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THE IDENTIFICATION OF COMPONENTS FOR A STRUCTURED REFLECTIVE TOOL TO ENHANCE CONTINUOUS PROFESSIONAL DEVELOPMENT OF ACCIDENT AND EMERGENCY PRACTITIONERS

By

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DECLARATION

I, Cecilia Jacoba Filmalter, declare that:

'The identification of components for a structured reflective tool to enhance continuous professional development of accident and emergency practitioners'

is my original work, and that it has not been submitted before for any degree or examination at any other institution. All the sources that have been used or quoted have been acknowledged by means of complete references in the text and bibliography.

_____

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Date

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DEDICATION

I would like to dedicate this work in loving memory of my sister, Mariaan.

Mariaan your place is in heaven

Your time on earth is complete now

No, matter how hard we try to unfold

Still our questions they linger on…on through the long…long sleepless nights

As long as we live, memories of you won't ever fade…

ABSTRACT

TITLE: THE IDENTIFICATION OF COMPONENTS FOR A STRUCTURED REFLECTIVE TOOL TO ENHANCE CONTINUOUS PROFESSIONAL DEVELOPMENT OF ACCIDENT AND EMERGENCY PRACTITIONERS

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Continuous professional development has become an essential part of contemporary nursing practice. Continuous professional development implies that accident and emergency (A&E) practitioners can never stop learning. A&E practitioners therefore must be prepared to seek new challenges and reflect honestly upon their performance and experiences and adjust their practice in order to obtain and maintain quality service delivery. Network sampling was done and a focus group was used to collect data. This study sought to identify components for a structured reflective tool to enhance continuous professional development of A&E practitioners.

Reflection was seen as an important learning strategy and components for a structured reflective tool to enhance continuous professional development of A&E practitioners were identified. In addition essential elements that should be in place prior to the implementation of reflection into clinical practice were identified.

Key concepts:

o   Accident and emergency practitioners; Clinical facilitator; Continuous professional development; Learning needs; Reflection; Structured reflective tool

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List of abbreviations

A&E Accident and emergency

CINAHL Cumulative Index to Nursing and Allied Health Literature

NDOH National Department of Health

RSA Republic of South Africa

SANC South African Nursing Council

UP University of Pretoria

CHAPTER 1

ORIENTATION TO THE STUDY

"Learning is not attained by chance, it must be sought for with ardour and attended to with diligence."

Abigail Adams

1.1   INTRODUCTION

In nursing education reflection is believed to have lasting benefits for clinical practice (Burns & Bulman 2001:157). Reflection reveals and scrutinises ordinary beliefs, insights and experiences (Terhune 2006:144). Therefore it is advocated by Terhune (2006:144) that reflection is an "*inquiry-based process*" aiding the consideration of concealed values and biases. Nurse practitioners are enabled by reflection to alter their practice by means of comprehension and rationalisation (Price 2004:47). Reflective practice is an approach to learning and clinical practice development that is client centred and which admits to the chaos and perplexity of the clinical practice environment (Price 2004:47). Reflective practice is linked to learning from experience and is considered an important strategy for healthcare workers who commit themselves to continuous professional development.

Accident and emergency (A&E) practitioners and health care providers, including nurse practitioners and doctors in the A&E unit, encounter a variety of clients. The A&E unit continues to be the "first port of call" to the hospital and health care for many clients (Proehl 1999:vii). These clients have diverse health needs, which vary from minor ailments to life-threatening conditions. The A&E practitioner's responsibilities include amongst others the initial assessment of the client, planning and initiating primary and secondary management. According to the South African Nursing Council (SANC) the professional nurse practitioner acts as the co-

ordinator of the multi-disciplinary team (SANC 1984:3). In the A&E unit the A&E practitioner performs the duty of multi-disciplinary team co-ordinator. Thus in order to provide safe and effective care A&E practitioners must keep their clinical knowledge and skills current.

In order to maintain clinical knowledge and skills, A&E practitioners must engage in continuous professional development. Manson, Fletcher, McCormick, Perrin and Rigby (2005:427) are of the opinion that continuous professional development may entail knowledge and/or skills depending on the individual needs of the A&E practitioner. Skill and knowledge preservation and development are necessary to ensure continued delivery of quality patient care. The A&E practitioner therefore must develop new knowledge and skills and in some cases, adopt new attitudes and values (Tabriz University of Medical Sciences 2002:1). The SANC states that all nurse practitioners should conduct their practice on a scientific base (SANC 1984:2) and in order to attain this, nurse practitioners should engage in continuous professional development.

Reflection is no longer merely seen as a learning style, but as a process skill that adult learners must master if continuous personal and professional development (lifelong learning) is to become a reality (Price 2005:33). Involvement in reflective practice is associated with positive alteration to quality care, inspiring professional growth and closing the gap between theory and practice (Ramage 2005:1).

Reflection however cannot take place in isolation. According to Burns and Bulman (2001:109) clinical facilitators act as the guide to explore and analyse practice to enhance continuous professional development. Thus the clinical facilitator structures the reflection to achieve meaningful learning. Johns (2002:51-52) emphasises that there must be a guide to the reflection process of which the advantages are paraphrased as follows:

- contradictions will be exposed and the sense of conflict emphasised

- it will challenge A&E practitioners to consider current practice from other perspectives
- new insights will be discovered and alternative responses will be explored

Reflection is linked to learning from experience and is considered an important strategy for experienced healthcare workers who undertake continuous professional development (Ramage 2005:1). Experience can be linked to both reflection and adult learning. Johns (2002:34) defines reflection as follows:

"*Reflection is a window through which the practitioner can view and focus self within the context of her own lived experience in ways that enable her to confront, understand and work towards resolving the contradictions within her practice between what is desirable and actual practice*".

1.2   BACKGROUND TO THE RESEARCH PROBLEM

As a clinical facilitator in a private hospital, one of the researcher's responsibilities was to determine the learning needs and promote continuous professional development within the A&E unit. The researcher's explicit goal in the A&E unit was the continuous professional development of the A&E practitioners.

In February 2006 the researcher conducted an informal training needs analysis in the A&E unit. During the informal discussion the clinical facilitator asked the A&E practitioners to present her with their current knowledge and skills needs. The purpose of the training needs analysis was to plan an exclusive continuous professional development programme for A&E practitioners for six months in advance, based on their identified needs. The A&E practitioners were not able to identify their own learning needs, but predominantly focused on the learning needs of other nurse practitioners working in the A&E unit. Reflecting on this experience, the researcher deducted that the A&E practitioners might lack the ability to identify their own learning needs or they may be oblivious of the

importance and impact of continuous professional development and lifelong learning.

The researcher approached the A&E practitioners as adult learners who had, during their careers in the A&E unit, accumulated knowledge and skills by means of experiential learning. The researcher agrees with Boud and Griffin (1987:19) that when adult learners can start with their own experiences, their attitude towards continuous professional development is more engaging and motivating.

The A&E practitioners attended formal courses designed by the American Heart Association as it is required for international accreditation. However there was no informal training except for representatives of companies who provided in-service training to all categories of medical practitioners working in the A&E unit. Exposing the A&E practitioners to reflection might motivate them to participate in continuous professional development as it may enable them to identify their own learning needs.

In April 2006 the researcher embarked on an electronic search for a structured reflective tool. Cumulative Index to Nursing and Allied Health Literature (CINAHL) database and Blackwell Synergy platform searches were performed because these databases contain accumulative nursing literature and joint health information. Key words used during the searches included: *assessment tools*, *assessment tools in reflection, guided reflective tool, structured reflective tool*. The word *tool* was also substituted with the word *instrument*. The results of the searches indicated that there is a lack of tools aimed at assessing reflection (Cise, Wilson & Thie 2004:148; Hanley & Higgins 2004:276; Seldomridge & Walsh 2006:134).

The lack of tools aimed at assessing and enhancing reflection made the researcher turn to educators of various institutions where reflection is an integral part of learning. The researcher contacted six experts in the field of A&E nursing, A&E nursing education and reflection through networking as suggested by Polit and Beck (2006:262). The identities of these

experts are not provided in this study but will be disclosed on request. These experts were asked whether they knew of any structured reflective assessment tool or a similar tool. None of the experts knew of such a tool. All the experts indicated a need for the development of a tool to assess and enhance reflective practice in the clinical setting.

1.3   PROBLEM STATEMENT

The A&E practitioners working in a specific private hospital in Gauteng were unable to identify their own learning needs. The identified learning needs would guide the clinical facilitator to develop a continuous professional development plan for A&E practitioners. The researcher realised that in order for A&E practitioners to engage in reflection as a method of continuous professional development a structured reflective tool must be developed. The realisation was supported by:

- the lack of available tools to assess and enhance reflective practice in the clinical setting (Cise et al. 2004:148; Hanley & Higgins 2004:276; Seldomridge & Walsh 2006:134)
- the need for the development of a structured reflective tool as expressed by the experts who were consulted

1.4   RESEARCH QUESTIONS

In view of the background and problem statement, the following research questions were formulated:

- Question 1: What are the views of clinical facilitators, lecturers of the A&E programme and experts in the field of nursing education with an interest and/or experience in the use of reflection?
- Question 2: What components need to be incorporated in the structured reflective tool that would enhance the continuous professional development of A&E practitioners?

- Question 3: What recommendations regarding the development of the structured reflective tool can be made?

1.5 AIM OF THE RESEARCH

The overall aim of this research was to identify and explore the components for a structured reflective tool to enhance the continuous professional development of A&E practitioners.

1.6 RESEARCH OBJECTIVES

In order to achieve the aim of the research, the following objectives were formulated:

- Explore the views of clinical facilitators, lecturers of the A&E programme and experts in the field of nursing education with an interest and/or experience in the use of reflection
- Describe components that need to be incorporated in the structured reflective tool to enhance the continuous professional development of A&E practitioners
- Make recommendations regarding the development of the structured reflective tool

1.7 FRAME OF REFERENCE

The frame of reference of the study can be described in terms of the relevant paradigm, assumptions and conceptual definitions (Polit & Beck 2006:155).

1.7.1 Paradigm

Polit and Beck (2006:506) define paradigm as: a "*way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one's approach to inquiry*".

The research was based on the paradigm of constructivism. Constructivism is a collective for radical constructivism, social constructivism, socio-cultural approaches and emancipatory constructivism (Gravett 2001:18). These types of constructivism support the assumption "*that learning is a process of constructing meaning*" (Gravett 2001:18). Each person when faced with new knowledge and skills already has an existing frame of reference. Therefore existing knowledge plays a vital role in the interpretation and absorption of new information (Kinsella 2006:278). The new information can thus be the outcome of an individual process or collaboration with other people (Gravett 2001:19).

According to Atherton (2005:2) constructivism is a philosophy of learning founded on the principle that, by reflecting on experiences, people construct their own understanding of the world they live in. Reflection is a process of "*reconstructing and reorganising*" an experience so that it adds value to the experience (Rodgers 2002:848). Fundamentally according to Rodgers (2002:846) the "*reconstructing and reorganising*" entails that people make sense of new experiences based on the significance collected by the person from previous experiences and prior knowledge of the world from other people's experiences.

1.7.2 Assumptions of the researcher

An assumption is an opinion that is acknowledged as the truth founded in logic or reason lacking evidence or confirmation (Polit & Beck 2006:495).

The researcher made the following assumptions during this study:

- Reflection contributes to theory and practice correlation (Smith & Jack 2005:36)
- The A&E practitioner will be able to identify learning needs and act upon it (Gustafsson, Asp & Fagerberg 2007:157; Sutton & Dalley 2008:64)
- A&E practitioners and clinical facilitators are adult learners
- Reflection will enhance the continuous professional development (Brunt 2005:255)
- Continuous professional development will lead to quality improvement of care (McCormack & Slater 2006:135)

1.7.3   Definitions of key concepts

1.7.3.1   Nurse practitioner

Nurse is described as "*a person trained to care for the sick, somebody caring for patients, somebody trained to look after ill and injured people, especially somebody who works in a hospital or clinic, administering the care and treatment that a doctor prescribes*" (Encarta 2003; Oxford English Dictionary 2008).

Practitioner is defined as "*somebody who practises a particular profession, especially medicine*" (Encarta 2003) and defined by the Oxford English Dictionary (2008) as "*a person engaged in an art, discipline, or profession, especially medicine*"

For the purpose of this study the nurse practitioner will include any person registered in terms of the Nursing Act 1978 (Act No.50 of 1978) and the Nursing Act 2005 (Act No.33 of 2005).

1.7.3.2   Accident and emergency practitioner

An accident is explained as "*an unplanned and unfortunate event that results in damage, injury, or upset of some kind*" (Encarta 2003).

Emergency is defined by the Oxford English Dictionary (2008) as "*a serious, unexpected and potentially dangerous situation requiring immediate action*".

Practitioner was already defined under section 1.7.3.1.

According to Heyns (2003:10) an A&E nurse is a professional practitioner registered as a nurse with the South African Nursing Council (SANC) who completed one or more of the following additional qualifications registered at the SANC:

- Medical and surgical nursing science: Trauma and emergency nursing
- Medical and surgical nursing science: Trauma nursing (Heyns 2003: 10)

An A&E practitioner in this study is regarded as a nurse practitioner registered as a trauma nurse who deals with people presenting with emergencies at the A&E unit in need of immediate medical assistance, and is consistent with the definitions provided by Heyns (2003:10).

1.7.3.3   Clinical facilitator

The Oxford English Dictionary (2008) defines clinical as "*relating to the observation and treatment of patients*".

Facilitator is defined as "*somebody who aids or assists in a process, especially by encouraging people to find their own solutions to problems or tasks*" (Encarta 2003).

A clinical facilitator is the person "*responsible for the selection and organisation of training*" (McCormack & Slater 2006:136).

The clinical facilitator in the context of the study is an A&E practitioner appointed in the clinical practice to facilitate the maintenance and development of skills and knowledge in professional practitioners working in the A&E unit. The clinical facilitator must be skilled to guide practitioners at the right pace, the right level and in the right way (Burton 2000b:326). For the purpose of this study the clinical facilitator will only focus on the maintenance and development of the skills and knowledge of A&E practitioners.

1.7.3.4   Reflection

Reflection: "*careful thought, especially the process of reconsidering previous actions, events, or decisions*" (Encarta 2003).

Reflection is described by Boud, Keogh and Walker (1985:19) as "*a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations*".

Rodgers (2002:863) describes reflection as "*a tool or vehicle used in the transformation of raw experience into meaning-filled theory that is grounded in experience, informed by existing theory and serves the larger purpose of the moral growth of the individual and society*".

Johns (2002:34 not in list of sources) describes reflection as "*a window through which the practitioner can view and focus self within the context of her own lived experience in ways that enable her to confront, understand and work towards resolving the contradictions within her practice between what is desirable and actual practice*".

Reflection is defined by Lowe, Rappolt, Jaglal and MacDonald (2007:143) as "*intentional mental processing, used primarily with complicated or uncertain situations or ideas in order to fulfil a particular purpose in the present future*".

For the purpose of this study reflection is defined as a process whereby A&E practitioners think about a situation and either verbalise or record their thoughts and emotions around it. During the process of reflection the A&E practitioner will examine his/her conduct and insightfully evaluate the positive and negative aspects of the situation. The A&E practitioner will thereafter apply these new insights in other situations.

1.7.3.5   Structured reflection

Structure is defined as "*to organise or arrange something so that it works as a cohesive whole*" (Encarta 2003).

Taking the definitions of reflection into consideration, structured reflection involves "*a guide for analysis of a critical incident or general reflection of experience*" (Ramage 2005:2).

For the purpose of this study the clinical facilitator structures reflection by guiding the A&E practitioner by asking encouraging questions, clarifying behaviour, thoughts and feelings and also using it as a debriefing session which ties in with the description of Johns' guided reflection (2002:51).

1.7.3.6   Structured reflective tool

A tool is defined as "*something used as means of achieving something*" (Encarta 2003). The Oxford English Dictionary (2008) defines a tool as "*a device or implement used to carry out a particular function*".

The structured reflective tool refers to an assessment tool that provides guidelines to the A&E practitioner and the clinical facilitator to identify

knowledge and skill shortcomings as well as emphasising proficient practice.

1.7.3.7   Continuous professional development

Continuous: "*continuing without changing, stopping, or being interrupted*" (Encarta 2003).

Professional: "*following occupation as paid job, very competent; showing a high degree of skill or competence*" (Encarta 2003).

Development: "*the process of developing, developing something, or of being developed, for example by growth, change or elaboration*" (Encarta 2003).

Torstad and Bjork (2007:818) describe continuous professional development as "*a process by which health professionals keep up-dated to meet the needs of patients, the health service and their professional development*".

The Architects Registration Board (2002:1) defines continuous professional development as "*the systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life*".

The A&E practitioner must be willing to accept that the A&E environment is dynamic and practice must be evidence based. In order to deliver evidence-based practice the A&E practitioner can never stop learning. A&E practitioners therefore must be willing to seek new challenges and reflect honestly upon their performance and experiences and adjust their practice in order to obtain/maintain quality service delivery. This statement correlates with the viewpoint of the Tabriz University of Medical Sciences (2002:10).

1.7.3.8 Quality improvement

Quality: *"excellence the highest or finest standard"* (Encarta 2003).

Improvement: *"getting or making better the process of making something better or of becoming better"* (Encarta 2003).

Lynn, Baily, Bottrell, Jennings, Levine, Davidoff, Casarett, Corrigan, Fox, Wynia, Agich, O'Kane, Speroff, Schyve, Batalden, Tunis, Berlinger, Cronenwett, Fitzmaurice, Dubler and James (2007:666) defines quality improvement as *"systematic, data-guided activities designed to bring about immediate improvements in healthcare delivery in particular settings"*.

Quality improvement entails that knowledge should be generated for a specific practice setting in order to render satisfactory and economic care to consumers of healthcare (Kahn & Fuchs 2007:710).

For the purpose of this study A&E practitioners must build on pervious experiences and consult available resources to ensure that new ideas implemented in practice are meaningful and beneficial to consumers of healthcare.

1.8 RESEARCH METHODOLOGY

Burns and Grove (2005:211) states that research methodology implies the complete plan for the study starting from conceptualising the research problem to the final strategies for data collection. Research methodology includes the research process and the different tools and procedures used (Mouton 2001:56). A brief overview of the research design and methodology utilised in this study is summarised. A detailed discussion is provided in Chapter 3.

1.8.1 Research design

A research design according to Polit and Beck (2006:509) is a broad plan intended to answer the established research questions incorporating requirements to augment the validity and reliability of the study. The research methodology applied in this study was qualitative and explorative, descriptive and contextual in nature.

1.8.1.1 Qualitative research

Qualitative research entails the "*investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design*" (Polit & Beck 2006:508).

The researcher's aim was to identify components for a structured reflective tool to enhance continuous professional development for A&E practitioners. Data was collected from professionals who are involved in the education and training of health care providers via a focus group. The data collected was analysed and themes, categories, clusters and sub-clusters were identified.

1.8.1.2 Explorative research

Explore is defined by Encarta (2003) as to "*investigate or study something: to make a careful investigation or study of something*".

Exploratory research is defined by Polit and Beck (2006:500) as "*a study that explores the dimensions of a phenomenon or that develops or refines hypotheses about relationships between phenomena*".

The study was explorative in nature in order to examine an unfamiliar phenomenon (Babbie 2005:89). The aspects of the research problem were explored by making use of a focus group with clinical facilitators and experts in the field of nursing education with an interest and/or

experience in the use of reflection as well as by conducting a literature review.

