and how these relate to formal and informal learning. First and foremost, as stated earlier, there has been debate about the paucity of evidence to support the use of reflection (Burton 2000). Some writers state that reflective practice as a learning tool is unsound (Mackintosh 1998) and that there is no evidence that it works to make nurses better at nursing (Newell 1992). However, there are also other issues pertaining to the practice of reflection that should be considered. The following section therefore considers issues relating to: reflection and the individual, reflection and privacy, consent and memory, positive versus negative experiences of reflection, and reflection as evidence.

2.5.1 Reflection and the individual

Many writers have expressed concerns about the impact of reflective practice on individual wellbeing. Indeed, some have suggested that it can affect an individual's mental health if they recall events that upset them or where their safety was compromised (Hunt 2001, Stuart 2000). Sometimes areas of examination may be pursued without the realisation that they are touching on core personal concerns or problems that might have been encountered in the past. Once this becomes apparent, it can have grave consequences for the individual if not handled carefully (Hunt 2001). Stuart (2000) proposes that reflection can therefore be a profound personal experience and that it involves an element of risk taking because there is an expectation that these reflections will be shared, whether in writing or in a group, and that returning to painful experiences can produce unexpected emotions and feelings that were not intended to be shared. These issues are discussed in more detail in relation to the ethical framework for this study, as discussed in Chapter 3.

2.5.2 Reflection and privacy

Another issue of concern relates to the ownership of reflection. Does the individual own the experience, for example, and if so, can they make decisions about what to do with it? Rich and Parker (1995) state that making people undertake written reflection, where they are required to record their thoughts and feelings, is an intrusion of privacy. Fernández-Peña et al (2016) consider this in their mixed method research with a small cohort of student nurses and highlight issues with understanding the concept of reflection and concerns about maintaining privacy in written journals that are to be formally assessed. The sense of audience can influence the nature and quality of reflection as well. For example, Platzer et al. (2000), in their research with post-registration students, discovered an element of passive resistance. That is, they report that students often choose an incident that has little significance to them, write about it using one of the prescribed models for reflection and describe a changed perspective. They do not engage emotionally, and they do not invest effort in it. It is this instrumental approach to reflective practice that Boud (2010)

indicates is becoming more prevalent. Any form of reflection also requires motivation and time. Being forced to reflect does not suggest that the exercise will necessarily be a fruitful one and Coward (2011, p. 883) and Trumbo (2017, p. 433) both identify that medical and nursing undergraduate students are suffering from “reflection fatigue”. I would suggest that this “reflection fatigue” may also be experienced by RNs. This is particularly an area of concern given arguments for building a community of nursing practice in which reflection is seen as an internal individual activity carried out because it is required or expected (Ghaye 2007). Boud (2010) recognises that individuals have common concerns and that they work in professional and inter-professional teams and that consequently it might be worth the team reflecting together on those areas of concern. Rather than seeing reflection as an individual process, such work suggests that reflection may be conceived as a collaborative process as discussed in section 2.6. This is a theme I return to later.

2.5.3 Consent and memory

Some writers have also expressed concerns about the patients or clients who are often the subject of reflective practice, pointing out that they have not agreed to themselves or their details being discussed or written about (Hargreaves 2010). Although case studies have been used for years as a way to describe care, Hargreaves (2000) suggests that, in reflective practice, details about the patient are not just given as facts, they are interpreted and judged by the individual reflecting upon them - a different thing altogether. Whilst anonymity must be adhered to (NMC 2018a) it is likely that patients, clients or relatives may be unhappy with someone examining their responses and emotions in detail and describing in writing what happened after the event. Clinton (1998) and Newell (1992) also point out that incidents or experiences are reliant upon memory, which may not be accurate. When a nurse shares an account of practice, it contains their opinions that are burdened by expectations, assumptions and their own feelings (Benner 2001). In other words, opinions, feelings and beliefs about the behaviour and attitude of specific patients are recalled but not always accurately. These perceptions of the nurse are

also discussed, written about and assessed by others not immediately within the purview of that particular patient's care, and this is without the patient's knowledge and consent.

2.5.4 Reflection as evidence

Writing about reflections can be particularly problematic. Hargreaves (1997) worries that "nurses' own reflections may place them in a vulnerable position, especially where formal investigation of care ensues", and when "the reflections which were intended to be confidential and personal, may take on the nature of 'evidence'" (p. 225). I have personally experienced this. As an RN and when I was completing a course, I reflected upon issues I was having managing the poor performance of a doctor in order to examine my own practice and ways I might do it differently. When this doctor was legally held to account, I was asked to make my written reflections public and then my training and experience were belittled for daring to write about a 'senior' doctor's practice and make judgements that were not mine to make. Bright (1996) however takes the view that reflection is a form of self-monitoring imposed by organisations, where the detection of errors, especially in decision making, is the purpose of reflection and that either the individual will correct it by having a changed perspective, or if it is written, others will correct their practice or call them to account.

Greenwood (1998) argues that there should also be reflection *before* action to prevent problems arising in the first place and this highlights another issue about bad practice (Burnard 1995). All RNs are required to abide by the Code (NMC 2018a) and this includes nurse educators. When nurses highlight bad or unsafe practice to other nurses, there is no choice but to act upon it. This can create many problems with other members of the team and may affect the decision of the nurse to share incidents and experiences, or perhaps even to think about them. This also has implications for researching reflective practice. In this study for example, as I am an RN and must abide by the Code myself, I clarified this

additional obligation to participants as part of the consent process (see Chapter 3, section 3.3.)

2.6 Towards shared reflection

In the discussion so far in this chapter, the emphasis has been on reflection by individuals. Increasingly, however, those working in the field of professional learning are moving away from individual reflection and the internal musings of the mind and towards a shared experience, be that as a group of nurses reflecting together or more formally structured by an organisation. For example, a number of researchers either use reflective practice groups in their data collection (Goudrea et al 2015) or explore the use of reflective practice groups as a tool for professional development (Bulman et al 2016). Clarke (2014) is one of the few researchers to use focus groups as a method to explore student nurses and nurse teachers' perceptions of reflection on action. Her findings suggest the same struggles with definition as discussed previously in section 2.2. and she subsequently develops another model of reflection to explain them. There are some examples where group reflection is inferred (Adamson and Dewar 2015) or studied (Smit and Tremethick 2017, Mettiäinen and Vähämaa 2013) with student nurses as the sample but predominantly, group reflective practice is investigated using RNs as the sample. An example of this is Dawber (2013a) whose evaluative study examines the use of reflective practice groups with psychiatric RNs and then, following the development of a model of reflection, further evaluates the use reflective practice groups with adult, general RNs (Dawber 2013b). What is unusual about Dawber's work is that the reflective practice groups meet in or near the area of practice. His work is quantitative and although he acknowledges the limitations in terms of purposive sampling and sample size, Dawber (2013a and b) concludes that these reflective practice groups can support RNs in their practice and have an impact on the quality of care. Similarly, Naidoo and Mtshali (2017), in their study exploring the use of communities of practice with nurses caring for HIV patients in South Africa, write that this kind of shared reflection can be supported by organisations and may lead to collaborative changes that are action orientated and may enhance autonomy. In this study, I hoped to better understand the

nature of sharing reflection and they ways in which RNs might support each other in the endeavour.

2.6.1 Collective reflection

In recent years there has been increasingly interest in a more overt kind of shared reflection using communities of practice (Edgar et al 2016, Naidoo and Mtshali 2017, Bulman et al 2016). Increasingly, writers and researchers are discussing ways in which this kind of shared reflection might be realised (Gustafsson and Fagerberg, 2004, Demissie 2015). Gustafsson and Fagerberg (2004, p. 612) in their phenomenological research about the links between RNs professional development and reflection, for example, ask: “Is reflection most effective when shared?” and conclude that multiple perspectives and sources present better opportunities to gather additional information and check assumptions. Demissie (2011, 2015) explores philosophical communities of enquiry with student teachers and infers that communities provide powerful opportunities to reflect on practice. Both Gustafsson and Fagerberg (2004) and Demissie (2011) however suggest that further research into shared reflection as a learning and professional development tool is necessary. Linked to this notion of shared reflection is the term “public reflection” which is defined by Raelin (2001, p. 12) as “when one reflects in the company of others who are committed to the encounter.” His work is connected to critical theory where he links reflection to social action. Although Raelin balances his ideas about public reflection with the consequences of social action, he makes it clear that sharing reflection or making it public can not only help solve individuals’ dilemmas but can also contribute collectively to realisations that problems are sometimes shared and to the breaking down of assumptions that might lead to new understandings. Raelin (2008), in a later work, used the concept of communities of practice (CoPs) to further explain his ideas. In considering the notion of public reflection in relation to this study, the importance and consequence of sharing reflection publicly is highlighted by Raelin (2001, 2008) and is of concern to RNs who are expected to do this verbally and in writing if they wish to continue to practice (NMC 2018d).

This trend towards a more collective kind of reflection is also evident in more recent work by Boud et al. (2006). Along with other key thinkers, they have moved on from earlier conceptions of individual reflection (Boud et al. 1985) to the notion of productive reflection (Boud et al. 2006a). The idea of productive reflection captures the notion that the critically reflective activity of the individual is at work within a particular context (reflection-in-action), and that this type of productive reflection is as a result of being in a place where the individual's thoughts about practice is generated and encouraged in the first place. Boud et al (2006b) argue that such productive reflection is most effectively facilitated by a combination of formal strategies and policies promoting reflection at work, consideration of the individuals learning activities at work; attention to cultural aspects of learning at work and, most importantly, group activities encouraging productive reflection in and on action. However, Boud (2006) warns that although reflection should be a legitimate part of work, there is a risk that this kind of approach is associated with "over-formalizing" (p. 159) or "instrumental" (p. 21) reflection. His co-writers warn of other issues with productive reflection, for example, Schenkel (2006, Chapter 6) sees the possibility of power relations being affected and Elmholdt and Brinkmann (2006) claim that productive reflection could be a method of exerting insidious control (Boud et al. 2006a). Nevertheless, Ellström (2006) sees productive reflection as the nexus between work and learning, where reflection at work, with others, becomes part of everyday working practice and supports groups to generate ideas and solutions bound to organisational aims and intent (Ellström 2006). Boud shares these views and identifies that embedded productive reflection can be "open, unpredictable, dynamic and changing" (Boud, 2010, p. 32). These ideas about collective reflection have been highly influential in shaping the focus and methodology for my own research as I am interested in how shared or collective reflection might be valuable to nurses, while at the same time avoiding the kinds of insidious control that Elmholdt and Brinkmann (2006) highlight.

2.6.2 Storytelling and reflection

In developing understanding of how knowledge circulates in communities, McDrury and Alterio (2001) discuss the role of storytelling in the context of higher education. They explore how using story can relate to reflection and contribute to professional development. They discuss their research using storytelling for reflective purposes and identify that reasons that stories are told about practice is either to make sense of an incident or for the release of emotions. They further suggest that, within such dialogue, the role of the listener is crucial; the storyteller can confirm and explain any questions that the listener might have, thus creating an opportunity for a deeper, more meaningful reflection and by this they mean the type of critical reflection discussed in section 2.4. (McDrury and Alterio 2001). Edwards (2014) arrives at similar conclusions based on her research with student nurses and storytelling for reflective purposes. She suggests that story can retrieve learning that has been forgotten and give meaning to half remembered instances and occurrences in practice. She writes eloquently about the use of story for reflection in nursing and nurse education and promotes the idea of finding meaning that originates from practice using reflective stories (Edwards 2014). Moon (2004), another author who has written has written extensively about reflection in nursing and health care, also recommends the use of stories with reflection and sees stories as a significant way to develop reflective learning.

A number of writers argue that the role of storytelling in education needs investigating further (McDrury and Alterio 2001), Moon 2004, Moon and Fowler 2008, Edwards 2014). However, the emphasis in all these studies is on storytelling- or story writing by individuals (McDrury and Alterio 2003, Moon 2004, Moon and Fowler 2008 and Edwards 2014). As my study progressed, I became increasingly interested in the role of stories when shared within groups of nurses, and in how sharing reflection through using stories might add to understanding about learning within communities of practice.

2.7 Conclusion

Drawing this discussion to a close, reflection has been a feature of education and professional development in nursing for some years now. The NMC and other nursing bodies have shown no inclination to remove its requirement from pre-registration courses or from the requirement to revalidate, so nurses continue to be required to engage in regular reflection if they wish to join or stay on the register. To what extent they comply is still debatable, but the above discussion identifies that reflection is still a contested concept, that there are nuances that are complex, and that consensus on the best approach to promoting reflection is difficult to reach.

In Section 2.2, I explored the background and origins of reflection, which included the role of emotion in reflection and gave examples of literature from the wide and extensive works on reflection and learning. Section 2.3 highlighted the variety of approaches to reflection including espoused theory and theory in use, reflection before, in, on and beyond action and formal versus informal/non-formal learning where notions of reflection consist of when and where it takes place. Section 2.4 considered levels of reflection including noticing, mindfulness, critical reflection and models that illustrate the range of levels of reflection, concluding that most of the literature focusses on how the individual might carry out reflective practice. Section 2.5 explored concerns about reflective practice to do with the effect on the individual, privacy, consent and memory and reflection as evidence, bringing in the ethical dimensions that have relevance for my study. Finally, Section 2.6 took account of shifts away from individual reflection to ways in which reflection can be shared, including a focus on the role of sharing stories.

In the light of this previous research and conceptualisation, my own study was driven by an interest in knowing more about what RNs thought about reflection and how they share it. As explored more fully in the Chapter 3, I approached this using focus groups as well as individual interviews and this gave me an opportunity to explore not only individual perceptions but to gain some insights into how they reflected together and the possible value of this process. As the

study progressed, I became increasingly interested in the role of storytelling in this process. In summary, the research questions addressed through this study are as follows:-

1. How do nurses perceive reflection?

Through this question I was interested in whether RNs could define reflection and if they did, how they did so. I was also interested in any implicit understandings of reflection that seemed to emerge through discussion, and in their perspectives on the value of reflection to their professional lives.

2. What are the features of shared reflection?

Through this question, I was interested in what shared reflection might look and feel like. I was interested in the kinds of interactions that seemed to be generated as RNs' talked together about their experience, and also in their perceptions of the value of this experience as an opportunity for reflection.

3. How might opportunities for sharing experience provide contexts for reflection?

Through this question, I was interested how sharing experience might provide an opportunity for reflection and if so, how this seems to happen. In the next chapter, in order to frame my research, I outline the methodology.

Chapter 3: The research design

3.1 Introduction

This chapter is concerned with the research design. It begins with a discussion of methodology, my positionality in the study and how the methodology developed as the study progressed. Next, sampling is discussed and the recruitment process explained along with details about the participants and their level of experience and nursing speciality. The types of data collection are then outlined: focus groups, follow-up interviews and independent individual interviews, along with schedules. Finally, my ethical framework is described and discussed.

3.2 Methodology

My study explores how RNs understand reflection, their perceptions of how it informs their everyday practice and how they use reflection together. To re-cap, my research questions are:

1. How do nurses perceive reflection?

2. What are the features of shared reflection?

3. How might opportunities for sharing experience provide contexts for reflection?

In exploring nurses' experiences of reflective practice, this study is influenced by interpretive/hermeneutic phenomenology, which is said to be a philosophy or the study of "meanings embedded in common life practices" (Lopez and Willis 2004, p. 728) and is underpinned by the philosophies of Heidegger (1927/2002a) and Schutz (1946, 1970/1972) and writers influenced by them. My theoretical position draws on two strands of thought: first Heidegger's ideas about interpretive phenomenology (Moran and Mooney 1927/2002a) and second, Schutz's notions about phenomenology in the social world (Schutz 1972). As the study progressed, I became increasingly interested, not just in what participants told me about their experience, but the way they did so during the study, and this led me to complement my phenomenological approach with approaches associated with narrative methodologies.

3.2.1 Phenomenological approaches

Interpretive phenomenology involves focussing on the lived experience of individuals and their perceptions of that experience (Heidegger 1962, in Moran and Mooney 2002). This is appropriate to my study because I was interested in the perceptions of RNs on the concept of reflection and whether these perceptions might relate to their practical experiences. By focussing on their accounts of lived experience, I was interested in their intentionality towards reflective practice, that is, their conscious awareness of reflection and how they directed their thoughts towards understanding what the term meant (Hickerson 2009).

Moving on from the notion of intentionality, Heidegger (1962) argues that the individual does not act within a separate and distinct world and proposes that people interact in the practical world or "being in the world" or "dasein" (Dreyfus and Wrathall 2009, p552). According to Dreyfus and Wrathall (2009), Heidegger (1962) states that people dislike distance, want to interact with each other and are eager not to be different from the norm, and so they are socialised into the local culture. As a result of this need for closeness and connection, he deemed that we are in the dasein; we are what we do. Heidegger (1962) claimed that we act like this because we have been socially conditioned into functioning in an unreflective way in the world (Dreyfus and Wrathall 2009, p288). These ideas resonate with my personal experience of nursing. Nurses, in my experience, carry out a lot of practical tasks without necessarily thinking about them; Rytterström et al. (2011) would call them routine or mechanical (ready-to-hand). Then, only when something is different, goes wrong, or appears wrong, do we bring the issue to our consciousness (unready-to-hand). It would seem that there are links between this philosophical approach and the ideas about reflective practice (Fook et al. 2006) and tacit knowledge (Moon 2004) that were debated in Chapter 2. It also follows that RNs use typification, described by Overgaard and Zahavi (2009) as a set of assumptions, or practical know-how (Schutz 1962), to bring some intersubjective agreement to their world. By this I mean the means of reaching, mainly unconsciously, agreement with each other

about how they practice nursing, within the sphere in which they are working. This can differ from clinical area to clinical area and might also be different from a broader concept of organisational agreement (Ghaye et al. 2008).

Following on from this, Schutz and Luckman (1989) discuss the common-sense knowledge with which ‘members’ of a social group approach the life-world, along with a stock of knowledge composed of ordinary constructs that are social in origin; they propose that ‘members’ of this social group appear to be already acquainted and may share these constructs, usually fairly successfully. This would seem to be the case in the nursing community, especially in specific contexts and settings (such as hospitals), where RNs may share a taken-for-granted world and a set of understandings about each other, about patients, and about care (Pierson 1999, Brooker and Waugh 2013). According to Schutz, this is another element in the pattern of typification and is an assumption that others have "systems of relevances" that are similar to their own (Schutz 1946, p 12).

This perspective has implications for the research process as well as for RNs knowledge and practice. In investigating reflection with experienced nurses, it would be difficult for an outsider with no experience of these systems of relevances to understand and appreciate the particular language that nurses use and the nuances of an RNs education and clinical practice. Burns et al. (2012, p. 53) when investigating reflexivity in midwifery settings identify that having a similar qualification and background helps with the ability to “’blend in’” and obtain a “’degree of acceptance’” from participants. Schutz (1946, p. 466) suggests that the researcher can therefore be the “well informed citizen” (the interpreter for the practising nurse) and this is what I hoped to bring to the process of this study. I aimed to understand and appreciate the experiences and

reflections of the participants in the context of an authentic and genuine attempt to share their perceptions and incidents. I believed that I was well placed to do this because of my extensive experience as an RN.

However, whilst sharing these similarities and the taken-for-granted world with my participants could seem to be advantageous, there are issues with this insider role. Burns et al. (2012), for example, warn that “role confusion and over-identification with participants” can create challengers for the researcher (Burns 2012, p. 53). Further commentary on my position as a researcher is therefore warranted.

3.2.2 Positioning myself

In approaching this study, I saw myself as an insider researcher, an experienced, RN who had previously worked with or taught the participants about elements of the nursing world. However, I was also conscious of being an outsider in this role of researcher and these tensions are eloquently discussed by Merton (1972). In distinguishing between insider and outsider researchers, Merton (1972) argues that the insider (emic) role is where one is involved and known in the community in which the research is taking place. The outsider (etic) role is where one is distanced from that which is being studied. Merton argues that researchers need to shift between insider and outsider roles as the situation warrants and this is supported by Simmons (2007) who reports on an ethnographic study into the role of nurse consultants in a hospital setting. Simmons explores how an insider role was important when recruiting participants, collecting data and understanding the findings but that an outsider role enabled her to separate herself from certain issues and conflicts that arose.

In considering the advantages and disadvantages of being emic or etic, Hammersley (1993) argues that human beings are unique and complex with different perceptions and so one cannot be classed as an insider or an outsider. It follows, he claims, that there are no advantages or disadvantages to being an insider or outsider as it depends on the purpose of the research. Whilst supporting this notion, Eder and Fingerson (2003) discuss the advantages of insider research and suggest that insiders are more likely to establish rapport due to a familiarity with the culture and that therefore more personal information may be shared by participants. Similarly, Blythe et al. (2013) identify that familiarity and

knowledge can generate depth, bring a greater understanding and inform the research process. Operating as an insider in this study, meant that I was familiar with the participants, the culture and the terminology of being an RN. On the other hand, Bonner and Tolhurst (2002) warn that the researcher may make assumptions about what is being said without seeking clarification and that the ability to take a step back is crucial so that the 'taken-for-granted' is examined. An example from my study was when a participant was discussing a patient who had died. My action was to console the participant and try and find ways to help her to manage this distressing part of the job, which I did, along with another experienced RN. At the time, I did not see it as significant because I had helped many RNs with the difficult situations that are a regular part of the practice of an RN. It was only when initially analysing the data and before the next data collection episode that I was able to step back, recognise an insider contribution to the data collection and, in stepping back, appreciate the importance of emotional labour in nursing (Delgado et al. 2017). This etic perspective about emotional labour became more significant in data collection. I knew that I would still get involved and help a struggling RN during further individual data collection but I also knew that other, more experienced RNs would help if they were present. For me, making judgements about the distinction between involvement and detachment was not easy (Greene 2014). In continuing with the example above, I therefore tried to ensure that I focussed on facilitating the group in future encounters, and allowed the conversations to ebb and flow, as guided by the participants. Using the interview prompt sheets allowed me to break eye contact and remain silent, trying to withdraw to an extent from my insider perspective, but when the participants struggled to explain a point or when there was a lengthy silence, I gave an example or asked a question.

In phenomenological terms, Husserl (1913/2002) writes that it is possible to establish rigour by disassociating oneself from the research and reducing the phenomenon in question to its "essence" (Moran and Mooney 2002, p. 59). Peshkin (1988) however states that this kind of 'bracketing' is

unachievable. He argues that our interactions with others are a part of ourselves and that acknowledging this is a fundamental part of qualitative research. This idea is also supported by van Manen (1991) who states that this suspension of involvement may be "obstructed by pre-conceptions and theoretical notions" (van Manen 1997, p. 184). I am of the latter school of thought. I do not believe I can extricate myself from my research because, in attempting to describe the experiences of others, I am influenced by my ontological position of what I know and my epistemological position of how I know it. Instead I aimed to ensure that I engaged in a "formal systematic monitoring of self" (Peshkin 1988, p .20) and worked to "actively seek out my subjectivity" (Peshkin 1988, p. 18). I attempted this by embracing my subjectivity and ensuring that I wholeheartedly immersed myself in the data collection and analysis. I also ensured that I frequently reflected and 'reflexed' and recorded those thoughts and ideas (an example of one of these reflexion records is in Appendix i) and I continue to do so in this thesis. As Merrill and West (2009) say, "it is important to think about how our own biographies may shape our interest in others and their lives." (p. 14)

3.2.3 Storytelling – an unplanned emergence

As I listened to the participants sharing experiences during focus groups and interviews, I realised that they were telling and listening to stories, even if these stories were "partial, selections of realities" (Plummer 2008, p. 485). These stories told by participants often had a sequence and included emotion, some kind of action and an outcome (McDrury and Alterio 2003). The stories were shared with involved listeners who responded, including myself. If, as Bruner (1987) so eloquently puts it "tellers and listeners must share some 'deep structure' about the nature of a 'life'" (p, 699), then sharing experiences that involve patients and, at times, life and death moments must be inclusive of deep structures of meaning.