1.8.1.3   Descriptive research

Describe is defined as "*explain; to give an account of something by giving details of its characteristics*" (Encarta 2003).

Descriptive research is defined by Burns and Grove (2005:734) as "*an accurate portrayal or account of the characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information*".

The descriptive design encouraged the researcher to identify and grasp the characteristics of the phenomenon being studied (Burns & Grove 2005:733). The study was descriptive as it was to describe the phenomenon truthfully within the context and was based on the data collected during the focus group.

1.8.1.4   Contextual research

Contextual is described as "*surrounding conditions: the circumstances or events that form the environment within which something exists or takes place*" (Encarta 2003).

Burns and Grove (2005:732) defines context as "*the body, the world, and the concerns unique to each person within which that person can be understood*".

The A&E environment and particularly the A&E practitioner was the focus of this study. Data was collected from clinical facilitators, lecturers of the A&E programme and experts in the field of nursing education with an

interest and/or experience in the use of reflection. The above-mentioned people are involved in educating training and facilitating A&E practitioners.

1.8.2   Research methodology

According to Polit and Beck (2006:4) the research methodology includes the scientific procedures to improve, refine and develop the base of nursing knowledge. Data was collected by means of a focus group with a sample from the identified population.

1.8.2.1   Population

A population is a group of individuals that has collective qualities (Polit & Beck 2006:506). The population included A&E clinical facilitators and the experts in the field of nursing education with an interest and/or experience in the use of reflection in Gauteng.

1.8.2.2   Sample

Polit and Beck (2006:509) states that a sample is "*a subset of a population, selected to participate in a study*". In this study the sample included seven A&E clinical facilitators and the experts in the field of nursing education with an interest and/or experience in the use of reflection.

1.8.2.3   Sampling

The researcher made use of snowball sampling, a form of non-probability sampling (Burns & Grove 2005:353). This indicates that the researcher took advantage of the social connections in the A&E environment in order to identify A&E clinical facilitators and experts in the field of nursing education and training, as well as those with an interest and/or experience in the use of reflection for the sample.

1.8.2.4   Data collection

Data collection describes the process of gathering material to address the research problem (Polit & Beck 2006:498). A focus group was utilised to collect data and gain insight into how A&E clinical facilitators and the experts in the field of nursing education with an interest and/or experience in the use of reflection view the use of reflection for continuous professional development (Pope & Mays 2006:21).

1.8.2.5   Data analysis

According to Polit and Beck (2006:498) data analysis involves 'the systematic organisation and synthesis of data collected'. Data was transcribed and coded by the researcher and an independent coder. The researcher and independent coder had a contact session and discussed the data. The data was sorted in themes, categories, clusters and sub-clusters.

1.9   ESTABLISH TRUSTWORTHINESS

The model of Lincoln and Guba (1985:289-311) was applied to ensure validity and reliability. The model uses four constructs namely credibility, transferability, dependability and conformability (Lincoln & Guba 1985:301-319; Streubert Speziale & Carpenter 2007:49). Establishing trustworthiness is meticulously discussed in Chapter 3.

- Credibility

Credibility refers to the assurance that data and interpretations are truthful (Polit & Beck 2006:332). The activities include prolonged engagement, persistent observation, triangulation, referential adequacy, peer debriefing and member checks (Lincoln & Guba 1985:301-316).

- Transferability

Transferability indicates to what extent the findings of the study can be applied to other contexts (Lincoln & Guba 1985:316). Steps taken to ensure transferability include thick description and purposive sampling (Lincoln & Guba 1985:316).

- Dependability

Dependability refers to data stability over time and in different conditions (Polit & Beck 2006:335). To ensure dependability the researcher made use of the following dependability audit aids: dense description, triangulation, peer examination and code-recode procedures (Lincoln & Guba 1985:316-318).

- Conformability

Confirmability refers to the objectivity of the data (Polit & Beck 2006:336). Objectivity was enhanced by means of bracketing (Streubert Speziale & Carpenter 2007:27). Bracketing was an ongoing process and the researcher was attentive not to allow predetermined ideas to direct the study.

1.10 ETHICAL CONSIDERATIONS

Compliance with ethical principles was crucial (Polit & Beck 2006:84). Before the research commenced, letters of approval were obtained from the Ethics Committee of the Faculty of Health Sciences, University of Pretoria and the Education Division of the private hospital group (see Annexures A and B).

To conduct research in an ethical manner it was essential to obtain informed consent from potential participants (Burns & Grove 2001:206). Informed consent consists of four elements, namely disclosure of fundamental information, comprehension, competency and voluntarism (Burns & Grove 2001:206).

In order to ensure informed consent the researcher implemented the following measures:

- Each participant received a letter containing information on the title, purpose and objectives of the research and the letters of approval from the ethics committees. This was done to encourage disclosure of essential information (see Annexure C)
- Comprehension was assured by exploring the views of clinical facilitators and experts in nursing education regarding reflection and structured reflection. During the focus group clear and consistent terminology was used
- Information was presented on a level that the participants understood ensuring their competency
- Voluntary consent was obtained by informing all participants that participation was voluntary and that they can refuse to participate or withdraw at any given time without stating a reason

Anonymity was ensured by distinctly stating in the information letter that the data obtained from participants may be reported in scientific journals, but that no information will be disclosed that could identify them as participants in the research. The right to privacy and confidentiality will be strictly applied in this research. For a more elaborate discussion on ethical considerations refer to Chapter 3 (see section 3.7).

1.11 SIGNIFICANCE OF THE RESEARCH

The significance of this research is integrated with the views of the SANC (1992:3), which states the following:

"*The development of the ability of analytical critically evaluative and creative thinking and the continuing stimulation of the capacity to interpret scientific data for nursing actions to draw conclusions and to exercise independent judgement, are of the utmost importance.*"

As a clinical facilitator, it is the researcher's responsibility to ensure that the above-mentioned goals are realised within the A&E unit. Reflection is associated with lifelong learning and professional development (Ramage 2005:1). A structured reflective tool may enable the A&E practitioner to identify personal learning needs, address these needs and engage in professional development, which may result in the improvement of quality care within the A&E unit. The identification of the components for a structured reflective tool is the initial step in developing a tool that could be used for the continuous professional development of the A&E practitioner working within an A&E unit.

Although this study will be conducted in a private hospital group, all clinical facilitators involved in the professional development of A&E practitioners could in future use the structured reflective tool.

1.12 LIMITATIONS OF AND REFLECTIONS ON THE RESEARCH

Due to the qualitative nature of the study the researcher will reflect on the research (Holloway & Wheeler 2002:267). The discussion in Chapter 5 section 5.5 contains the methodological reflection and study specific reflection by the researcher. The limitations are discussed in Chapter 5 section 5.6.

1.13 LAYOUT OF THE RESEARCH

This chapter introduced the topic of the study, namely identifying components for a structured reflective tool to enhance the continuous professional development for A&E practitioners. The research questions, aims and objectives of the study were described. The research design and ethical considerations were briefly discussed.

Chapter 2 orientates the reader towards the literature already published. The literature review offers the reader the context of the study in order to

illuminate contemporary and historical information (Polit & Beck 2006:133).

Chapter 3 outlines the research design and methodology and addresses population; sampling, data collection and data analysis processes. Establishing trustworthiness, ethical considerations, actions and competence of the researcher as well as publication of findings are also discussed in this chapter.

Chapter 4 represents the results of the data analysis. The discussion includes feedback from the focus group and contains literature control.

Chapter 5 discusses the conclusions drawn from the data analysis, recommendations for further research and reflections on the study.

1.14 CONCLUSION

In this chapter, a brief introduction was given regarding reflection and its implementation to enhance continuous professional development for A&E practitioners. The chapter also provided and overview of the research problem, research objectives, research design and methodology. The next chapter examines the literature pertaining to the topic of the study: identifying the components for a structured reflective tool to enhance continuous professional development of A&E practitioners.

CHAPTER 2

LITERATURE REVIEW

"*There are three principal means of acquiring knowledge...observation of nature, reflection, and experimentation. Observation collects facts; reflection combines them; experimentation verifies the result of that combination*"

Denis Diderot

2.1   INTRODUCTION

A literature review is an "*organised written presentation of what has been published on a topic by scholars*" (Burns & Grove 2005:93). The purpose of the literature review according to Polit and Beck (2006:133) is to "*provide [the] reader with a background for understanding current knowledge on a topic and illuminate the significance of the new study*". The literature review for this study was conducted in order to provide a broad overview on reflection as a learning strategy to enhance the continuous professional development of A&E practitioners, ultimately leading to quality improvement.

2.2   REFLECTION

Reflection is thought to be actions individuals embark on to examine their experiences with the intention to gain new knowledge and understanding (Sutton & Dalley 2008:64). Reflection has been defined by Lowe, Rappolt, Jaglal and MacDonald (2007:143) as "*intentional mental processing, used primarily with complicated or uncertain situations or ideas in order to fulfil a particular purpose in the present future*". Fiddler and Marienau (2008:75) pronounces reflection as an examination of nurse practitioners' private experience. The authors continue by stating that reflection is an

indispensable arbitrator between experience and the significance of the experience for future practice (Fiddler & Marienau 2008:75).

Reflection has been emphasised as a prevailing method to educate nurse practitioners (Schutz 2007:26). According Hyrkäs, Tarkka and Paunonen-Ilmonen (2001:505) reflection is linked to the quality of care. Implementing reflection allows nurse practitioners to take risks and investigate aspects of their practice for which there are insufficient theoretical explanations (Platzer, Blake & Ashford 2000:1002).

The starting point of reflective practice can be traced back to the educational philosopher John Dewey (1859-1952) (Tate 2003:773). According to Rodgers (2002:843) even though Dewey is mentioned in numerous books and articles written on reflection, the actual meaning of reflection is missing from contemporary literature. Rodgers (2002:843) further states that reflection has lost its meaning and has become "everything" to "everybody". This implies that the term reflection is used for every new educational trend and that authors each have their own interpretation of what reflection is and what it ought to be.

The researcher deems it important to take a close look at Rodgers' study, which aims to define reflection by scrutinizing Dewey's work. Rodgers (2002:845) extracted four criteria that characterise Dewey's notion of reflection and the purposes it served. The criteria are paraphrased as follows:

- Reflection is a significant process that moves a nurse practitioner from one experience to the next with profound understanding of its relationships with, and associations to other experiences and ideas. It is the thread that makes continuity of learning feasible, ensures the development of the individual and, ultimately, society. It is a channel to essential moral ends.
- Reflection is an orderly, meticulous, disciplined way of thinking, with its roots in scientific inquiry. The scientific method includes exact steps: observation and an in depth account of the experience,

an examination of the experience that includes origination and development of theories and investigation (Rodgers 2002:863).

- Reflection needs to take place during interaction with others.
- Reflection necessitates the value of personal and intellectual growth of oneself and of others.

The above-mentioned criteria are in line with the constructivism paradigm of learning as discussed in Chapter 1 (section 1.7.1).

2.2.1   Modes of reflection

In the literature reviewed two modes of reflection were identified, reflection-on-action and reflection-in-action (Gaye 2005:61; Schőn 1987:26).

2.2.1.1   Reflection-on-action

In the literature focusing on past experiences and then reflecting on it are referred to as reflection-on-action. Reflection-on-action is regarded as a reflective enquiry of past activities that stimulated professional development (Dahlgren, Eriksson, Gyllenhammar, Korkeila, Sääf-Rothoff, Wernerson & Seeberger 2006:72). Reflection-on-action is described by Eraut (2004:48) as an intentional technique of thinking that can be utilised in problem-solving situations. Gaye (2005:61) affirms that reflection-on-action is a way of making sense and learning from experience. The process of reflection-on-action as explained by Stein (2000:1) is a revisiting of an event and remembering feelings and thoughts of the experience, assessing the outcome of the situation against the practitioners' expectations and reality. Reflection-on-action indicates that when practitioners are exposed to a certain situation, they will be competent in integrating knowledge gained from previous experiences. Reflection on past experiences is done with the intention to improve the preparedness of practitioners for future problems and decisions (Eraut 2004:48).

2.2.1.2   Reflection-in-action

Reflection-in-action entails that nurse practitioners must think about their actions while performing these actions and reshape actions during the "doing" process (Schőn 1987:26; Gaye 2005:60). According to Tate (2003:775) reflection-in-action, entails thinking during the course of the experience, which is a more advanced skill that takes time to develop.

Reflection enables nurse practitioners to examine situations meticulously and consider how their perspectives influence their practice. Thinking is therefore the deliberate establishment of connections between actions and its consequences (Dewey 1966:151). The self-confidence of the nurse practitioner thus increases in the event of dealing with conflicting values (Green 2002:10). Reflection is seen by Hyrkäs et al. (2001:503) as a way to enhance the development of autonomous, skilful, self-directed nurse practitioners because reflection often directs the nurse practitioner to seek additional information. This statement is supported by Borduas, Gagnon, Lacoursiére and Laprise (2001:104).

2.3   MODELS OF REFLECTION

There are several models of reflection to guide the process of reflection (Ramage 2005:2). A model is defined by Encarta (2003) as "*a simplified version of something complex used, for example to analyse and solve problems or make predictions*". Models of reflection imply the abilities to "*describe experiences, critically analyse situations, develop new perspectives and evaluate the learning process*" (Burns and Bulman 2001:10). The models of reflection designed by Gibbs (1988), Atkins and Murphy (1995) and Johns (2000) will now be discussed and are summarised in Table 2.1.

2.3.1   Gibbs' model of reflection

Gibbs' model of reflection (Gibbs 1988 in Johns 2002:49) is aimed at making reflection more accessible, by encouraging nurse practitioners to examine their own learning (Boud, Keogh & Walker 1985:91). The reflective model is uncomplicated making it easy for nurse practitioners to initiate the use of reflection (Ramage 2005:4). Gibbs' model of reflection inspires nurse practitioners to clearly describe the event that took place. The descriptive phase leads to the analysis of thoughts and feelings experienced during the event. The nurse practitioner is also urged to recognise and analyse good and bad points of knowledge and skill application as well as emotions involved during the event (Ramage 2005:4). As nurse practitioners become aware of the good and bad points they are bound to attempt to make sense of the situation. The making sense phase is followed by concluding if any other action could have been taken. The conclusion phase must lead to action and the nurse practitioners must consider how they will handle a similar situation in the future (Ramage 2005:4).

2.3.2   Atkins and Murphy's model of reflection

According to Atkins and Murphy (1995:34) the initial step in reflection is the recognition of "*uncomfortable feelings and thoughts*". The recognition of the uncomfortable feelings and thoughts spring from the realisation that the knowledge applied in the situation was inadequate (Atkins & Murphy 1995:34). The awareness of the uncomfortable feelings and thoughts is followed by a detailed description of the situation. The situation described is then critically analysed. The critical analysis examines knowledge and feelings involved in the situation (Atkins & Murphy 1995:34).

The nurse practitioners are forced to challenge knowledge and assumptions in a critical manner in order to evaluate the value of their existing knowledge framework. The model is concluded by a step that

enquires if learning did take place. The answer to the question must be followed by action as according to Atkins and Murphy (1995:34) the reflection process is not complete without action. In their model of reflection Atkins and Murphy (1995) takes care to ensure that positive points of situations are also reflected upon, as the exclusive focus on negative points will obstruct "*the rational consideration of the events*" (Atkins & Murphy 1995:34).

2.3.3   Johns' model of reflection

According to Johns (2002:49) the cyclical process of reflection will only be of practical to use to people who are not familiar with reflection. The truth is that reflection does not take place in an orderly fashion but is a more holistic process (Johns 2002:49). Nurse practitioners "*struggle to know how to reflect*" (Johns 2002:47). The model of reflection developed by Johns (2000) was specifically developed to structure reflection in such a way that it will guide the nurse practitioner through the reflection process (Johns 2002:47). The model of reflection is organised in such a way that it encourages progression of thought. Nurse practitioners are guided to take a serious look at themselves and to record feelings and thoughts significant to the event that took place (Johns 2002:47). The event is then described in detail. This leads to the analysis of the event by asking questions about the situation, which encompasses feelings, thoughts and knowledge (Johns 2002:47). After the analysis the action taken during the event and the present knowledge and skills of the nurse practitioner is evaluated. The nurse practitioner also considers alternative actions and plans for the future, should the situation arise again (Johns 2002:47).

Table 2.1: Comparison of models of reflection

Model		Gibbs' model of reflection	Atkins and Murphy's model of reflection	Johns' model of reflection
Description		All the models of reflection reviewed necessitate a detailed description of the event up for reflection		
Focus	**Analysis**	What were you thinking and feeling? What was good and bad about the experience?	Analyse feelings and knowledge relevant to situation -Identify knowledge	What was I trying to achieve? Why did I act as I did? What are the consequences of my actions? How did I feel about this experience when it was happening? How did the patient feel about it? What influenced my decision-making and actions? Challenge assumptions
	Evaluation	What sense can you make of the situation?	Imagine and explore alternatives Evaluate relevance of knowledge -does the knowledge help to explain or solve problems? -how complete was the use of knowledge?	Could I have better dealt with the situation? What other choices did I have? What would the consequences of these other choices be? How do I feel about the experience now?
	Conclusion	What else could you have done?	Identify any learning which has occurred	How can I make sense of this experience in light of past and possible future experiences?

(This table was adapted from Atkins & Murphy 1995:32; Johns 2002:47, 49)

2.4   THE VALUE OF REFLECTION

Nurse practitioners proclaim that they are positive towards reflective practice and pronounced changes in their clinical practice (Paget 2001:210). Reflection is credited by Burton (2000b:326) as an active process for developing self-awareness, learning and developing personal knowledge and skills resulting in a desirable change in behaviour and practice.

Thus reflection allows nurse practitioners to determine the special care for a patient eluding the waste of time and resources (Mantzoukas 2008:220). Nurse practitioners as expert practitioners internalise knowledge from experience by reflection-on-action and then unintentionally relate the knowledge to different situations in the practical setting and prepare them for future situations (Stein 2000:2). Therefore reflection causes improvements in the quality of care as it triggers awareness and the generation of new knowledge (Gustafsson et al. 2007:157).

However, vagueness and the popularisation of the concept, perplexing theories and inconsistent study results have presented problems for its implementation in practice (Hyrkäs et al. 2001:506).

2.5   ARGUMENTS AGAINST REFLECTION

According to Rolfe and Gardner (2006:593) there is an emerging uneasiness around the use of reflection as some academia considering it to be a form of exploitive supervision to assist management to create an obedient workforce. Gilbert (2001:202) is of the opinion that reflection is a confessional technique of subjectification. Reflective practice tends to assume an unsophisticated or idealistic position and fails to recognise the ways in which reflective descriptions construct the world of practice (Taylor 2003:244).

Practitioners cannot be aware of all the conscious facets of nursing practice because there are aspects of practice that cannot be consciously represented (Clinton 1998:197). Reflection is a personal journey that can contribute to apprehension if the misconception arises that practitioners are required to record their learning merely for policing purposes (Maggs & Biley 2000:194). Reflective practice can be a very distressing process and it will take time to become fully operational (Platzer et al. 2000:1002). The use of reflection in the classroom situation has been successful according to Stein (2000:2). The transition from classroom to practice however poses a challenge to all adult educators.

In the clinical practice experience plays an important role as it is the starting point for reflective process (Burns & Bulman 2001:10).

2.6   REFLECTION AND EXPERIENCE

Reflection is indirectly a deliberate consideration of experiences and ideas (Sutton & Dalley 2008:64). No significant experience is possible without some element of thought (Dewey 1966:145; Duffy 2007:1402). It can ensue fairly passively by allowing emotions and experiences to surface in the course of daily life. Thoughts concerning ideas and experience can be prompted by guided discussions or reading academic literature (Boud et al. 1985:131). The review of literature according to Mantzoukas (2008:218) will ensure that the knowledge and or skills gained are based on research evidence making nurse practitioners more credible. Gustafsson et al. (2007:152) furthermore concludes that for the purpose of understanding and expanding knowledge, adult learners are encouraged to consider their own learning styles by means of reflection.

Dewey (1966:140) proclaims that experience is mainly an active-passive situation. Therefore, according to Hopstock (2007:429) the importance of an experience lies in the perception of connections of knowledge and future applicability. Reflection upon experience provides individuality to the interpretation of the experience (Dewey 1966:166). Learning from

experience (experiential learning) is one of the aims of reflective practice (Tate 2003:773). Reflection blends theory, practice and learning through experience to construct alterations in knowledge, insights and behaviour (Duffy 2007:1404; Stein 2000:1).

Nurse practitioners are enabled by facilitation to reflect critically on their experience, thus developing the ability to link experiences to personal, social and cognitive perceptions (Gustafsson et al. 2007:152; Mallik 1998:54). As a result the clinical facilitator is a key person in developing reflective practice (Duffy 2007:1404).

2.7   CLINICAL FACILITATION

Clinical facilitation entails the creation of a learning culture in the clinical setting that will ensure professional development and an increase in the quality of care rendered to health care consumers (McCormack & Slater 2006:135). Clinical facilitation became increasingly popular in the 1990's, according to Burns and Bulman (2001:106). Organisations started to endorse professional practice development and accountability. The endorsement has its foundation in the need to satisfy healthcare consumers and to provide safe nursing care (Burns & Bulman 2001:106). Clinical facilitation can broaden personal horizons by including perspectives and viewpoints of others (Burns & Bulman 2001:106). Clinical facilitation has a favourable influence on nurse practitioners, their patients and the quality of their clinical practice (Bedward & Daniels 2005:64; Burns & Bulman 2001:109).

From the constructivist paradigm Gravett and Geyser (2004:46) supports the implementation of clinical facilitation as it ensures that learning takes place during interaction beneficial to learning as opposed to learning in isolation.

2.7.1 The clinical facilitator

The person responsible for clinical facilitation is the clinical facilitator. There are a variety of terms used to describe the person facilitating the learning process. These include but are not limited to "*clinical supervisor*" (Howatson-Jones 2003:37), "*clinical education facilitator*" (McCormack & Slater 2006:135) and "*clinical nurse educator*" (Considine & Hood 2000:71). For the purpose of this study the researcher will use the term "*clinical facilitator*" (Mallik 1998:53).

2.7.1.1 Qualities of the clinical facilitator

The qualities of clinical facilitators should incorporate listening skills, professional reliability, truthfulness and adaptability (Howatson-Jones 2003:40). Becoming and being a clinical facilitator is an ongoing process, representing the same developmental process clinical facilitators aspire for in their nurse practitioners (Higgs & McAllister 2007:e56). Nurse practitioners often criticize the clinical facilitator as being autocratic, judgmental and narrow-minded (Ling Lau, Chuk & Wei 2002:203). Clinical facilitators consequently have to obligate themselves to continuous professional development (Higgs & McAllister 2007:e56). The ability to assess self-effectiveness and willingness to engage in learning from others are vital for the clinical facilitator (Boud & Griffin 1987:135; Burns & Bulman 2001:116). The voyage of development and evolution as a clinical facilitator requires effective learning strategies integrating reflection on their own practice (Higgs & McAllister 2007:e56).

Clinical facilitators should set preconceived notions aside and each nurse practitioner must be inspired to reflect and learn from their individual experiences. Consequently the clinical facilitator must be prepared to participate in mutual problem-solving and respect individual learning approaches and experiences (Howatson-Jones 2003:40). Clinical facilitators are therefore required to confront all aspects of their teaching and reflect honestly on nurse practitioners' opinions of their teaching

style. The clinical facilitator through the process of reflection must adapt and develop teaching strategies (Ling Lau et al. 2002:206). A wide range of learning approaches should be implemented based on the relevance and applicability to practice (Gibson 1998:458). In order to facilitate the transfer of knowledge to an adult learner the clinical facilitator must have patience and time (Russell 2006:350).

2.7.1.2   The role of the clinical facilitator

Clinical facilitators are responsible for the scope and coordination of training and consequently influence the culture change toward learning (McCormack & Slater 2006:136; 142). The clinical facilitator must therefore encourage responsible practice and employ resources to enhance reflection in such a way that practice is promoted effectively (Osmond & Darlington 2005:9). The clinical facilitation role corresponds with a coach or helper rather than a director (Boud & Griffin 1987:201). The term *"critical friend"* is used by Dahlgren et al. (2006:72-78) to describe facilitation of professional development. Therefore the clinical facilitator as an adult educator endeavours to assist the learner to decide about learning goals, methods and assessment (Boud & Griffin 1987:201).

Clinical facilitators are faced with the challenge to encourage the learner and reinforce the process of learning (Russell 2006:350). An effective approach involves showing the learner the connection between knowledge and skill and the probable positive outcome (Russell 2006:352). The clinical facilitator needs to enlighten the learner that learning from specific cases can be transferred to other situations (Payler, Meyer & Humphris 2008:67).

2.7.2   Guiding reflection through clinical facilitation

Reflection emphasises learning through exploration and examining of practice and self-assessment binding the process of clinical facilitation and reflection together (Burns & Bulman 2001:109; Russell 2006:350). The

reflective process is formalised by clinical facilitation (Burns & Bulman 2001:110), as clinical facilitation is not a constant monitoring of the nurse practitioner, but a consultation to discuss practice at a certain time (Burns & Bulman 2001:115).

To develop competence in practice, safeguard the patient and deliver guided support to practitioners; clinical facilitation through structured reflection may aid nurse practitioners to personally evaluate the practice (Maggs & Biley 2000:192). Furthermore Burns and Bulman (2001:111) state that self-assessment must form part of the clinical facilitation and reflection process. In order to enable the experienced nurse practitioner to evaluate and improve the quality of care, the clinical facilitator must structure reflective activities to raise crucial awareness of standard practices and to uncover limitations through systematic problem-solving processes (Fiddler & Marienau 2008:76; Taylor 2001:406).

2.7.2.1   The process of guiding reflection

According to Brackenreg (2004:266) it is logical that facilitation design should merge the deliberate use of sufficient time, resources and strategies, which encourage and educate the nurse practitioner to move beyond the concrete experience. Brackenreg (2004:267) continues that without planning for and proficient use of reflection after the action stage, the nurse practitioner will most likely be left with questionable learning outcomes, or worse defenceless, because of unsolved emotional issues. Therefore the clinical facilitator has to clarify and uncover the effects and outcomes of the action stage through effective reflection sessions otherwise nurse practitioners will be left to their own devices to explore meaning. However along the way nurse practitioners gain confidence and develop their own ability to think critically. Johns (2002:53) clearly states that the culture change to utilise and introduce structured reflection is not an easy one, but important because contemporary nursing practice necessitates professional accountability and dedication to lifelong learning (Brunt 2005:255).

Reflection prompts practitioners to reflect on experiences and engage in continuous professional development that leads to the preservation of high standards of care and the improvement of services resulting in competent accountable nurse practitioners (McCormack & Slater 2006:135). Reflective clinical teaching is significant because of the potential advantages to practitioners, patient care and clinical teaching. Reflection is therefore a form of experiential learning (Boud & Griffin 1987:16).

2.8   EXPERIENTIAL LEARNING

Experience is defined by Encarta (2003) as *"the knowledge of and skill in something gained through being involved in it or exposed to it over a period of time"* and *'"knowledge acquired through the senses rather than through abstract reasoning"*. Experience is further clarified by the Oxford English Dictionary (2008) as "*practical contact with and observation of facts or events*" as well as "*knowledge or skill acquired over time*"

Craig (1997:1) defines experiential learning as "*knowledge, skills, and/or abilities attained through observation, simulation, and/or participation that provides depth and meaning to learning by engaging the mind and/or body through activity, reflection, and application*".

Experiential learning advocates that people consequently grow and develop by merging intellectual and social processes (Phitayakorn, Gelula & Malangoni 2007:158). Therefore experiential learning is "*based on experience: derived from or relating to experience as opposed to other methods of acquiring knowledge*" (Encarta 2003). Nurse practitioners define thoughts and feelings that will influence their learning experience (Russell 2006:349). In order to ensure that nurse practitioners internalise learning, they will need to reflect on the experience and connect the knowledge gained with past and possible future situations (McNeil, Hughes, Toohey & Dowton 2006:529).

2.8.1 Kolb's learning cycle of experiential learning

Kolb's experiential learning cycle, according to Sutton and Dalley (2008:64) offers structure to reflection on an experience. Kolb's experiential learning cycle as illustrated in Figure 2.1 assumes that transforming experiences creates new knowledge (Kolb 1984:41; Phitayakorn et al. 2007:158). The cycle has four phases, concrete experience, observation and reflections, formulation of abstract concepts and generalisation and testing implications of concepts in new situations (Kolb 1984:21). The person engaging in experiential learning can enter the experiential learning cycle at any point, but must follow the sequence for learning to take place (Davies & Lowe 2007:1). In Figure 2.1 the learning cycle of experiential learning as developed by Kolb (1984:21) is presented.

The four entry points include:
- Concrete experience
- Observation and reflection
- Formulation of abstract concepts and generalisation
- Testing implications of concepts in new situations

Figure 2.1: Kolb's learning cycle (Kolb 1984:21)
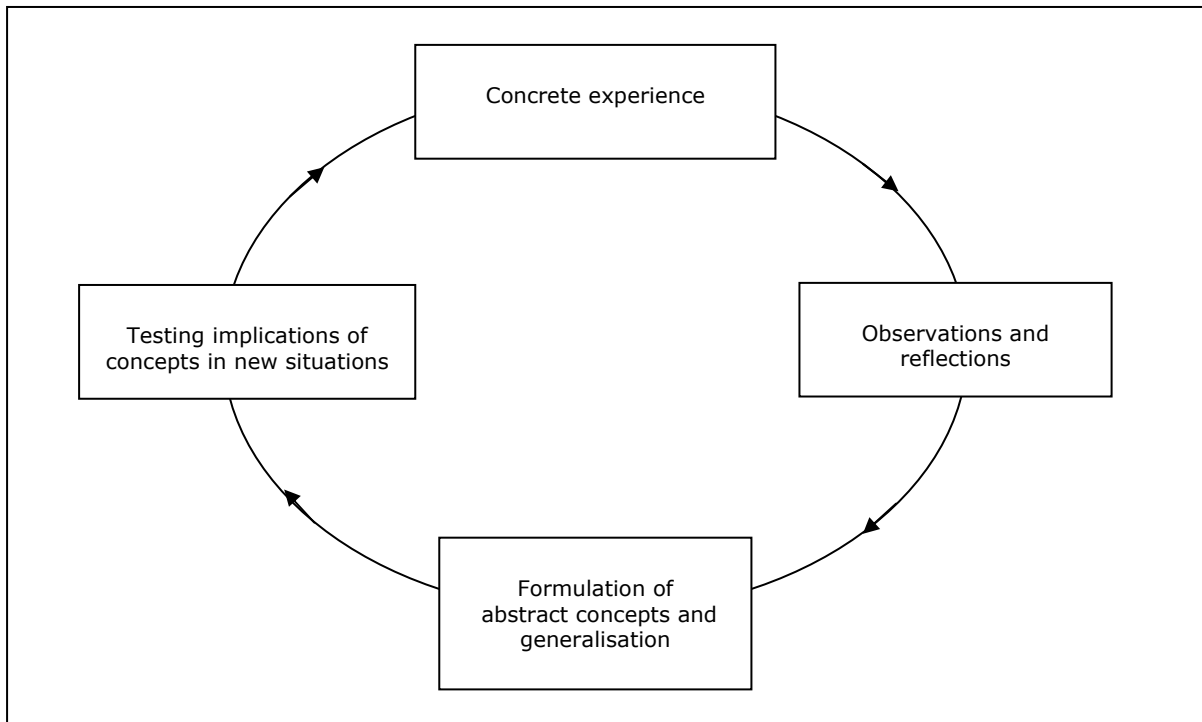
Source: Kolb (1984:21)

2.8.1.1 Concrete experience

Concrete experience is associated with an event that has taken place in which a nurse practitioner or a team of nurse practitioners was involved (Allin & Turnock 2007:1). The concrete experience phase is therefore the doing or execution of actions (Davies & Lowe 2007:1). According to Kolb (1984:21) the concrete experience phase is the basis for observation and reflection.

2.8.1.2 Observations and reflection

Reflective observations and active experimentation is associated with the transformation of experiences (Kolb 1984:38; Phitayakorn et al. 2007:158). Observations and reflections arise from analysis and judgements regarding the event (Davies 2007:1). According to Phitayakorn et al. (2007:159) reflections and observations are necessary

for learning to take place because without these concepts there are no deliberations on past experiences and their meaning.

2.8.1.3 Formulation of abstract concepts and generalisation

The formulation of abstract concepts and generalisation is related to "*developing an understanding of what happened by seeking more information and forming new ideas about ways of doing things in the future*" (Allin & Turnock 2007:1). To enable nurse practitioners to plan and formulate alternative strategies to handle similar situations, they have to read relevant literature and reflect on events (Davies & Lowe 2007:1). The newly formed abstract concepts and generalisations will lead to active experimentation.

2.8.1.4 Testing implications of concepts in new situations

Davies and Lowe (2007:1) labels this phase as an active experimentation. Testing implications of concepts in new situations begins the learning cycle once again. Nurse practitioners apply new knowledge either gained from new information or experience and engage in new concrete experiences (Davies & Lowe 2007:1).

Experiential learning is "*a holistic integrative perspective on learning that combines experience, perception, cognition and behaviour*" (Kolb 1984:21). Reflection and experiential learning are linked to assisting adults to learn.

2.9 LEARNING

Learning entails the construction of knowledge that can be applied and the continuation to learning new things (Eyler 2002:520). Adults use a variety of learning strategies depending on their personal learning styles and the situation in which learning takes place (Berings, Rob & Simons 2008:432).

Some adults learn to broadly understand the holistic picture while others favour a chronological course of action towards learning (Stavenga de Jong, Wierstra & Hermanussen 2006:156). Learning is facilitated through the use of educational paradigms.

2.9.1 Educational paradigms

An educational paradigm can be defined as a model that forms the basis of teaching and learning (Encarta 2003). There are two main educational paradigms, which are used, in educational institutions.

2.9.1.1 The teacher centred paradigm

The first educational paradigm is the teacher centred paradigm (Gravett & Geyser 2004:44). This paradigm corresponds with pedagogy, which entails that the teacher takes responsibility for what is to be learned and when the learning will take place (Conner 2005:1). The teacher is therefore the pivotal character in this teaching strategy and the student a passive receiver of content. The result of this is that adult learners view learning as a burden and most have lost their interest in learning (Conner 2005:2).

Adult learners experience difficulty in engaging in the adult learning process because of their prior educational experiences (Platzer, Blake & Ashford 2000:1002). In addition Platzer et al. (2000:1004) states that mainstream education participants in their study reported that prior education was based on accumulation of facts and adult learners were not motivated to think or discover things for themselves. Yoshimoto, Inenaga and Yamada (2007:75) states that if the adult learner is still inexperienced and needs to be socialized into a professional role, the pedagogical approach is applicable.

2.9.1.2 The learning centred paradigm

The second educational paradigm is learning centred (Gravett & Geyser 2004:44). This paradigm resembles adult learning (Gravett 2001:36). The term andragogy is used as an alternative word for adult education (Gravett 2001:65). It is habitually proclaimed that the great majority of adults are not concerned with learning and are not motivated in the direction of continuous education (Knowles, Holton & Swanson 1998:38). Malcolm Knowles (1913-1997) the father of andragogy however changed the way educators approach adult learners (Knowles et al. 1998:v).

2.9.2 Defining the adult

In order to illuminate the way Knowles et al. (1998:64) made assumptions on adult learning, their definitions of adults are included. Knowles et al. (1998: 64) defines adults on four levels:

- "*Biological definition*" to become biologically adult when reproduction can take place;
- "*Legal definition*" to become legally an adult with the freedom to make your own decisions;
- "*Social definition*" to become socially an adult performing adult roles such as a full-time worker;
- "*Psychological definition*" to become psychologically an adult is to arrive at a self-concept of being responsible for ones own life and being self-directing personally and professionally.

2.9.3 Assumptions of adult learning

Knowles et al. (1998:64-69) makes some assumptions based on their andragogical model to direct adult educators. These are as follows:

- "*The need to know*" (Knowles et al. 1998:64). Adults must know why they need to learn before engaging in learning. Lyons

(1999:31) correspondingly affirms that the adult learner needs to know why there is a need to learn before engaging in learning. Therefore, if adult learners assess their own learning needs, they will realise their limitations and the need to fill the gaps (Hopstock 2007:428).

- "*The learners' self-concept*" (Knowles et al. 1998:65). Adult learners have a will to self-direct their development and may resent and oppose situations in which they feel others are enforcing their will on them (Russell 2006:350). According to Boud and Griffin (1987:85) learning takes place primarily when conflict is present within oneself and the status quo is no longer acceptable. Russell (2006:350) states that adult learners engage in learning with a purpose and generally take the leading role in the learning process. It is therefore important to challenge adult learners without frustrating them (Russell 2006:350).

- "*The role of the learners' experience*" (Knowles et al. 1998:65). Adult learners have to find a balance between a full-time job, domestic responsibilities and continuous professional development (Russell 2006:353; Tennant & Fieldt 2004:168). Subjective experience remains the starting point for most adult learners (Boud & Griffin 1987:19). Learning from experience is also known as experiential learning (Jarvis, Holford, Griffin 2003:53) and is discussed in detail in section 2.3.

- "*Readiness to learn*" (Knowles et al. 1998:67). Adults become ready to learn when the learning experience will improve their ability to cope with everyday circumstances. Consequently it is essential to provoke their need to know.

- "*Orientation to learning*" (Knowles et al. 1998:67). Task or problem focused learning is constructive in motivating adults to learn. Again it is clear that the adult learner must be able to utilize what was learned in practice. Customisation of information is important because adults learn when they understand that the information is related to them and their working environment (Hopstock 2007:428).

- "*Motivation*" (Knowles et al. 1998:68). The level of motivation is a familiar predictor of learning results (Hopstock 2007:425). Internal pressure is the most influential persuader to learn. Adult learners are motivated by desires of improved self-esteem, job satisfaction and value of life (Knowles et al. 1998:69). When adult learners have a general sense of moving forward and are made aware of the fact that their clinical practice becomes outdated, it acts as a motivator to learn (Gaye 2005:4; Russell 2006:349).

2.9.4 Barriers against participation in learning

Hoptock (2007:428) warns that if adults engage in learning 'without knowing what, who and how' the adult learner will lose interest and become apathetic. The feelings of resistance and passivity will be exacerbated when their time and content of what is to be learned is controlled (Hopstock 2007:428). The adult learner will barricade learning if they do not see the need for changing their behaviour or how the learning will positively influence their daily practice (Russell 2006:352). Barriers to learning exist because adults have social and occupational responsibilities to fulfil (Lieb 1991:2).

2.10 REFLECTION AS AN ADULT LEARNING STRATEGY

"A strategy is a carefully devised plan of action to achieve a goal, or the art of developing or carrying out such a plan." (Encarta 2003).