The relationship between storytelling and reflection has been explored by a number of other writers (Sandelowski 1994, Stockhausen 2005). Alsup (2006), for example, shares stories from participants in her research into

teacher identity. The insights generated into teacher identity mirror many of the issues faced by RNs in their path towards and to living within the community of experienced RNs. Alsup (2006) argues that stories or beliefs "grounded in real-world experiences and connected to various understandings of self……can result in reflective thinking and identity growth, rather than superficial and reductive summaries of educational jargon" (P. 170-171). In my study, stories told by RNs were varied in nature. Many indeed were very short and often told as part of an ongoing dialogue. However, they appeared to present valuable insights into RNs' perceptions of reflection and also into how they share insights about practice as RNs.

With a growing awareness of the importance of the stories shared by participants, I decided to draw on narrative approaches in order to more fully explore what was happening in the focus groups and interviews. Further justification for this approach comes from Connelly and Clandinin (2000) who argue that the study of narrative helps to illuminate the ways that humans experience the world. Developing these ideas, Chase (2011) makes the point that narrative allows the teller to make sense of things, to organise information, to shape the story and interpret events (Denzin and Lincoln 2011). In focusing on stories, however, it is important to consider the ways in which storytelling is shaped by the listener who is an active participant in the process (Gubrium and Holstein 1998). In my study therefore, I was interested in both the stories the participants told, and the ways in which these appeared to be shaped by, or told in response to, ongoing dialogue among the group or between interviewer and participant. Chase (2011) proposes that knowledge gained in this way is characterised by multiple voices, multiple truths, different perspectives and is transient and situated. In exploring RNs experiences of reflective practice, telling stories from the past about clinical situations and recollecting stories about patients and other professionals present, I was therefore interested in capturing multiple voices, truths and perspectives.

Traditionally, narrative approaches have tended to focus on one person telling a listener, interactively or not, their story (Connelly and Clandinin

1990, Haigh and Hardy 2011, Edwards, 2014). Few researchers have linked narrative to focus group work, although this is now increasing. Ryan et al. (2014), for example, write that, in their experience, the use of narrative during focus groups “revealed a collective knowledge and identity” (p. 339). Indeed, in my study there was a richness, intensity and complexity evident in the group dynamics of the focus groups and the sharing of stories highlighted the intensely personal nature of the participants’ memories, morals, beliefs, actions and aspirations (Kamberelis and Dimitradis 2011). In collecting the data during focus groups and interviews, I therefore attempted to encourage the telling and sharing of stories through interactive interviewing (Tillmann-Healy 2003) and telling stories from my own practice.

3.2.4 Assembling the story

In considering how the stories are assembled, Gubrium and Holstein (1998) argue that stories are not complete prior to their telling but are assembled to meet the particular requirements of the situation and context, and that storytellers amend their stories depending upon the audience and the responses they give. For example, in Focus Group 3, when commenting on a story about the significance of the colour and sheen of a patient’s skin in predicting death or illness, one of the listeners said; “It’s weird isn’t it? (FG3:2); to which the storyteller responded “Yeah, and that’s why I couldn’t believe it. (FG3.1) The storyteller then continued more enthusiastically to nods of agreement (noted in fieldnotes) and murmurs of assent (on audio file).

Mol (2002) identifies that comments could be assumed to be simple but indeed are not. Even something as straightforward as “I’ve got an example” (FG2:1) is not quite so simple as it seems. This was the first story told in the Focus Group 2 and the non-verbal behaviour by other participants when this was said was recorded in my fieldnotes as, “eye-rolls”. However, the participant was unaware of these signals and continued to tell her story. This example identifies some of the challenges of analysing responses in that there could be a number of different ways of interpreting these, for example, an ‘eye-roll’ could be mis-interpreted, it

could have been about something unrelated but happening at the same time, it could be about the person, it could be about the story or a myriad of other interpretations. Gubrium and Holstein (1998), for example, discuss how people engage in narrative editing and they suggest that, when thinking about which stories to tell, participants are sifting through their memories and may be thinking about which bits of the story they are going to tell and what they are going to omit. These different conceptions of stories will be further expanded upon in Chapter 4, data analysis.

3.2.5 Summary of methodology

In aiming to investigate perceptions of reflection and ways in which RNs can reflect together, my methodology involved an approach which combined elements of an interpretive phenomenological design and aspects of a narrative approach. In doing so I was careful to ensure that I recorded my thoughts and ideas at all stages of the research design. Approaches to data collection were therefore designed to be emic and etic as the circumstances dictated. More detail on these is provided in the next section.

3.3 Data collection

In investigating RNs' perceptions and experience of reflective practice, I drew on a combination of methods: focus groups, follow-up interviews and individual interviews. Each of these is explored below. Overall 22 RNs were involved in the study. Further details about the sample strategy and participants can be found in Section 3.3. Throughout this thesis participants are anonymised and referred to using codes. These codes index the interview/focus groups in which they participated, for example, FG1.1 refers to a participant who attended Focus Group one and arrived first. FG2.5/FU refers to a participant who attended Focus Group two and an individual follow up interview. II:1 refers to a participant who attended an independent individual interview. Details of participants' experience, codes and numbers of interviews are summarised in Table 1.

Table 1 - The range of clinical experience and nursing speciality

Code meaning: FG=Focus Group; FU= Follow-up individual interview III = Independent Individual interview

Code	Years qualified	Field	Speciality
FG1.1	29	Mental health	Older people/community
FG1.2/FU	31	Paediatrics/midwifery	Orthopaedics
FG1.3	29	Adult	Mixed/Older people
FG2.1	28	Adult	Orthopaedics
FG2.2/FU	26	Adult/midwifery	Practice Nurse/Diabetes
FG2.3	12	Adult	Practice Nurse/Public Health
FG2.4/FU	36	Adult	Palliative/Breast care
FG2.5/FU	8	Adult	Medical/District nurse
FG3.1	37	Adult/midwifery	Medical
FG3.2	12	Adult	Orthopaedic
FG3.3/FU	17	Adult	Critical Care
FG4.1	24	Adult	Critical Care
FG4.2	33	Adult	Orthopaedics
FG4.3	23	Adult	Critical Care
FG4.4/FU	6	Adult	Orthopaedics
FG4.5/FU	27	Adult	Medical
FG4.6	28	Adult	Accident and Emergency
III.1	42	Adult	Medical/care of the elderly
III.2	15	Adult	Surgical
III.3	11	Adult	End of life/community
III.4	13	Adult	Cancer Care
III.5	13	Adult	Oncology

3.3.1 Sampling and recruitment

In recruiting RNs to participate in this study I was keen to generate a sample that would reflect a range of levels and types of experience. As I needed to specify a number in my proposal for which I gained ethical approval (see Appendix ii), I followed Morse's advice (Morse 1991), that it is best to overestimate the requirement in case there are problems in the data collection. For ethical approval, I specified a maximum of five focus groups, and held four and specified a maximum of 15 individual interviews and held 13 in total. I believed that these numbers would be sufficient to provide a diverse sample while also being manageable given other commitments. Importantly I was not trying to achieve a representative sample, but rather to explore a diverse range of perspectives linked to different levels of experience, roles and specialism.

A combination of purposive and opportunistic sampling was used to identify my study participants. Purposive sampling is a widely used technique in qualitative research for the identification and selection of

information-rich cases for the most efficient and effective use of limited resources (Patton 2002). It involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Creswell and Plano Clark 2011). In addition to the participants' knowledge and experience, Bernard (2002) and Spradley (1979) comment that the availability and willingness of people to participate, along with their ability to articulately express experiences and opinions is important, and I saw this as fundamental in my study. In my study therefore, I was careful not to persuade or coerce those who did not want to participate. The participants who volunteered appeared happy to express their opinions and share experiences. Where I believed a participant was unable to share as many opinions and experiences in a focus group, I asked if they would be willing to do a follow-up interview, in all cases, they agreed.

Silverman (2010) writes that we should be careful about the limitations we impose on the population and be critical about how and why this type of sampling is being used. To take account of these limitations, I made it clear from the start, plus going forward in the research and in reporting on the research, that the participants were known to me and that indeed some were friends. This suited my plans for an interactive form of interviewing, that required the sharing of personal experiences (Tillman-Healy 2003), a process which Ellis and Berger (2003) write is akin to friendship.

I commenced the recruitment process using social media, more specifically the social network site Facebook. I chose to use Facebook because I knew that there were RNs linked to me on the site. For professional purposes, social media is now seen as having the potential to disseminate information and, for the purposes of this study, to reach and multiply professional contacts exponentially (Ferri et al. 2012, Bianchini 2012, Liebeskind et al. 1996). Thus, I felt that it would prove a useful way of recruiting participants.

Recently a number of concerns have arisen linked to sharing information on social media (NHS England 2015, NMC 2018a, Davis 2013, Jones and Swain 2012). I therefore chose to use Facebook only to recruit participants using a prepared and approved statement, so that the response from individuals and the rest of the data collection process, including sending the information sheet and consent form would take place away from the social media site. I posted a message as follows:

> *"To RNs on this site, would you be willing to participate in my research? It would involve an individual interview in person/Skype/FaceTime and/or participation in a focus group of no more than seven people. I am carrying out research under supervision to complete a Doctorate in Education and I want to know about the practice of reflection in nursing. If you are interested then please send me a private message to find out more. There is no pressure to participate and messaging me does not mean that you are agreeing to participate."*

After posting the first message nine people agreed to participate within 24 hours. Two sent me a private message, as requested. The other seven commented publicly (public means to all 197 friends that I am connected with on Facebook) and agreed to participate. In commenting publicly, they implied that they were not concerned about anonymity and it was not an issue for them but I was careful to make no further comment that could be seen by others and I ensured that all further communication remained private (see ethical framework, section 3.4. for further details of how I dealt with anonymity during all stages of the study).

As a result of the initial posting on Facebook, I recruited 14 participants who expressed no preference for focus group or individual interview. Using this method of participant recruitment is unusual and relatively new, so there is little evidence or advice about how to proceed, however there are many established qualitative procedural texts that offer advice on participant recruitment more broadly (Denzin and Lincoln 2011, Silverman 2010, Gray 2018, Kvale and Brinkmann 2015). I therefore decided to post

a further two times at two monthly intervals and recruited 12 more participants the second time and a further 9 in the final trawl (see Table 2 for summary of participants recruited at each stage). Of these, six did not arrive for the Focus Groups and I was unable to arrange another time to meet, seven did not respond to the email and follow up message, sent privately, following their initial agreement.

Table 2 - Recruitment process for Facebook

		Agreed	Did not respond to email with attached information sheet	Responded to email with attached information sheet	Did not arrive at Focus Group	Independent individual interview arranged
198 friends 67 of which are RN	First post response	14	1	13	3 - FG1	2
	Second post response	12	3	9	3 – FG3	2
	Third post response	9	3	6		1

Once I had received either a public or private expression of interest in participation, I sent a private message and received an email address where I could send the information sheet and consent form (see Appendix iii). I gave each participant a time, date and place where the focus group and/or individual interview would take and asked them to sign and return the information sheet to me either before or at the start of the focus group or independent individual interview to indicate their consent. The information sheet was distributed to allow plenty of time for participants to read, understand, ask questions, and seek clarity if necessary.

3.3.2 Focus groups (FG)

Focus groups provided the main method for generating data for this study. During focus groups, RNs were invited to reflect together about their clinical experiences, stimulated by a series of questions. This generated

what were often rich and lively discussions from which I was able to both gain insights into their perceptions of reflection, and through observing their interactions, some ways in which shared reflection takes place. It has been argued that conversations with individuals rather than with groups of individuals are more appropriate for phenomenological research. Webb and Kevern (2001), for example, state that phenomenological research is about the 'essence' of an individual's experience and that in some way, it could become corrupted by the influence of others. However, others, like Spiegelberg (1983), argue that a phenomenological approach need not necessarily be restricted to individuals because it provides an opportunity to explore issues of shared importance (Breen 2006). Furthermore, Kitzinger (1995) proposes that responses from individuals are not necessarily straightforward. She, and others believe that interviewees will adapt what they are saying in response to the interviewer and that individuals' interviews are just as much a product of interaction and conversation as are focus groups (Kitzinger 1995, Morgan, 2010, Wilkinson, 1998). This means that, as Bryman (2004) notes, the focus group approach provides the researcher with the opportunity to study ways through which members of the group collectively make sense of a topic and construct meanings. Therefore, it seems reasonable to consider focus groups as a way to ask questions about perceptions of reflection and to explore how RNs collectively share their experiences as part of that reflective process.

Through the focus groups, I wanted to bring a group of individuals together to think and talk about reflection, and to consider the possibility of intersubjective agreement amongst nurses on what constitutes reflection and the outcome of reflection. At the same time, I believed that listening to a group of nurses discuss how they explain and justify their practice of reflection, through the process of reflection, might uncover something about the process of shared reflection on nursing practice. In this way I hoped that these focus group discussions with RNs about their practice would be rich areas of data collection about reflection. It is worth noting here that as far as I am aware nurses' reflection has not been explored in

this way previously and therefore, I was hopeful that this approach would offer new insights. I gained ethical approval for five focus groups and completed four as no participants were able to attend the fifth and it was not possible to rearrange. Numbers in each group varied as they were dependent on availability at specific times. Table 3 includes information about the number of participants and length of focus groups. It also summarises details of individual follow up interviews, which are considered in the next section.

Table 3 – Number of participants and duration of data collection

	Focus group 1	**Focus group 2**	**Focus group 3**	**Focus group 4**	**Individual Interviews**	**Totals**
Participants	3	5	3	6	5	22
Duration (breakdown in brackets)	41.16 minutes	37.12 minutes	34.10 minutes	38.11 minutes	145.01 (Interview 1 13.10 minutes) (Interview 2 38.31 minutes) (Interview 3 49.16 minutes) (Interview 4 31.56 minutes) (Interview 5 12.08 minutes)	295.50 minutes 4 hours 55 mins
Follow-up work duration total figure (breakdown in brackets)	22.13 minutes	58.50 Minutes (FG2.2 24.27 minutes) (FG2.4 17.10 minutes) (FG2.5 17.13 minutes)	35.30 minutes	52.00 minutes (FG4.2 28.07 minutes) (FG4.5 23.53 minutes)	N/A	168.30 minutes 2 hours 49 mins

3.3.3 Follow-up Individual interviews (FG: FU)

In addition to the focus groups, I conducted seven follow-up interviews. in order to follow-up certain individuals who had little opportunity, or perhaps motivation, to speak frequently during the focus groups and to more fully explore elements of their specific conversations. Lambert and Loiselle (2008) lay emphasis on combining focus groups and individual interviews and identify that it enriches the data significantly because it allows for further exploration of topics arising from the focus groups. For example, I

chose to follow-up one of the RNs (FG1.2) from Focus Group 1 because I was interested in the metaphor that they had used to describe the element of surprise in reflection-in-action (Schön 1983). On another occasion (Focus Group 2), I saw a more experienced RN (FG2.4) comfort a less experienced RN (FG2.5) who was quiet and I wanted to explore this further. In the follow-up interviews, FG2.4 discussed why she felt compelled to comfort the less experienced RN and in a separate follow-up interview, FG2.5 explained why she had been so upset. I also used the follow-up interviews to provide a further opportunity to explore aspects of the reflective process I found intriguing and facets that seemed to provide specific insights into aspects of shared reflection. As Barbour and Kitzinger (2001) suggest, individual follow up interviews can allow the researcher to explore how the focus groups may have encouraged and suppressed those opinions and beliefs expressed by the individuals. For example, I chose to follow-up two participants from Focus Group 4. FG4.5 was the most senior RN in the room managerially and I wanted to explore her thoughts about the focus group with her as she was not the most experienced person and I felt there may be aspects of her experience that she would be more comfortable to discuss one to one. FG4.2 was the most experienced nurse and the least vocal in the focus group, my emic position meant I know she was generally quiet but I wanted an opportunity to explore her perceptions more fully.

3.3.4 Independent individual interviews (III)

In addition to the focus groups and follow up interviews, I also conducted independent individual interviews with five RNs. These interviews were arranged as the participants were unable to attend focus groups. While it was clearly not possible to gain direct insights from these interviews about the process of shared reflection, these interviews did become a rich source of data as they allowed the time and opportunity to more fully explore notions of individual and shared reflection individually. Atkins and Wallace (2016, p. 86) see individual interviews as providing a flexible "opportunity for dialogue ... [that] allows the interviewer to probe and clarify and to check they have understood correctly what is being said". These

opportunities to meet with individuals and ask questions about their perceptions of reflection ended up taking the form of joint discussions during which we both shared something of our life history and experiences. I therefore became what Silverman (2011) would describe as an “active participant” in my own interviews (p. 164). Silverman (2011) rejects the notion that interviews are just conversations and claims that interviews are far more complex and intricate than that, indeed that they may be jointly constructed. An example of this was in an independent individual interview with III:3 where we shared information about our career history and found ourselves reflecting on how we had arrived in our respective jobs and how much we enjoyed those jobs. In response to her questions about my role, we then moved on to discuss teamwork. Rubin and Rubin (2012) describe this approach as “responsive interviewing”. They suggest that interviewing is a “dynamic and iterative process” that is as much about the naturalness and personality of the interviewer as it is about eliciting information from the interviewee. (p. 15). Nevertheless, I had concerns about the role I might have played in influencing the participants’ views on reflection during these interviews so, after each one, I actively checked my subjectivity (Peshkin 1988) and returned to my ethical framework (see Appendix viii) to consider whether I had conducted the interview with honesty and integrity.

As part of the preparation for my study, I produced a list of questions for the focus group interview (see Appendix v). I used similar questions for the follow-up and independent individual interviews (see Appendix vi and vii). I also wished to use conversational cues and move from general questions about the nature and definitions of reflection, to more specific ones about how the participants reflect in and on practice (Stewart and Shamdasani 2015). For example, for the focus group interview, I moved from a general question about the participants believed reflection to be, to a more specific question about whether they had ever gone home and written anything down about something that happened at work. I discussed my guiding questions and examples with my supervisors to gain a different perspective and some advice so that I could produce a well-designed

guide that would be iterative in the light of my experiences and encourage group members to relax, open up, think deeply, and consider alternatives (Kitzinger 1995, Redmond and Curtis 2009).

3.3.5 Fieldnotes

Initially I had intended to take extensive fieldnotes during/after interviews and focus groups in order to supplement the audio data by noting non-verbal communication. Gibbs (2007) identifies that such notes are not planned or structured and are taken in the field or immediately after. Here is an example:

> *All Participants sitting up straight and demonstrating non-verbal confident behaviour when discussing managing ward. (Written fieldnote, FG1)*

These written records of observational data in the field represent "the process of transformation of observed interaction to written public communication" (Jackson, 1990, pp. 6-7). I became concerned however that I was not making many fieldnotes during the focus groups as I was concentrating on the group and immersed in their stories and ideas. As Lave and Kvale (1995 p. 180) suggest, I found that taking notes was distracting and interrupted the flow of conversations.

I did however take what I refer to as 'verbal fieldnotes'. During the focus group, I made verbal comments noting various non-verbal behaviours and then sought clarification from the group regarding my observations. These were transcribed along with the interview/focus group data. Here is an example of this from Focus Group 1:

> *"It's quite interesting because each time every one of you have said you're more confident, whenever you talk about intuition, you sit up and you do this (mimics sitting up straight and leaning slightly forward), so when you do have that kind of moment, or whatever it is you have, is that what you do, you kind of just sit up?"*

Whilst I appreciate that these field-notes were limited and based on moments selected by me, an analysis and interpretation of these limited fieldnotes proved most useful. Field-notes such as these provided a

means by which I was able to capture what was happening in the moment and verify my understanding with the participants in real time. Moreover, Miles and Huberman (1994) also suggest that you can find systematic ways of expanding information recorded in the fieldnotes. Following this advice, following each focus group and individual interview, I also noted the people, events or situations that were involved, what the main themes and issues were, which research questions were most discussed, initial speculations about the situations discussed, where the most energy was directed and which areas I felt it would be important to pursue in subsequent focus groups and/or interviews (see Appendix i).

3.3.6 Transcriptions

In relation to the large amount of audio data, I had to make decisions about whether it should be transcribed and how. Lave and Kvale (1995, p.178) state that “to transcribe means to transform" and that “in short, transcripts are impoverished, decontextualised renderings of live interview conversations”. The transcriptions, for example do not generally include the setting and local environment. For example, they do not specify whether it is hot or cold, comfortable or uncomfortable is not usually captured in a transcript, and neither is what happened immediately prior to this event. Despite these limitations, and the emergence of new ways of capturing data, it is generally acknowledged that a written record of the data allows for additional data analysis and through this, confirmation of codes, categories and themes (Silverman 2011, Kvale 2007 and Richards 2015). Indeed, after the initial listening phase, I used the transcripts continuously to code and categorise, to confirm verbal fieldnotes and to check my understanding of the context of the memos as discussed in data analysis. (Chapter 4, section 2.1.). The transcriptions were also invaluable during the writing phase of the research.

Richards (2015, p. 67) provides a useful transcription checklist and I used this to ensure that I had a rigorous method of ensuring that the transcripts were produced and checked. Initially I transcribed part of the first focus group and the first individual interview myself as Lave and Kvale (1995) identify that researchers can learn about their own interview techniques

and can start analysing as they transcribe. However, when I attempted to transcribe the first individual interview and focus group, I found that I learned little except that it was a painfully slow process, where all my attention was on listening and typing and certainly not on the initial analysis. I therefore arranged for the other recordings to be transcribed externally. In arranging for transcription there were several choices. Silverman (2011) discusses whether transcriptions should be verbatim and include pauses or whether they should be translated into written Standard English and full sentences. I chose to have them transcribed verbatim to preserve as much of the original feel of the conversation as possible. In order to avoid problems associated with reliability and confidentiality (Gibbs 2007), I used a professional transcription service familiar with the needs of researchers. I made sure that they were aware that I wanted verbatim transcripts and sought written confirmation that confidentiality would be maintained. I was assured that they were familiar with the needs of researchers and that one transcriber would be used. Once the transcripts were returned, I checked the completed transcripts against the audio recordings. There were very few amendments necessary. There were some minor errors where medical or professional terms were used but very little in the way of correction was required. Surprisingly the few amendments I had to make were related to lack of clarity, not in the focus groups, as one would imagine, but in one of the follow-up individual interviews, the quality of the recording was compromised by external noises outside my control. I also listened to the audio tapes and amended the transcripts where names had been mentioned to preserve confidentiality. In all cases participants were invited to verify the accuracy of the transcript and to email to confirm that they were happy for me to use the transcript and/or to send me any amendments or extracts they would like to be deleted from the dataset. I received email confirmation, some after a few reminders but no amendments were requested. All interviews and focus groups were transcribed and for the purposes of clarity and to match the transcripts, where examples from the data are given, my questions and responses are highlighted in bold.

3.4 Ethical considerations

Formal ethical approval was obtained for this study but the detail and thinking about ethical considerations is important in introducing the research design. In describing the ethical framework for this study, it is worth noting that I started my study with a number of assumptions that became ethical concerns. The first assumption was that ethical and moral considerations are so much a part of my practice as a nurse that, although I know they are needed, issues such as consent and confidentiality seemed self-evident and not necessarily worth exploring and clarifying. The second issue was that I might become overly concerned with the ethical dimensions and blur the boundaries between nurse and researcher in my need to attend to the Code (NMC 2018a). Therefore, I decided to construct an ethical framework (Appendix viii) to ensure that I approached this study with knowledge and understanding of research as well as nursing issues.

My framework continued to evolve in response to the literature review and the practical considerations of collecting data and my growing understanding of the process of conducting research. For example, Hunt (2001) warns that reflection can sometimes turn into therapy and recalling difficult incidents can affect someone's mental health. For this reason, I worked closely with the participants and pointed out at every meeting that they could seek assistance. Below is an example from the transcript for FG2.

> *Some of the things that we've discussed may be distressing to you. So, if they are you can either get in touch with me or, on the information sheet that you've got a copy of, there is my supervisor that you can contact, or you can use your local support mechanisms, or I can put you in touch with a counsellor. (Christine)*

I believed that, for it to be of any worth, the ethical framework was a work in progress and a practical document, so I returned to it frequently. The framework is based upon a number of highly regarded works in moral philosophy, education and health care and the rationale for this follows.

Firstly, the framework is influenced by Beauchamp and Childress's (2013) pivotal work on the principles and scope of biomedical ethics. Their discussion about reciprocity is particularly relevant to this study, as I wanted to ensure that the participants would also benefit from this research. I therefore included a question to ensure some benefit for them (as well as the obvious personal benefit for me) in the ethical framework. I also made sure that I set ground rules at the start of each data collection episode to take account of everyone in the focus groups and interviews and in making sure they were aware of how they could use the discussion for revalidation. After completing the study, I believe that they did benefit as they suggested that their discussion about practice was useful to them. One participant, for example, said, "it's great to be able to sit and chat about the 'touchy feely' stuff". Another participant said that she wished that she had the opportunity to discuss patients in a supportive setting in the clinical area.

Secondly, I took account of autonomy (Beauchamp and Childress 2013). In the context of this research, autonomy can be considered as respecting the right of the participants to make a reasoned, informed choice about whether they want to participate and a reasoned, informed decision about what and when they want to share about themselves and their experiences. I did not follow up those who did not respond to my initial email and made no comment about their lack of response. It was their decision, not mine. Those who could not attend, once they had agreed to participate, contacted me. Some made arrangements for an independent individual interview, some did not. Again, the decision was theirs. During the data collection, autonomy was about respecting the participants decisions about whether and what they want to share. I took account of this by setting ground rules at the start of the interviews about confidentiality, reciprocity and respect for each other and I monitored the interviews to intervene where appropriate to ensure that everyone had an opportunity to speak if they indicated that they wanted to.

At times however, the principles of autonomy and reciprocity were at odds. One individual, for example, did not have the freedom to speak as he wished and share stories because another participant was more dominant. Had I intervened and shut down the dominant participant, I would have been restricting her

autonomy and yet I was uncomfortable letting the group continue because there was a lack of the reciprocity that I had asked for in the ground rules. I therefore chose to individually interview the quiet participant as a follow-up to explore this and his stories further thus choosing the primary principle of autonomy.

Thirdly my framework was influenced by the work of Gillon (1994), who does not see the primary purpose of an ethical framework as offering answers or rules, but as "a common set of moral commitments, a common moral language and a common set of moral issues." (p69) This resonates with Seedhouse (2009) and ensures that pertinent questions are asked about who is benefitting from the research and whether there is a wider context. As previously stated, I am a Registered Nurse bound by The Code (NMC 2018a), so if the participants of the study had shared practice that was questionable, there would have been wider consequences. This fact was on the information sheet and reiterated at the start of the focus group, so that participants were aware of this if they started to discuss anything that might be construed as inappropriate or reportable as bad practice. I anticipated that it was highly unlikely that this would happen, as all were experienced RN who are bound by the same code of conduct and indeed it did not. Nevertheless, I wanted to remain vigilant. Part of this vigilance was also to ensure that participants knew they would be anonymised and that they would have an opportunity to withdraw themselves and the data at any point up until the data analysis process. The work of Gillon (1994) was included in my ethical framework because it allowed me to ask questions with possible moral dilemmas and still uphold a primary principle. For example, I interrogated whether it was possible to carry out research asking nurses to reflect on their practice and do no harm? Was it possible to ensure that their privacy was upheld and yet publish the findings to benefit all? Using this part of the ethical framework allowed me to think carefully and act to reduce ethical dilemmas and consult the participants where I felt there was an issue.

For example, after every group and individual interview I identified resources available to the participants should they feel upset or harmed by their recollections (see the interview prompt sheets in Appendices v, vi and vii).

Fourthly my framework was influenced by Stutchbury and Fox (2009) who use the work of Flinders (1992) to separate their framework into different phases of the research: recruitment, fieldwork, and reporting. These phases, they suggest, may require different questions and raise different concerns. Drawing on this work, I therefore considered each phase in terms of reciprocity, autonomy and my commitments. This process generated a series of questions and approaches which together formed my ethical framework. This is summarised in Appendix viii. I frequently referred to this framework during all phases of the study and found it invaluable, in tandem with interrogating my subjectivity (Peshkin 1988) in positioning myself in my own work and reminding myself about the importance of this ethical process. Below I consider ethical issues that arose at each stage of the process.

3.4.1 Recruitment

When I started this journey, I did not expect to use friends as participants. However, as the recruitment process progressed, the opportunity to involve personal friends arose as they, and colleagues, asked about my educational experience. I was aware that there were ethical concerns about using social media and more specifically Facebook in relation to privacy (Rosenblum 2007) and so I took steps to ensure that once contact had been made about the research, all other communication took place using other, more private forms of communication. In addition to this, in terms of recruiting RNs, as highlighted by Flinders (1992), there is a possibility that there could be a "risk to their professional reputations" simply as a result of agreeing or not agreeing to take part in the study, or as a result of disclosing information about their work (p. 103). As well as informing the participants about what I wanted to explore in writing and verbally, I established and negotiated ground rules at the start of each data collection episode to ensure that the participants were aware of the risks.

3.4.2 Fieldwork

I considered the ethical considerations relating to fieldwork in two parts as conducting the focus groups and interviews required different ethical considerations to those associated with the analysis of the data. For

example, when I conducted a focus group, I needed to ensure that the group understood that I was there as a researcher using an ethical code and as a nurse using the NMC Code (2018a). In the literature review (Chapter 2), I discussed issues associated with ownership of reflection and how far of reflection should be public (Raelin 2001). In the data collection phase, the RNs did not appear to have any concerns about this. Indeed, there was only one occasion when I was asked to turn the audio recorder off. This was when three RNs were expressing their frustration with student nurses and one said, “I just wanted to hit him”, she then jokingly said, “delete that from the tape” (FG1). When I asked the RN, who had said that to check the transcripts and pointed out what she had said about deleting it, she expressed no concern and said she was only being honest and the “tape” comment was a joke. I therefore left it in.

In the information sheet and at the start of each interview, I asked participants to keep the conversations confidential whist acknowledging that confidentiality was a difficult thing to achieve in a focus group (Parker and Tritter 2006). Kamberelis and Dimitriadis (2011) accept that there is a risk of breaking confidentiality in focus groups but identify that “The potential risk of participants breaking anonymity in focus groups was outweighed by the potential information that could only be gleaned from group interviews” (p. 557). I pointed out, in each episode of data collection, the public nature of reflection and the use of reflection as evidence in my literature review (Bright 1996, NMC 2018a, Hargreaves 1997) and no participant raised any concerns about what they had shared. I have no way of knowing whether, subsequently, confidentiality was broken but I have not witnessed any issues that arose out of the data collection.

I was also aware that the participants gave consent to attend focus groups without necessarily knowing who else would be there and that they would find it difficult to withdraw once they had arrived. This happened in Focus Group 2 where one participant was affected by the arrival of another RN. I knew both participants but did not know of recent issues at work. This was one occasion when knowing them helped because the subtle signs were there. I therefore contacted one of the participants afterwards and

privately, for a follow-up interview, so that I could explore this in more depth. Some of that follow up interview involved a private discussion but after clarifying her position, the participant was quite happy to continue with the follow up interview without compromising the integrity of the study or my integrity as a researcher.

Despite such concerns, Kamberelis and Dimitriadis (2011) note that, often, participants are more comfortable in a group, which they perceive as a supportive and safe space because they fear the possible interrogative nature of an individual interview. Again, I hoped that my familiarity with participants meant that the fear of interrogation was diminished somewhat. However, in acknowledgement of this, I felt it important to ensure reciprocity and share something of myself within the focus and individual interviews. I hoped that they were reassured by this. Ellis and Berger (2003) encourage this more collaborative approach and write that this more open form of interactive interviewing allows researchers to “explore emotional complexities” (p. 482), as discussed in Chapter 2. This approach does however generate questions related to validity, which I address in my discussion about my position as a researcher in section 3.2.2. of this chapter.

Using friends as participants evolved as part of the process of considering methodology and finding participants. However, as Wainwright (2014) identifies, working with people I knew made it easier to establish a rapport and also made it possible to ask, sometimes difficult, questions. An example of this was when I asked a participant in a follow up interview, “What was wrong with you during that focus group?”. This participant had been, for her, quiet and so I asked to do a follow up interview. She replied that one of her best friends was dying and that she was helping to care for her, her husband and the children. I did not know! We cried! We moved on! She wanted to complete the interview and feel that she had done and thought about something else that day. I was not sure about including it here, let alone in the transcript so I asked her. She did not want to remove anything from the transcript at a later stage when I asked her as she felt that removing our conversation would be like removing her friend and so it

is included here and stays in the transcript as a memorial but is not included in the analysis.

3.4.3 Reporting

No participant in my study asked to change anything on the transcripts they were sent. However, it is important to note that a few admitted outside of the data collection that they had not read the transcripts and, when questioned, said they trusted me, which is an ethical burden but also an honour. Because of this I listened carefully to the audio files and scrutinised the transcripts to ensure that no participant could be identified and that nothing had been said that would compromise the individual in terms of their professional practice.

During the analysis, I also ensured that I was honest, rigorous and careful especially in relation to issues of confidentiality and fairness. I told the participants (in person and on the information sheet - see Appendix iii) that they could withdraw at any time prior to or after the focus group had met and at any point until the data became anonymised, which would be on return from transcription. I ensured that transcription occurred one month after the final data collection episode to give the participants time to think about their contribution and I reminded them one week before sending the audio files for transcription. I verbally repeated what would happen to the data at the start of the discussion. I made it clear that all the information collected would be kept strictly confidential (subject to professional limitations) and that confidentiality, privacy and anonymity would be ensured in the collection, storage and publication of any research material. However, I did state that anonymised data might be viewed by supervisors at the university. I informed participants that the data generated during this research would be kept securely in paper or electronic and that audio material would be stored in encrypted form on a computer and on an external hard drive. I also informed them that I had to adhere to the strict University rules about managing data and that they could access my data management plan if they wished.

Finally, in writing up the research, I needed to ensure that I was honest, rigorous and trustworthy (Seedhouse 2009, Flinders 1992, Stutchbury and Fox 2009) and that I reported the findings as accurately as I could whilst acknowledging that my subjective experience informed the thesis. I returned to the ethical framework (Appendix viii) several times during the write up. It reminded me that I had a responsibility to finish the research and publish it. Appendix viii is the final iteration of the ethical framework.

3.5 Summary

In summary, section 3.2 of this chapter has outlined the methodological thinking that underpins this study and my positionality. It has also attended to how the methodology developed as the study progressed, and in response to the data, to focus more on how participants explored their experience together, drawing on aspects of narrative methodology. Section 3.3. deals with data collection and includes sampling and recruitment and methods of data collection (focus groups, individual follow up interviews and independent individual interviews). Finally, section 3.4. addresses ethical considerations, along with examples of how my ethical framework guided me through the whole process of data collection, analysis and beyond. In chapter 4, I discuss how the data was analysed.

Chapter 4: Data analysis

4.1 Introduction

This chapter explains the process of data analysis which was conducted in three phases. As outlined in Chapter 1, this study aimed to explore how RNs perceive reflection, the features of shared reflection and how opportunities for sharing experience might provide contexts for reflection. The process of analysis therefore was designed to focus both on *what* the participants talked about in terms of their experiences of reflection and shared reflection in particular, and *how* they spoke about this.

The approach to analysis was influenced by Glaser and Strauss (1967)'s approach to constant comparative analysis, initially developed as part of the grounded theory approach. Constant comparison involves comparing similarities and differences in separate types and pieces of data (Corbin and Strauss 2008). This approach is now considered to be a useful approach to analysis of qualitative data (Thorne 2000). The first phase of analysis involved listening and double listening (White 2000) to the recorded interviews and focus groups to immerse myself in the experience, further developing fieldnotes and memos to record thoughts and generate tentative codes and fighting familiarity. The second phase involved listening to the focus groups as interactions and included analysing what was being said and how it was being said, analysing contradictions and identifying multiple voices. In the second phase, I also began comparing the audio files, field notes and memos with the transcripts to continue to generate codes and categories. The third phase involved further analysing the written transcriptions and continuing to compare them with the initial codes, fieldnotes and memos to refine the categories and generate themes. This final phase also involved a return to listening while examining the transcripts in a critical way to ensure that the final themes were robust and derived from the data. There follows a detailed discussion and rationale for each stage of the data analysis.

4.2 Phase 1 - Listening and double listening

At the start of the analysis, I followed the advice of Forsey (2010, p569) who proposes that engaged listening is a significant element of analysis. To this end I first listened to the audio recordings of focus groups, follow-up and independent individual interviews without writing to be sure that I immersed myself in the data (Charmaz 2006, Mackey 2005). Of note is that I found that when I listened only, I was again immersed in the experience and could recollect visually the surroundings and expressions as well as re-engaging with the stories being told and the responses, as well as the discussions that flowed around the topic areas.

I also engaged in a process of 'double listening' (White 2003). This process relies on the idea that the meaning in a story is only apparent when one experience contrasts with another experience (White 2000). The double-listening technique, borrowed from psycho-analytical research, consists of "paying attention to the fragments" (Westmark et al 2011, p. 31). To my knowledge, this analytical technique has previously only been used in individual interviews and for traumatic or therapeutic use (e.g. White 2003, Denborough 2005) but I found it useful in analysing comments and responses in Focus Groups as well as individual interview interactions. Double listening involves concentrating on the "absent but implicit" (White 2003, p. 321), that is, the background to the story that is not discussed but implied. This type of listening can generate insights into meaning, co-construction and can unearth assumptions, values and beliefs about what is being said. For me, double listening provided opportunities for me to move away from a procedural attempt at analysis towards a more embedded type of analysis (De Fina and Georgakopoulou 2012). It involved a period of concentrated listening and adding fieldnotes several times for each data collection episode.

In further considering this method of analysis, Carey et al. (2009) describe double listening in terms of figure ground theory, in that what is foregrounded in the story may well obscure that which is in the background. In explaining his approach, White (2000) states that it is necessary to listen to the dominant story but at the same time listen for the stories that lie underneath or behind the story and to acknowledge that the preferred story is being told but at the same time, it is

possible to uncover other stories that are at the borders of the dominant story (White, 2000; 2003). This contrast in what is being said, is where double listening is useful because “no matter how compelling any given story might be, no matter how powerfully it is ensconced, there are always other stories” (Freedman and Combes 2009, p. 354). An example from my study demonstrates such multiple layers and how the dominant story is under-layered by other stories. In this example (from Focus Group 3), one participant was listening to a story and then said this. *“Obviously you’ve got your clinical eye and you can see when someone’s going downhill and deteriorating.”* (FG2:5). The first time I listened to it I just moved on to the next story and found nothing unusual about it. The second time I listened, I remembered I had questioned the concept of the “clinical eye” in the focus group. My fieldnotes ask the question, “Why is everyone nodding? What is the clinical eye? Why is it an eye? What about the other senses? Why is no-one else questioning it?” When I listened again, consciously listening for underlying stories, I became interested in the word “Obviously”. The participant had assumed we all knew what she meant, and I did not pick it up as being unusual until I listened for what was underneath the dominant story of the critical eye. As a result of identifying this, I started to consider the sense of belonging I felt in this focus group and looked for other hidden or non-dominant clues that would support these ideas. I found that they were there, not just in this focus group but in others and in the individual interviews. I then started to understand this sense of belonging in terms of a community of practice (Lave and Wenger (1991), see Chapter 2 section 6.1.) and this led to the development of categories and then a theme - Belonging.

4.2.1 Using Memos

As I worked with the data, I continued to engage in a process of memoing. Memos are records of the researcher’s developing ideas about codes and their interconnections (Glaser, 2002; Corbin and Strauss, 2008). The memos document the researcher’s thinking processes rather than describing the social context. An example of a memo is from my notes on Focus Group 4. During this Focus Group, there had been an extended discussion about how you know what you know and FG4:3 was discussing how, as an RN working in the Accident and Emergency unit, she could

predict when a patient is about to become violent. In this memo, I reflect on the significance of this:

> *Kicking off is an interesting term when they are discussing exaggerated body language. Everyone is agreeing with them and this is becoming a joint story now. Is this how a community of practice (Lave and Wenger1991) develops or is this a community in practice consolidating this feeling of belonging? Do they know that they are reflecting and would they consider this to be reflection? It is certainly part of the process, Atkins and Murphy, Gibbs, Johns, Goodman, any reflective model would include this. Also, on the one hand they are saying they just know (tacit) and on the other they are explaining how they know (possibly building new knowledge?). Why is everyone nodding when I don't remember knowing this? Is it salient knowledge as Benner says? Am I emic or etic? Do I belong? Do they realise that they are reflecting? And that they're doing it together? Are they reflecting on how they reflect-in-practice? (FG4)*

Through these memos I collected secondary data or, to use the words of Glaser and Strauss (1967, p168) "caches." I continued to use this memo system to record thoughts and ideas as they occurred during the process of analysis, so as to "saturate" the categories (Glaser & Strauss 1967, p61)

4.2.2 Fighting familiarity

Delamont and Atkinson (1995, p148) suggest that there is discipline that can be adopted when being analytical that makes the familiar seem strange. They recommend that one should make that being studied a problem, and in this way achieve the distance needed to "fight familiarity". Delamont et al. (2010) further clarify this stance and recommend "taking the standpoint of the 'other'" (p. 8) and considering the experience from the participants' perspectives. In my study, these dominant familiar stories become strange when examined for underlying stories. The more that I listened to the recordings, memoed and examined the transcripts, the more convinced I became that, although these nurses were discussing the everyday and not the extraordinary, if anyone else listened to them, it would seem extraordinary. They were talking about death and illness and critical instances in people's lives. They were talking about violence and

drunkenness, grieving and dying in horrible circumstances, and yet at the time it did not seem shocking. That is not to say that they were disrespectful. It is through the gradual process of listening and note-taking that I became aware of the shocking nature of what was being discussed. I also became aware of their passion and pride in the profession. These concepts were layered underneath the discussions about how they knew what they knew.

Gubrium and Holstein (1998) remind us that the shape of storytelling is affected as much by the listener as by the teller; the listener often prompts the story in the first place so that narrative production is collaborative and informed. Indeed, Bruner (1987) informs us that our perceptions and activity, our identity and agency are a result of the way we create a narrative and construct ourselves in the world. Within the focus groups and individual interviews, it was clear that members identified themselves and me as within the same community and having the same identity, broadly speaking. Phrases like, “you know what it’s like”, “you’ve had that experience haven’t you?”, “what are we like hey?” all contributed to the conclusion that they assumed we were operating in the same community.

In analysing interactions De Fina and Georgakopoulou (2012, p. 126) write that it is important to consider “what kinds of environments encourage, nourish or equally prohibit stories”, so in addition to analysing the quality of responses, as outlined above, I also considered several aspects of the discussions in relation to narrative control (Gubrium and Holstein 1998). Narrative control refers to the ways in which individuals make choices about what they share by controlling the story but also to when narrative control is used by another to attempt prevent a story from being told, to alter the trajectory of the story or to defend their own perspective. In this case I was interested in how participants seemed to exercise narrative control over each other, for example through using sarcastic humour. The following extract provides an example of narrative control in which a participant was effectively stopped from continuing a discussion. I had asked whether they thought anyone could reflect:

FG1:2 I personally think there are very few situations that people walk away from and actually don't give it another thought. I just wonder whether sometimes we make reflection a little bit more complicated than it really is, that it's just something you kind of do naturally anyway.
FG1:1 I guess, I would say some people with personality disorders, for instance, can't reflect.
FG1:2 You're such a mental health nurse, aren't you, you really are? (Laughter)

The final comment made by FG1:2 was said in a humorous tone but was perhaps a form of narrative control, because it seemed to be a way of mocking not only FG1:1's comment but also her choice of career. My insider knowledge helped with this, as I am aware that there are sometimes tensions between different fields of nursing. While the first participant continued, her response was very brief, suggesting that the attempt at control may have partially worked.

It is important to note here that I also played a role in narrative control during data collection. Firstly, this was because, as (Gubrium and Holstein (1998) point out, I convened the group and organised the individual interviews, I gave the participants an information sheet identifying what I wanted to discuss and invited them to participate. I also made decisions about when we would start and finish and asked prompting questions when I thought there were pauses in the conversation.

4.3 Phase 2 - Analysing focus groups and interviews as complex interactions

Markova et al. (2007) state that focus groups provide complex interactional data, which is both a source of richness and a challenge for the researcher. Kamberelis and Dimitradis (2011) also identify that focus groups can act like magnifying glasses when examining social interactions and can shine a light on more intense interactions than when using individual interviews or observations. They believe that focus groups give greater "access to social interactional dynamics that produce particular memories, positions, ideologies, practices, and desires among specific groups of people" (Kamberelis and Dimitradis 2011, p. 559). In my study,

therefore, I was interested in learning how RNs share reflective stories and interact with each other through telling and listening and at this point I started to listen using the written transcripts and move between written and audio data.

4.3.1 Analysing what and how

Gubrium and Holstein (1998) discuss the relationship between the 'hows' and 'whats' in recognising that told stories are actively constructive and locally constrained. By this they mean that storytellers amend their stories depending upon the audience and the responses they give. In this way I applied "analytic bracketing" (Gubrium and Holstein 1998, p. 165) and examined the way the conversations unfolded. For Gubrium and Holstein (1998), analytic bracketing involves moving between a focus on what is being said and how it is being said. In the example below, it can be seen that personal accounts were built up not just from experience but also through interacting with an audience and this not only attends to the 'how' in co-construction but the 'what'. The following example (Table 4) is quite a long one but illustrates how I used the prompts to code participants' responses. To give a context, FG1:3 had arrived late and FG1:2 had non-verbally expressed her displeasure by tutting and aggressive eye contact which I noted in my written fieldnote. FG1:1 had just made a comment about instinctively knowing when someone was missing. My questions and comments are in bold and not preceded by a code. In this example, FG1:1, who is a mental health nurse was musing about patients going missing and this prompted FG1:2, who is a paediatric nurse, to tell a story about a child who went missing. FG1:3 then moved away from the story itself to ponder what skills or knowledge were required to have that instinctive feeling but only after appearing to re-assert her dominance and place in the group by reminding the others that she was a manager.