Hopstock (2007:428) advocates that, in line with Knowles, adults pursue learning skills necessary for practical situations and are therefore problem-based learners. Effective reflection on experience enhances the prospect that nurse practitioners will identify gaps in their knowledge or skill, or more subtly, identify prejudices to beliefs, which would benefit from further investigation (Gustafsson et al. 2007:157). Trying to improve practice therefore begins with reflecting on what actually happens in practice (Gaye 2005:59). Reflection requires a disposition to consider the

possibility that events with an undesirable outcome might have taken a different course had the nurse practitioner either behaved differently or been able to invite another party to engage differently with them (Henderson & Johnson 2002:5). There is some evidence that reflection involves the integration of theory and practice and a review of old perspectives causing retention and/or abandonment of some views and ideas (Crowe & O'Malley 2006:80).

Nurse practitioners move from acceptance of information to re-examining and critiquing professional assumptions, particularly concerning their significance and appropriateness for practice (Smith 1998:896). Reflective nurse practitioners therefore take their experiences and turn them into special kinds of learning (Gaye 2005:12) ensuring that the knowledge gained is usable in practice (Gaye 2005:4). Reflection may thus guide the nurse practitioner to realise the need to know.

Gaye (2005:6) recognises the predicament of nurse practitioners. He states that nurse practitioners want change but also want stability and are willing to respond to clients' needs but within limits. Gaye (2005:6) continues that to become a reflective practitioner, the nurse practitioner must adopt coping strategies to deal with the dilemma of a volatile working environment.

Reflection appeals to adult learning as it proclaims intellectual growth and development of the adult learners' ability to see the need for learning and the consequences of personal growth (McNeil et al. 2006:528; Stein 2000:1).

Adult learners require a perception of themselves as an individual and as a professional practitioner. Once these perceptions have been established the practitioner will acknowledge the need to develop. Self-awareness is a complex skill to develop. Reflection encourages adult learners to identify and contemplate their values, attitudes and personal preferences (Henderson & Johnson 2002:8; Payler et al. 2008:67). Reflection may also be a medium through which morals or philosophy can be confronted

or changed, and subsequently adjustments in practice may follow (Green 2002:4). To appreciate the adult learners' self-concept, their values, attitudes and self-awareness it is essential to examine the role of experience.

A&E practitioners working in an A&E unit are experienced adult learners who have to engage in continuous professional development while facing the barriers to participation in learning every day. This statement is supported by (Chan & Garbez 2006:216).

2.11 THE ACCIDENT AND EMERGENCY UNIT

The A&E units of hospitals form part of the healthcare safety net and are the custodians for unplanned hospitalisation (Kelly 2005:192). A&E units historically were places people sought healthcare when they were critically ill or the care they needed was more than what physicians could offer at their offices (Snyder, Keeling & Razionale 2006:198). A&E units care for a vast variety of patients from the mentally ill to people with imported diseases (Holdsworth, Belshaw & Murray 2001:449; Smith 2005:230).

A&E units also care for victims of crime and perpetrators, collecting evidence and are therefore at the forefront of forensic healthcare (Kelly 2005:192). The environment is often overcrowded and disorderly and any person in need of help is attended too (Kelly 2005:192). Doctors, A&E practitioners, nurse practitioners and often members of the medical emergency services staff the A&E units.

2.11.1 Accident and emergency practitioner

Nurses have been involved in the delivery of emergency care since the early 20th century (Snyder et al. 2006:207). Contemporary A&E practitioners are recognised as advanced practice nurses (Chan & Garbez 2006:216) as they are harried practitioners who need to have an extensive variety of clinical knowledge and skills and are answerable to

many people (Taylor 2001:406). The aim of specialised A&E nursing education therefore is to develop practitioners who are proficient, informed and react to the changing needs in clinical practice (Ling Lau et al. 2002:202).

In a study conducted by Parsons, Cornett and Burns (2005:201) all staff of the A&E unit in their population seeks amongst other things "*excellence in patient care*" and "*educational development*". Hadley (2005:217) declares that "*improvements in practice are essential*". A&E practitioners therefore have to engage in continuous professional development (Parsons et al. 2005:202). A&E practitioners, however, are not a standardised population; their learning needs depend on their experience (Forbes, While & Ullman 2005:79).

2.11.2 Accident and emergency practitioners and structured reflection

A&E practitioners engage in reflection in ways that most appropriately suit their individual needs for practice and professional development (Burns & Bulman 2001:111). A&E practitioners do not partake in learning opportunities unless it is compulsory and the process is lead in such a way that it is undemanding for them (Platzer et al. 2000:1007). The clinical facilitator's goal is to work with A&E practitioners towards attaining awareness and assisting them in acknowledging their responsibility towards the patient (Burns & Bulman 2001:114). Guiding reflection through clinical facilitation is therefore more than imposing standards and performance indicators (Burns & Bulman 2001:111). The process of clinical facilitation utilising structured reflection provides support, motivation and morale improvement to A&E practitioners reducing stress and burnout (Burns & Bulman 2001:121; Lowe et al. 2007:147).

A&E practitioners may have lost connections to their deeper selves in the healthcare culture that confronts them with daily events of suffering and deep distress This statement is supported by Johns (2002:51) who also

states that A&E practitioners protect themselves at a deep level by desensitising themselves to cope with the daily challenges of their practice. The clinical facilitator needs to guide A&E practitioners to cope in non-desensitising ways and acknowledge and value their work as emphasised by Johns (2002:51).

The clinical facilitator and A&E practitioners must be open to challenges reconstructing current knowledge and be aware that all actions have to be continuously reassessed (Gaye 2005:16). A&E practitioners will only allow critique of current practice if the relationship between the clinical facilitator and themselves is non-threatening and respectful (Bedward & Daniels 2005:64). Subsequently the practitioners can provide quality service to clients.

Johns (1996:39) endorses that A&E practitioners must understand and decipher each clinical situation, applying and appraising existing information. The A&E practitioner must react and adjust to the clinical situation while considering the desirable outcome (Mazmanian 2007:141). The clinical facilitator therefore must create teaching approaches to assess the A&E practitioner's level of knowledge and to be tolerant and supportive towards them (Payler et al. 2008:67). During the reflective consultation the clinical facilitator should focus on the positive and not negative aspects of practice to alleviate fear (Ling Lau et al. 2002:203; Russell 2006:352).

The clinical facilitator and the A&E practitioners should be aware that in healthcare there is a natural and necessary predestination for learning from failure (Gaye 2005:7). Learning through failure can therefore function as a catalyst for turning the situation into a learning experience to improve practice (Gaye 2005:4). A&E practitioners who are unacquainted with reflection may find themselves on unfamiliar ground and not engage in clinical facilitation unreservedly (Burns & Bulman 2001:111). Burns and Bulman (2001:112) states that the success of clinical supervision relies on the effectiveness and quality of the relationship between the A&E practitioners and clinical facilitator.

2.11.3 The relationship between the clinical facilitator and the accident and emergency practitioner

The relationship between the clinical facilitator and the A&E practitioner is crucial for the success of clinical facilitation (Bedward & Daniels 2005:64). The nature of the relationship between the A&E practitioner and clinical facilitator needs to be clarified and intentional to reduce conflict (Burns 2001:110). A&E practitioners demand that clinical facilitators must be experienced competent practitioners, who are capable of flexible teaching strategies and offer suitable learning opportunities (Considine & Hood 2000:77). The clinical facilitator must offer constructive feedback promptly, respecting the learner without inhibiting enthusiasm (Ling Lau et al. 2002:203).

A&E practitioners may become blunted or numbed because of the *"unsympathetic"* working environment and therefore act defensively (Considine & Hood 2000:76; Johns 2002:52). Clinical facilitators must support A&E practitioners to become emancipated and take appropriate actions to resolve inconsistencies in their practice (Johns 2002:53). According to Higgs and MacAllister (2007:e51) learning will only be successful if the clinical facilitator demonstrates respect to A&E practitioners and their experiences.

A&E practitioners have a sense of vulnerability and fear that prevents them from openly discussing their actions in a critical manner (Platzer et al. 2000:1003). The creation of a non-threatening learning environment and an accommodating atmosphere, where A&E practitioners can express themselves openly and honestly, is of the utmost importance (Payler et al. 2008:67). According to Tate (2003:775) the clinical facilitator summarises and applies theory to the experience, but A&E practitioners have the responsibility to delve into theory applicable to their personal needs.

If A&E practitioners have an inclination that the clinical facilitator's only focus is to judge their performance, they may be less inclined to disclose

facts about their practice (Burns & Bulman 2001:114). A safe environment is therefore of great importance (Burton 2000:326). Clinical facilitators must engage the reflective process with sensitivity, undertaking a contract of confidentiality to promote mutual trust (Burns & Bulman 2001:116). It is imperative to focus on successful aspects of nurse practitioners' work no matter how small (Gaye 2005:4).

The relationship between the clinical facilitator and A&E practitioner must be open and respectful in order to form alliances and exchange information to support continuous professional development (Howatson-Jones 2003:38). The skilled clinical facilitator needs to guide the A&E practitioner at the appropriate pace, level and in a way that ensures flexibility and understanding of learning methods. Clinical facilitators must explore new ideas, share their personal experiences and be willing to be thought provoking and challenge A&E practitioners to engage in their own development (Burns & Bulman. 2001:116). Therefore clinical facilitation is a dynamic process (Burton 2000b:326). An enforced relationship could possibly present obstacles towards acceptance of clinical facilitation and the dynamics of the relationship (Howatson-Jones 2003:8).

The clinical setting is full of training opportunities (Borduas et al. 2001:105) and the clinical facilitator must cultivate the development of professional growth in order to sustain learning in practice (McCormack & Slater 2006:135) regardless of the type of relationship between the learner and facilitator.

Professional development and growth is synonymous with continuous professional development.

2.12 CONTINUOUS PROFESSIONAL DEVELOPMENT

Torstad and Bjork (2007:818) describes continuous professional development as "*a process by which health professionals keep up-dated to meet the needs of patients, the health service and their professional*

development". There is substantial national and international awareness in developing effective strategies to support lifelong learning, also referred to as continuous professional development (Forbes et al. 2005:79). In South Africa there are aspirations to introduce compulsory continuous professional development for the nursing profession (SANC 2006:2). The National Department of Health (NDOH) aims to expand continuous professional development to all categories of health care providers in order to ensure competent health care delivery (NDOH 2007:16).

The maintenance of knowledge and skills is highly recommended because of the dynamic nature of contemporary healthcare (Gibson 1998:452). The failure to update professional knowledge and skills has long been recognized as a cause for the deterioration in competence (Sutton & Dalley 2008:63). Development and learning should be part of everyday practice (Gibson 1998:457).

2.12.1 The accident and emergency practitioner and continuous professional development

A&E practitioners can provide a definition for lifelong learning and continuous professional development (Ryan 2003:502). Acknowledging that continuous professional development will enhance their competence in clinical practice, the responsibility for continuous professional development remains with A&E practitioners who need to lead the learning and development process (Burton 2000b:327). Continuous professional development is the main cause of change and the attitudes of A&E practitioners and their employers will predominantly determine the success of a continuous professional development programme (Joyce & Cowman 2007:627).

In order to establish a foundation for continuous professional development a learning needs analysis is an important activity. A learning needs analysis guides A&E practitioners to identify their own learning needs and inspire economic use of time to learn using available resources to meet

the care needs of their patients (Forbes et al. 2005:79). According to Howatson-Jones (2003:39) A&E practitioners do not read journals and articles unless it is for a formal education programme. Therefore the introduction of continuous professional development alone is inadequate to produce a culture of lifelong learning (McCormack & Slater 2006:136).

A study conducted by Ward and McCormack (2000:259) focused on personal and professional development when the optimum learning environment was provided. The outcome implies facilitation of learning needs to be thorough balancing learning and aspired results (Ward & McCormack 2000:265). Continuous professional development therefore requires a combination of teaching strategies changing between specific training and education to a more reflective approach including clinical facilitation (Forbes et al. 2005:79; Gibson 1998:457). The main purpose of engaging in reflection to enhance continuous professional development is to improve the quality of care rendered to health care consumers (Torstad & Bjork 2007:824).

2.13 QUALITY IMPROVEMENT

Quality improvement is defined by Schneider (2006:2) as "*any process or tool aimed at reducing the quality gap in systemic and organisational functions according to the dimensions of quality*". Lynn et al. (2007:666) defines quality improvement as "*systematic, data-guided activities designed to bring about immediate improvements in healthcare delivery in particular settings*".

Quality improvement in healthcare has developed dramatically over the past decade (Kahn & Fuchs 2007:709). Measuring quality and seeking improvement in practice forms part of the daily routine and has become an integral part of healthcare establishments (Kahn & Fuchs 2007:709). The reason for quality improvement arises from growing needs and rising expectations from healthcare consumers and financial constraints (Blaise & Kegels 2004:337; Lynn et al. 2007:666).

2.13.1 The accident and emergency practitioner and improving quality care

A&E practitioners are key role players and have more influence on quality improvement than any other health professional because of their direct contact with healthcare consumers (Price, Fitzgerald & Kinsman 2007:44). Healthcare systems and organisations therefore compel A&E practitioners to be more effective and accountable for their actions (Blaise & Kegels 2004:337).

The increasing demands and rapid changes in healthcare systems require A&E practitioners to generate knowledge from their specific setting guiding them in improving their practice (Hallin & Danielson 2007:62; Kahn & Fuchs 2007:710; Lynn et al. 2007:667).

2.14 REFLECTION ON THE LITERATURE REVIEW

According to Harford and MacRuaic (2008:1885) Dewey and Schon advocated that learning depends on integrating experience, reflection theory and practice. The researcher constructed a theoretical framework to illuminate understanding of the literature as it applies to an A&E unit, clinical facilitation and A&E practitioners. The theoretical framework is presented in Figure 2.2.

Figure 2.2: Theoretical framework
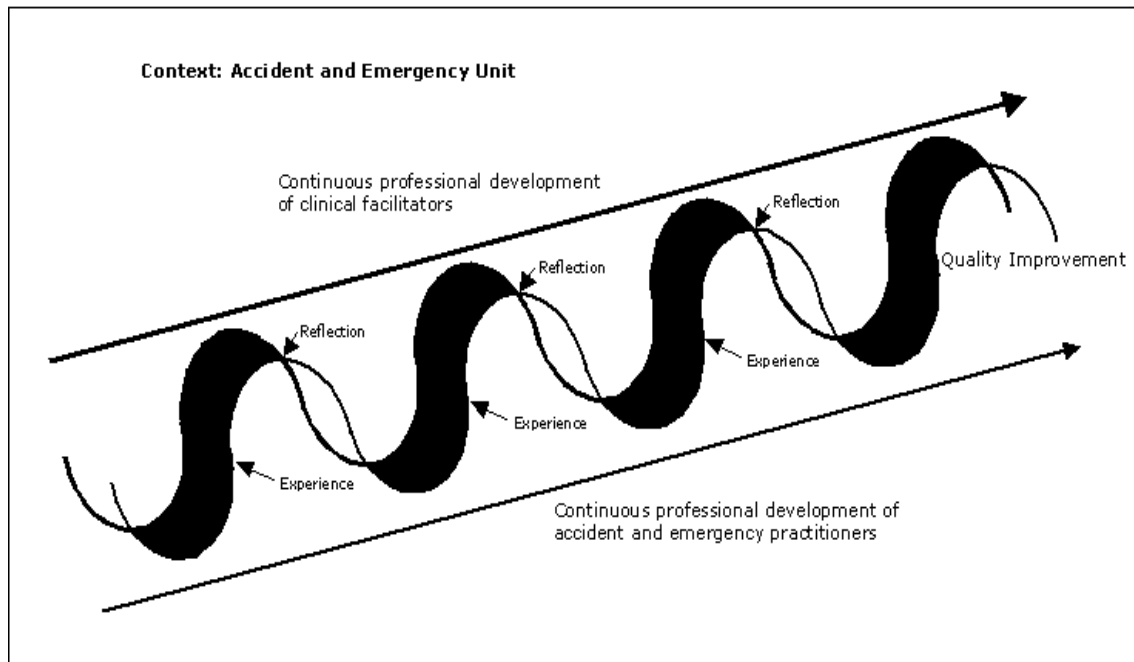
From Figure 2.2 it can be derived that clinical facilitators and A&E practitioners work in an unpredictable environment and should have a sound base of knowledge and skills (Smith 2005:230). In order to obtain and maintain a sound base of knowledge and skills, both the clinical facilitator and the A&E practitioner need to engage in continuous professional development (Higgs & McAllister 2007:e56; Joyce & Cowman 2007:627). Continuous professional development starts with an experience that is reflected upon (McNeil et al. 2006:529). Reflection on an experience provides the clinical facilitators and A&E practitioners with the opportunity to figure out what was good and what was bad about the event as well as knowledge applied and lack thereof (Urzua & Vasquez 2008:1935). In other words reflection modifies the perspective of clinical facilitators and A&E practitioners (Berings et al. 2008:420). The modification according to Gustafsson et al. (2007:157) occurs because A&E practitioners, together with clinical facilitators examine how they reach the decision for action during an event. The clinical facilitators and A&E practitioners then consult evidence based resources and specialist information to ensure that knowledge and skills are kept current (McWilliam 2007:73). The new knowledge and skills are then applied to practice and reflected upon again.

The experience and reflective process is continuous as reflection is a strategy for continuous professional development (Torstad & Bjork 2007:824). Reflection is a meaningful activity that moves A&E practitioners from one experience to the next with an intense perception of the relationship between experience and knowledge. It is the train of thought that makes continuous professional development reasonable and ensures the advancement of the A&E practitioner and clinical facilitator and in due course, society (Rodgers 2002:845).

The process of experience and then reflection on that experience leads to continuous professional development. A&E practitioners and clinical facilitators are therefore equipped to render quality care to patients and engage in quality improvement (Lynn et al. 2007:667).

2.15 CONCLUSION

The issues touched on in Chapter 2 include reflection, clinical facilitation, experiential learning, adult learning, continuous professional development and quality improvement. The discussion of the literature obtained is related to the context of the study.

It is evident from the literature that reflection can be a valuable asset to continuous professional development but some stumbling blocs do exist. There is no single set of guidelines on how to use reflection as a strategy for clinical practice. The use of a clinical facilitator however is important to ensure that the reflective process is not followed in isolation and that A&E practitioners are steered in the right direction.

The following chapter contains a detailed discussion on the design and methodology used for this study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

"If we knew what it was we were doing, it would not be called research, would it?"

Albert Einstein

3.1 INTRODUCTION

This chapter describes the research design and methodology applied in this study. Chapter 3 describes the research process regarding data collection, data analysis, trustworthiness, ethical considerations as well as actions and competence of the researcher and the publication of findings. In addition it includes how the components for a structured reflective tool that could enhance continuous professional development for A&E practitioners were identified.

3.2 RESEARCH DESIGN

A research design refers to "*the structures within which the study is implemented*" (Burns & Grove 2005:211). Research design according to Polit and Beck (2006:509) is a "*general plan for addressing research questions, including specifications for enhancing the studies integrity*". Green and Thorogood (2006:34) states that a research design refers to "*the what, how and why of data production*" to answer the research question. As stated in Chapter 1 the research design followed in the study was qualitative, explorative, descriptive and contextual. This design was followed in order to identify the components for a structured reflective tool that could enhance continuous professional development for A&E practitioners.

3.2.1 Qualitative research

Qualitative research involves exploration, characteristically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design (Polit & Beck 2006:508). Qualitative research has achieved eminence and visibility in especially the helping professions, which includes nursing (Mirriam 2002:3; Pope & Mays 2006:1).