This juxtaposition between what is told and how it is told means that it is possible to learn as much about the context from reflecting on *how* stories were told in the group as it was from the content of the stories themselves.

Table 4 - Coded transcript from FG1

What	Transcript	How
	So I'm going to ask you a harder question now, which is can you give an example of something that you know but you don't know how you know it, if that's your definition?	
Unconscious action	FG1:2 Yeah, it's hard to think of a hard and fast example. I can think of situations. I have to go back to, again, a ward here, but certainly being on a ward and being in charge of a particular shift, I think especially if it's a very busy day, in that situation, I have anyway, I've done lots of things that I've got no idea why I know, just done it.	Individual
	I can give you an example. Night duty again, I don't know why, night duty is one of them things where I remember more about what happened, probably because I had more time to think about it but I was in charge on a ward and I said right we've got to go down to the side ward because I think Mr So and So's going to fall out of bed. So off we went, down to the side ward, and sure enough Mr So and So was just climbing over the top of the cot sides, if you'll forgive the expression, as if he was going to fall, so again, the people I was working with How did you know that? How did you know that? I don't know, just know. It's just intuition. When you've worked nights for long enough, those sorts of things come up.	
Intuition	FG1:1 You intuitively know that that's not a good thing. You have to go and find why is that person missing? Sometimes it turns out to be OK because they've gone to the toilet or whatever but you just know deep down you're not comfortable with that thought or that perception.	Dominant Collective
	I suppose the thing is, because I've worked with children as well, it's like you're not actually counting the number of people who are there, and you're not -	
	FG1:1 No, you just notice.	agreement
	- consciously thinking is there a gap somewhere? You just know that somebody is missing. You know who it is and you know you've got to do something about it, don't you?	
Cannula - Shared language Finished the story with an outcome	FG1:2 Also, if you had to make a guess, which one was missing, even though you know who it was, I can think of one occasion I was thinking missing person where I lost a child who escaped, he was about 12, still had his cannula in as well, and I just instinctively knew there weren't enough children on the ward and if I was going to choose one, it was him that was missing, and at that point the ward I was on looked directly over ..... Park and the bus route, and I again instinctively actually, intuitively, I looked out of the window and he was standing at the bus stop. (laughter) So we got him. But yeah again it's down to experience really, isn't it? I just knew if there was anybody going it was going to be him, and it was him. We got him back though.	Agreement Assertive Well developed Collective Laughter
	Are you all right, FG1:3, now?	**concern**
	FG1:2 Are you with us, FG1:3? Are you in the zone?	Dominant Control
	Have you got anything you want to share?	
Automatic actions Difference between doing and knowing. Reading a room	FG1:3 Two things that come out of what you guys were saying, one was something about knowing and doing because there's something in this about an automatic behaviour, an automatic doing something and you don't know where that comes from, and I think there's something, a difference between an automatic do and a know. One might lead to the other but sometimes you do automatic stuff and I think automatic is an important word as well. There's an automatic thing that you do so it might be reading a room to say, and you end up knowing somebody is missing. I think we're all very capable, as humans, of reading a room and knowing which souls are in the room, who's doing what, everything. We don't know we're doing it but we've got a feel for that instantly; therefore if something is missing we know.	Tentative Fieldnote (others nodding) More confident Tentative
	Do you think everybody has that feel?	
I am a manager Understanding Feelings Understanding teams	FG1:3 I think it's potentially some people are better at it than others. And I think it's more difficult because as a manager I feel further away from clinical practice and I know you want to do it in relationship to clinical practice but trying to go back to instances of examples where I've done stuff. For me, it's more likely to be something about connecting into how somebody is feeling or what's going on in the team. So, something is going on with you, I don't like, you're different, yes. You've not said anything. I just know the back story perhaps and I'm connecting into that. That's more likely to be how I operate.	Dominant (possibly reminding other participants that she is a manager) confident

What	Transcript	How
	But it relates to patients as well I think because we're picking up on, you're not right, there's something different about you.	
	(Laughter)	Laughter
Laughter	FG1:1 no I'm not.	Disagreement possible dig at FG1:3 (field note)
Story Acknowledging experience as being relevant Evaluative Confidence to act Difficult conversations with Doctors	FG1:3 Sorry, it wasn't directed at you at all but, yes, I suppose we had a patient who had dementia and she was fit and able to walk around and boy could she walk and she had a tendency to walk round in the room in circles and she had a particular chant that was her, we always thought it was a soothing rhythm. It wasn't a song, just a chant. She couldn't connect into anybody else at all and over time one or two people who had some seasoning at, you know, who had been in the business awhile said this has changed. This chant's different; we couldn't articulate it; she's not as comfortable. And from that detection of just a change, subtle changes in her behaviour, the whole team ended up investigating what was going on with this woman. And the end of the story was she'd got angina and her chants and her movement changed when she was having an angina attack. She couldn't tell us so she was in pain. But the trouble we had persuading the doctors that what the issues were stunning, and all we'd got to work on was that this person with dementia had a subtle change in behaviour but about four of us got it on the same day.	Restricted Tentative Acknowledgement of put down Increasing confidence (double listening)

4.3.2 Analysing contradictory elements

The above is also an example of examining contradictory elements of the conversations. Ryan et al. (2013), Belzile and Öberg (2012) and Moon (2000) write that there is a dearth of advice on focus group analysis but do offer some suggestions for analysing interactions. These include having a clear theoretical framework (Ryan et al. 2013), sequential analysis (Belzile and Öberg 2012) and knowing the benefits and pitfalls of analysing focus group data (Moon 2000). When analysing the interactions, I noticed that there were contradictions in the interactions between participants, signifying a process of negotiation within the focus groups, so I used a combination of analytical tools, some of which were borrowed from narrative analysis. In the first tool, I constructed a series of prompts (see Table 5) to start to understand the negotiations and contradictions. Whilst this binary way of looking at narrative has its critics (Squire et al 2005, Fook 2015) and in no way is one word more dominant than another, the prompts did provide a way into an analysis of the interactions and allowed me to focus on, not only what was said, but how it was said. They also fostered the discipline of careful sifting and checking and re-checking of the audio as well as the written data.

Table 5 – Contradictory prompts

Opposing tones	Source
Agreement or disagreement	Kidd and Parshall (2000)
Well-developed or restricted	Belzile and Öberg (2012)
Dominant or tentative	My addition
Individual or collective	McCormack (2000)

4.3.3 Analysing multiple voices

In using a binary way of examining the data, I was aware of the limitations of only using this type of analysis even during the challenges involved in identifying the dominant or preferred story (Riessman (2008), Chase 2011, Kim 2016). So, I considered the work of Gubrium and Holstein (1998, p. 163) who recommend that "stories are analysed as much for the ways in which storytellers and the conditions of storytelling shape what conveyed." For this reason, I did not just consider what had been said, but the activity of storytelling and the environment in which each story was told. This meant that I was looking at the content of the stories within the very specific context of RN talking only with other nurses who are bound by their professional code of conduct and where they believe that they can confidentially share stories about their practice.

By examining these, I gained insights into the what Kim (2016) would see as multiple voices. These multiple voices included individual multiple voices as well as the literal and layered multiple voices of focus group participants. The following example is of a fragment from Focus Group 4. The group had been discussing the uncomfortable feeling that prompted more thought and action in clinical practice. Here, every participant contributed to a discussion about the recognition of a need to act when they believe a patient is about to have a cardiac arrest and might die. My questions are in bold.

> ***So can you think of a specific example where something's happened where you've noticed something? (directed to FG4:4) It's a difficult one ain't it?***

FG4:4 Yeah, I think it's things like FG4:2 was saying, they've perhaps not responded in a way that they have been last time you saw them or, I don't know, even things like they'll have a different colour about them.
FG4:2 Yeah, I think colour is…
FG4:4 Even a simple change.
FG4:5 Yeah, but how many times do you say it and you see a patient come in and they've come in with something non-specific and you take one look at them and go what's the matter? (general verbal agreement)
FG4:5 How many nurses do that?
But what is it?
FG4:5 Well, with them, it's things like the colour and the way they look and the way that they hold themselves, and they sort of have a look about them, certain patients, don't they? You just look at them and think there's something going on there.
FG4:2 I get a feeling inside of me, like this real, it's an emotion, I think, that you think - I can't describe it.
FG4:1 (agreement) This isn't right.
FG4:2 Yeah, but it is quite a strong emotion which again stimulates me to action.
When you say its inside, whereabouts inside you?
FG4:2 I'd love to say my heart (laughter) but I don't think - all sounds so emotive but there is, you know, we go through the day and we're fairly on, and then something drives you, something stimulates and drives you and it's emotive.
I know it sounds daft, the reason I'm asking you is because when I get it, it's here (points to area of diaphragm).
FG4:2 Is it there?
FG4:1 Yeah. I can point to exactly, it's here.
FG4:2 Is it?
FG4:1 Yeah, and that's why people I suppose call it a gut feeling, don't they?
FG4:2 I suppose if you ask me to locate it, it might be somewhere central.
FG4:3 That's your fight and flight isn't it?
FG4:2 I think you're probably right. I feel that burst of adrenalin because -
FG4:3 You can't leave your patient.
FG4:2 - you're in automatic mode and then all of a sudden you wake up, so maybe it is something to do with that.

In using this example, it is possible to identify a number of voices and layers here. For example, by focusing on FG4.2's comments about her heart, a reader might identify a wish to **acknowledge** emotion, but at the same time FG4:2 expresses concern that it might not be acceptable to be emotional. Alternatively, a reader or listener might consider this as an admission of being driven to act, in addition to the laughter, when mentioning the heart which might suggest that **acting** with emotion is also not acceptable. Or a reader might focus on the allusion to the rest of the day and the acknowledgement that this participant is alert and acting appropriately in her role most of the time but that there are occasions when she is not. Finally, and rather importantly, there is the implicit acceptance that if anything should happen to this patient then she would try 'with all her heart' to resuscitate them.

I unravelled these voices and layers through listening exclusively to start with, then listening again with fieldnotes, while making memos, and then listening repeatedly to ensure that I was familiar with the overt discussion and could move that to one side to listen to the covert messages in that appeared to be present in what participants said.

4.4 Phase 3: Further refining codes, categories and themes.

In coding data, I drew on approaches developed through grounded theory. Charmaz (2000) proposes that grounded theory coding generates the bones of your analysis and that coding is the pivotal link between collecting data and developing an emergent theory to explain these data. These elements of the grounded theory process are advocated by Strauss and Corbin (1990). In my research, this took the form of a number of different techniques under the umbrella term, "open coding." These were "breaking down, examining comparing, conceptualizing and categorizing data" (Strauss & Corbin 1990, p.61). As Strauss and Corbin (1990) suggest, the differentiation between these coding stages is artificial, and the formal steps in the analysis tended to occur simultaneously.

Each transcript was examined separately and in depth in order to ask questions of the data and make comparisons using the "constant comparative method"

(Strauss and Corbin 1990, p. 62). I used constant comparative analysis for all the data irrespective of how it had been collected because as the data collection proceeded, it became apparent that categories and themes were emerging. Appendix ix is an example of a refined analysis and is the end result of numerous iterations and paper copies, the amount of which is not possible to include. During the coding process, I constantly compared data against data to generate multiple categories. (Glaser and Strauss 1967). As part of generating the categories, a line by line analysis was used, as Strauss and Corbin (1990, p. 72) identify that this can be the most "generative" approach to identifying concepts. The line by line analysis produced many concepts from each of the transcripts, so much so that I began to feel that the whole was an undifferentiated mass and that I was falling into a "relativist morass"(Usher & Bryant 1989, p.18). I was reassured by Strauss and Corbin (1990, p. 204) who liken coding to putting together a puzzle. Gradually the ideas began to take shape as I found recurring themes and similarities in the data. Coding the data in this way led to a stage of grouping codes in order to discover the categories (Corbin and Strauss 2008, Charmaz 2006). Corbin and Strauss (2008) define a category as a higher order and more abstract concept, consisting of compared and grouped codes.

The categories produced themes and the themes that emerged from the data were checked and rechecked with the audio as well as the written data, using binary and multiple ways of analysis. I continued to until completeness and data saturation occurred. Rubin and Rubin (2012) suggest continuing analysis until two things happen, the first is “Completeness: What you hear provides an overall sense of the meaning of a concept, theme, or process.” (p. 72) and “Saturation: You gain confidence that you are learning little that is new.” (p. 73). When no new categories or themes surfaced, code saturation (Guest et al 2006) occurred. The final themes were:

Theme 1 - Perceptions of reflection: A persistent and necessary component of clinical practice or a means to an end?
Theme 2 - The significance of emotions to reflection
Theme 3 - Confidence, self-deprecation and humour in RNs reflective accounts
Theme 4 - Belonging – the community of reflective nursing practice

4.5 Summary

This chapter has outlined the data analysis methods using listening, double listening, field notes, memos, constant comparative analysis and analytic bracketing and some part of narrative analysis. It has explored how my analysis of interview and focus group data examined not only what participants spoke about, but how they did so. This approach gave me insights into the interactions between participants and the ways in which they identify and share reflections. In the following two chapters I present the findings generated through this analysis in the form of themes. Chapter 5 is concerned with a description of what participants stated about reflection. Chapter 6 will focus on how they spoke about reflection and the significance of this to thinking about the role, quality and process of reflection in RN practice.

Chapter 5: Findings – What RNs say about reflection

5.1 Introduction

This chapter is the first of two chapters that present the findings derived from the data analysis, focusing particularly on the first of my research questions: How do nurses perceive reflection? In considering how nurses perceive reflection, I begin by outlining the different ways in which the participants appeared to define reflection (Section 5.2.), before going on to explore their different perspectives on what reflection involves, drawing out a number of themes that emerged from my analysis. First, I consider formal reflection (Section 5.2.1.), and as part of this, levels of reflection (Section 5.2.2.). The relationships between reflection and practice are explored in the next section (Section 5.3.) and include recording reflection (Section 5.3.1) along with notions about reflection before, in, on and beyond action (Section 5.3.2.). Section 5.4. is about the capacity to reflect and includes experience and reflective conversations (Section 4.1.) There follows a discussion about reflection as a shared process (Section 5.5.) and it includes, learning from observing the reflections of others (Section 5.5.1.), learning from observing others (Section 5.5.2.) and working in a reflective team (Section 5.5.3.). Finally, the role of feelings in reflection is the area of discussion for section 5.6. and contains a section about translating feelings into rational explanations (5.6.1.). Throughout this chapter I draw on examples from the interviews and focus groups to illustrate and exemplify these themes. For the purpose of clarity my own questions and responses are highlighted in **bold.**

5.2 Definitions of reflection

5.2.1 Formal reflection

When asked to define reflection, participants initially struggled to find the words and then described it either as a persistent and necessary component of clinical practice or a means to an end in terms of revalidation requirements.

For example:

> ***So, if I was to say to you do you know what reflection is or reflective practice, could you give me a definition do you think? It's a tough one I know.***
> *I'm not sure if I could give you a definition. I could give you what I feel like a synopsis of what reflection would be.*
> ***Yeah do that then.***
> *I think reflection is where you're able to look at a particular incident or experience or something that you've actually done, and then be able to analyse that yourself. And from there be able to say what you've maybe done well or maybe what you've done not so well. And then from that analytical experience then be able to say from there okay you can understand that, and then what would you do differently in the future? So if I was doing it properly like I should be doing, what is it, what if, what now, and what was the other one? If what now and what, I can't remember now. (III:3)*

This initial response was typical of the responses I was given when I asked this question during all interviews and focus groups. Indeed, having told me that she found reflection hard to define III:3, when prompted, seemed to be paraphrasing Gibbs' (1988) model of reflection, which, as explored in Section 2.4.3., is commonly used within nurse education. She seemed to have a perception that this was the 'proper' way to do it but that this was not necessarily something she engaged in. Similarly, when asked to define reflection, four of the participants in Focus Group 2 had a conversation during which their responses relied on a model of reflection (Gibbs 1988), which appeared to be recited by rote. The comments below illustrate the efforts they made to understand the nature of reflection but it seems that the way in which they saw reflection was task orientated, something they had to do.

> ***So if I said to you do you know what is reflection and do you think everybody can do it - that's a bit of a question, isn't it?***
> *FG2:3 I know the reflective cycle, I think. So, when you look at the cycle where you think of something, a situation or an experience, and then you break it down, and then you try and think of what could have been done differently or to improve the situation or improve how you felt and then you come to a conclusion.*

FG2:4 do find it difficult actually to stop and do that during the course of the practice, but perhaps you're doing it all the time.
FG2:2 I think it's something you've consciously got to do because I think there's that analytical bit of it, isn't there? It's not just like reflecting on a memory or something, where you just think oh that was nice. When you're doing it work-wise you've actually got to, you've not got to but you're supposed to take it further, aren't you? You're supposed to move it on. And so it's more of a conscious view of doing something with that information rather than just thinking about that information, and I think maybe that's where I sometimes don't…
FG2:4 To actually write it up.

In this conversation, the first participant (FG2:3) was reciting Gibbs' (1988) model of reflection, without acknowledging the source or demonstrating recognition that this was a model of reflection that she had been taught. FG2:4 then alluded to reflection as a chore, contrasting this with reflecting on a memory, which was considered "nice". FG2:2 agreed and suggested that she saw a distinction between reflection as a pleasant memory and the reflection that was something she had to do for work, something that was expected of her and something that required a formal action, one that she did not always do. It is interesting that, like III:3 in the previous section, by using 'you're supposed to', FG2.2 seems to be suggesting that while she feels there is a process she should be going through, this is not something she really engages in. The fourth participant agreed with the third suggesting that, in addition to those activities, further effort was required to write up the reflection. These examples illustrate the way in which participants across the sample seemed to see reflection as something official, something that had to be done in a particular way. Moreover, while they could recite models of reflection, they did not suggest that these were models.

As for formal learning, the participants suggested that there was an expectation that they should formally reflect but they were still unclear about the definition of reflection. For example, when asked what they perceived reflection to be, two participants in a focus group had the following to say:

FG3:2 I find that really hard because I do remember in my master's being a module on reflection.
FG3:3 That's what I was going to say: module on reflection.
FG3:2 Looked at loads and loads of different models

This is interesting because even those participants who had completed a module on reflection at master's level still struggled to define reflection but yet were keen to say that they had done a module and learned about lots of different models.

5.2.2 Levels of reflection

Discussions about whether everyone can reflect or whether there are different levels of reflection prompted much discussion. Opinions differed about whether everyone can reflect. For example, one participant was adamant initially that everyone could reflect and then questioned herself and amended her answer.

Everyone can reflect. I think definitely everyone. Well I think everyone can reflect but maybe in their own way. And people maybe reflect on things more in-depth than others. (III:3)

Questions about whether everyone can reflect caused some debate in two of the focus groups. In the example below, the RNs in Focus Group 4 debate whether reflection is linked to experience and discuss the practical assessment document that student nurses bring to the clinical area, in which the student must demonstrate evidence of reflection on practice in writing. Within the assessment document there are also lists of practical skills that student nurses must demonstrate and all these skills along with the written reflection are assessed by continuous assessment by an experienced RN who has completed a mentorship course and who signs the document at the end.

FG4:6 It's like when you first look at their reflections in their assessment documents. They're all descriptive, aren't they? It's like I did this, did that and de de. What did you learn? And that's the hard bit that they can't do, ain't it, that they can't sit back and think what was it I actually learned when I did that bed bath with that patient?
FG4:4 they often blame somebody else (general agreement)

FG4:5 You would argue that what we're saying is the exact opposite that some people don't reflect because they need some guidance to reflect, where others I think do it more easily. And I do think over time we all probably, in a practice-based profession, probably learn to reflect effectively. But I think it's inevitable that people junior to the role probably won't do it so well.

The above example is interesting in that the participants appear to be discussing levels of reflection rather than reflection per se (Swan 2008). They also seem to suggest that the practice of reflection in nursing is something to be learned, which would suggest that not everyone can reflect. There is more evidence of this type of discussion in Focus Group 1. My questions are in bold.

Do you think everybody can reflect?
FG1:2 I think everybody does reflect, whether they admit it or not.
FG1:1 No, I disagree: I think some people struggle to reflect. I think some of the students we work with struggle to understand what it's all about and, like you say, it isn't about picking things apart and saying I must do better in future, that it is about thinking about it, looking at different alternatives. So I think some of them struggle and I know, personally I've got a niece who I think probably is on the learning difficulty spectrum, and she does not understand reflection whatsoever. She's not clued into people's emotions and she says things and then doesn't understand why she gets a certain reaction. So I think some people can't reflect. But I do agree that you can teach people to improve reflection skills.

What is interesting here is the first comment, that reflection is not necessarily seen to be something to admit to. Although it is unclear which type of reflection is being discussed, this may reflect a view that formal reflection is not valued by these participants. Also, FG1:1 seems to comment about levels of reflection initially and then she moves on to link reflection to emotion and is suggesting that the ability to reflect is associated not necessarily with feeling an emotion (Fook et al. 2006, Dirkx 2006) but with the ability to understand emotion, which is different. Whilst this participant appears to acquiesce, she then suggests that reflection skills can be improved which would seem to imply that the reflective ability must be there in the first place. The discussion continued and the

response was interesting because FG1:2 makes a distinction between informal and formal reflection in trying to clarify what FG1:1 meant.

> *FG1:2 So I suppose that's why I'm saying I think everybody does reflect. It's just whether you reflect in an academic way, isn't it, or in the way we kind of are encouraged to do, is that what you mean, sorry, FG1:1?*

Here the conversation seemed to be moving on from whether anyone can reflect or whether anyone can reflect in the way in which they are encouraged to do. This participant appears to be altering her assertion to be more specific about what she means. She seems to be suggesting that there is a difference between everyday reflection and the kind of reflection required by the NMC.

Following on from the links participants made between informal and formal reflection, on occasions, they referred to different levels of reflection. For example:

> *FG3:1 I think it depends on what you think you mean by reflection. You know, in the literature it always says doesn't it, that it involves that learning. That you've learned from that experience. And that seems to be intrinsic to true reflection. But I think a lot of people do reflect on situations and don't necessarily learn. And I think they can't always, they might think about things but not make sense of it. So you do reflect, I think a lot of people reflect, but the ability to make sense of it and learn from it, that's a higher level skill, I think, personally.*

In a follow-up interview a participant from the same focus group developed these ideas with reference to a particular incident with a junior member of staff in an emergency situation. The participant took over and revived a patient and did not realise that the staff nurse he was working with felt undermined by this action. The example suggests that, on further reflection on action, he is questioning his decision making and changing his perceptions. Mezirow (1981) sees this as critical reflection and the highest of seven levels of reflection in his model of reflective practice.

FG3:FU3. What I didn't do, and it was a while later, was really think. Actually it probably was that not being aware is thinking well all right, I could have let them be involved. It was all a bit grey really, what's gone on, why did I end up doing that? And it's kind of like yeah, I should have stuck with the first person. I was trying to manage everything. But in terms of what actually happened, that became apparent when I wrote about it and questioned the learning theories behind it …[unclear]. Because up until that point I would never have, never ever have thought …[unclear].

The recording was unclear in parts but, even so, this participants' comments suggest that while he may have struggled to define the concept of reflection, instead of being fatalistic or outcome driven (the patient survived) he was attempting to link theory with practice in this instance and change his perspective (Fook 2010).

Some participants gave different insights into the kinds of experiences that promoted depth in reflection. The following is a longer extract from a focus group. We had been discussing reflection and one of the participants had relayed a story about a young man on a ward who had appeared to be drunk but instead, had a serious and deteriorating head injury that required surgery (because of her intervention, the patient survived). My questions are in bold:

So if I was stood next to you and I was a student nurse and I said how can you tell that it's not drunkenness?
FG4:6 That's hard Christine
Would you be able to tell me? Wouldn't it be really good if you could learn that a lot quicker?
FG4:6 Some of the things are the same, what somebody acts when they're drunk, somebody who's got a massive head injury can act the same.
FG4:5 I think a lot of this is about not taking things for granted and about not assuming that we know everything and that we do try to listen to other people, because we all make mistakes and it's important to learn from those mistakes and sometimes that means that next time somebody says that to you, you'll listen to them and you won't assume that you know it all. And it's that. So you may have a drunk person and it may be drunkenness but you're not going to take for granted that it is because you've seen it where it isn't. Does that make sense?
FG4:6 Yeah. It is

FG4:5 So sometimes a bit more questioning, is it this or is it this, and being a bit more careful sometimes, I think, about making assumptions that everything is OK.
FG4:6 Sometimes what you don't know, sometimes it's more frightening because you just put it down, don't you? You think they're drunk. They've got to be drunk, it's nothing else. And so many times that can happen and it's only if you've had that bit where you become less judgmental because you've been judgmental before and something's happened that you think hold on a minute.
FG4:2 I think it's something to do with assessment skills though because I think again that is the one skill that evolves the more experienced you are that you become much better at assessing a patient.
FG4:3 It's far deeper than what you've been taught, isn't it?

This is a fascinating and very detailed discussion in which the participants seem to be co-constructing how they know what they know. As Brookfield (1995, 2017) would say, they appear to be hunting their assumptions and recommending that others do that too. There is also an element of the typification that Schutz (1946) writes about and the possibility that they are problematising the taken-for-granted discussed in Chapter 2, section 4.2. (Mezirow 1998). The participants seem to be acknowledging that experience, yet again, is the key but there is no overt acknowledgement that they are reflecting on their practice. The examples given in this section illustrate how the participants are grappling with the concept of reflection and suggests that they do seem to be clear that there are levels of reflection even though they do not always overtly describe them as such.

5.3 Relationships between reflection and practice.

5.3.1 Recording reflection

The NMC requirement for reflection to revalidate (see Chapter 1.3) was discussed in a number of focus groups and interviews. It appeared to be viewed with resignation and doubt. For example, one participant commented: *"Even though the NMC are pushing us for five pieces of reflection, I'm not sure you do have to be that structured."* (FG1:1). At

times, participants felt that they were reflective but acknowledged that they did not comply with the revalidation requirements even when they felt they were reflecting. In a follow up interview, one participant talked about revalidation while we were discussing whether she wrote any reflections down and she knew that the NMC required five pieces of reflection.

> *I haven't really thought about this seriously, because it's not until November, and I probably should, I probably should be doing them now actually anyway, for my own peace of mind (FG1:2)*

Hence there appeared to be a dichotomy between the definition of reflection as an activity carried out in and just after practice (Schön 1991) and writing about reflection and finding literature to reach a perspective transformation (Mezirow 1981). For example, one participant said:

> *Despite the fact that I always say I'm not particularly reflective, I think I am, I'm not very good at formalising it. It just doesn't float my boat to have to do that but I know that I am quite reflective. (FG1.3 FU).*

Another participant admitted:

> *I don't actually document anything. Sometimes if I want to evaluate things, I talk to professional colleagues about it. I know my job pretty well. (FG2.FU2).*

This participant seems to be implying that documenting reflection is related to inexperience and that now she knows her job well, she does not find it useful to document reflections. This focus on the value of reflection-in-action rather than reflection on action was also explored by a participant in another focus group who said:

> *FG2:3 I think for me it's a constant thing, because it's a thought process that goes on constantly and reflecting on a past experience or an action…… I feel that even in clinical practice reflection helps you to analyse your action and work around what happened and what could be done. So I think it is useful. I also know that a lot of people find it difficult to write down because of the time factor. But it's almost like a discipline that you have to cultivate and do it almost immediately so that you don't forget. Because as soon as you leave, moments and hours, you kind of forget the smallest detail that might be very relevant to*

your practice. So it is something that you've got to actually train yourself to doing constantly.

This participant seemed to be reflecting some of the issues with reflection associated with memory, in that she is just not sure that she will remember all the details of the incident, which is one of the concerns highlighted in Chapter 2.5.3 and, at the same time, she appears to be recommending that writing reflections is a discipline and one that requires constant effort. So, there are differences of opinion, some participants seem to be suggesting that writing reflections is a necessary part of learning to become a nurse but that they need to write less as they become more experienced. Others see writing reflections as enabling them to think more deeply about issues at work and yet others see it as a chore.

5.3.2 Reflection before, in, on and beyond action

While all participants struggled to provide an explanation, most were able to articulate different approaches to reflection. In the focus group extract below, for example, an RN initially stated that she does not know what reflection is but, in describing how she reflects, seems to distinguish between reflection in and on action (Schön 1983).

FG3:3. I think that reflection for me mainly takes place during the event. And I think there's a times that you're that busy that you move on to something else and then reflection may take place afterwards. Or I guess it may take place a day or two later on an evening, trying to make sense of things. But again, the more experienced you become the more you know the things that you're able to think about on the spot or be parked for later.

For this participant, reflection-in-action appeared to be the most frequently used, however she seemed to be suggesting that she could comfortably choose whichever form of reflection she deemed necessary. This was a view also expressed by other participants. These participants also suggested that reflection-in-action occurred more frequently the more experienced one became, as illustrated in the example below.

FG3:2. There's a lot to be said for reflecting as you do something, but I think that comes with experience. The longer you're qualified.

In addition to distinguishing between reflection in and on action, some participants also alluded to reflecting before action, or 'anticipatory action' (van Manen 1991) which involves thinking about what happened before and anticipating what might happen in the future. Sometimes they linked such anticipatory reflection to a 'changed perspective' (Mezirow 1981), where their outlook on something changed as a result of thinking about what they had done or were doing. Below is an example from the data (Focus group follow up interview FG2:FU5).

> *Yeah exactly. I was taking someone's blood a couple of month ago and these new sort of -*
> ***Cannulas***
> *- cannulas that we have, it wasn't screwed on properly, so of course I took…*
> Cannula = a fine plastic tube slid directly into a vein, usually in the back of the hand, to give fluids or drugs that will have an immediate effect.
> ***Right, went everywhere?***
> *Exactly, I took someone's blood and you can imagine the mess. So I thought well I'll never do that again. So now I make sure I…*
> ***You always make sure it's screwed on before you put it in?***
> *Exactly I examine and make sure everything's fine before, yeah, so little things like that yeah. As I say I think you learn something every day. (FG2:FU5)*

While, as discussed in Section 2.3.4., there has been much debate about the relative value of reflection during or after this practice, this RN is suggesting that reflection is more fluid, and involves a combination of reflecting before, during and after practice. Below one participant highlights the array of reflective practice she claims to use. I say 'claims' because of course, it could be her espoused theory (Schön (1983).

> *FG3:1 I think it's thinking about what you're doing. I think it's thinking about what you're doing either before you do it and thinking about what the best way might be to do it. It's thinking about stuff whilst you're doing it, is it working? Is there a better way I could be doing it? And then after you've done it thinking about that, and thinking did I do it right, could I have done it any better? So personally, I think there's a lot written about reflection,*

but I think it's just that mental thinking and evaluating what you're doing all the time, before during and after. That's my view.

This example suggests that reflection is something this RN does all the time and assumes that others do too.

In a number of different focus groups and individual interviews, participants discussed whether reflection takes place most effectively in a formal or informal or non-formal learning context (Cheetham and Chivers 2001, Eraut 2000). While acknowledging that formal reflection was a necessary part of NMC revalidation, some participants suggested that they saw more value in informal learning than in the formal process of reflection required by the NMC. An example of this is provided below.

FG1:2 You don't necessarily formalise it and say I'm going to follow this model of reflection or I'm going to sit down and write it down or…..
FG1:1 ……..sometimes I think some of the best reflections are when you just manage five seconds somewhere to think about something and it's like oh, yeah, I didn't think about that and perhaps I could do it like that in future.

At the same time, some participants suggested that they saw reflecting on action, not as a formal activity but as something that was part of their everyday practice, perhaps as a natural extension of reflecting in action. See below:

FG4:5 I think we all reflect almost every day of our lives but not in a formal sense. So you go home. You sit down with your cup of tea and you play back things that have happened in the day and maybe I should have said that and maybe I should have dealt with it that way and I'm not happy about that and I'll make sure I do that in the morning. But we do that. I mean how many times did you go out from a late shift and not sleep properly because your brain wouldn't switch off because you were running through everything that had happened on that shift and the things you needed to make sure you did the next day. So, we do it when we're having contact with colleagues about certain things. We do it when we have contact with students about certain things. You think that went OK, then you think about it later, thinking what can I do that's going to make - so we all do that thing subconsciously but not in a formal sense, we don't write it down.

FG4:1 It's not restricted to work; it's any sort of social situation that you find yourself in, I think.
FG4:3 When you come home you think did I say something stupid, usually after that third glass of wine (laughter)

These participants suggest that they see reflection as part of their everyday practice, much as Brookfield (1995) claims. Their conceptions of reflection seem to be associated with reflection as a collaborative, rather than an individual activity. There is further evidence of the idea of reflection as everyday activity in the individual follow-up interview from another focus group. See below:

We do it when we're having contact with colleagues about certain things. We do it when we have contact with students about certain things. You think that went OK, then you think about it later, thinking what can I do that's going to make - so we all do that thing subconsciously but not in a formal sense, we don't write it down (FG1:2).

In considering where and when reflection takes place, it seems that the participants are suggesting that reflection takes place informally in the workplace and when with other RNs and they see this as a valuable, ongoing and necessary component of clinical practice. This seems to contrast with the way they appeared to describe the formulaic, formal reflection, which they seemed to think is required by the NMC and formal courses, so they consequently perceive it to be a means to an end.

5.4 The Capacity to reflect

5.4.1 Experience and reflective conversations

On many occasions, participants indicated that the ability to reflect was dependent upon experience. Below, in an example from a follow-up interview, an experienced RN is discussing her concept of reflection. She identifies that she enjoys reflective conversations about practice and how she struggles to have these conversations with inexperienced student

nurses. Importantly though, she acknowledges that she has no expectations that students would be able to reflect, at a deep level, on practice, which is interesting in terms of the expectation that student nurses will critically reflect on practice as part of their formal professional learning.

> *I think there's, I think I'm quite a deep thinker and a reflector and you can do charts that tell you that, but I think I know myself I reflect and I like deep conversations about practice, theory and how the two influence themselves, but experience as part of that. So I think I seek out people who I know I can have those conversations with. I do think student nurses, I have conversations with student nurses, but their questions are more superficial and they haven't always got the depth of thinking and nor would I expect them to have, because they haven't had a great deal of experience to start making the links. (FG4:FU2)*

Here, the participant appears to believe that experience is important as are conversations that link theory and practice, which is in keeping with Brookfield's ideas about looking through different lenses (Brookfield 1995, 2017). She seems to identify the theory lens, the autobiographical lens, the student's lens and colleagues' lenses as a way to investigate practice and she infers that reflection can bridge the gap. It is also interesting to note the possibility that this participant might be unconsciously demonstrating the concept of performativity (Ball 2003) as a way of justifying who she is when she says she is a deep thinker and reflector because "charts" demonstrate her to be. Yet, when she talks about what she enjoys and moves to a more reflective conversation about what she likes, she demonstrates a more fluid and empathetic approach to those less experienced than she (Dirkx 1997). For example, in response to my question (in bold);

> ***And what about more junior qualified nurses?***
> *Again, it depends. I think it depends how long they've worked there. I do think some are more open to it. I think there's, there is something, and I don't know whether this is right, around intellect, that there's different levels of intellect, there's different openness to reflect. But again, because their experience is limited, they*

haven't started making the links. So I think you can have a conversation with them that starts to stir their thinking and you can see that potential in them where I think, you know, there comes a

point where I can't get from them what I need and I think you can see you've gone as far as they can go at that point. They've got to go away and do it themselves then. (FG4:FU2)

Similarly, other participants suggested that reflective conversations with other experienced peers enabled a deeper, more critical reflection on practice. See below:

FG4:2 I think there is a different (verbatim) though when you have reflective discussions with your peers that are all quite experienced. There's a difference in the movement of where you go from where you start your discussion and where you end.

When asked to clarify this belief about experience enhancing reflection on practice, one participant had the following to say.

FG3:2 I think you just become aware, more aware of what reflection is and what it is that you're doing. I think you do it as a junior, as a student, and then as you become more experienced, I think you're more confident to be aware of what you don't know, and to learn from what you've done, rather than thinking I've done something wrong. I think as you become more experienced and more confident, you then think that could have gone better but you sort of rationalise it more.

For these participants, it seems that reflection and experience are inextricably linked because they perceive reflection to be at different levels and of a different type, depending on experience. So, the more experienced the RN, the more a positive story is used and the more focus is on using reflection to learn.

It is also of note that some participants seemed to recognise one of the pre-requisites of reflection identified by Boud et al. (1985), that of self-awareness.

FG4:2 I think there is a difference though when you have reflective discussions with your peers that are all quite experienced. There's a difference in the movement of where you go from where you start your discussion and where you end. I think also there are

people even that we work with that are not reflectors. They don't really participate in those discussions. So I don't think everybody does reflect in the same way and gets not as much out of it as others maybe.

FG4:1 One year's experience ten times.
FG4:2 I think that's what I'm saying, that some people aren't terribly self-aware, and I think if you're not terribly self-aware, I don't know how the hell you can reflect.

On the one hand they are suggesting that reflective discussions happen with experienced RNs, on the other they seem to be suggesting that experience and self-awareness are linked so that an RN who has been working for a long time in practice might not necessarily be experienced or reflective if they are not self-aware.

5.5 Reflection as a shared process

5.5.1 Learning from the reflections of others

In Chapter 2, I discussed the historical notion that one cannot reflect on someone else's reflection, a claim that is perpetuated in nurse education today (Fook et al. 2006, Edwards 2015). This notion of only being able to reflect on your own practice was rationalised by the participants as being associated with formal learning and individual assessment rather than what might be more beneficial in practice. Below is an example:

What I tell my students is you can only reflect on your experience because it's their academic work and it's important that it's about their development FG4:FU4.

However, as they reflected on the process of discussing reflection during this study, it became evident that the participants felt that they had benefited from listening to others' reflections on experience. For example, FG1:FU2 explained what she had learned from the reflections of others in the focus group when I was seeking recollections of the focus group to confirm the accuracy of the transcript at the follow up interview. She started to list what she had found useful.

OK one is the listening to the experiences of other people including yourself, and actually reading that's now reminded me,

so that was one of the things that I found informative. But the other thing was actually not listening, not just listening to other people's experiences, but listening to other people's opinions of what they felt about reflection, particularly – can I mention a name?

Yeah.

All right, particularly FG1.1, when I was reading back through that, because FG1.1 and I although obviously we didn't particularly debate it at the time, obviously had quite different opinions in some ways about reflection and the way people reflect and I like that. I like that debate, because it makes me think actually not necessarily that I'm wrong or she's right or vice versa, but it's interesting to find, have a different point of view. So that, I would suggest that's what made it informative for me.

What FG1:FU2 appears to be suggesting here is that it is not only listening to others reflect that is helpful but also the debate about reflection. In a different way, another participant considered what could be learned from the reflections of published writers:

Well I think even when you're just reading journals you are reading somebody else's experience aren't you and then you reflect on that and see whether it, you know, so you do it anyway. We do learn from that anyway don't we? You know, in journals there's things about the way that people have developed services and what they've learned from that and, you know, you can think oh I could avoid the pitfalls if I did that in a different way or yeah that's a good way of doing it (FG2:FU2)

What both seem to be suggesting is that they learn by considering their own experience in the light of others' experience and ideas but not necessarily in clinical practice. FG1:FU2 also discussed the notion of shared reflection and reflective conversations in practice, highlighting the value of this shared reflection in a clinical practice setting. In the following example, a participant advocates for handover as an opportunity for shared reflection (Handover is a formal meeting in the practice area and generally on a ward, where nurses on one shift are handing over to the next shift and discussing patients, their diagnosis and their nursing needs).

It's a moment where if you have been on, well obviously will have been on the previous shift it's your opportunity obviously to hand over to the next shift, but also to reflect on things that have gone

great, things that have gone wrong, things that are still left to be done. I think there's, the handover I think personally can be so powerful. So yeah, I'm happy to share my experiences there with anybody that's willing to listen. That's the bottom line (FG1:FU2).

This example suggests the significance of sharing reflections in professional meetings, yet in an 'informal setting'. Indeed, it may be that a successful handover depends on this element of reflection as a part of it.

5.5.2 Learning from observing others

Related to the theme of shared reflection as learning from observing others, a participant was clear that it is common practice to reflect on someone else's practice and gives specific examples of this. See below:

Actually, a lot of what we do, particularly when we're working as a team, is reflect on what other people have done and how, as a team, things have worked in that environment. So, I think people can reflect on other people's and think actually – and students do it all the time with the mentors because they watch their mentors and people and one of the things they come back and say I don't want to be like that. Now that's learning from watching other people and learning how, from they're doing, how they want to be and how it feels to be treated in the way that they were treated.

So, I think people can learn from reflecting on other people but I think it's really important that they reflect on themselves and how they manage because sometimes it's about they did that, why didn't I do something about it. So they behaved in that way, why didn't I challenge them or why didn't I say I wasn't happy? And it's all those sorts of things. And there's lots of evidence out there about people being frightened to challenge somebody in authority or challenge the doctor or whatever it is. So sometimes it is about if that happened again, I'd do this. (FG4:FU4)

FG4:FU4 seems to see such opportunities as an important element of working in practice. She not only identifies that learning from reflecting on the practice of others happens but that it is a way to learn how to act on behalf of patients (NMC 2014) and to manage risk (NHS 2015, NHS England 2017).

5.5.3 Working in a reflective team

Some of the stories and discussions focussed on teamwork. In the focus groups, teamwork was highly valued as a learning tool and as a support mechanism but it also seemed to support the notion of sharing reflections and seeking solutions together. In the example below, FG1:3 had been quiet in the focus group, she had arrived late and may have been affected by a comment from FG1:2. “Are you with us, FG1:3? Are you in the zone?” This was said in a jocular tone but on analysis appeared to be a reprimand. I then said, “Have you got anything you want to share?” and FG1:3 said:

> *I suppose we had a patient who had dementia and she was fit and able to walk around and boy could she walk and she had a tendency to walk round in the room in circles and she had a particular chant that was her, we always thought it was a soothing rhythm. It wasn’t a song, just a chant. She couldn’t connect into anybody else at all and over time one or two people who had some seasoning at, you know, who had been in the business awhile said this has changed. This chant’s different; we couldn’t articulate it; she’s not as comfortable. And from that detection of just a change, subtle changes in her behaviour, the whole team ended up investigating what was going on with this woman.*
>
> *And the end of the story was she’d got angina and her chants and her movement changed when she was having an angina attack. She couldn’t tell us so she was in pain. But the trouble we had persuading the doctors that what the issues were stunning, and all we’d got to work on was that this person with dementia had a subtle change in behaviour but about four of us got it on the same day. (FG1:3)*

This fascinating, insightful story is packed with many ideas but I want to draw out the emphasis on teamwork. She shares how the experienced RNs spotted a change and altered other members of the team who, together, worked out what was happening. This “mutual engagement “Lave and Wenger 1991, p. 73) is one of the defining characteristics of a community of practice (CoP). It is a “mode of identification”, as is “alignment” (Wenger and Wenger-Trayner 2010, p4) where the FG1:3 and her team members discussed their concerns, checked their

understandings, reached a solution together and formulated a plan for action to convince the medical staff to act.

This perception of the importance of team was repeated in the individual interviews as well. In this example from FG4, arising from a question about what they reflected on, participants had been discussing when something goes wrong and how they dealt with it.

> *FG4:2 I think it's about the team you work with. I think we're very lucky that we can walk in an office somewhere and have quite a detailed and in-depth reflective discussion with our colleagues, and I bet you can as well FG4:1 and FG4:4.*

FG4:2 seemed to value her place in the team and the opportunities it gave her for the reflective discussions that she assumed were part of her practice. Interestingly, FG4:4 said "We can to a certain extent, yeah." in a tentative voice, implying that the opportunities to reflect were either not present or not valued where she worked, and the conversation moved on. These conceptions of being able to reflect in teams and with colleagues could be part of productive reflection (Boud et al 2010) where reflection is seen to be shared, benefit the work and lead to action and may suggest that these RNs are not just discussing a community of practice for RNs but a community of practice for reflective, registered nursing practice.

5.6 The role of feelings in reflection

Whilst descriptions of the process of reflection discussed in the previous sections vary from formal to informal, and from individual to shared, they largely present reflection as a rational process that drives decision making in practice. Some of the participants' comments however, suggested that such decision making was driven more by feelings. When asked to describe how they knew what they knew as they told stories, the participants frequently cited an uncomfortable feeling that happened when first recognising an issue (Atkins and Murphy 1993). In the example below, two participants in Focus Group 4 attempt to explain the nature of that uncomfortable feeling:

> *FG4:2 I get a feeling inside of me, like this real, it's an emotion, I think, that you think - I can't describe it.*

FG4:1 (agreement) This isn't right.
FG4:2 Yeah, but it is quite a strong emotion which again stimulates me to action.
When you say it's inside, whereabouts inside you?
FG4:2 I'd love to say my heart (laughter) but I don't think - all sounds so emotive but there is, you know, we go through the day and we're fairly on, and then something drives you, something stimulates and drives you and it's emotive.

What FG4.2 refers to as 'a strong emotion' seems to prompt an urge to resolve whatever is causing the emotion. In some ways this response could be seen as the opposite of reflection, i.e. an unconscious response. However, at times, participants suggested that such feelings were the starting point for more systematic forms of reflection. Although not quite so specific, the extract below from Focus Group 3 exemplifies how participants often attributed strong feelings to attempts to uncover tacit knowledge.

FG3:1 Definitely have conversations about it, definitely had conversations about those feelings in handover report, particularly, I think is a key time where you can have those conversations. But I think it's more, it's the walk around handover, I have never agreed with handovers in offices. I think the handover report you've got to be able to see that person that you are talking about as you're talking about that patient and getting all that information. Because if you've not been on duty and somebody's telling you about this person, and it's not fitting with what you're seeing, I think there's something about being able to see the person when you're getting that information. So yes, and I would share all those things. (verbal agreement) I have got uncomfortable, I feel uncomfortable about this patient somehow today, I don't know what it is, I can't put my finger on it.

FG3:2 And I think your colleagues would, because again I think about the nursing intuition thing that we're maybe not happy with, but I think your colleagues would probably, oh she's not happy about him, let's go and have a look. They would trust, if a colleague of mine said something about this patient, that is like an alarm, that's a bit of a red flag, why aren't you? You want to go and investigate further.

This example seems to suggest a number of different things. First, it suggests that RNs value the opportunity to talk to each other. Second, they appear to imply that there are times they want to explore their feelings with others and times when that feeling is not questioned or debated. Finally, they seem to

suggest that visually checking out their feelings and questioning those feelings themselves is helpful in to trying to understand what is going on. These

reflections around practice seem to suggest there is an association between reflection and feeling and it may be that reflection is being driven by tacit, embodied knowing.