Qualitative research methods aim to explore and describe a phenomenon as experienced by people who lived it (Burns & Grove 2005:52; Polit & Beck 2006:16). In this study health services are investigated from the perspective of the professionals who are involved in the education and training of health care providers in the A&E environment. Researchers who use the qualitative approach "*attempt[s] to surpass the content of what was said in order to gain new insights and understanding about the data and phenomenon under study*" (Dew 2007:436).

The qualitative researcher asks research questions that will generate data to gain understanding of a specific phenomenon (Green and Thorogood 2006:6). Data generated through qualitative research entails that the data is produced in a written form (Avis 2005:5; Bowling 2007:352). The participants of the research were therefore allowed to express their views and opinions in their own words on their own terms (Avis 2005:5). In order to collect data the researcher needed to interact with the participants. This is referred to as fieldwork in qualitative research. Polit and Beck (2006:500) defines fieldwork as "*activities undertaken by researchers to collect data out in the field*". The data for this study was collected through a naïve sketch and focus group as discussed in section 3.4.

The researcher becomes an instrument and develops skills to enhance competency in the entire research process (Henning 2004:10). Complete

objectivity was therefore impossible as the researcher does the data analysis (Streubert Speziale & Carpenter 2007:12).

3.2.2 Explorative design

The explorative design was used during the conduct of the study. The study explored dimensions of the phenomena as described by Polit and Beck (2006:500) which entailed reflection and the continuous professional development of A&E practitioners. The explorative design illuminated the underlying process of the phenomena being studied (Polit & Beck 2006:21).

The study had to be explorative in nature as the researcher wished to explore phenomena of which little is known (Babbie 2005:89). The researcher explored the dimensions of the research problem through the completion of a naïve sketch and the use of a focus group with clinical facilitators and experts in the field of nursing education with an interest and/or experience in the use of reflection and a literature review.

3.2.3 Descriptive design

The descriptive design was used because little was known about the focus of the phenomena (Polit & Beck 2006:19). The descriptive design assisted the researcher to identify and understand the nature of the phenomena under study (Burns & Grove 2005:733). The study was descriptive as it intended to describe the phenomena accurately within the context and was based on the data collected during the focus group.

3.2.4 Contextual design

The contextual design denotes the environment and the circumstances in which the study took place (Burns & Grove 2005:732; Holloway & Wheeler 2002:34). The focus of this study was the A&E environment and especially the A&E practitioners, who have completed a post-basic qualification in

A&E nursing. Contextual data was collected from clinical facilitators, lecturers of the A&E programme, and experts in the field of nursing education with an interest and/or experience in the use of reflection.

3.3   RESEARCH METHODOLOGY

Research methodology entails "*the entire strategy for the study*" from beginning to end (Burns & Grove 2005:211). Research methodology according to Polit and Beck (2006:509) entails "*techniques used to structure a study and to gather and analyse information in a systematic fashion*".

The research methodology emerged as the researcher made choices and took action in order to answer the research questions (De Vos, Strydom, Fouché & Delport 2003:272; Newell & Burnard 2006:22). According to Newell and Burnard (2006:22) the methodology has to be "*practicable*" and fall "*within the expertise of the researcher*". Qualitative research methodology is both flexible and evolving as the researcher explores the depth, richness and complexity inherent to the identification of components for a structured reflective tool that would enhance the continuous professional development of A&E practitioners (Burns & Grove 2005:52). In order to answer the research questions the population was identified.

3.3.1   Population

A population is defined as "*a set of individuals having some common characteristics*" (Polit & Beck 2006:506). The population included A&E clinical facilitators and the experts in the field of nursing education with an interest and/or experience in the use of reflection in Gauteng. The reason for using this population was because the researcher is of the opinion that this population could further illuminate the phenomena under study (Holloway & Wheeler 2002:157).

3.3.2   Sampling

Sampling takes place from the identified population. Burns and Grove (2005:750) states that sampling entails the "*selection of groups of people with which to conduct a study*". The selection of participants from the population ensured that justifiable conclusions could be drawn from the data collected (Saks & Allsop 2007:157). The research methodology, urged the researcher to locate a homogeneous sample (De Vos et al. 2003:274). A homogeneous sample is the result of the researcher deliberately involving participants with similar traits and characteristics (Holloway & Wheeler 2002:286; Polit & Beck 2006:501).

In order to locate a homogeneous sample, snowball or network sampling, a form of non-probability sampling, was used (Burns & Grove 2005:353). Snowball sampling involves people in a particular community who can direct the researcher to potential sources of further information (Newell & Burnard 2006:59). This led the researcher to take advantage of the social networks in the A&E environment in order to obtain A&E clinical facilitators and experts in the field of nursing education and training as well as those with an interest and/or experience in the use of reflection for the sample. The researcher then contacted the A&E clinical facilitators and the experts which were thus identified.

3.3.3   Sampling size

There are rigorous instructions on sampling size in qualitative research literature (Newell & Burnard 2006:60; Polit & Beck 2006:273). Participants are selected for their expertise and experience (Streubert Speziale & Carpenter 2007:29). According to Bowling (2007:379) small sample sizes are used when the data collection method involves interviewing. The reason for the small sample is because the analysis of the data via interviewing is a "*complex, expensive and time consuming*" process (Bowling 2007:380). However the sample must be able to provide rich perceptions on the phenomena under study (Bowling 2007:380).

Sampling continues until data saturation is achieved (Polit & Beck 2006:273). Data saturation implies that there is "*sampling to the point at which no new information is obtained*" (Polit & Beck 2006:273).

An invitation to participate in the focus group was extended by telephone to seven potential participants with the characteristics identified for the purpose of the research.

3.4   DATA COLLECTION

A naïve sketch and focus group were used to collect data with the intention to better understand how the A&E clinical facilitators and the experts in the field of nursing education with an interest and/or experience in the use of reflection view the use of reflection for continuous professional development.

3.4.1   Naïve sketch

The naïve sketch is a data collection method similar to open-ended questions. It was developed in phenomenological orientation according to Giorgi (1985:1). In keeping with the research design and objectives, naïve sketches were beneficial towards the context of the research (Giorgi 1985:1).

The naïve sketch contains open-ended questions that focus group participants were asked to complete in writing as suggested by Vogel (2003:43). This initiates attentiveness to the questions posed in the focus group (Giorgi 1985:3). The integration of the naïve sketch into the focus group is discussed in detail in section 3.4.2

3.4.2   The focus group

As stated by Pope and Mays (2006:21) a focus group is a "*group interview that capitalises on communication between research participants to generate data*". Focus groups were initially used in marketing research but in recent times it has become popular as a data collection tool for qualitative nursing research (Burns & Grove 2005:542; Hopkins 2007:528). The purpose of the focus group was to use experts to guide the researcher to generate data regarding the research questions.

The focus group relied on the dynamics of the group to facilitate research participants to communicate and explain their views in ways that do not always occur in one-to-one interviews (Burns & Grove 2005:542). The data was produced through social interaction where the participants were provided with opportunities to remember forgotten thoughts and feelings and generate spontaneous insights to build on answers of other participants (Holloway & Wheeler 2002:117; Pope & Mays2006:21). Therefore the focus group was conducted with a homogeneous sample, which works better than a heterogeneous sample (McLafferty 2004:193).

The data collected produced large volumes of concentrated data in a short time frame (De Vos et al. 2003:307). On the other hand McLafferty (2004:193) is of the opinion that a focus group is a "*time-consuming data collection strategy*". Even though a focus group discussion was time-consuming, it was regarded as a strategy that provided a rewarding richness in the data collected (McLafferty 2004:193).

There are guides as to the size of the focus group. Polit and Beck (2006:292) states that a focus group should consist of five to ten people. De Vos et al. (2003:311) claims that a small group of four to six participants is preferable, specifically when they have a great deal to share. If the group is too big it can become disorderly as well as increasing the difficulty of data analysis. Pope and Mays (2006:21) set the

size of the focus group between four and eight people. In this study the focus group consisted of four participants.

3.4.2.1   Preparation for the focus group

The researcher made the initial contact with the potential participants by telephone and gave a short introduction about the aim and objectives of the study. A follow-up telephone call to remind potential participants of the time, place, purpose and importance of the focus group was made two days before the scheduled meeting as suggested by Holloway and Wheeler (2002:114).

The researcher had no experience in the conduct of a focus group and therefore recruited an expert independent facilitator to lead the discussion as advised by Holloway and Wheeler (2002:115). The focus group facilitator was a specialist in the field of psychiatric nursing with vast experience in focus group management techniques as proposed by Burns and Grove (2005:544). The researcher and the focus group facilitator had a meeting two days prior to the focus group discussion to clarify the questions to be asked during the focus group. The focus group facilitator also guided the researcher about her role as the fieldworker and the process of taking field notes.

On the morning of the focus group the researcher ensured that there were clear directions to the venue from the entrance of the building so that participants would not get lost. The venue was prepared in such a way that the participants sat around a table, enabling them to make eye contact with everybody attending as recommended by Burns and Grove (2005:543; Kitzinger 2006:26). The equipment set up included two audio recorders which were used in order to ensure that loss of data was kept at a minimum. Refreshments were also supplied.

3.4.2.2   Conducting the focus group

Four of the seven participants invited to the focus group attended the session. The participants were welcomed by the researcher and provided with refreshments as well as an information letter, consent form and a naïve sketch (see Annexure C). The naïve sketch contained the exact questions that were discussed during the focus group:

- What are your views on reflection as a learning strategy to facilitate CPD of A&E practitioners?
- What should be included in a reflective tool as a learning strategy for A&E practitioners?

Participants seated themselves around the table. The focus group facilitator set the mood of the group by creating a non-threatening, comfortable, accommodating environment as recommended by Burns and Grove (2005:542). All the participants were either in the process of completing a master's degree or doctorate or had completed their master's or doctorate studies. Because of this there was good camaraderie between all the participants (Bowling 2007:395).

The facilitator commenced the focus group by extending a warm welcome to all of the participants and thanked each one for their willingness to participate. She explained the purpose of the focus group and informed the participants of the expectations. The first part of the focus group would take 30 minutes in order to complete the naïve sketch and then a discussion would follow on exactly the same questions. The purpose of the naïve sketch was to allow the participants to organise their thoughts and clarify any misconceptions (Giorgi 1985:3).

The researcher was introduced and the participants were informed that the focus group discussion would be recorded (De Vos et al. 2002:304). The researcher also explained the research aim and objectives as well as the A&E unit as context in which the data will be utilised once the study is

completed. Written consent for this was obtained from the participants (Polit & Beck 2006:93). The participants were made aware of their rights as participants especially the right to withdraw at any time (Polit & Beck 2006:89) and that anonymity was ensured.

The participants were left in the room to allow them to complete the questionnaire containing the same questions discussed during the focus group.

The researcher and focus group facilitator returned to the room after 30 minutes. The focus group facilitator explained that the focus group discussion was going to start and explained the role of the researcher as fieldworker. The role of the fieldworker included taking notes about the seating arrangements, the order in which participants spoke to assist with voice recognition, non-verbal actions such as eye contact, gestures between group members or fidgeting, striking themes and as much of the conversation as possible as suggested by De Vos et al. (2002:317-318).

The facilitator continued and explained the ground rules and the fundamentals the focus group discussion was based on (Freeman 2006:495). For ground rules see Annexure D.

The focus group facilitator skilfully guided the participants to stay focused and get closure on the questions as advised by Polit and Beck (2006:292) and Burns and Grove (2005:544). The focus group facilitator also prompted some of the participants who were not as assertive as others to share their opinions (Holloway & Wheeler 2002:115). The facilitator gave a summary after each question was discussed to enable participants to verify the outcomes or disagree with them (Holloway & Wheeler 2002:117).

One of the participants had to withdraw from the focus group during the second question session due to personal reasons. The focus group lasted two and a half hours, with one break during which refreshments were served.

3.5   DATA ANALYSIS

Data analysis denotes "*exploration of the meaning of data through processes of organisation, reduction and transformation*" (Holloway & Wheeler 2005:291). The data analysis was done in order to arrange the data collected in a meaningful way (De Vos et al. 2002:339). The data analysis required flexible and creative procedures to ensure the essence of the data was reflected (Holloway & Wheeler 2002:235). The entire focus group discussion was recorded and then transcribed verbatim (Pope & Mays 2006:63) and typed by the researcher. The transcription represents precise details of what "was said and done" during the focus group (Pope & Mays 2006:63).

The transcribed data comprised of data collected from the naïve sketches, focus group discussion and the field notes. The transcription included laughter and pauses. A large margin was left on transcripts for coding and categorising of data (Taylor-Powell & Renner 2003:6; Holloway & Wheeler 2002:116). See Annexure E for an extract from the transcription. Coding of data implies that data is sorted into themes that emerged from the data during the analysis process (Bowling 2007:387).

The transcribed data was then sent to an independent coder who is familiar with the coding of qualitative research. Bowling (2007:387) declares that data should be categorised by the researcher and an independent coder. The independent coder signed a confidentiality agreement (see Annexure F) and commenced with the task. The researcher simultaneously commenced with the data analysis with the aim to become immersed in the data and identify themes and patterns in the data collected as suggested by Holloway and Wheeler (2002:238).

The data was analysed using the steps as set out by Taylor-Powell and Renner (2003:1-5) and Tere (2006:1). The steps are as follows:

- Step 1: *"Get to know your data"* (Taylor-Powell & Renner 2003:2). Data was read and re-read and recordings were listened to several times. This allowed the researcher to become immersed in the data and sensitised to important issues (Holloway & Wheeler 2002:236; Pope & Mays 2006:69)

- Step 2: *"Focus the analysis"* (Taylor-Powell & Renner 2003:2). Data was sorted in such a way that all the data gathered for each question was put together namely the naïve sketches, transcripts of the questions and the field notes (Taylor-Powell & Renner 2003:2; Tere 2006:1). The raw data cannot offer explanations and therefore the researcher needs to scrutinise the data in order to make sense of the data collected (Pope & Mays 2006:65)

- Step 3: *"Categorise information"* (Taylor-Powell & Renner 2003:2). Line by line coding was done using words and phrases as used by participants to create *'in vivo codes'* (Holloway & Wheeler 2002:239). The use of the participant's own words ensured that the researcher did not impose her own ideas and framework on the data (Holloway & Wheeler 2002:239). These codes where reduced to represent themes found in the data (Holloway & Wheeler 2002:239). The data was read and re-read to ensure that data and themes were accurately categorised (Taylor-Powell & Renner 2003:3).

- Step 4: *"Identify patterns and connections within and between categories"* (Taylor-Powell & Renner 2003:5). The data was summarized in order to capture connections and contrasts in participants' responses within the themes (Taylor-Powell & Renner 2003:5).

- Step 5: *"Interpretation – bringing it all together"* (Taylor-Powell & Renner 2003:5). A list was assembled containing important findings made during the categorising of data. The researcher and the independent coder had a contact session to compare themes that were discovered during the data analysis. Themes identified were

comparable, only the words used to describe the themes were different, but the crux was the same.

The data was sorted in themes, categories, clusters and sub-clusters (see Figure 4.3). The researcher and the independent coder compared and discussed the categorisation and agreed on themes, categories, clusters and sub-clusters (Bowling 2007:387).

The researcher discussed the identified themes, categories, clusters and sub-clusters with the supervisors. Once consensus was reached with the researcher's supervisors, the researcher returned to the participants and asked them to review the findings in order to enhance the credibility of the study by means of member checking.

3.6 ESTABLISHING TRUSTWORTHINESS

Trustworthiness is defined by Polit and Beck (2006:511) as "*the degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability and conformability*". The establishment of trustworthiness is necessary to confirm that the research outcomes are the truth and will enhance the professional practice (Holloway & Wheeler 2002:250). The model of Lincoln and Guba (1985:289-311) was implemented to ensure validity and reliability. The model uses four constructs credibility, transferability, dependability and conformability (Lincoln & Guba 1985:301-319; Streubert Speziale & Carpenter 2007:49). The constructs will be defined and application thereof is summarised in Table 3.1: Strategies to ensure trustworthiness.

3.6.1 Credibility

Credibility pertains to the activities to ensure that the study describes the research problem truthfully (De Vos et al. 2003:351; Lincoln & Guba 1985:301). "*Credibility is demonstrated when participants recognise the reported research findings as their own experiences*" (Streubert Speziale

& Carpenter 2007:458). The activities include prolonged engagement, persistent observation, triangulation, referential adequacy, peer debriefing and member checks (Lincoln & Guba 1985:301-316).

- *Prolonged engagement*, according to Polit and Beck (2006:332) "*is the investment of sufficient time in data collection activities to have an in-depth understanding of the culture and views of the group under study and to test for misinformation*". Polit and Beck (2006:332) continues stating that prolonged engagement will assist in building a trusting relationship between the researcher and participants. In this study the researcher was actively involved in the A&E unit and was responsible for the clinical facilitation of personnel at the time of data collection

- *Persistent observation*: Data collected credibly involves persistent observation which "*refers to the researcher's focus on the aspects of a situation that are relevant to the phenomena being studied*" (Polit & Beck 2006:333). The purpose of persistent observation according to Lincoln and Guba (1985:304) is to "*identify those characteristics and elements in the situation that are most relevant to the problem and focusing on them in detail*"

- *Triangulation*: Polit and Beck (2006:511) explains triangulation as "*the use of multiple methods to collect and interpret data about a phenomenon so as to converge on an accurate representation of reality*". In this study data was collected via naïve sketch and a focus group discussion and the data was analysed by the researcher and an independent coder

- *Referential adequacy*: According to Lincoln and Guba (1985:313) the raw data collected must be adequate to allow "*later analysis and interpretations*". In this study the focus group discussion was digitally recorded and transcribed verbatim ensuring that the raw data can undergo further analysis and interpretation

- *Peer debriefing*: According to Polit and Beck (2006:333) it "*is a session held with objective peers to review and explore various aspects of the inquiry*". The researcher made use of expert supervisors in order to gain insight and different points of view. Data collected was analysed by an independent coder who was completely objective towards the study

- *Member checks*: Polit and Beck (2006:334) states that member checking involves requesting study participants to react on initial findings and understanding of data analysis. Study participants were contacted via e-mail to comment on preliminary study findings

3.6.2 Transferability

Transferability denotes the extent to which findings of the study can be applied to other contexts (Lincoln & Guba 1985:316). According to Polit and Beck (2006:336) transferability also refers to the sampling and design of the study. The findings of the study can be applied in other contexts as it addresses the issue of making reflection more practicable in the clinical setting. Steps taken to ensure transferability include thick description and purposive sampling (Lincoln & Guba 1985:316).

- *Thick description* refers to a "*rich, thorough description of the research setting, and the transactions and processes observed during the inquiry*" (Polit & Beck 2006:336). In this study the researcher presented a thick description of the setting, participants involved in the study, method of data collection and methodology. A comprehensive transcription of data was also available. When is it a thick description and when a dense description? Compare with Ch 1 and par 3.6.3. below

- *Purposive sampling*: According to Polit and Beck (2006:507) this entails "*a non-probability sampling method in which the researcher selects participants based on personal judgment about who will be*

most informative". Snowball sampling is an example of purposive sampling and the sampling process was discussed in detail in 3.3.2 and 3.3.3

3.6.3 Dependability

Dependability entails that the study findings are truthful and reliable (Holloway & Wheeler 2002:255). According to Lincoln and Guba (1985:316) and Streubert Speziale and Carpenter (2007:49) demonstrating credibility is sufficient to also exhibit dependability. The researcher will provide evidence on how the conclusions were reached (Holloway & Wheeler 2002:255). This will guide other researchers embarking on an analogous study (Holloway & Wheeler 2002:255). To ensure dependability the researcher implemented the following: dependability audit, dense description, triangulation, peer examination and code-recode procedure (Lincoln & Guba 1985:316-318).