5.6.1 Translating feelings into rational explanation

Reflection-in-action, often involving the resolution of incongruity, frequently led to an action. Such action often took the form of what the participants called ‘THE CONVERSATION’ (capitalised to reflect their emphasis). ‘THE CONVERSATION’ was normally with a doctor but could be with another health care professional or a more senior nurse and signalled the need for them to see the patient immediately. It is common for doctors and other health care professionals to be covering more than one ward or more than one patient and so prioritising who they must see is a feature of the judgment’s that doctors make and this must be informed by the assessment by the nurse. Asking a doctor to see a patient based on little more than a feeling in this technocratically rational environment is not easy, and ‘THE CONVERSATION’ featured a number of times in their discussions. The participants discussed the challenges involved humorously most of the time and expressed frustration at other times. Interestingly my field notes identify that as the participants were discussing ‘THE CONVERSATION’, their body language altered, and they mimicked their verbal confidence by sitting up in their chairs and using bold eye contact. This suggested the authenticity of their conversations as the non-verbal actions seemed to be embedded in their comments about what actions they would take and how they would take them.

The experienced nurses in the focus groups, follow-up interviews and individual groups said that, in the context of ‘THE CONVERSATION’, they had learned the skill of talking assertively but acknowledged that if they asked a doctor to see a patient, no matter how reluctant that doctor was, the nurse made sure that they did. Focus Group 4 discussed the length of time it might take for a doctor to arrive and acknowledged that in the

places where doctors and nurses worked together regularly or where a doctor had got to know a nurse, they had no trouble in having ‘THE CONVERSATION’ and that it could be shortened. While much has been written about the nurse doctor game (Stein 1967, Stein et al. 1991, Holyoake 2011), many now state that professionals in health care are on a more equal footing (Price et al. 2014). Indeed, the participants in this study appeared to be saying that they saw the interactions associated with ‘THE CONVERSATION’ as involving two respectful colleagues who acknowledge each other’s expertise and often use shorthand to communicate verbally. However, it still appeared that in having ‘THE CONVERSATION’, nurses have to work across different modes of knowing so that, while as explored above reflection may be driven partly from embodied, tacit or felt experience, once they have to talk to doctors this must be translated and more rationalised.

5.7 Summary

In summary, it is clear from the data discussed above that reflection is still a contested concept amongst RNs in this study (Ghaye et al. 2008). Some see formal reflection as a chore and suggest that they are being coerced by the NMC (2017) to produce reflective pieces that are an academic exercise. Participants also expressed different opinions about whether all can reflect and about how the depth and quality of reflection depends on experience. Some participants believe that the more experienced one is, the deeper one is able to reflect in terms of levels of reflection (Mezirow 1981). On the one hand reflection is seen as an activity that not all can do, on the other hand it is seen as a level of thinking that gets deeper and more complex the more experienced one becomes. Participants also discussed recording reflections, some seeing the value and some with reluctant resignation seeing it as a means to an end. Informal reflection appeared to be highly valued. The feelings associated with reflection-in-action were discussed and a kind of embodied reflection was seen by participants as essential to the problem-solving activities that take place in anticipation, in, around and on practice. Finally, participants seem to be suggesting that, contrary to official guidelines, there are many occasions when

reflection can build productively on the reflections, experiences and actions of others.

Chapter 6: Findings – How RNs shared reflection

6.1 Introduction

When I embarked on this study my research was underpinned by assumptions about the nature of reflection being technical and rational. However, as the focus groups and individual interviews unfolded, I realised that the conversations not only expanded in much more fluid ways than perhaps a textbook on reflection might suggest, but that there were dimensions of participants' conversations that were themselves interesting in terms of thinking about the process of reflection. For example, I became increasingly interested in how the emotions displayed and discussed, and how a sense of community and laughter, appeared to be important in laying the foundations for reflection. Moreover, they also seemed to demonstrate a kind of sharing of experience that perhaps differed from typical descriptions of reflection in and on action, as discussed in Chapter 2.3.4. It appeared that the discussions themselves were valuable as professional exchanges, and that similar discussions might potentially themselves be useful in terms of developing professional knowledge. In this chapter therefore, I explore, not just what was said but the way in which it was said. I begin by considering the emotional nature of the discussions about practice by exploring love, pride, passion and compassion and how emotions appeared to be managed, which is distinct from the feelings expressed when sharing reflections as discussed in Chapter 5.6. Next, I deal with the way confidence, humour and self-deprecation were woven into the stories and conversations, sometimes all at once. I end with conclusions about belonging to a community of reflective, registered nursing practice by teasing out a series of themes related to notions of shared history and perspective; the process of finding a place in this community of reflective RNs; the development of shared language and sharing interests and stories about practice. In commenting on how participants discussed their experiences, I draw on what I gained from the double listening process, which foregrounded how the participants were expressing their opinions, sharing conceptions of reflection and reflecting on how they reflected in practice. (As in previous chapters, where examples from the data are given, my questions and responses are highlighted in bold.)

6.2 How we feel: Emotions expressed in the RNs' reflective stories

One of the noticeable features of the focus groups and individual interviews was that participants spoke about their feelings and beliefs in a way that was often emotionally charged. Here, I begin by discussing a range of feelings that participants expressed through the stories, specifically pride, passion and compassion. Next, I consider how participants spoke in relation to their experience of feeling and managing emotion.

6.2.1 Love, pride, passion and compassion

Some of the participants within the focus groups and in the follow-up and individual interviews identified that they felt pride in what they had done during their nursing career and how they had performed. As one participant reflected, she said:

> *There's been lots of incidents where people have said, you know, you've really helped or you've really made a difference. And that's what it's all about really isn't it?" (FG2:FU5)*.

This view was echoed by another participant, in a follow-up interview for another focus group, who said:

> *Yeah, I really enjoyed that, I did a good job there. And, I don't know, yeah you keep going over what you did right. (FG3:FU3).*

Some participants expressed pride in the profession that had implications for their whole life, not just their job. They suggested that being an RN had given them life skills and added confidence. FG2.3 below enthusiastically expresses her opinion:

> *FG2:3 I do think nursing is phenomenal. I mean it's probably one of the worst paid jobs for the amount of work you do as a nurse. But I think that the overall training and experience you go through a nursing course and the stuff you learn from it is quite incredible, because you seem to kind of have knowledge of not just that patient thing, you kind of become quite well-rounded in lots of things, you know, and people just look to you, you'll know this (general agreement)*

The words in brackets in the above example were added when listening to and reading the transcripts. Independently, one of the individual interviewees also expressed similar thoughts, simply stating "- and I love being a nurse." (III:3) Another participant was more specific and said *"So I joined the hospice, applied for hospice, (name of hospice), and worked there for two years which I absolutely loved. Love end of life." (III:4).* In her reference to 'end of life', this participant is referring to her love for coordinating, managing and caring for patients at the end of their life and helping them to have a 'good' death. When discussing their love of nursing, some were very specific about what they loved. In the example below, one participant states what she loves and then makes it clear that she only loves a particular type of nursing work.

> *I like the acuity, I like the speed. I like the complex patients. So, once I qualified, I got my first job on ENT, and MaxFax. Loved that for a year and then they put me onto a secondment on surgical assessment unit (pause). (III:2)*
> ENT = Ear nose and throat. MaxFax = Maxillofacial medicine and surgery (dealing with the face and jaw). Surgical assessment unit= where new patients are admitted to hospital who are suspected of having an illness that may require surgery

On the audio recording, the participant's voice was clear and firm for the most part but when she uttered the last phrases, her voice was low and muted, the implication being that she did not "love" being on the surgical assessment unit.

Another emotion frequently noted during analysis was passion, that is passion about the job and/or learning from someone who is passionate. Some participants alluded to the specialism they practised in as being what was special and actually used the word 'passion'. One participant in an individual interview said;

> *So I left there and I went back to doing my community out-of-hours nursing. That's what I went back to do. And that's where my passion is really, out-of-hours nursing. (III:3).*

Yet another participant said; *"And so I learned a lot from her because she was passionate about – it was a GI (gastro-intestinal speciality) thing." (FG4:FU4).* Others did not specifically mention passion but, when listening to the recordings, it felt that they spoke with passion. Below is an example of this implied passion:

> *Yeah, exactly. Then moved here with my husband a year ago. Always wanted to go into cancer – lost my mum when I was 19 through cancer so I think that is probably why I've always been interested in that. And then came here, absolutely loved it. They said there was a job, and I thought, do you know what, I absolutely love it. The time I get with the patients – when you are at university you get the holistic care, you actually get to practice it here, and that's the difference. I don't get that 15 minutes making a bed and that's all I get with that patient to find out everything. I can sit there for two hours with that patient, so a massive difference (III:2).*

This passion was often expressed on behalf of the patient as well, as compassion. The RN below provides a good example of this during a general discussion about patients in a focus group.

> *FG4:6 I think sometimes you want it for the patient because you know they can't and if you're confident in what you're thinking, you've got to think nobody else is listening, they are going to either be sent home and then they'll be coming back*

Again, the transcript gives a hint of what she is expressing but records of the listening analysis say, "said passionately". These comments were part of the discussions where I had asked them about an example of reflection or where we were discussing their reflection and it arose from a reflective story they were telling. These conceptions of pride, passion, love and compassion were more obvious than I expected and seemed to express a more emotional aspect of reflection that I had not previously considered. Whenever I asked about examples from practice, emotions were an integral part of the example and ensuing discussion. In Chapter 5.5., I considered the role of emotions, exploring how feelings often appeared to prompt reflection. These examples however illustrate how emotions were frequently integral to nurses' stories of practice. This seems to suggest

that that nursing itself is emotionally charged and that it is not possible to extract reflection from that context. Rather than approaching reflection as a rational process, therefore, these nurses considered their practice in relation to their wider values and commitments as nurses.

6.2.2 Generating a context for reflecting on the emotional dimension of nursing

In addition to talking about their feelings for the work, some participants also reflected on the significance of this feeling for their professional lives. In the instance presented below, a very experienced RN (30 years qualified) refers to an incident when she showed emotion at work and felt uncomfortable about crying. It is worth noting that, through the double listening process, I focused not just on content but also how she talked. I felt that, as she spoke about the strain of feeling that she should not cry in front of patients, there seemed to be defiance in her voice, as if she knew that it was not acceptable to cry, but that she had done so anyway, and had felt ultimately that this was the right thing to do.

> *FG2:2 I remember I did cry in front of somebody when something that they said prompted an emotion in me that wasn't anything to do with them. And I apologised for that is because I did feel so unprofessional. And then the woman cried because she told me that her son had killed himself. And it was the first time that she had been able to tell somebody professionally, not professionally, to tell a professional about how she really felt.*

After the initial apology to the patient and in the telling of the story, an initial sense of guilt seems to be replaced with a passionate defiance and pride, linking two emotions discussed above. The story this participant told ended with her justification for showing genuine emotion and its role in assisting a patient to disclose information that contributed to more holistic care. It seemed that she was managing her emotions in such a way that there was a positive shift in attitude at the end, that crying, whilst not comfortable for the RN, meant that the patient benefitted in some way from this show of emotion. It seems therefore that, in the focus group, FG2:2, not only found a way to talk about her emotions but that sharing

the story generated an opportunity for her to reflect on the emotional nature of nursing and how to manage this.

This expression of defiance, confidence and justification seemed different from the views expressed by a less experienced RN who aspired to feel less emotion. This participant was much less experienced than the others in the focus group (she had eight years post qualification experience). Interestingly, she was also one of the oldest in the group, having come into nursing in her early forties. In the following extract, she discusses a 56-year-old patient who died unexpectedly.

> *FG2:5 I must say, Christine, I've been the opposite as well, where it's been a total shock when someone's passed away, and I haven't expected it at all. I had a patient last year. I went off on a week's holiday, came back and he'd passed away, and that was a total shock. So I hadn't expected, you know, sometimes it can be the other way.*
> *FG2:4 Did you feel you should have picked that up then?*
> *FG2:5 I was devastated, yeah. And I did think I did reflect on that. But again it was septicaemia, not with the condition he had, it was a different condition.*
> *FG2:5. You know, whenever anyone passes away we're always upset about it.*
> *Of Course (researcher).*
> *But they obviously didn't take it as badly as me (wry laughter)*
> Septicaemia = an infection of the blood that is usually fatal

The less experienced RN appears to try to manage her emotions by accepting that she was more affected than the other nurses she is working with. In moving towards managing emotions in this way, she seems to be considering her perspective on this at a deeper level (Schmidt and Diestal 2014). She appears to alter her understanding of what happened to find a way of managing her emotions and includes an acknowledgement of how she is feeling along with the ability to verbalise her distress. This way of managing emotions is discussed in Chapter 2, section 2.2. The wry laughter comment was added to the transcript after using the double listening technique and a memo written shortly after says:

"Why is this nurse aspiring to be less upset? Why is she hoping to become less emotional about what is clearly an emotional subject? Is it a coping mechanism? Is it about the emotional labour of nursing (Hochschild 1983)?"

It is of note that one of the more experienced RNs tried to comfort this participant as she struggled with her emotions. The actual transcript shows little of this, see below:

> *FG2:5 Exactly, it had.*
> *FG2:4 I think you're able to just pick up clues, like you said there was a clue that, on reflection, you know, there was a clue. With septicaemia, you know, it's…*
> *FG2:5 Well, this is it, yeah.*
> *FG2:4 Usually they're not really, are they?*
> *FG2:5 No.*

However, the expression and tone evident on listening to the audio recording and in notes taken at the time suggest that this short, minimally verbal encounter in the middle of a focus group comforted the less experienced RN and reinforced that this experience would help her manage her emotions in the future. FG2:4 is suggesting that FG2:5 should reflect on what happened think about what clues were there to indicate that this patient has septicaemia. FG2:5 had been relatively quiet up to this point and most of the other participants had been reflecting on positive incidents or elements of their job. In the example above, FG2:5 is not only focussing on a negative incident from her practice, she also seems to be seeking assistance and drawing in FG2:5, who had been discussing reflective incidents with the others, to help after watching and listening to the others in the group. Of interest here is that the focus of the reflective discussion seems to be partly about patient care, but it also seems to be about self-care and that this opportunity for shared reflection perhaps provides a valuable opportunity for both.

As they engaged in such discussion, they reflected on how they managed their emotions (Msiska et al. 2014) by elucidating different nuances of

sadness. In the example below, FG2:2FU4 distinguishes between being sad about her own personal circumstances and being sad because of a patient's circumstances.

> *My own sadness, you know. I think that's when I feel as if I've let people in or down where, you know, it's not appropriate because you don't want to be burdening somebody else with your thing when they've come to see you. I think it's different if it's like just general empathy I think there is nothing wrong with that. I think my patients feel that I care about them, it's not like I'm…(FG2:FU4)*

This example appears to suggest that FG2:FU4 has rationalised and discriminated between different types of sadness and what she feels is appropriate in her practice (Gross et al 2013). In other instances, the RNs talked about feeling emotional but not being able to show it as there was an expectation that they would not (McCreight 2005). For example, when discussing leaving a job in paediatric oncology (childhood cancer), one participant stated;

> *I found that a bit, I found it hard going. It was very interesting, but it was a bit too emotional I think for me with the children. We lost about six kids in nine months, so that's hard. But even then I still, oncology, I still knew that was where I wanted to be. (III:5).*

Another participant said: *"I think we are quite skilled at managing to get along with people and hiding things that maybe do upset us, you know." (FG3:FU2).* This insightful comment is indicative of the level of self-awareness and depth of understanding about emotion and its integral relationship with the work of nurses. It is often called emotional labour (Hochschild 1983), where the ability to reappraise the situation and think cognitively about the emotion or nature of the emotion is believed to assist coping in difficult circumstances. This skilful management of emotions is said by Traynor (2017) to lead to resilience. An important consideration is the idea that not managing emotions leads to ill health and burnout (Schmidt and Diestal 2014) and so to manage emotions effectively means reflecting on how one felt in practical situations and reviewing and realigning feelings in order to become more resilient. In considering emotions as a feature of reflective conversations, it may be that the

sharing of emotional stories, such as the ones in the previous section, helped to create a climate in which nurses could reflect on emotional dimensions of nursing and how to both acknowledge and manage those emotions and that this may in itself help to support nurses' emotional resilience.

6.3 The way we tell it: Confidence, humour and self-deprecation in RNs' accounts

This section focuses on two (sometimes contradictory) features of the conversations that surfaced as the participants spoke with one another and with me: confidence, and humour, and a third – self-deprecation- that often combined with both.

6.3.1 Confidence and self-deprecation

Some participants seemed to switch from confidence to self-deprecation as they told stories about their experiences and in response to the comments and cues from other participants and myself. Whilst they told stories confidently, there was often an assumption that the experiences they described were nothing out of the ordinary. This is consistent with Delgado et al.'s research (2017) which found that such self-deprecation is often used to maintain comfortable and collaborative affiliations with others. Many of the participants did not always seem aware of skills they seemed to possess, or at least, did not refer to these explicitly. The very first story shared in a focus group, for example, was an example of the modest and unassuming way that many of the stories were told:

> *I suppose a very simple example is that I was a community psychiatric nurse for a number of years. So I assessed numerous people and usually it was very, very straightforward. You did the assessment. You left and you wrote up everything's fine, but I remember going to see this gentleman and he did marvellously in the assessment and on paper there was nothing I could find wrong. But I knew deep down something wasn't quite right. So I asked my psychologist colleague to go back and assess him using more detailed assessment tools, and he was in the very early stages of dementia, but the assessment tools that I was using as a nurse couldn't pick that up, because he was bright enough to be*

able to hide that. When I thought about it later, I think perhaps with me the alarm bell was that he was an accountant in the days before we had calculators and things, and when I asked him to do the serial seventh, which is a routine test, take seven away from hundred blah, blah, blah, he couldn't do that. And I'm sure lots of people can't do that but when I thought back I was thinking well that for me was what really made me question something's not quite right because he should have been able to do that very easily. (FG1:1)

This seemingly "simple" story is a rich and detailed example of using experience, expertise and reflection to make decisions about practice and the term "simple" astounded me. This participant could link the assessment with the previous profession of the client and make a judgment to follow-up, based on the answer to one question, out of a significant number of others. What is surprising and significant about this is that the RN seemed to lack awareness that she had performed a highly skilled assessment. The self-depreciating way she told the story and assumption that anyone could do it was out of the ordinary. She did not seem to recognise, within the story or after, that these were complex issues and indicative of an experienced, intelligent and problem-solving individual. Benner (1984) talks about this lack of recognition as being part of being an expert, in that one unreflectively deals with day to day activities unless prompted otherwise.

This combination of self-deprecation and confidence were features of the data and yet seemed contradictory. It is possible that some of this is linked to managing slightly different and more positive emotions than those discussed in the previous section. However, in reflecting on practice, the participants seemed to enjoy the opportunity that sharing reflections gave them to explore elements of their practice and that this blend of confidence and self-deprecation seemed to help provide a context in which nurses felt able to share.

6.3.2 Humour and self-deprecation

Laughter was the first category to be identified during the data analysis. Indeed, when I was using the double listening technique, I found I was

laughing out loud in places and smiling through most of the iterations. The first fieldnote I wrote related to laughter and this developed into the first memo. There were numerous citations in the transcripts to laughter, and indeed self-deprecating humour was often used by participants to deflect praise, which could be seen as a type of passionate humility (Yanow 2009). Given that this was the case, it seemed important to review the apparent role of laughter in reflections shared. Firstly, many stories contained humour or humorous anecdotes that were mixed with the kind of self-deprecation described above. One participant summarised this tendency succinctly: *"I think that, as nurses, we're very good at dumbing down what we do" (FG1:1).* On several occasions' participants acknowledged that this self-deprecating humour was in response to a complement or acknowledgement of skill. During one focus group, when asked if she felt proud about her intuitive, swift and successful action with a patient and subsequent conversation with a doctor, one participant said, *"I think so but if you go around saying that, they'll probably say we're all mad." (FG2:1)* and this was followed by laughter from the group. This laughter could be interpreted as 'consonant' laughter, which meant that, not only was she being self-deprecating but that her comment was acknowledged by the others as reflecting a consensus. Richards and Kruger (2017) see this laughter at oneself as a moderating action for self and for others, in that it brings the conversation away from the intensely personal and encourages others to share the moment. Street (1995), on the other hand sees this as the "tyranny of niceness" (p. 31), which is pervasive in contemporary nursing despite many attempts to change perceptions. As such, it is possible that it may militate against reflection, or at least against the possibility of exploring alternate perspectives or understandings.

While humour often seemed to work to bring the group together, on occasions it appeared to be used to control the conversations. For example, in Focus Group 1, FG1:3 arrived late. FG1:2 did not appear pleased even though FG1:3 explained why. FG1:2 then said,

> *I can only imagine what you're going to come up with. Who invited her, for goodness sake? It will all be deep stuff. Should have brought cookies. PAUSE. Carry on. LAUGHTER" (FG1:2).*

On analysis, I realised that this participant was effectively shutting down the other RN and was surprised, as it came from someone I would not normally have believed exerted this kind of control over conversations.

The content of the stories also had significant amounts of humour in them, often when describing difficult events with a positive outcome. Watson (2011) sees this type of gallows humour as a coping mechanism with the focus being on the situation, not the patient. At the time, these stories did not seem shocking, either to the reciters of the stories or the recipients. For example, one participant told the group:

> *FG1:2 I can think of one occasion, I was thinking missing person, where I lost a child who escaped, he was about 12, still had his cannula in as well, and I just instinctively knew there weren't enough children on the ward and if I was going to choose one, it was him that was missing, and at that point, the ward I was on looked directly over (name) Park and the bus route, and I again instinctively actually, intuitively, I looked out of the window and he was standing at the bus stop. (LAUGHTER) So we got him. But yeah again it's down to experience really, isn't it? I just knew if there was anybody going it was going to be him, and it was him. We got him back though.*
>
> Cannula = a fine plastic tube slid directly into a vein, usually in the back of the hand, to give fluids or drugs that will have an immediate effect.

A child going missing from a hospital, especially one who is very ill, otherwise he would not need the cannula, is a very serious event and could have been catastrophic, so telling it with humour and underplaying her role distinguishes this RN as experienced and confident.

Often, stories were told in a matter of fact way, as if nothing unusual had occurred or stated in a humorous way, even though what was being discussed was life and death or at the very best, responsibility for extremely ill patients. Below is another example of humour used to demonstrate the absurdity of some of the things that experienced nurses do and yet underplays the significance of the expertise required.

FG3:1 I used to be the queen of the nasogastric tube, OK. (LAUGHTER)

Nasogastric tube = a flexible feeding or drainage tube passed by the nurse through the nose, down the back of the throat, avoiding the trachea and lungs, into the stomach.

This comment was proudly and yet wryly said to overcome the difficulty and absolute skill required to successfully pass a tube down someone's nose and into their stomach, with the minimum of discomfort and without choking them.

On another occasion, FG4:FU4 shared a story to demonstrate how she learned but her tone was self-deprecating and suggested that she intended for me to see the funny side of the story.