- *Dependability audit*: Entails the assessment of truthfulness of study results (Holloway & Wheeler 2002:255). Personal logs and field notes will be kept to ensure that decision-making processes can be evaluated. The service of an independent coder was used to ensure that data analysis results were objective and accurate

- *Dense description*: The researcher provided a comprehensive description (Polit & Beck 2006:44) of the research methodology to ensure that should other researchers undertake a similar study, the research methodology can be refined or used in the same way

- *Peer examination*: As suggested by Lincoln and Guba (1985:318) the researcher made use of expert supervisors to reinforce dependability of the study

- *Code-recode procedure*: Polit and Beck (2006:401) advised that the data is coded by an independent coder and the researcher. The results were discussed between the mentioned parties. After the discussion and review of the results, it was discussed with the expert supervisors and consensus was reached

3.6.4   Confirmability

Confirmability refers to the objectivity of the data (Polit & Beck 2002:336). To ensure confirmability the researcher made use of an independent coder and an expert supervisor (De Vos et al. 2003:352). Bracketing further enhanced confirmability. Bracketing 'is the cognitive process of putting aside one's own beliefs, not making judgements about what one has observed or heard and remaining open to data as they are revealed' (Streubert Speziale & Carpenter 2007:27). The process of bracketing is important 'if the researcher is to share the study participant's views of the studied phenomena' (Streubert Speziale & Carpenter 2007:28). Bracketing was an ongoing process and the researcher was attentive not to allow predetermined ideas to direct the study.

Table 3.1: Strategies to ensure trustworthiness

Strategy	Actions	Application of criteria
Credibility	Prolonged engagement	Researcher's profile: -actively involved in A&E nursing -actively involved in clinical facilitation and personal and professional development of A&E nurses -various positions in the emergency environment (pre-hospital, A&E unit, management, clinical facilitator and lecturer)
	Persistent observation	-following a process of constant and tentative analysis
	Triangulation	-conducting a literature review -conducting a focus group interview (FGI) -using an independent coder -using experts to validate data
	Referential adequacy	-use of audio tapes -obtaining extensive field notes -verbatim transcripts -debriefing summaries
	Peer debriefing	-independent coder -expert supervisors
	Member checks	-data obtained validated by FGI participants
Transferability	Thick transcription	-provide rich, comprehensive transcription of data obtained -provide research methodology
	Purposive sampling	-purposively selecting participants -obtain maximum quantity of specific information
Dependability	Dependability audit	-personal logs and field notes will be kept -use of independent coder
	Dense description	-describing research methodology comprehensively
	Triangulation	-comparing independent coder's data analysis with researcher's version to ensure correctness -using more than one source of data
	Peer examination	-expert supervisors -independent coding
	Code-recode procedure	-a consensus discussion between coder, researcher and supervisors
Conformability		-using independent coder -using expert supervisors

3.7 ETHICAL CONSIDERATIONS

In research there are moral principles governing the manner in which the research takes place. The study involved human subjects and the researcher aimed to protect the participants (Holloway & Wheeler 2002:47). Careful attention was therefore given to ethical considerations described by the Belmont Report quoted by Polit and Beck (2006:86). Detailed discussions regarding ethical considerations also appear in Holloway and Wheeler (2002:47-66), De Vos et al. (2002:62-76) and Burns and Grove (2005:176-208). The following ethical principles were adhered to in this study:

3.7.1 Principle of beneficence

The researcher has a responsibility to above all do no harm (Burns & Grove 2005:190). This is the most basic ground rule of research. This principle's scope and its application in the study were as follows:

3.7.1.1 Protection from harm and discomfort

Discomfort and harm can be physical, emotional, social or financial (Polit & Beck 2006:87). The researcher predicted only temporary discomforts, which entail no more discomfort than ordinary life (Burns & Grove 2005:190). The participants were informed well in advance of the focus group discussion to enable them to make prior arrangements. The researcher conducted the research in a safe environment and ensured that the questions were phrased in such a way that they would not impose any harm.

3.7.1.2 Protection from exploitation

The researcher assured the participants that information they shared would not be used against them in any manner (Polit & Beck 2006:88). The researcher assessed the risk/benefit ratio and therefore used an

expert facilitator to conduct the focus group to ensure that the data collection process minimised emotional harm (De Vos et al. 2002:313). It is the researcher's honest opinion that the research will benefit the A&E profession as well as users of health care.

3.7.2 Principle of respect for human dignity

The researcher held the belief that participants are human beings who have the right to make their own decisions and express their personal opinions (Polit & Beck 2006:88). The principle of respect for human dignity implies the following:

3.7.2.1 The right to self-determination

The right to self-determination was assured by informing the participants that their participation was voluntary and that they could refuse to divulge any information at any stage of the research (Polit & Beck 2006:88-89). The participants were also informed that they could ask for explanations on any aspect of the study at any time (Polit & Beck 2006:89).

3.7.2.2 The right to full disclosure

The participants received an information letter detailing the nature of the study and the role of the researcher (Polit & Beck 2006:89). The researcher emphasised the right of all participants to decline participation in the study at any time without the risk of being discriminated against (Polit & Beck 2006:89).

3.7.3 Principle of justice

The principle of justice signifies the right to fair and equal treatment to all participants of the research (Polit & Beck 2006:90). This principle entails the following:

3.7.3.1   The right to fair treatment

The study participants were selected based on research requirements and the value they would add to the research subject (Polit & Beck 2006:90). Purposive participants who refused to partake in the study were not treated with unfairness nor were participants who withdrew from the study (Polit & Beck 2006:91). The researcher ensured the participants that agreements entered into during the study would be honoured and that they would all be treated with respect and consideration (Polit & Beck 2006:91).

3.7.3.2   The right to privacy

The researcher made all participants aware of their right to privacy through the information letter before the commencement of the focus group. The researcher deemed the disclosure of this right as imperative as the participants were to divulge their personal attitudes, beliefs and opinions regarding reflection (Burns & Grove 2005:186). During the transcription of data collected all participants were assigned a random alias. Only the researcher has access to the true identities of the participants. The participants were also informed of the fact that their identities would not be disclosed during the publication of study findings.

3.7.4   Informed consent

All participants received an information letter stating the nature of the study and expectations. A confirmation of consent form was attached to the letter. The researcher allowed the participants to read the letter and they were given the opportunity to clarify facets that were unclear (Burns & Grove 2005:195). The participants were all in agreement and completed the confirmation of consent. The informed consent attachment was removed from the letter and handed back to the researcher. These consent forms were kept in a safe place by the researcher.

3.7.5 Confidentiality

In order to protect the participants the data collected from the focus group discussion was transcribed by the researcher. When a person was addressed by their name, the researcher replaced the name with an alias as discussed in 3.7.3.2.

The researcher made use of an external independent coder who signed a confidentiality agreement.

3.8 ACTIONS AND COMPETENCE OF THE RESEARCHER

The researcher has the responsibility to be competent and adequately skilled before, during and after the study (De Vos et al. 2002:69). The researcher therefore completed a postgraduate programme in research methodology. Periodic meetings and discussions with expert supervisors ensured further competency.

3.9 PUBLICATION OF FINDINGS

The research findings will be published in order to encourage the application thereof in the clinical setting (De Vos et al. 2002:72). The researcher and expert supervisors ensured that the final research report was impartial, transparent and exact (De Vos et al. 2002:72). To convey the researcher's appreciation to all participants they will be informed of the research findings without breaching the confidentiality agreement.

3.10 CONCLUSION

The chapter described the research design and methodology. Data was obtained by means of a focus group with the intention to extract responses relevant to the research problem from the specifically selected participants. An independent coder and the researcher did the data

analysis. The participants were assigned random aliases to ensure that confidentiality remains intact.

CHAPTER 4

DATA ANALYSIS AND FINDINGS

"You have to lead people gently toward what they already know is right."

Philip Crosby

4.1. INTRODUCTION

In this chapter, the analysis of data obtained trough the naïve sketches and focus group are discussed. Results were interpreted and sorted in themes, categories, clusters and sub-clusters.

During the data analysis three main themes were identified.

- Theme one: Reflection
- Theme two: Prerequisites for implementing the structured reflective tool
- Theme three: The components for the structured reflective tool

Figure 4.1 provides an outline of themes, categories, clusters and sub-clusters. Each theme, its categories, clusters and sub-clusters will be discussed in detail. This discussion includes verbatim transcripts supporting the discussion. Literature relevant to the data is provided as literature control.

Figure 4.1: Summary of data analysis
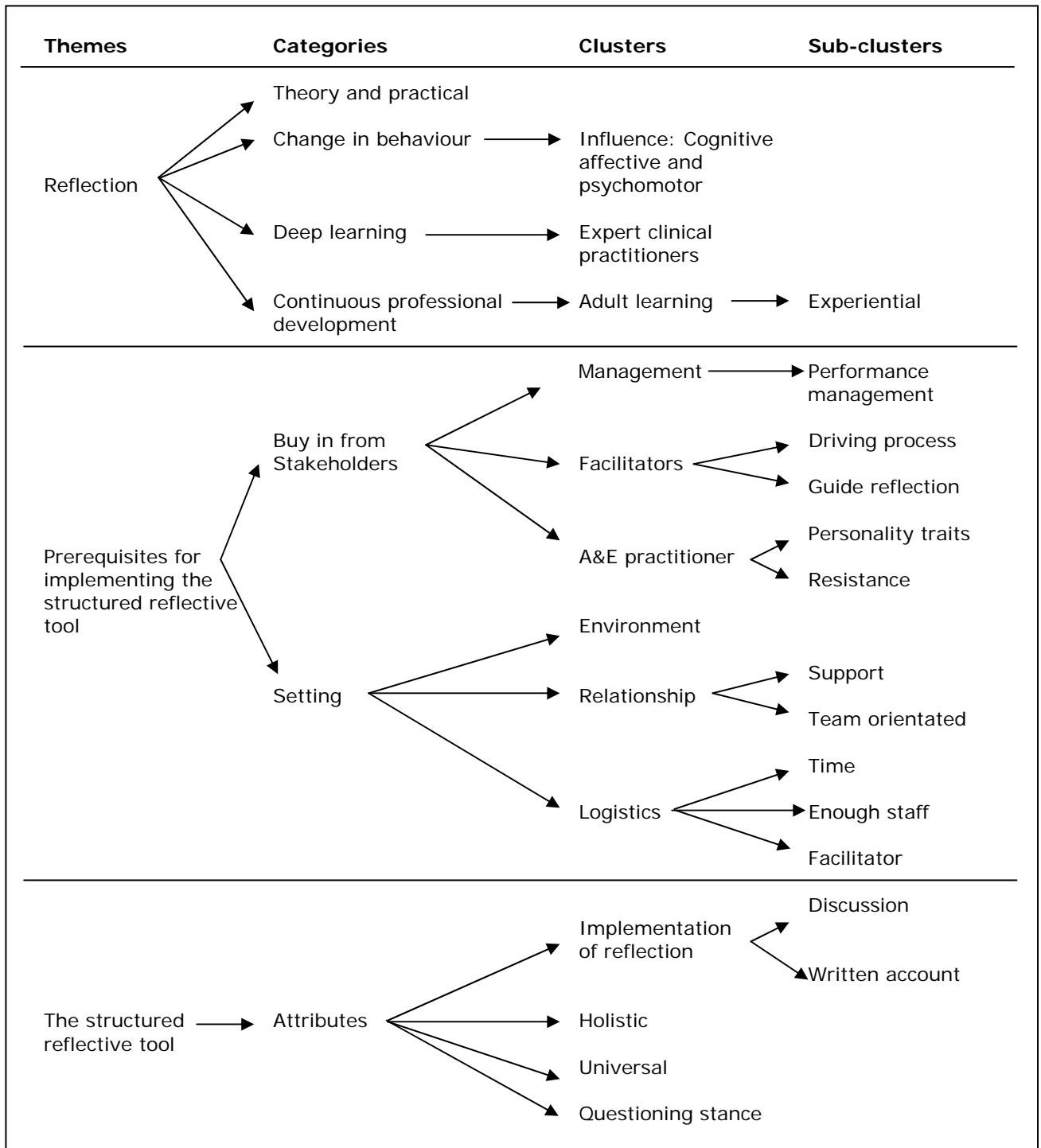
4.2   OVERVIEW OF PARTICIPANTS OF THE FOCUS GROUP

Four selected individuals participated in the focus group. Their biographical data is summarised in Table 4.1. All participants of the focus group were female and had at least one post-basic qualification. Two of the participants of the focus group were actively involved in training A&E practitioners with one of them having daily contact with A&E practitioners. The other two participants were experts in the use of reflection as a learning strategy. The experience of the participants of the focus group ranges from two to nine years.

A summary of the data analysis was sent to participants (see Annexure G). All participants responded to the enquiry and agreed on the themes, categories, clusters and sub-clusters.

Table 4.1: Biographical data of focus group participants

Gender	Academic qualifications	Current post held	Field of speciality	Experience in utilising reflection as a learning strategy	Clinical facilitator in A&E nursing	A&E lecturer	Expert in the field of nursing education with an interest and/or experience in the use of reflection
Female	• B Cur (IetA): Clinical	• A&E clinical facilitator	• Trauma and Emergency • Critical Care Nursing Science	3 years	Yes	No	Diploma in Nursing education
Female	• MA Health Sciences • BA Hon (CL) • B Cur	Lecturer	• Critical Care Nursing • General and Surgical Nursing	9 years	No	No	Yes
Female	• B Cur • B Cur Ed et Admin • Diploma in Critical Care Nursing • Diploma in Trauma and Emergency Nursing • M Cur – Research Methodology	Lecturer	• Trauma and Emergency Nursing • Nursing Education	2 years	No	Yes	No
Female	• PhD	Lecturer	• Neonatal Nursing • Nursing Education	7 years	No	No	Yes, both

4.3 THEME 1: REFLECTION

The first theme *reflection* deals with the views of the members of the focus group regarding reflection as a learning strategy to facilitate the continuous professional development of A&E practitioners. One respondent stated that:

> "*...reflection is something we have been doing for a long time, without realising it... it is an important part of every person, learner or not...*"

McBrien (2007:129) argues that reflection is deliberate learning and that the practitioner consciously considers an experience in order to acquire different perceptions, which in due course will augment professional practice. The enhancement of professional practice is as a result of the meticulous intellectual practice that is encouraged by reflection (Williams 2001:30). A&E practitioners can generate a rich comprehensive knowledge foundation through reflection (Gaye 2005:59; Walker 1996:29). However, even though reflection has long been advocated as an important developmental tool in nursing education, the use of reflection on qualified nurses does not receive the same attention (Walker 2007:1).

Yet according to Mamede and Schmidt (2004:1303) reflection conforms to contemporary psychological theories that try to explain the development of professional expertise. The application of reflection however is considered challenging as is evident from the following quotation:

> "*...(reflection is) very important, but also very difficult to implement...*"

There is no explicit comprehension of how reflection really works and if all participants of reflection benefit from it (Lockyer, Gondocz & Thevierge 2004:55). Practitioners need to develop reflective skills and understand reflective processes (Atkins & Murphy 1993:1191; Markham 2002:286). The way to develop and understand reflective processes is not clear therefore reflection can become an academic exercise instead of a developmental strategy (Lockyer et al. 2004:55; Duke & Appleton 2000:1565). The literature nevertheless embraces reflection as a means to develop competent professional nurses (Williams 2001:33).

Reflection has been integrated in the health profession in general and specifically nursing in order to illuminate the decision-making processes during practice (Mantzoukas 2008:219).

The way participants view reflection as a learning strategy is captured in the following quotations:

"...I feel reflection can be valuable as a learning strategy..."

"...so this is a very good strategy that you have here but there's a way of implementing it I think it's... it's positive I really think there's a place for it..."

"...but is sounded to me as if most of you agree that it can be a very valuable strategy in terms of the um... the holistic component thereof..."

"...I think is a very difficult thing to do as a learning strategy and what I understand we are... your focus is on post-basic people who are already trained... so (they are) not learners, and that is another point if that for reflection as a strategy to enhance learning to maintain skills to work that person must be a lifelong learner..."

Phillips, Fawns and Hayes (2002:240) describe reflection as a teaching and learning strategy that assists theory-practice correlation and aids the formation of personal professional identity.

The participants however stated that reflection should not be used as a learning strategy in isolation.

> *"…it must be something that is in cohesion with something else you can not use it as learning strategy on its own…"*
>
> *"…I think we said it in the beginning you cannot use it alone you… it has to be in cohesion with a lot of things. If I listen to all of us it has to be in cohesion with relationships with um… environment um… teamwork…"*
>
> *"…it cannot be a strategy in isolation to enhance professional skills… in professionals because if they are just gonna reflect, reflect, reflect but nobody gives themselves a basis of learning on the newest… 'weet'… clinical practice and evidence based practice they are going to reflect on where they were in skills…"*

An alternative learning strategy was not mentioned during the focus group discussion. From the literature it is clear that facilitators need to be flexible and context bound during the facilitation of continuous professional development (Stetler, Lergo, Rycroft-Malone, Bowman, Curran, Guihan, Hagedorn, Pineros & Wallace 2006:35; Holdsworth, Belshaw & Murray 2001:450). Therefore the insightful facilitator will be aware of the fact that different learning strategies can unearth different categories of knowledge (Landmark, Hansen, Bjones & Bohler 2003:840).

The categories, clusters and sub-clusters that emerged from the data analysis under the theme reflection are summarised in Table 4.2.

Table 4.2: Categories, clusters and sub-clusters that emerged under the theme: Reflection

Categories	Clusters	Sub-clusters
4.3.1 Theory and practice correlation		
4.3.2 Change in behaviour	4.3.2.1 Influence: Cognitive, affective and psychomotor	
4.3.3 Deep learning	4.3.3.1 Expert clinical practitioners	
4.3.4 Continuous professional development	4.3.4.1 Adult learning	4.3.4.1.1 Experiential learning

4.3.1   Theory and practice correlation

The participants were of the opinion that reflection will assist with theory-practice correlation as contained in the extracts below:

"*…reflection is important during exam time, as the learner can go back to past work experience and incorporate it into the theoretical aspect of emergency nursing (A&E practitioners)…*"

"*…correlation of theory and practice - using knowledge and skills…*"

"*…it's not only learning the theory but many experiences in practice that can correlate the theory and practice and also the affective component through the theory and the practice so it makes it more holistically – structured tool or uh… reflection…*"

Reflection connects theory and practice in such a way that clinical judgement is explicated (Smith & Jack 2005:36). Because there is a

deliberate use of theory in practice, quality service delivery is ensured (Walker 1996:28).

4.3.2   Change in behaviour

The fact that reflection assists in theory-practice correlation indicates that learning takes place. The learning that takes place will inevitably change the A&E practitioners' behaviour as identified by the statements below.

"…using reflection different cognitive, affective and psychomotor skills could be changed…"

"…I see learning as change and if you can't reflect on something and if you are unable to "create" your own, not only your own knowledge and also your emotions too…"

"…learning for me is change of behaviour if you have changed your behaviour you have learned…" "…I think that… that is where reflection as a strategy could support change of behaviour. Change that person as an individual…"

"…look if they changed their behaviour then you will know that they are reflective. Their attitude towards this will determine if your strategy was effective…"

"…reflection is the ability to combine the knowledge and skills and your emotions, your personal experience, your new theory that you learned. You combine all of these and create change either within yourself or in practice…"

The assumption that reflective learning will change behaviour is supported by Glaze (2001:645). Reflection arouses awareness that practice is either appropriate or unsatisfactory (Walker 1996:219). The A&E practitioner will therefore become cognisant of new viewpoints and possible actions and change behaviour accordingly to benefit the patient (Lockyer et al. 2004:53; Mantzoukas 2008:219; Atkins & Murphy 1993:1190). Profound reflection on clinical practice is essential to grasp the reality of practice and bring about change (Nelville 2004:133). A&E practitioners must consequently reflect on their approach to practice, to pinpoint shortcomings and strong points and continuously develop skills (Leppa & Terry 2004:196).

4.3.2.1   Influence: Cognitive, affective and psychomotor

With the use of reflection, learning takes place in either the cognitive, affective or psychomotor domain. This learning then influences the other domains leading to new knowledge (Lockyer et al. 2004:51).

The cognitive domain is concerned with the acquisition of knowledge relating to the process of acquiring knowledge by the use of reasoning, intuition, or perception (Encarta 2003).

The affective domain relates to the psychology of emotional expression relating to an external expression of emotion associated with an idea or action (Encarta 2003).

The psychomotor domain is associated with the physical and mental activity relating to bodily movement triggered by mental activity, especially voluntary muscle action (Encarta 2003).

The focus group participants made the following comments:

> *"…looking back and discussing what have happened and what did you learned from the situation may bring about change…"*
>
> *"…this type of learning is learning that take place and may influence behaviour, which is what one really aims for…"*
>
> *"…reflection then focuses on practice and affective component that is enriched…"*

Reflection creates a motivating educational environment where shortcomings are handled as opportunities for improvement of future care (Walker 1996:30).

One participant stated:

> *"…(A&E practitioners)… do not… view structured reflection as necessary it is a very skills orientated environment and emotions do not play a role…"*

Stuart (2003:218) clearly declares that learners all bring their presumptions, experience, thoughts and feelings to clinical practice and this preconceived knowledge influences the way that a situation is analysed and acted upon.

4.3.3 Deep learning

The learning that takes place depends on what approach the adult learner takes. If the adult learner only memorises information so that it can be

reiterated for the purpose of passing examinations it is a surface learning approach (Lowe & Kerr 1998:1031). This will lead to demotivation and the adult learner will not be interested to attain hands-on experience (Zang 2004:77). The adult learner that engages in deep learning thinks creatively and investigates all possible outcomes (Zang 2004:77). This can ensure that the adult learner will be equipped to apply knowledge gained, in different situations and future practice.

A participant commented as follows:

> "...but with reflection... um... it is really deep learning that take place..."

Lockyer et al. (2004:55) and Lowe and Kerr (1998:1031) are of the opinion that reflection is the medium to transfer superficial learning into deep learning.

4.3.3.1   Expert clinical practitioners

The A&E practitioner works within an area of specialisation and therefore needs to be an expert clinical practitioner. The diverse environment demands that A&E practitioners are proficient in a wide variety of clinical skills based on expert and general nursing knowledge (Walker 1996:29).

The following statement was made during the focus group:

> "...reflection is absolutely worthwhile to develop clinical specialists and leaders..."

Expert practitioners utilise knowledge and skills in a multifaceted way, creating a sphere where theory and practice cannot be detached (Durham & Hancock 2006:256). Reflection can enable A&E practitioners to unravel deep-rooted knowledge used in clinical practice (Durham & Hancock 2006:248). A&E practitioners need to develop and practice reflection to ensure that all actions and knowledge will be validated against best practice guidelines (Walker 1996:30). Reflection therefore has the capacity to foster continuous professional development, which will encourage A&E practitioners to expand their foundation of knowledge ultimately benefiting the patient (Walker 1996:30).

4.3.4   Continuous professional development

Continuous professional development is synonymous with lifelong learning (Tabriz University of Medical Sciences 2002: 10). This is essential for the nursing profession, which is in a state of constant change (Gustafsson & Fagerberg 2004:272). The participants of the focus group were well aware of the fact that continuous professional development is important for clinical practice as evident in the following statements:

"…therefore reflection could assist A&E practitioners to enhance their practice…"

"…it is very important if a person grow and develop in the same mouth that is one of the most difficult just *as well to um… it, it is not easy just very important…"*

"…individuals must show properties of lifelong learning – thus, must want to continuously improve on current practice and/or keep skills…"

"…to enhance learning to maintain skills to work that person must be a lifelong learner…"

Reflection is perceived as an important method to promote personal and professional development in order for nurse practitioners to practice with professional integrity and to improve patient care in the long run (McBrien 2007:128, 129; Mantzoukas & Jasper 2004:926; Gustafsson & Fagerberg 2004:273, 272, 279; Burton 2000a:1010). Not only is continuous professional development important for the practitioner in clinical practice but also for the person facilitating the reflective process (Mangena & Chabeli 2005:294).

4.3.4.1   Adult learning

The participants were of the opinion that in order to implement reflection as a learning strategy, A&E practitioners needed to be approached as adult learners.

"…a degree of adult learning with critical analytical skills-

-Individuals must be adult enough to know what they are doing right and wrong and then be able to admit such

-Individuals must show properties of lifelong learning – thus, must want to continuously improve on current practice and/or keep skills

-Individual must have the internal motivation to want to change their behaviour

-Individuals must be able to handle negative criticism and use it constructively…"

"…my honest opinion is that you have to be adult… if… you do not have adult perceptions and a clinical value system this is… will not work…"

"…they are professionals they are adults maybe they are not adult enough to understand reflection or what ever… but they are adult in their profession and they've worked to get where they are so if you don't have a good relationship with them then reflection will not work…"

These quotations are in line with the assumptions of how adults learn (Knowles et al. 1998:64-69) as discussed in the literature review (Chapter 2). Lieb (1991:1) summarized the assumptions as follows:

- Adults are autonomous and self-directed
- Adults have accumulated a foundation of life experiences and knowledge that may include work related activities, family responsibilities, and previous education
- Adults are goal orientated
- Adults must see a reason for learning something
- Adults are practical, focusing on the aspects of a lesson most useful to them in their work
- Adults need to be shown respect

4.3.4.1.1 Experiential learning

Experiential learning pertains to learning from experience. Reflection permits adult learners to contemplate and make sense of what happened (Boud et al. 1985:8). The focus group participants were seen to be aware of that fact.

> *"…reflection is important during exam time, as the learner can go back to past work experience and incorporate it into the theoretical aspect of emergency nursing [A&E nurse practitioner]…"*
>
> *"…this is a very useful method to teach students/learners/registered nurses from what they experienced in their practical situation…"*
>
> *"…then also to past experiences and new experiences and this integration of information and that is where experiences and feelings, emotions are coming in…"*

Driscoll and Teh (2001:102) describes reflection as "*an intentional practice based learning activity*". Therefore reflection and experience shape an A&E practitioner, which can make skilled clinical decisions and take action (Stockhausen 2006:55). These skilled clinical decisions and actions are founded on the reflective process that enable A&E practitioners to explore the experience methodically, develop personal knowledge and ultimately deliver quality service (Walker 2007:1; Markham 2002:286; Lockyer, et al. 2004:50; Johns 2005:37; Johns 2001:237). The ability of the A&E practitioner to reflect is influenced by practical experience that can act as a restrictor or activator for future practice (Landmark et al. 2003:835; Stuart 2003:225).

4.4 THEME 2: PREREQUISITES FOR IMPLEMENTING THE STUCTURED REFLECTIVE TOOL

The focus group participants were convinced that there are certain aspects that need to be addressed before the structured reflective tool could be implemented in practice. The categories, clusters, sub-clusters that emerged under the theme prerequisites for implementing the structured reflective tool are summarised in Table 4.3

Table 4.3: Categories, clusters and sub-clusters identified under the theme: Prerequisites for implementing the structured reflective tool

Categories	Clusters	Sub-clusters
4.4.1 Buy in from stakeholders	4.4.1.1 Management	4.4.1.1.1 Performance management
	4.4.1.2 Facilitators	4.4.1.2.1 Driving process
		4.4.1.2.2 Guide reflection
	4.4.1.3 A&E practitioners	4.4.1.3.1 Personality traits
		4.4.1.3.2 Resistance
4.4.2 Setting	4.4.2.1 Environment	
	4.4.2.2 Relationships	4.4.2.2.1 Support
		4.4.2.2.2 Team orientated
	4.4.2.3 Logistics	4.4.2.3.1 Time
		4.4.2.3.2 Enough staff
		4.4.2.3.3 Facilitator

4.4.1 Buy in from stakeholders

The focus group participants stated the following:

> "...stakeholders have to buy in and have to support reflective practice..."
>
> "...I just think before you start something as well, that everybody that you want to buy in must know what it is about..."

Stakeholders in this study are those persons directly concerned and associated with reflective practice in the clinical setting (Encarta 2003). The stakeholders include but are not limited to management, facilitators and A&E practitioners. These stakeholders need to invest in the structured reflective tool and reflective practices to ensure that reflection becomes the engine to continuously improve service delivery. If reflective learning is disregarded and not supported by the organisational philosophy - reflection in daily practice will become incongruous (Mantzoukas & Jasper 2004:927).

4.4.1.1 Management

The following comments regarding management were made during the focus group:

> "...there should also be support from the bigger crowd um... management of the organisation..."
>
> "...very, very important that management have to buy in if management does not buy in to it you can't actually... can't implement that..."

Management needs to understand the purpose and advantages of reflection for their organisation to ensure that resources will be made available (Mantzoukas & Jasper 2004:926). Many arguments around the use of reflection in an organisation exist and even though management is aware of all facets of reflection, cooperation is often lacking (Mantzoukas & Jasper 2004:926). However if the institution does not impose reflection, A&E practitioners might disregard it completely as supported by Cotton (2001:517).

In the literature there is much discussion regarding the role of the supervisor, who is also part of the management team. In the A&E unit the supervisor is the unit manger and usually also an A&E practitioner. The participants mentioned the following:

> "…the unit managers are too busy managing administrative tasks and there is no facilitators so there is nobody driving learning…"
>
> "…traditionally it used to be the unit managers task (facilitation of learning) that is not the case anymore and where it actually still is the unit managers task, they don't focus on that number one and they can't…"
>
> "…I think in the private sector there is so much pressure on the unit manager because they are set certain goals and if they do not stick to certain goals there will be financial um… targets…"
>
> "…I don't think it should be the unit manager that (facilitates learning)…"
>
> "…something I think it shouldn't even be the unit manager (that facilitates learning in the unit)…"
>
> "…it (facilitation of learning) can be either a facilitator of the unit manager…"

The occupational learning literature advises supervisors to be actively involved in facilitation of learning (Hughes 2004:275). However Hughes (2004:285) uncovered that, supervisors do not engage in facilitation of learning and the employees invite this lack of encouragement. The A&E unit manager may find facilitation of learning challenging or unachievable. Therefore a person who is not part of management could fulfil this function, if learning in the work environment is seen as a high priority as, supported by Hughes (2004:286).

4.4.1.1.1   Performance management

In order to encourage buy in from especially A&E practitioners, the focus group participants made the following comments:

> "...the incentive so you link it (to the structured reflective tool/continuous professional development) and then you get buy in from management if you link it in such a manner look you have to do this in order for you to have a meet expectations or an exceed expectation..."
>
> "...you link it (to the structured reflective tool/continuous professional development) to performance evaluation; you link reflective learning to the evaluation of performance base... their salary increase at the end of the year you have to link it to an incentive..."

The literature however warns against linking clinical facilitation sessions to performance management, as it can be perceived as a reprimanding practice (Bedward & Daniels 2005:63; Driscoll & Teh 2001:99).

4.4.1.2 Facilitators

The facilitator plays the role of change agent activating and implementing learning in the work place and therefore this person also needs to buy in to the programme and reflection as a learning strategy (Stetler et al. 2006:36). One participant said:

> "…*when I started being a clinical facilitator there was nothing in place for me to guide me what to do; I had to start from scratch*…"

Bedward and Daniels (2005:51) is of the opinion that the person facilitating learning in the clinical setting as well as the adult learner should get initial guidance on how to approach clinical learning. The skilled facilitator will be able to offer the practitioner room and the opportunity to reflect on practice (Driscoll & Teh 2001:99). Currently the leading setback is the shortage of time and facilitators not backing reflection (Liimatainen, Poskiparta, Karhila & Sjögren 2001:656).

4.4.1.2.1 Driving process

The facilitator was identified as the driving force behind clinical learning and reflection as mentioned in the following quotations:

> *"…the unit managers are to busy managing administrative tasks and there is no facilitators so there is nobody driving learning…"*
>
> *"…I'm saying it should be driven by someone cause there has to be a core person driving it you can't just let it be. It can be a facilitator…"*
>
> *"…she's still the facilitator she's still driving it but she is now just facilitating it…" "…you need somebody (the facilitator) to drive learning…"*

Manias and Aitken (2005:69) and Maggs and Biley (2000:193) support these notions as they state that to advance practice and assist with change, facilitation of learning in the clinical setting must the responsibility of one person – the clinical facilitator.

4.4.1.2.2   Guide reflection

Reflection is a collaborative activity that assesses perceptions and beliefs within the setting of the research in order to achieve circumstantial conception. Therefore the parties involved must engage in habitual contemplation (Forneris & Peden-McAlpine 2006:3). The A&E practitioner needs to interpret experiences and associate meanings with existing knowledge but they need assistance as supported by Stuart (2003:219).

The focus group participants made the following comments:

> *"…it is important to guide new reflective practitioners how to do this for example through a guided reflective interviews…"*
>
> *"…um… for a lay reflectioner it is very difficult to reflect because not all people know what is reflection so you have to guide them how to reflect um… after the question…"*
>
> *"…though first of all I think when she starts she should guide the people on how to do it…"*

The facilitator is the guide to stimulate A&E practitioners to view their practice from other angles initiating examination of actions and theory behind it and constructing other possible outcomes as supported by McBrien (2007:129); Hughes (2004:276); Spencer and Newell (1999:349) and Stuart (2003:217). The facilitator through interactive dialogue as stated by Forneris and Penden-McAlpine (2006:9) guides A&E practitioners to develop reflection as a learning strategy thereby ensuring direct assessment of their practice as supported by Maggs and Biley (2000:192) and Spencer and Newell (1999:354). The assessment of practice encourages A&E practitioners to alter practices and deliver quality service. This statement is supported by Johns (2001:237) and Stetler et al. (2006:28).

The facilitator also plays a supportive role (Johns 2005:40). The A&E practitioner is granted the opportunity to discuss difficulties and concerns in a professional manner with little risk of being judged as supported by Johns (2005:40) and Markham (2002:286). The problems and concerns are turned into new understandings to be taken into consideration for future practice (Johns 2005:40).

4.4.1.3   Accident and emergency practitioners

A&E practitioners find themselves in a demanding work environment where they daily deal with complicated and rare clinical situations and have to make hasty judgements as supported by Mantzoukas (2008:217).

The focus group participants stated the following:

> "…I, I feel very strongly about what I'm experiencing here and that is that there is a big difference between a student and an already qualified person…"
>
> "…I just think it's (reflection) a personal thing the way you reflect is a personal thing…"

> "...they are professionals they are adults maybe they are not adult enough to understand reflection or what ever... but they are adult in their profession and they've worked to get where they are so if you don't have a good relationship with them then reflection will not work..."
>
> "...even if it's just an environment where people know; look we are peers we are all trained we are all post-basic but your expertise is... 'jy weet'... everybody not all of our experience can be perfect in every single field in the A&E environment..."

All nursing practitioners have the capacity to engage in reflective practice for A&E practitioners this will enable them to decipher problems and assess their practice (Walker 1996:29). However no matter how good the opportunities and facilitation of learning is, the A&E practitioners have to decide for themselves to take on reflective practice as supported by Stuart (2003:219).

4.4.1.3.1 Personality traits

The participants were convinced that A&E practitioners are people with difficult personalities as is evident from the following:

> "...I think as a learning strategy in the accident and emergency (A&E environment) it is a very difficult thing we have type A-personalities who um... do not... view structured reflection as necessary it is a very skills orientated environment and emotions do not play a role...."
>
> "...it is with a type A-personality I found it is very difficult for people to reflect and to... to... to... um... admit that they did something wrong and could've done something better. They don't respond positively..."

> "…it might have a negative comeback just from knowing their personalities…"

> "…reflection might state… may be of assistance of dealing with this difficult issue of people's personalities… maybe something that they are suppressing and not thinking about… and by giving a voice for them they will… may be more open and you will maybe have more um… um… conducive environment…"

Scott (2007:1) states that the A-type personality has become a commonly used term. People with an A-type personality are seen to have the following characteristics (Scott 2007:1; Lankton 1998:1; Sharma 2008:1):

- Time urgency
- Edginess
- Driven
- Pervasive antagonism

The researcher could find no explicit evidence linking A&E practitioners to type A-personalities in the literature review. From personal experience and consultation with supervisors it was debated that all A&E practitioners possess some or all of the A-type personality traits (Heyns 2008).

4.4.1.3.2 Resistance

The personality traits have the potential to bring about resistance to reflective learning. The participants were mindful of possible resistance as is clear in the next statements:

> "…*what you are saying is that you can anticipate resistance to that tool*"
>
> "…*I agree when it comes to people who are already trained they not like students they are not open like this anymore…*"

Reflection is a personal journey that will awaken feelings of awkwardness and sometimes embarrassing feelings about actions decided upon (Maggs & Biley 2000:194; Markham 2002:286; Lockyer et al. 2004:56). The awareness of these realisations may lead to irritation and confusion amongst A&E practitioners as supported by Cotton (2001:513); Nikolou-Walker and Garnett (2004:305) and Hobgood, Hevia and Hinchey (2004:768). Reflective practice can be advocated by organisations and facilitators but could be resisted by A&E practitioners as supported by Cotton (2001:514). Therefore reflection should not be enforced on A&E practitioners, but they must be informed that reflection will assist them in practice as supported by Burton (2000a:1015) and Walker (1996:30). Effective learning strategies are positively implemented when there is proficient planning and buy in from significant stakeholders and the A&E practitioner as is evidenced in this study, as supported by Hamilton, McLaren and Mulhall (2007:27).

4.4.2 Setting

The stage to implement reflective practice must be set impeccably. The following comments were made during the focus group discussion:

> "…*if the environment is conducive to that… if the management structure form that unit's is in such a manner that they will allow them to have time of reflection then it will work but if the environment is not conducive to it will not work…*"

"...if they are adult enough and the environment is right and the relationship between the people it can really work as... as... a strategy they should have and you have to have... a strategy to work..."

"...the moment that you... um... put a person in a... let's call it a reflective practitioner the moment that you... put in situation where... the environment does not support reflective customs practice that's gonna create a helluva lot of frustration, a helluva lot of rebellious and negative conflicting um... situations..."

"...if you don't have the time and the staff to do that it's not gonna work and you have to make it an... an institution you have to have it happen inside..."

The literature reviewed is rife with obstacles to implement reflective practice. Even though continuous professional development and reflection are encouraged by organisations and academics, there is little to no official support and creation of opportunities to engage in these activities in work time (Lockyer et al. 2004:50; Stetler et al. 2006:36; McKnight 2006:150; Mantzoukas & Jasper 2004:926; Liimatainen et al. 2001:657).

4.4.2.1   Environment

The environment must be conducive to reflective practice as evident by the next statements:

"...there should be, the environment should be conducive to that from the hospital perspective..."

"...I feel very strongly about that the environment has to be conducive has to be open for it (reflection)..."