When I was as student and I maybe told you this, when I was a student nurse on one of my first areas we had a gentleman that came in with a really severe asthma attack. And he came in on the late shift and he was really poorly and I came on the next morning and when I walked round to the bay that I was looking after, he was laid down, snuggled up in bed, wrapped up and I thought oh he must be feeling a bit better. (joint laughter)

I'm sorry, I shouldn't laugh. (researcher)

And a few minutes later they come running in and wheeling him off to ITU because obviously his respirations were so depressed that the poor bloke could hardly breathe and he'd given up. He was exhausted.

And I suppose he would never lie down, would he? (researcher)

He was exhausted. And again I've never forgotten that because it was just such a stupid thing to think. Oh he must be feeling a bit better. But again it's one of those things you learn. So things like posture and all those sorts of things are really important. That's one of the things that when we're doing simulation scenarios, one of the things that even as a responder that I've seen people do, they'll be play-acting in a scenario and they lay down when they're breathless.

ITU = Intensive Care Unit.

Yeah absolutely not. (researcher)

And it's like, no. You know, if you've got a breathless patient lying down, that's not a good sign.

Never happens, no that's right. (researcher)

We both laughed together at what was a seemingly unfunny occurrence, importantly not at the patient but at the lack of understanding that, as a more experienced RN, FG4:4 saw as naive. From an emic perspective and to further explain the context, a patient with breathing problems rarely lays down as it makes it more difficult to breath. If someone with a known breathing problem who is ill enough to be in hospital lays down then it is commonly a sign that they are deteriorating and immediate action is required by the nurse.

As I analysed the data, I was both surprised and yet not surprised by the amount of humour, not only in the story telling but also in the lively discussions that became a feature of the focus groups and individual interviews. It seems that these discussions helped to generate an atmosphere in which people felt able to share. For the most part, this seemed to generate an enabling atmosphere, although at times, the use of laughter to control the conversation suggested the ways in which different power relationships might be at play in the group and how humour may have worked to uphold certain kinds of understandings and made it difficult to explore alternate viewpoints. In most cases, this humour seemed to be generated by – and help to generate- a feeling of connectedness (Atkinson 2006). This connectedness is explored further in the next section which explores a variety of ways in which the process of sharing reflection on practice generated a sense of belonging

6.4 Belonging: A community of Reflective Nursing Practice

In this section I explore the theme of “belonging” in relation to the sense of belonging generated between RNs themselves in the focus groups and in the follow-up and individual interviews, as well as the sense of belonging within a wider community of practice in nursing (Lave and Wenger, 1991). Clearly, the focus groups were temporary groupings and it would not be possible to generate a deep-seated sense of community in such a short time, but there were features of the groups’ interactions that seemed to suggest that reflections unfolded in a particular way because of an emerging sense of community.

Within this theme, I consider four categories: a shared history and perspective, shared language, and finding a place in the community.

6.4.1 A shared history and perspective

Sharing a history of learning is an important part of belonging to a community of practice (Lave and Wenger, 1991). It is this shared history of learning to become an RN and shared appreciation for what it means to be an RN that means the participants have "a shared domain of human endeavour" (Wenger and Wenger-Trayner, 2015, p. 1) and which contributes to the community in which they practice. These conceptions of a community of practice are helpful in articulating the sense of belonging that was apparent in the data. In this section, I explore ways in which the groups themselves seemed to cultivate this sense of shared history and perspective.

The example below is an extract from an individual interview in which III:3 was finishing a story, apparently seeking comfort from me because she had told an emotional story, and expressing a sense of belonging to the wider nursing community of practice:

> *Because we all have the same mindsets. We all have the same, we all work on the same, we're all reading off the same hymn sheet, do you know what I mean? Everyone seems to be qualified the same way, were taught the same way, had the same assessment, very similar assessment skills, has the same dedication to the job, the same proactivity, the same responsibility, dedication, same mindset. (III:3)*

These sentiments were not necessarily shared by all the participants but demonstrate a belief in a shared experience and the way in which this helps RNs to deal with difficult and emotional elements of their job. It may be that this sense of community bolsters not only reflective practice but could encourage a sense of history, continuity, commitment and promote good practice. Or it may be the other way around: that reflective practice and a shared history bind RNs into a community of practice. This link between reflection and belonging appeared in a follow-up interview when one participant RN said unprompted:

I can't say I went away and thought deeply about the focus group because, and this is the honest truth, because I'd enjoyed it and I was with people that I knew and I thought it was a really, actually interesting I have to say and almost informative, informative is probably the right word, conversation. I probably didn't think about it very deeply, because it was just something I kind of enjoyed and then not necessarily walked away from but, you know, left the room. However, I think, because I'd enjoyed it, well one of them is just because I'd enjoyed it, I did think about it (FG1:FU2).

In this comment, FG1:FU2 seems to be implying that she learned in an enjoyable way that made her think and this was because she was with people she knew, even if she seems to struggle to articulate what she thought about after the focus group or how and why she enjoyed it.

Throughout the process of data collection, there was a sense of comfortableness, not only for the participants but for me. During the focus groups and in the individual interviews, the participants seemed to enjoy themselves. Rich and diverse stories were told, and the stories seemed to prompt conversations about the nature of nursing and the ways in which nurses communicate. A number of those interviewed in the focus groups and the individual interviews related stories about when they were less experienced, usually after having spoken about their skilled practice with confidence.

6.4.2 Shared language

During the focus group discussions, it appeared that the participants' shared language of nursing played an important role in facilitating reflective discussions. In the example below the conversation was prompted by a question about reflection-in-action and tacit understanding. In response, these participants have what seems to be a coded conversation.

FG4:3 When somebody is about to go off.
FG4:5 I was just going to say that, yeah.
FG4:3 The patient in a bed, you say, not right, going to go off. Everything is fine on paper and the student nurse will say why do you know? I don't know. Nine times out of ten they go off don't they for whatever reason.

In this extract, the participants use language that is familiar to all experienced RNs. ‘Going to go off’ means that a patient is about to have an acute episode, usually a respiratory or cardiac arrest (where breathing or breathing and heart beat suddenly ceases). “Not right” means ‘I can’t explain myself but we need to closely monitor this patient or be prepared to take immediate action’. FG4:3 and FG4:5 seem to be agreeing with each other, using this shared language. In addition, this shared language and the tone in which it was spoken seem matter of fact, even though they are describing a catastrophic occurrence that can result in death. This use of shared language could have advantages and disadvantages in relation to reflection. On one hand, having to stop and explain what something means or take care not to offend someone with the matter of fact way it is said may mean that “engaged thinking-in-action” (Benner et al 2011, p. 10) and rapid decision making is interrupted. On the other hand, being challenged by a student nurse to stop and explain thinking could uncover tacit knowledge (Benner 2001, Moon 2004). In terms of this research, this shared language seemed to be important in sustaining the group and the interviews. The participants appeared to be comfortable using the euphemisms and not necessarily having to moderate their language or tone and this seemed to allow them to continue to reflect on their own experiences and on each other’s.

6.4.3 Finding a place in the community

During the process of data collection and analysis, it became apparent that there were participants who appeared to be comfortable with their place, not only in the focus group community but in the wider community of nursing practice. There were also others who seemed to aspire to that position, and this varied according to the individual’s level of experience. In the example below, as the participants in FG4 were discussing a rare complication of having a fractured limb, I noticed that FG4:4 was quiet and she worked in an orthopaedic ward where fractured limbs are commonplace. My question is in bold:

Have you seen one FG4:4?
FG4:4 No…
FG4:3 I've seen a few, yeah.
FG4:2 But, you see, I practiced longer than FG4:4 so I would imagine they don't have as many now either. That's the other thing.

FG4:4 did not seem comfortable when asked but FG4:2, who had seen this complication appeared to defend FG4:4 and give a rationale as to why FG4:4 might not have seen such a thing. What is interesting here is the way in which the more experienced RN helps the less experienced RN feel part of the group. The example below has been used before but I use it here in a different context. After listening to other members of the focus group tell stories about how they knew what they knew, FG2:5 decided to share something that had upset her, FG2:4 and I sympathised:

FG2:5 I must say, (Researchers name), I've been the opposite as well, where it's been a total shock when someone's passed away, and I haven't expected it at all. I had a patient last year. I went off on a week's holiday, came back and he'd passed away, and that was a total shock. So I hadn't expected, you know, sometimes it can be the other way.

FG2:4 Did you feel you should have picked that up then? (sympathetic tone)

FG2:5 I was devastated, yeah. And I did think I did reflect on that. But again, it was septicaemia, not with the condition he had, it was a different condition.

It happens so rapidly, doesn't it? (researcher)

FG2:5 Exactly, it had.

FG2:4 I think you're able to just pick up clues, like you said there was a clue that, on reflection, you know, there was a clue. With septicaemia, you know, it's…

FG2:5 Well, this is it, yeah.

FG2:4 Usually they're not really, are they?

FG2:5 No.

Septicaemia = a rapidly developing, life threatening infection in the blood.

It is notable here that the less experienced RN feels comfortable enough in the group to share that experience and appears to be seeking a

response when she says she was devastated by the death of a patient. Her comments seemed to prompt sympathy, as evident in the tone of FG2:4's voice, but also FG2:4 seems to be helping FG2:5 to reflect on the incident and think about the clues that were there, possibly so that FG2:5 may be able to recognise the incident if it happens again so that she will not be so shocked. Double listening identified the questioning and sympathetic tone but also identified the story underneath the story where someone was seeking assistance, not necessarily only to prevent death, which is unlikely, but also so that she was not so shocked if it were to happen again. FG2:4 suggests that she reflect on what clues were there to suggest septicaemia and to remind the less experienced nurse that septicaemia is rarely the primary diagnosis but that certain conditions pre-dispose to it.

Not all participants appeared to be as comfortable in one another's company and some shared insights into why this was the case (which will not be shared directly for ethical reasons). This highlights how the quality of reflection may well be influenced by interpersonal factors or by participants' prior experience of working. Some may never feel they have a place in the community. However, within the focus groups there did appear to be some evidence of legitimate peripheral participation (Lave and Wenger 1991). This is where apprentices spend time with experts and learn. During the focus groups themselves, experienced RNs facilitated the learning of others in an informal way as opposed to the formal coaching and mentoring often promoted in institutions and during individual interviews, my opinions were sought on incidents from practice. This is important in illustrating the kind of learning that may occur through participants' participation in a wider community of nursing practice, but it may also suggest that the focus groups themselves seemed to generate rich opportunities for learning and might even be seen as emergent communities of practice (Lave and Wenger 1991). What is surprising is that this potentially emergent CoP foregrounded an element of learning and support rarely acknowledged in the literature on reflection by nurses but which, in my experience, is commonly seen in practice.

6.5 Summary

In this chapter I have drawn on the focus group data to explore how stories were told and experiences shared. In doing so, I have highlighted several features of these discussions which may well be relevant to the reflective practice of RNs. These included: the emotional dimension of what is being discussed, practiced, reflected upon and managed; the use of a mixture of humour, confidence and self-deprecation in sharing; and the way in which these orientations combine with a shared history, shared language, an interest in sharing stories and experiences, and the process of finding a place (or not) within a community. Together these findings explore some of the ways in which nurses may generate a supportive context for reflection as they share experiences together. While the data also suggested some ways in which such opportunities may have limited possibilities for reflection, it may be that reflection can be promoted by encouraging RNs to come together to share experiences and stories, or that the practice of being an experienced reflective RN is embodied in these communities.

Chapter 7: Discussion

7.1 Introduction

This study aimed to explore Registered Nurses perceptions of reflection. The research questions were:

1. **How do nurses perceive reflection?**
2. **What are the features of shared reflection?**
3. **How might opportunities for sharing experience provide contexts for reflection?**

In this chapter, I consider each of these questions in the light of the findings discussed in each of the previous chapters. As discussed in Chapter 3, as my study progressed, I became increasingly interested in what I could learn from attending to how nurses discussed reflection and talked about their practice. For example, reflective storytelling, which was originally intended to be an elicitation device, became the core of the data collection and listening to the stories became a crucial part of the data analysis. In what follows, therefore, I consider both what the participants discussed (as explored in Chapter 5) and how they did so (as explored in Chapter 6).

7.2 How do nurses perceive reflection? A persistent and necessary component of clinical practice or a means to an end?

7.2.1 Perceptions of formal reflection

As noted in Chapter Two, there is a wide body of literature on the meaning of reflection and its interpretation in the professional milieu. Scholars such as Mezirow (1981), Dewey (1933), Brookfield (1995) and Boud et al. (1985) note that reflection can take many forms and have many layers, and that despite the considerable thought and energy that has been devoted to defining reflection, it remains a contested concept. It therefore came as no surprise that the RNs in the study were unclear about the definition of reflection. Indeed, when asked to define reflection, several of the participants cited reflective practice models in a manner that Schön

(1983) and Boud (2014) might call technical rationalist. The model of reflection most cited by the participants was Gibbs' model (1988). This model is predominantly used in undergraduate programs, although at Master's level there is an element of choice in the models that they can use. It is difficult to establish whether, for the participants in this study, perceptions of reflection were dictated by the courses that they undertook or by the requirement to demonstrate reflective practice for revalidation (NMC 2018d) or by their experiences of reflection in practice.

All the participants, educated to degree or Masters level, will have been required to include evidence of reflection in numerous written assignments and to engage in regular written reflection is an ongoing professional requirement. However, all struggled to define reflection and, if this is the case, it may mean that they struggled to articulate a definition because it has multiple meanings and complexities. However, that does not necessarily mean that they cannot or choose not to reflect. Cheetham and Chivers (1998, 2001) see reflection as part of the route to professional competence but Chivers (2003) found that many of their research subjects that participated in their study of professional learning and professional competence, regard reflection as part of this process. Therefore, it may be that, rather oxymoronically, reflection is so much a part of experienced RNs practice and such a part of their contextual and ingrained prior experiences that they reflect tacitly. It certainly appeared to be the case in my study that many participants engaged in reflection without necessarily identifying it as such.

It is also interesting and of note that, in the discussions about the definition and purpose of reflection, the participants seemed to differentiate between different kinds of reflection. Drawing on Schon's distinction between reflection-in-action and reflection on action, I use 'reflection-in-action' to refer to thinking in action about patients, patient care and the necessary actions that are part of an RN's practice, which was seen by the participants to be a useful tool in practice. I use 'reflection on action' to refer to those activities that take place outside of the clinical area (Schön 1983). Some participants however referred to reflection as completing

written pieces of work that were required either for a programme of study or for revalidation with the NMC (2018d). In such cases, the participants seemed to regard reflection as an onerous task, carried out in order to revalidate and maintain registration with the NMC, something they had to write down and something that required a specific format. These compulsory tasks relating to reflection on action, seemed to prompt cynicism amongst those RNs who discussed them, signifying the possibility of "reflection fatigue" (Coward 2011, p.883, Trumbo 2017, p.433). It seems that – for these RNs at least- the NMC have turned reflection into the technical rational procedure that Schön (1983) and later Boud (2010) argued against when deliberating on the purpose of reflection.

These distinctions raise notions of formality and informality in relation to the process of reflection. While participants often referred to reflection as a formal process, the data suggested that reflection in practice was a more continuous activity Dewey (1933). The use of reflection as a tool to connect theory and practice has also be widely discussed in the literature (Borton 1970, Rolfe 2014b, Kolb 1984, Gibbs 1988, Driscoll 1994, Brookfield 1995, 2017) and more specifically in the nursing literature (Johns 1995, Atkins and Murphy 1993, Rolfe et al. 2001), yet this study suggests that RNs view reflection in a different way. When asked about reflection, the connection between theory and practice was not discussed. However, they did comment on how important experience was to the recognition of theory as an asset to practice and on the kinds of reflection they saw as beneficial. These aspects are discussed in the section that follows.

7.2.2 The kinds of reflection that seemed to be of value

Of particular note was participants' perception that sharing experiences or discussing practice whilst undertaking reflection was seen as an enjoyable and necessary part of the assessment and action associated with patient care. Indeed, many participants identified how much they enjoyed these reflections in and on action, during short breaks in or near the clinical environment, with other health care professionals or during the handovers

that are part of most RNs' working day. Moon (2004) has highlighted the value of sharing reflection and storytelling to reflect on practice, and identifies that reflective practice is used as a coping mechanism in professional or complicated situations that can be unpredictable. Such positive benefits seemed to be reflected in participants' references to the usefulness of handover at or near the patients and their comments about how helpful it is to share incidents and stories from practice with other RNs. Participants' enthusiasm for this kind of reflection was distinct from what seemed to be a cynicism or reluctant compliance to complete the written reflection required by the NMC for revalidation and in post-registration or postgraduate courses.

This research seems to reveal a complex thinking and acting before, in, on and beyond action that goes beyond what is expected to be evidenced in the NMC documentation (NMC 2018d). Schön (1983) focusses on reflection-in-action and calls this this artistry or knowing in action, and similarly Benner et al. (2011, p.10) refer to "engaged thinking-in-action" as what happens in the moment in clinical practice. However, what the participants discussed also seemed to reveal the anticipatory reflection espoused by van Manen (1991) and the reflection beyond action cited by Edwards (2017). It was striking that they described all these types of reflection as being embedded in their moment-to-moment clinical decision making. When they discussed how they knew what they knew, the participants said that they, sometimes rapidly, considered previous incidents or experiences, made on the spot judgements and deliberated over the potential consequences beyond the incident, so that they could take action on behalf of a patient. The examples and discussions seemed to expose nuances of thinking and acting that an expert intuitive nurse uses when reflecting but unless challenged at the time or afterwards, they did not seem to be consciously aware of reflecting before, in, on and beyond action and, unless challenged, they did not intentionally direct their thoughts towards understanding what reflection meant (Hickerson 2009).

In considering whether one can learn from someone else's reflection, what stands out in this research is that the participants were clear that one

could and that sharing reflective stories was an effective way of doing this. Without exception, the participants believed it was possible to learn in this manner. This contradicts much of the earlier literature on reflective practice where authors were clear that one could only reflect on one's own experience to achieve perspective transformation (Schön 1983, Mezirow 1998, Johns 1993). Indeed, much of the more recent research about reflective practice in nursing, whilst advocating sharing reflection, still examines the effect on the individual (Heckemann 2015, Pai 2016, Knutsson et al. 2018) and not the collective nature of reflection. Interestingly, the NMC now require RNs who are re-validating to discuss the required five written reflections with another registrant (NMC 2018d). This appears to be a positive development given that the findings of this study indicate that the RNs felt that they needed to share and reflect on practice with other RNs in order to construct knowledge in practice and test their theories in action without risk to the patient (Schön 1983). However, it may be that further changes could be made to recommendations that might enrich the quality of reflection.

7.3 What are the features of shared reflection?

7.3.1 The significance of emotions to reflection

Because of many years facilitating groups and teaching reflective practice, plus attention to the literature that recognises an adverse emotional response to reflection (Cotton 2000, Stuart 2000, Hunt 2001, Rolfe and Gardner 2006), I expected that the process of sharing thoughts on reflection in practice might produce negative or difficult emotions. In anticipation of this, the information sheet I gave participants at the outset provided details of counselling facilities and I checked with all participants, at the end of each data collection episode, that they knew where to get assistance if anything during the discussion upset them. Although there is no way of knowing about what happened afterwards, all the participants, without exception, expressed no need for counselling at the time of asking and indeed, some treated my comments with a wry disbelief that I would think they might need counselling. During the data collection, however, some participants told stories full of emotion and frustration with

themselves and other professionals. These stories were generally met with sympathy, understanding and an acknowledgment from the other participants that these emotions are part of the messy business of being an RN or as Schön (1983, p. 42) would put it “The swampy lowlands of practice”.

The emotional aspects of the study initially seemed irrelevant, but as I considered the data-set as a whole, it appeared that these emotional, embodied dimensions of reflection were relevant, not least perhaps because nursing is an overtly embodied and emotional practice. As previously discussed in Section 2.1.2., there is a link between emotion and reflection (Fook et al. 2006, Dirkx 2006, Edwards 2014, Heckemann et al. 2015, Adamson and Dewar 2015, Meziane et al 2018). In some ways, this reflects the ideas, explored earlier, that emotion and reflection are inter-related in that reflection was often linked to an awareness of feelings and also that reflection may help with learning to manage emotions or sustaining the management of emotions in the difficult situations common to the practice of nursing.

In relation to this study and in considering these emotions, it became evident that most participants spoke about managing their emotions, often termed emotional labour (Hochschild 1983) as discussed in Section 2.2.2. Hochschild (1983) and Rees (2013) see emotional labour as the ability to cognitively change beliefs about patient care or an incident in practice so that there is a more positive attitude and some sort of resolution. Gross (2013) is clear that this kind of emotional management reduces burnout and promotes resilience. Whilst there are many different definitions (Traynor 2017), resilience is thought to be a personal capacity to deal with adversity and the demands that are associated with nursing in practical settings (Delgado et al. 2017). Adaptation is also seen as important, as is the ability to manage emotions by changing perceptions (Aburn et al. 2016), an ability that seemed to be evident during participants’ discussions of distressing events, which they often framed in relation to positive outcomes, for example, when they discussed a ‘good’ death. Delgado et al. (2017) identify the use of resilience in emotional labour and,

interestingly, discuss personal and professional development and education as being factors that can increase resilience and therefore reduce burnout in the emotional labour associated with nursing. It is possible that opportunities for sharing reflective stories as part of professional development and education may help with managing emotions and therefore support RNs to increase or sustain resilience.

This research challenged assumptions about the relationship between length of service and ability or willingness to reflect. In terms of the sample, the minimum number of years that the participants practiced as RNs was eight and the maximum was 43. It could be argued therefore that all the RNs were experienced. My data suggest that the less experienced RNs in this study saw value in sharing incidents and emotions with more experienced RNs, as through such opportunities they could seek and receive advice about not only the incident but how to manage their emotions (Hochschild 1989, Schmidt and Diestal 2014). Sharing these reflections and seeking assistance in this way may link to notions of legitimate peripheral participation (Lave and Wenger 1991) where the less experienced members of a community of practice (CoP) watch, listen and learn from those at the core. Tentatively I would suggest that, within this research, these less experienced RNs were learning how to be reflectively practicing nurses.

7.3.2 The way we tell it

In designing this study, I did not expect the amount of laughter and joy that would be generated as RNs talked about their practice. Nor did I expect to experience, along with the participants, the sense of belonging that recounting these experiences would engender. Repeatedly during the analysis, there was evidence of humour and of a pride in the job and passion about good patient care. Linking these experiences to the literature, Richards and Kruger (2017) state that laughter is a moderating behaviour that helps RNs manage emotional labour (Hochschild 1983). On the other hand, Atkinson (2006) suggests that humour stimulates speculation and reflection as does Bergson (1911, 2005) who goes one step further and says that humour requires reflection.

The laughter during data collection was often loud and sometimes raucous but it was never cruelly aimed at patients or relatives or carers. Often, it was self-deprecating, so much so that self-deprecation became significant in the data set of this study. Atkinson (2006) would argue that incongruent laughter focusses on general principles and is not inherently individually cruel or prejudiced. She says that the laughter is not aimed at an individual but at the situation or circumstances and that reflection is stimulated by these situations which can then prompt further thought and conversation. In my study, this sense of incongruity when sharing experiences often produced reflective conversations and amusement at the irony of a given situation. Critchley (2002) says that humour has social significance and this was apparent in the data collection by invitations from the storytellers to share the amusement at the circumstances or as a strategy to deflect congratulatory comments when telling of proud or effective moments in clinical practice. It is worth noting though that laughter sometimes appeared to have a controlling influence and that such communities may not always be conducive to rich, deep reflection for all. As always in any interaction, there is power at play (Fairclough 2010).

The range of emotions expressed and the tendency towards the positive elements of the stories were truly surprising and an unexpected outcome of this research. The evidence is in the written transcripts, in the field notes and memos and remains in the recordings of the focus groups, follow-up interviews and individual interviews. Without exception, they all had laughter in them and embedded in that were the reflections on practice that prompted such laughter and enjoyment.

A striking and unanticipated feature of the data was that the participants said that they enjoyed telling and listening to stories. It is not possible to argue, based on this study's data, that the shared discussion of stories is more valuable than other kinds of reflective exercises, formal or informal. However, I do suggest that the sharing of stories provides a different and possibly valuable mode of reflective practice. Significantly though, at no

point during or after the data collection did any participant overtly acknowledge that they were reflecting on their practice when they were telling or listening to one another's stories. Yet, as they told stories, they did often identify perspective transformation (Mezirow 1981) in the way they explained a change in how they perceived something, such as an attitudinal change or a changed, knowing action. In this sense they did seem to be demonstrating reflection. They also seemed to demonstrate reflection when listening to and responding to each other's stories, in that they all seemed to be reflecting on the one story being told and using their own similar experiences to reach conclusions about practice. These skills of being able to reflect around practice were not acknowledged explicitly as reflective practice but the stories and experiences seemed to show elements of critical reflection that would be valuable to less experienced RNs. The following section expands on what happened as the participants discussed their experience, and the possible value of such experience to them as nurses.

7.4 How might opportunities for sharing experience provide contexts for reflection? Belonging to a community of reflective nursing practice

Sharing stories was not the focus of this research, the stories emerged as part of the data collection and from the analysis. Their significance as part of uncovering the reflective practice of RNs increased as the study progressed as did the potential for the role of the story in creating and maintaining a community of reflectively practicing, engaged, confident and caring RNs. Lave and Wenger (1991) identify how learning happens in communities of practice, and consequently argue that we can usefully learn from the way that existing communities of practice work when thinking about learning. Taking these views into account, the work of Lave and Wenger (1991 and Wenger (1998) is helpful in articulating what was happening as participants shared stories during focus groups and interviews.

As explored in Chapter 2.6.1. for Lave and Wenger (1991), communities of practice (CoPs) are groups of people: who have a shared interest (the domain);

who interact regularly in groups to share experiences and information and help each other to learn and understand (the community); and who develop a shared practice as practitioners (the practice) (Wenger and Wenger-Trayner 2015). Lave and Wenger (1991) argue that learning occurs through participation in communities of practices, as individuals at the periphery of the community learn the language, rules and organisation of the community. Learning therefore is socially constructed as newer members become more confident and practiced in the requirements of interacting in the community. In this study, although the groups were newly formed, participants shared a domain of interest in the practice of nursing, shared experiences and stories, made time to listen and interact with each other, and offered practical help for the newer, less experienced members.

Therefore, CoPs might offer a productive way of thinking about nursing practice because we know that RNs practice in busy, stressful, resource driven areas, where their work can have a significant impact on individuals, families and communities (NMC 2018c). RNs and their work are embedded in the community in which they live and work as illustrated by Naidoo and Mtshali (2017), whose research with RNs caring for HIV (human immunodeficiency virus) patients, demonstrates that there is a role for critically reflective learning and the sharing of lived experiences and dilemmas related to this work. Indeed, Wenger and Wenger-Trayner (2015) use the example of nurses having a break in the cafeteria and using that as an opportunity to share and learn in a CoP. Added to this, Edgar et al. (2016) report on their experiences of setting up a more formal community of practice with community nurses with the intention of sharing nursing evidence and transforming practice. They liken it to walking a tightrope between meeting the needs of the organisation, the needs of the staff and the needs of the patients, whilst, at the same time, dealing with the barriers and enablers of maintaining a community of practice. Edgar et al.'s (2016) experience provides further evidence of the stressful and emotional nature of working and learning together as RNs and is mirrored in the work of Dawber (2013a and b), which supports the notion that "nursing is a socially embedded and collectively held practice" (Benner 2001, p. xi).

In this study, the RNs seemed to identify with each other in the focus groups as well as in the individual interviews and appeared happy to talk about their practice and nursing. Wenger and Wenger-Trayner (2015) remind us that communities of practice are not just collections of people but that these communities must have certain characteristics. The first characteristic of a community of practice, that of the domain, is where members share a commitment to the community and have developed ways of managing in that domain. In my study, participants seemed comfortable with each other and their commitment to practice was evident in the stories they told with such passion and pride.

The second characteristic of a community of practice is that of interacting within and building the community. What is interesting is the emphasis here on the irrelevance of where the community gets together. In my study, the whereabouts of the meetings became insignificant. Wherever we met, there was a sense of togetherness and warmth, even in the coldest classroom or in the meeting room where the table almost scratched the walls on all sides and created a barrier between all of us. Learning to interact within this community of practice is a hallmark of becoming central to that community (Lave and Wenger 1991). As the focus groups and individual interviews progressed, I noticed how the participants adopted certain ways of interacting with each other and with me, noting particularly the role of stories, passion, pride, compassion, humour and self-deprecation that was evident.

It is this learning to interact within the community that I want to attend to next, with reference to Lave and Wenger's (1991) notion of legitimate peripheral participation. In my study, there were some participants in the focus groups that I followed up because, although they had been qualified for some years, they appeared to be on the periphery of the main group. By the periphery, I mean that they listened intently to the stories and interactions between the other more experienced nurses and asked questions about how those RNs knew what they knew (e.g. see Section 6.4.2.) before sharing their own stories. Moreover, others encouraged and permitted this participation through their willingness to share stories and reflect on how they reflect in practice and their willingness to both show emotion and discuss how they manage emotion. Discussions such

as the ones I facilitated seemed to provide an opportunity for confident, reflective, experienced nurses to reflect on and test their theories in action with each other (Schön 1983). It is not possible to know how far this experience was beneficial to those participants at the periphery of the focus group in terms of developing their own reflective practice. However, from their comments, it seemed that they were looking for “ways to belong” (Lave and Wenger 1991, p.35) and afterwards it did appear that they had found it valuable to listen to others’ stories, to reflect on what had been discussed and to ask questions about the situated practice of nursing. In some ways, it could be argued that, through legitimate peripheral participation, they were learning about the reflective practice of nursing.

The third and final characteristic identified by Wenger (1998) is associated with practice, which he writes has structure and meaning in a historical and social context and is not just doing. Indeed, Wenger and Wenger-Trayner (2015) cite nurses meeting regularly at lunch time as a major source of knowledge for their community of practice. In the context of the discussions I observed, this source of knowledge took the form of the stories that RNs shared with each other about patients and their practice, reflecting on how they knew what they knew. Working with other RNs or having access to other RNs appeared to be a crucial part of the expression of tacit knowledge as part of the reflective process. That is, they were able to reflect on and share partially constructed or assumed ways of knowing about how they knew what they knew.

Some of the participants believed that central to this process in a clinical practice setting was successful team working. The participants talked about being able to share stories with their colleagues and reflect on the issues to reach a solution. They also shared stories with me that seemed to suggest that they had resolved problems in practice but needed reassurance that the resolution was one that was within the sphere of the community of practice (Lave and Wenger 1991, Wenger 1998). Some talked about meeting over a cup of tea to discuss these moments (see Section 5.3.2.) and others identified the importance of the handover (see Section 5.5.1.) as being somewhere to share these reflective stories and both gain validation for the unconscious feeling and for the appropriate problem resolution. What is significant is that the participants

who discussed this felt that if they could not individually resolve the dissonance, they generally shared their concerns with others, sometimes individually and sometimes with in a group conversation at handover or at coffee breaks.

Lave and Wenger (1991) write that CoPs take time to develop and that learning is embodied in the whole person and how that person interacts in society. From this perspective, they believe that learning is a social activity where internal processes associated with emotions and aspirations are as much a part of learning as the acquisition of knowledge and skills. It may therefore be that whilst some of the features of a community of reflectively practicing nurses existed in the focus groups, such as emotion and connectedness, other dimensions would need more time to develop. However, it did seem that the focus groups were conducive to the kind of learning facilitated through the communities of practice that Lave and Wenger describe, and as such they provided some valuable insights into the possible workings of shared reflection.

7.5 Summary

In summary, it is evident from the data that reflection is still a contested concept and can be viewed by RNs as a formal requirement of revalidation and not necessarily a means of sharing and learning from practice. However, my data also provided valuable insights into what RNs may gain from shared reflection. Although the sample is small, the RNs in this study have revealed that it may be possible to learn from the reflection of others and that coming together in what they believe to be an informal setting has much to offer in the development of experienced, reflective, confident, caring RNs. There is scope for further investigation into such opportunities. There are also suggestions that using humour, self-deprecation and sharing a sense of pride, passion and compassion for patient care and the profession of nursing, may all contribute to a sense of belonging and being part of a community of reflective registered nursing practice, and that this in turn may well be important in facilitating and enabling both reflection itself, and learning about what reflective practice might involve. In addition, sharing stories may be one way of establishing and consolidating a place within this community of reflective registered nursing practice and productive reflection may provide opportunities for encouraging

such a community. The following chapter offers final conclusions to the study and presents a series of recommendations for RNs and academics in terms of actions and further research.

Chapter 8: Conclusion

This chapter will summarise the key findings of this study in relation to the three research questions posed at the beginning of this study. It will also consider the implications of these findings for future practice in nursing education and in nursing practice, in summarising the contributions this study may make. The limitations of this study will also be discussed with some critical reflections on the study and its methodology, leading to a consideration of potential avenues for further research following on from this work. My own reflections on the process of researching reflection with other RN's will weave in and out of this final chapter.

8.1 The research questions

The first research question asked: How do nurses perceive reflection? RNs in this study struggled to articulate what they believed reflection to be when asked directly but they were able to discuss levels of reflection and reflection in and on practice during their reflective storytelling and discussion. It is not clear whether they had internalised what they learned and were applying it unthinkingly or whether they were consciously retrieving what they thought I wanted. They were clear however, that one can learn from others' reflection and that sharing reflection was a regular and much valued activity in practice and on practice. The participants saw this type of reflection as different to the reflection required for revalidation with the NMC, which they believed was a means to an end.

The second research question asked: What are the features of shared reflection? This question uncovered surprising findings, in terms of the emphasis placed on being in a community of RNs who enjoyed telling and listening to reflective stories as part of something they perceived to be collective rather than individual reflective practice. It seems that reflection for RNs is a very emotional process and these feelings should be acknowledged and supported in environments where reflection is taught, shared or exemplified. The way the participants in this study shared reflection seemed to be valuable to them because it provided an opportunity to for them to gain peer support for the emotional labour of nursing. Participants shared how they managed emotions both negative and positive in sometimes humorous, sometimes self-

deprecating and sometimes confident ways and, for the most part, their love, pride and passion for nursing was embodied in the reflective stories they told.

The third research question asked: How might opportunities for sharing experience provide contexts for reflection? In sharing reflections, the RNs in this study seemed to value questioning and validating their own and other's ideas and see some merit in continuing to share the thought-processes associated with the reflecting around practice. There appeared to be an emerging community of reflectively practicing RNs where the more experienced were able to share how they knew what they knew in terms of reflecting on how they reflected in practice to reach a changed perception or to act rapidly. These skills of being able to reflect around practice were not acknowledged explicitly as reflective practice but the stories and experiences seemed to show elements of critical reflection and an ability, when encouraged, to uncover tacit knowing in practice that would be valuable to less experienced RNs.

8.2 Limitations of the study

This was a small study carried out by one researcher. The participants were friends who were ex-colleagues or previous pre-and post-registration students that I had taught. These relationships could have meant that only those sharing a similar philosophy about nursing participated, or indeed that participants shared only what they thought I would like to hear. This research is therefore not generalisable, nor was it intended to be. The intention was to add insights into individual experiences to the body of knowledge about reflection and the community of practice that is made up of reflective experienced nurses. As a result of these limitations, it is inevitable that a recommendation from this study is that more research should be carried out, to help to deepen and extend understanding about the possible communities of reflective nursing practice. Given the insights my study provided into the value RNs placed on sharing reflective stories before, in, on and beyond action, ethnographic studies could be conducted, exploring more specifically, places and spaces where shared reflection may take place. There is also scope for investigating the feasibility of productive reflection in the workplace. Further in-depth interviews with RNs could be conducted in order to tease out more perceptions about the meaning

of reflection and there could be more detailed interaction analysis of shared reflection in order to more fully understand the processes of RNs' reflection in practice, and also to understand how different power relationships might play through such processes. Finally, the content of the reflective stories told within this study contain a wealth of embodied knowledge and information about the practice of nursing, some of which is not documented in the nursing literature, therefore further studies exploring how that knowledge is uncovered through reflective practice might prove invaluable in building nursing theory.

When I started this journey, I did not expect to use friends as participants but the opportunities to uncover the research questions and share stories with friends was presented. Brewis (2014) reported that "recruitment of respondents from amongst our personal networks is not commonly reported in qualitative publications". I had some ethical concerns so therefore I produced a detailed ethical framework so that I could be as clear as possible about how these data would be used. Tillmann-Healy (2003) argues that friendship and fieldwork are similar endeavours in many ways, as both involve being in the world with others, both involve being in different roles in different contexts and moving between these roles as the situation warrants, both have conflicts, challenges and loss and at some point, both come to an end. The advantages and disadvantages of researching with friends were discussed in Chapter 3, section 3.1. It became a deliberate strategy to ensure that a relationship already existed that would promote honesty and comfort. In line with the interpretive tradition, the study draws on my interpretations of what happened during the data collection. As an inexperienced researcher, experienced nurse and mature student, it is inevitable that my own prejudices and interpretations are part of the whole process. I hope that "actively seeking out my subjectivity" (Peshkin 1988, p18) and thinking about how my own biography has shaped this research (Merrill and West 2009) is evident throughout.

The dynamics of focus groups can be problematic and it may be that there were individuals who did not feel able to share or who felt that they should agree with the prevailing ideas of more dominant members (Kitzinger 1995). Use of the double listening analytical tool tried to expose some of this, as did the follow-up

interviews. Inevitably though, the focus groups and individual interviews can only be snapshots in time, one-off occurrences that are never to be repeated. Therefore, I believe that it is even more important to stay true to the data and, as faithfully as possible, to share what happened and how it happened. Regularly interrogating my subjectivity and using my ethical framework helped guide this process, as did the analytical tools.

The mix of data analysis methods is unique and, in particular, the double listening process I used as an analytical tool has not, to my knowledge, been previously used in focus groups other than as a therapeutic device. Narrative methods of data collection and analysis have also traditionally been used with individuals rather than groups and collecting data that could be sensitive and personal in a group setting is risky but rewarding. These methods for analysing focus group data and reflections, although seen as a possible limitation, proved invaluable and could be used in future research where reflections, incidents or stories are being shared with others in a professional context.

The last limitation relates to the extent to which I was able to judge whether shared reflective practice enhances skill acquisition or better patient care. In the literature, there is no evidence that sharing reflections or stories enhances patient care or skill acquisition directly and there is little evidence that it indirectly enhances it either (Fook et al. 2006). While my study suggested that some nurses believe that sharing reflective stories has a role in enhancing nursing practice and patient care, my study cannot throw light on whether this is actually the case. Indeed, it is possible that sharing experiences in these ways could reinforce practices that may not be advantageous to patients. Therefore, more ethnographic or mixed method longitudinal studies examining the effect of reflection on enhancing clinical judgement would be useful.

8.3 Contributions to knowledge

The contributions to knowledge made by this study are:-

a) **Greater clarity about the perceptions of RNs in relation to what they believe reflection to be.**

   This study makes no attempt to produce a neat and tidy definition of reflection, nor is a model produced at the end to attempt to explain it. Many authors have already done this. Instead, this study focusses on what RNs believe reflection to be as they are the ones expected to carry it out. It provides valuable insights into the contrast between participants' perceptions of reflection as required by the NMC and the emotional and embodied reflection associated with practice.

b) **Insights into the value of shared reflection in promoting professional learning through supportive communities of reflective nursing practice.**

   Contrary to much previous writing that has prompted reflection as an individualised activity, this study reveals the potential value of shared reflection in creating and sustaining a community of reflective RNs. While further research is needed to explore this process and the value of such activity to practice, this study suggests that reflective communities can provide a valuable resource for experienced RNs to come together and share experiences.

c) **A conceptualisation of reflection as more than a skill and as a social and emotional practice that both generates and is generated by a developing sense of community.**

   Whilst reflection is taught as a skill and the participants acknowledged the value of this, this study suggests that reflection is more than a skill and is a socially constructed, embodied part of nursing practice. The thoughtful, considered critical judgements and actions that participants spoke about seemed to be embedded in their practice and resonated with other RNs including myself.

d) **Insights into the value of sharing stories in supporting reflection.**

   This study suggests that sharing authentic experiences from practice can encourage less experienced RNs to learn from and share their own

reflective stories, not only in order to explore the patient care issues raised, but also to support them in managing their emotions in a resilient way. Facilitating groups where experienced RNs share reflective stories about how they know what they know could help less experienced RNs and student nurses to learn about the emotional labour of nursing and how to manage those emotions that are a part of the RNs everyday practice.

8.4 Recommendations

Benner et al. (2011) purport that clinical wisdom in all its various forms can positively influence nursing care and enhance the standing of the profession in identifying new knowledge including knowledge gained through experience. However, unless there is a way in which such knowledge gained through experience can be shared then it can remain the internal musings of a reflective experienced practitioner. My findings suggest that there is a need to provide circumstances where stories can be told about how RNs know what they know; and in which experienced practitioners can have conversations with less experienced practitioners – or indeed those less confident in the process of reflection- in environments where they feel able to tell stories and share their situated knowledge.

A surprising finding of this research was that even when reflecting on practice through their stories and ongoing discussion, the participants never acknowledged or appeared to recognise that this process involved reflection in and on action. If reflection-in-action is the being in the moment, creating dissonance and solving problems then these participants were reflecting in action with each other or with me to solve problems about practice, with confidence. They were also reflecting on how they reflect in action. Indeed, they saw this learning from others who are reflecting on their practice as a valuable way to learn and an important part of their development as registered nurses, even if this was not theorised. A recommendation of this study, therefore, is that RN’s are given an opportunity to explore conceptions of reflection in such a way that they overtly recognise their reflective practice and that such opportunities should exist in formal and informal settings.

While prior research has an important part to play in RNs reflection, this study suggests that educators and experienced RN should work to develop and sustain a community of reflective nursing practice that is practically situated, caring, emotional, reflective and confident. One of the ways that this community may develop is through the telling of reflective stories of practice that are authentic, passionate and emotional to less experienced RNs and students aspiring to become part of the profession. The RNs in this study gave freely of their own time but they all, without exception, stated that they had enjoyed the experience and wished they could have the opportunity to tell and listen to reflective stories again. Working in a supportive and reflective team was seen by them to be an important opportunity and those who did so felt they were able to more easily able to listen to and tell their reflective stories. They also expressed pleasure and pride that they were able to share reflective stories as a part of their work. The work of Boud et al. (2006a) on productive reflection might be useful in considering the place of these types of informal learning groups at work. Boud et al. (2006a) write that productive reflection as a way to legitimise reflection in and on action at work using a combination of strategies that include group reflective learning activities. They warn however, that formalising reflection in this way could lead to issues such as instrumental and superficial reflection and complex power relations. One of the features of this study is that participants came together either as a group or individually with me outside the clinical area but attending to and talking about their knowing in practice. Such encounters, if facilitated to encourage reflection on knowing in practice might usefully be used to promote the reflective practice of RNs. Productive reflection, it seems is being advocated by the RNs in this study as a way forward in practice and I would support and recommend that there are informal yet structured places and spaces at work to support this.

It is interesting to note that the most recent iteration of revalidation required by the NMC (2018) specifies that an RN must discuss their five required written reflections with another registrant. Hopefully this research, when published, will add to the body of knowledge supporting this move and a more overt and evidence-based rationale will appear with the requirements. My advice to the

NMC, as a registrant, educator and researcher, is not to make assumptions about reflective practice but to be explicit about the rationale for reflection, to encourage a range of approaches to reflection, and to be open to less formal, structured approaches. Building a community of reflective RNs takes commitment and explanation, thereby ensuring that RNs are clear, not only about what they have to do but why they should do it.

8.5 Final reflections and epilogue

Following completion of this study, I think that shared reflection is important but I have concerns. I believe that this study went well and I think that storytelling is a useful process in reflection. Sharing reflection and telling stories from practice is an interesting and thought-provoking way to examine your practice, Upon analysis of the data, I was worried because two participants in different groups may have been performing for their audience and it seemed that they only discussed their own expertise with little consideration of the patient.

I think that reflection would work better if stories were shared that explored the patient's experience and perceptions, particularly if given from the nurse's perspective and whether that influenced their practice.

From a personal perspective, in keeping with the biographical advice given by Merrill and West (2009), my own story has to be the end. After so many years believing that I was autonomous and had agency (especially at the bedside), I have come to realize, aided by Lave and Wenger (1991) and Salomon and Perkins (1998), that my beliefs are conditioned and socialized by the community in which I practice. This experience has created a powerful internal need to explore reflective practice and the nature of nursing knowledge and yet with no motivation for resolution. Rather I have sought a greater understanding of the needs of the profession related to the needs of the individual nurse and the effect that the reflective practice of nursing may have on patient care.

What is unique about this study are the individuals who participated in it. The contribution of each RN was valuable, and they contributed to new understandings in terms of what is understood by the term reflection and how

telling stories and being together contributes to a robust and supportive community of practice along with the potential for the co-construction of new knowledge. I have a clearer appreciation of the passion and hard work of each and every one. Tillmann-Healy (2003) would say that it is not possible to differentiate between the researched and the researcher because of the complexity of human interactions, but I can say that I feel honoured that these RNs chose to participate in my study and share their stories and it is a privilege to be able to be their (and my) voice.

I have always been interested in the role of storytelling in education as a means of enhancing learning and bringing the 'clinical' into the classroom and so it was a privilege and a joy to sit and listen to registered nurses who were friends and colleagues share their stories. I did not expect so much emotion, I should have. This may be because when I started this journey, I had a mechanistic and instrumental view of carrying out research, much like the way in which reflection is often viewed and has been implemented by educators and practitioners. The participants blew this view out of the water. I felt a sense of intimacy, of comfort and of familiarity and this was apparent to me in every encounter. These feelings seemed to be shared by those in the focus groups and individual interviews.

This sense of belonging meant that I share the self-deprecation, humour and confidence with my friends and colleagues and, from an emic perspective, it means that I have tended to downplay my role as facilitator of the groups and interviews. Knutsson et al. (2018, p. 116) write that, for reflective groups to be successful, a "good atmosphere" should be facilitated carefully and skilfully. From an etic perspective, my role as an experienced and interested facilitator and interviewer in exploring reflection with the participants gave a very particular genuine and engrossing nuance to the analysis and findings from this study. This could be a limitation and it could be an advantage but, as Usher (2009, p. 173) writes, "Experience is something to get immersed in."

Of course, some of the best data I collected were the stories which could not be shared, either for confidentiality reasons or because they were generated outside of the data collection process. Still now, participants and other RNs who

know of my research come and tell me stories. I still find them interesting; they are still full of emotion, humour and self-deprecation and they are still respectful of patients and their families. I suspect I will always listen to and value nursing stories. I also hope that this research does something to raise the profile of nursing stories to others as a rich source of knowledge and provocation for reflection.

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