First of all the unit manager has to create the opportunity and give encouragement, supporting learning in the unit (Hughes 2004:286). Secondly the facilitator needs to establish a reassuring environment to make learning possible (Maggs & Biley 2000:192). If the above are not in place, reflection and therefore learning will not take place.

4.4.2.2   Relationships

A safe environment is not enough and the relationships of all parties involved need to be in good order. The participants felt very strongly that good relationships are of utmost importance to facilitate reflection. This point of view is evident from the following statements:

> "…*like I said at a time people have to for reflection to work as a learning strategy the people that's involved in it must have a good relationship but if there's not a good relationship with all parties reflection will not be positive it can become negative*…"

> "…*if they are adult enough and the environment is right and the relationship between the people it can really work as… as… a strategy they should have and you have to have… a strategy to work*…"

> "…*for me the relationship is where you have to start using all kinds of strategies to teach your colleagues and you… you must use them as colleagues…*"

> "…*you have to have a good relationship so it… in a casualty there is not good relationships [laughter] amongst all staff members involved so if there is different staff members that feel threatened by other staff members or um… I… 'Jy weet'… not necessarily threatened feel whatever that relationship between those people are not good then that won't work so you have to make sure that the relationship within the team is good…*"

> "...the integrated nature thereof what's very important in um... using reflections in relationships... the component building a relationship..."

> "...and be honest don't come with the attitude that I'm the lecturer I know everything because you don't know everything and you sometimes come to think that I don't and they really enjoy that you become actively involved and come back to them with information..."

The main relationship of importance to this study is the relationship between the facilitator and the A&E practitioner. There must be a high degree of trust between the facilitator and A&E practitioner as supported by Burns and Bulman (2001:114); Hughes (2004:282) and Smith and Jack (2005:36). If there is lack of trust the A&E practitioner will not divulge intimate thoughts and feelings to the facilitator (Hughes 2004:282). In order to ensure that the relationship works, a safe environment needs to be created incorporating mutual confidentiality and respect (Markham 2002:287; Chirema 2007:200). The above mentioned is only possible if there is excellent communication (Stetler et al. 2006:35) and the facilitator has the ability to appreciate the individuality of each A&E practitioner as supported by Nelville (2004:129). However the relationship is not static and can be terminated at any time if the parties do not stay within set boundaries (Markham 2002:286).

4.4.2.2.1   Support

Practitioners engaging in reflective learning need support from each other and the management, as stated by the participants of the focus group.

> "...if they are not buying into each other for support them um... um... this strategy then will become something that is just a back lashing..."

> "…students (and A&E practitioners) have to be able to take positive and negative feedback from others and from themselves…"
>
> "…reflection as a learning strategy can only be effective if there is enough support and time given within the actual work environment…"
>
> "…they are very supportive of each other…"
>
> "…yes they do learn from it I learn from it um… but the support is very important in the relationship…"

A&E practitioners will only have the willingness to develop reflective practice if support from peers, management and senior staff is visible as supported by Driscoll and Teh (2001:101-102) and Glaze (2001:646).

4.4.2.2.2   Team orientated

The participants were not all sure about the role the team has to play in reflective learning but some indicated that the whole team also needs to be involved in the reflective process. The following statements were made:

> "…teamwork - how did the team work together…"
>
> "…so in other words you have to make sure before you… before you start this learning strategy you have to have a team building day, you have to take them out for team building make sure the team is a team…"
>
> "…include the team how… how do we function as a team…"

Markham (2002:286) is of the opinion that reflection can take place individually or as part of a team approach to learning. If reflection occurs within a team approach the participants need to be mindful of each other and be able to learn from good practice and turn mediocre practice and mistakes into learning opportunities (Gaye 2005:185).

4.4.2.3   Logistics

Logistics pertains to the planning and control of resources to enable reflective practice (Encarta 2003). A participant had the following to say:

> "…*they have to make sure the logistics is there. The time, the staff, the opportunities, the person who's going to do that*…"

The deficit of knowledge about reflection as a strategy to develop skills and knowledge, together with prescribed numbers of staff and declining resources, complicates the clinical situation that could enable nurse practitioners to reflect (Burton 2000a:1014). In order to overcome constraints of time and other resources nurse practitioners need to become inventive (Markham 2002:286). In the literature reviewed no possible solutions on how to overcome the constraints were discussed.

4.4.2.3.1   Time

Time is a valuable resource and because of the A-type personalities of A&E practitioners they will be very aware of the lack of time they have as is evident by the following statements:

> "…*it's (reflection) also very time consuming*…"

> *"...there must be time set aside to come and reflect on what... what was happening here and what you gonna do so if your managers is not allowing for that time or if the staff allocation is not in that manner then they not gonna do it because you can't tomorrow reflect on what happened today..."*
>
> *"...there is time set aside for... half an hour to an hour for people to do that if they do that it will work..."*
>
> *"...and so debriefing sessions is a very, very good tool in an A&E environment but like I said you have to have time to do it..."*

In the A&E units there are many things happening at the same time and this is not conducive to reflection. The A&E practitioner lacks time and understanding of the benefits of reflective practice as supported by Lockyer et al. (2004:52). Reflection necessitates time and enthusiasm (Burton 2000a:1015). There are however no satisfactory resolutions on how to overcome the problems facing reflection in clinical practice (Kilminster & Jolly 2000:836).

4.4.2.3.2   Enough staff

The participants commented that if there is enough staff and the correct skills mix, reflective practice might be possible.

> *"...I think number one if we again... we focus on the A&E environment so if there is not enough staff on duty in order for them to reflect on patient care um..."*
>
> *"...they have to have adequate staff in such a manner that because when you are going to use reflection or they..."*

> "…*I think, suggestion that should be that the staffing and that managers should look at how can they make sure that there is enough staff on duty and that they…*"

The worldwide shortage of nurses and the high emigration rate of South African nurse practitioners deem to be a big stumbling block including and not limited to reflective practice (Oosthuizen & Ehlers 2007:14). In the study conducted by Oosthuizen and Ehlers (2007:21) the result shows that nurses leave for a vast variety of reasons, 94.2% of the study participants expressed that insufficient staffing was a reason for emigrating or leaving the nursing profession. The recommendations made contains the statement that more nurses need to be appointed but how viable this recommendation is, is currently unclear (Oosthuizen & Ehlers 2007:23).

4.4.2.3.3 Facilitator

A facilitator with the right attitude is necessary to guide the learning of A&E practitioners. The following statement was made:

> "…*I think your attitude (as facilitator) as well you can't have reflection and with an attitude and expect them to do it with you, you have to change your attitude*…"

The facilitator has to examine the experience with the A&E practitioner in a considerate and objective manner directed at celebrating exceptional practice and turning weaknesses into learning opportunities as supported by Richardson (2004:1283.e1). However the facilitator has to take expenses and staff shortages into consideration when planning for a reflective session (Manias & Aitken 2005:69).

4.5 THEME 3: THE STRUCTURED REFLECTIVE TOOL

The structured reflective tool refers to an assessment tool that provides guidelines to the A&E practitioner and the clinical facilitator to identify knowledge and skill flaws. The categories, clusters and sub-clusters that emerged from the data analysis are summarised in Table 4.4

Table 4.4: Categories, clusters and sub-clusters identified under the theme: The structured reflective tool

Categories	Clusters	Sub-clusters
4.5.1 Attributes	4.5.1.1 Implementation of reflection	4.5.1.1.1 Discussion
		4.5.1.1.2 Written account
	4.5.1.2 Holistic	
	4.5.1.3 Universal application	
	4.5.1.4 Questioning stance	

4.5.1 Attributes

Attributes refer to the characteristics that the structured reflective tool should have (Encarta 2003).

4.5.1.1 Implementation of reflection

The question asked during the focus group was: What should be included in a reflective tool as a learning strategy for A&E practitioners? The participants also commented on how to possibly go about to implement reflection in the A&E unit.

> "...I think we can do it but it must not, maybe it shouldn't be such a structured tool you can have your tool that you can use but you can do it with them without them actually knowing it..."
>
> "...but we do have a little bit of structure and that structure guides us a lot and it you can get your tool to be you know... just be um... um... What shall we say in a... in a... flowing out of that structure like if you wanna know what to include there..."
>
> "...I think you should stick to the structure that is being used not make it completely self-reliant..."
>
> "...I think you must just make the tool and include things in the tool that they are actually using anyway..."

A variety of mechanisms exist to record and apply reflection. These include but are not limited to: debriefing or discussion sessions, reflective journals or diaries, portfolios of evidence and clinical facilitation (Cotton 2001:516).

4.5.1.1.1   Discussions

This includes the debriefing sessions, which are defined by Encarta (2003) as formal inquiring gatherings after an event has taken place. The participants provided the following inputs:

> "...I think maybe in the emergency situation um... that... um... sort of discussion will work much better... help to do reflection but they actually don't think that they are learning but in actual fact they are learning um..."

> *"…I think the way to use reflection is um… what we call debriefing session…"*
>
> *"…and so debriefing sessions is a very, very good tool in an A&E environment but like I said you have to have time to do it…"*

The participants of the discussion should all have been involved in the event up for debate and will take on attributes of a focus group (Forneris & Peden-McAlpine 2006:11). The discussion should take place as soon as possible after the event has taken place because the activities that happened will be fresh in their minds without fabrications (Walker 1996:28). Again time to do this comes into question. The discussion also needs to take place with the respect and confidentiality in relationships as already discussed.

4.5.1.1.2   Written accounts

These include diaries, journals and portfolios of evidence. The written accounts mentioned by the participants were the following:

> *"…I think there is other tools that can also be used I don't know whether the practitioners will use that by using a diary…"*
>
> *"…you have to and one of the things you must have is a portfolio of evidence that they have, throughout the year…"*

The written accounts give the A&E practitioner the opportunity to privately review events and put it into words where it can be used as a reference and give some objectivity encouraging improvement of knowledge and skills as supported by Lockyer et al. (2004:56); Chirema

(2007:193); Hannigan (2001:280) and Burton (2000b:326). The A&E environment can contribute to the practice of written reflection (Walker 1996:29). However there are hurdles to journal writing. The nurse practitioners in favour of keeping a reflective journal or diary are in the minority (Eraut 2004:50). The quality of entries is also questionable and many A&E practitioners will become irritated with this practice, as it is time consuming as supported by Corcoran and Nicholson (2004:230, 235) and Lyons (1999:30).

The researcher agrees with Lyons (1999:30) that if written accounts of events are used to promote reflective practice there must be a discussion to ensure that learning did take place. The facilitator could assist the discussion in a group or individually.

4.5.1.2   Holistic

Nursing is based on holistic care of the patient (Finfgeld-Connett 2008:6). In order the treat a patient holistically the A&E practitioner needs to learn holistically. A participant made the following comment:

> "…it's not only learning the theory but many experiences in practice that can correlate the theory and practice and also the affective component through the theory and the practice so it makes it more holistically – structured tool or uh… reflection…"

Johns (2005:44) advocates reflection as a holistic learning approach allowing the development of experts. A&E practitioners will only be able to become experts if they engage in reflection altogether, integrating thoughts, feelings, knowledge, skills and experience as supported by Gustafsson and Fagerberg (2004:272).

4.5.1.3   Universal application

The tool to be developed needs to be applicable to all learning situations to prepare the A&E practitioner for any situation whether simple or complex (Mantzoukas 2008:18). The following comments were made:

> "...*such a tool must be something you can use on any type of learning opportunity...*"
>
> "...*you still have to be universal for any kind of situation and you should concentrate on what it is that you want from her...*"

The following counter-arguments were raised:

> "...*we used it on our priority one patients... on our code red patients...*"
>
> "...*organised debriefing session after P1/code red patient resuscitations – led by nursing team leader...*"

Walker (1996:28) proclaims that all situations have the possibility to become custom and the A&E practitioner will fall into a routine without validating practice. Therefore even the simplest action could be used as a reflective learning opportunity (Walker 1996:30; Johns 2005:38).

4.5.1.4   Questioning stance

The participants of the focus group felt that in order to facilitate learning there must be questions to structure the discussion. The questions are similar to questions posed in the models of reflective learning of Atkins

and Murphy (1994), Gibbs (1988), and Johns (2000). The questions in these models are compared in Table 2. Johns (2005:39) however reminds all facilitators that the questions posed should only be a guide.

Table 4.5: Comparison of models of reflection and focus group summary questions

Focus	Summary from focus group	Gibbs' model of reflection (1988 in Johns 2002:49)	Johns' model of reflection (Johns 2002:47)	Atkins and Murphy's model of reflection (Atkins & Murphy 1995:32)
Description	All the models of reflection reviewed as well as the comments of the focus group necessitates a detailed description of the event up for reflection			
Analysis	**Cognitive** (knowledge) component- What do you know about...? What did you know? **Psychomotor** (skills) component- What skills did you display/not display? **Affective** component- How did you feel at the time? How do you feel now?	What were you thinking and feeling? What was good and bad about the experience?	What was I trying to achieve? Why did I act as I did? What are the consequences of my actions? How did I feel about this experience when it was happening? How did the patient feel about it? What influenced my decision-making and actions?	Analyse feelings and knowledge relevant to situation -Identify knowledge -Challenge assumptions
Evaluation	**Cognitive** component- What knowledge do you need in future? **Psychomotor** component- What skills do you require **Affective** component- What has changed or stayed the same? How do you use this new understanding? What has been the value of this experience?	What sense can you make of the situation?	Could I have dealt better with the situation? What other choices did I have? What would be the consequences of these other choices? How do I feel about the experience now?	Imagine and explore alternatives Evaluate relevance of knowledge -does it the knowledge help to explain or solve problems? -how complete was the use of knowledge?
Conclusion		What else could you have done?	How can I make sense of this experience in light of past and possible future experiences?	Identify any learning which has occurred

4.6   CONCLUSION

Data collected during the focus group discussion was coded and analysed. The data was sorted into themes, categories, clusters and sub-clusters. Relevant literature was studied in order to validate the findings. It is clear from the literature and research findings that reflection is a valuable learning strategy but it does not come without hurdles. The researcher's conclusions and recommendations will be discussed in Chapter 5.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

"*And since you know you cannot see yourself, so well as by reflection, I, your glass, will modestly discover to yourself, that of yourself which you yet know not of.*"

William Shakespeare

5.1 INTRODUCTION

In Chapter 4, the results of the research were discussed and corroborated by references to the relevant literature in order to place research findings in context. In this chapter the conclusions, recommendations and reflections on the study are discussed.

5.2 SUMMARY OF THE STUDY

The aim of this research was to identify the components for a structured reflective tool to enhance the continuous professional development of A&E practitioners. The research questions to be answered were:

- What are the views of clinical facilitators, lecturers of the A&E programme, and experts in the field of nursing education with an interest and/or experience in the use of reflection?
- What components need to be incorporated into the structured reflective tool that would enhance the continuous professional development of A&E practitioners?

- What recommendations regarding the development of the structured reflective tool can be made?

In order to answer the research questions the following objectives were established:

- Explore the views of clinical facilitators, lecturers of the A&E programme, and experts in the field of nursing education with an interest and/or experience in the use of reflection
- Describe components that need to be incorporated into the structured reflective tool to enhance the continuous professional development of A&E practitioners
- Make recommendations regarding the development of the structured reflective tool

To arrive at the research questions and objectives, the researcher conducted a literature review to gain information regarding the phenomena. The participants were drawn from the identified population using a non-probability sampling technique. The result was that a group of four was selected to participate in the investigation of the concept of reflection during a focus group discussion.

Three main themes were extracted from the focus group discussion namely reflection, prerequisites for implementing the reflective tool and the components for the structured reflection tool. Lincoln and Guba's (1984) model for the trustworthiness of qualitative research was used to ensure that data obtained was trustworthy. Several practical strategies appropriate for the four criteria of trustworthiness were applied namely: credibility, transferability, dependability and conformability. From the data analysis themes with categories, clusters and sub-clusters emerged and recommendations were formulated to implement reflection in the A&E unit and to develop a structured reflective tool.

5.3 FINDINGS OF THE STUDY

The conclusions will be discussed in conjunction with and according to the themes.

5.3.1 Theme 1: Reflection

The theme of reflection was identified during the data analysis and falls under the objective:

- Explore the views of clinical facilitators, lecturers of the A&E programme, and experts in the field of nursing education with an interest and/or experience in the use of reflection

The participants of the focus group emphasised the fact that reflection is a very important learning strategy but challenging to implement. Reflection can assist A&E practitioners to enlighten their decision-making process. However the participants pointed out that reflection should not be used in isolation. No alternative teaching or learning strategy was however mentioned.

In the literature reflection is embraced as a way to ensure professional development of nurse practitioners. The main reason for this is that reflection is a means for integrating theory and practice. The reflection on theory and practice awaken thoughts and questions about the suitability of practices. This leads to the identification of strong and vulnerable points in current practice and urges the A&E practitioner to learn. The learning that takes place when using reflection occurs in the cognitive, affective and/or psychomotor domains.

The participants of the focus group therefore highlighted the fact that reflection is a means of deep learning because reflection changes superficial learning into deep learning. This prepares A&E practitioners to handle any

situation because the learning that occurred can be transferred and applied to diverse situations in practice.

Nursing practice however is faced with constant change. Therefore continuous professional development was important to all participants of the focus group. A&E practitioners need to engage in continuous professional development in order to ensure that their knowledge and skills are kept current. Reflection in this study was perceived as a strategy for continuous professional development. The participants of the focus group emphasised the importance of approaching A&E practitioners as adult learners. Adult learners learn best from experience and by integrating reflection with the experience, A&E practitioners will make clinical decisions and take action with authority.

5.3.2   Theme 2: Prerequisites for implementing the structured reflective tool

The theme prerequisites for implementing the structured reflective tool emerged during the data analysis and falls under the objective:

- Describe the components that need to be incorporated into the structured reflective tool to enhance continuous professional development

Before the participants of the focus group commented on the components that need to be incorporated into the structured reflective tool, they were concerned about the prerequisites for implementing the structured reflective tool. To implement the structured reflective tool it is essential that all stakeholders buy in to the structured reflective tool and reflection as a learning strategy for continuous professional development.

Management was identified as an important role player in implementing the structured reflective tool. The management needs to invest in the programme and must be made aware of the purpose and advantages of reflection. Their buy in is of utmost importance as they have the ability to ensure that resources will be available to implement reflection. Some of the participants of the focus group were of the opinion that the structured reflective tool should be part of performance management, but the literature clearly states that A&E practitioners might perceive it as a police practice.

In order to implement the structured reflective tool there must be a dedicated facilitator. The facilitator must also be an A&E practitioner with skills to facilitate learning through the structured reflective tool. It was found that even if optimal circumstances for continuous professional development existed in organisations there must still be a dedicated individual responsible to drive the process. The A&E facilitator must drive the process and ensure that there are opportunities to engage in reflective practice. The A&E facilitator is responsible for structuring reflection and guiding A&E practitioners on their journey to new understandings and the consideration of this new understanding for future practice.

Continuous professional development of A&E practitioners is the prime reason for implementing a structured reflective tool. Therefore the buy in is very important. A&E practitioners are however difficult people to work with and the participants of the focus group were well aware of this fact. They stated the A&E practitioners have A-type personalities or at least traits of A-type personalities. With personality traits of A&E practitioners taken into consideration many of the participants of the focus group predicted resistance toward a structured reflective tool.

The management, A&E facilitator and the A&E practitioner must contribute to setting the scene for the implementation of the structured reflective tool. A supportive environment must be created with good working relationships.

The relationships between the unit managers, the A&E facilitator and the A&E practitioners need to be respectful, open and honest. The relationship within the team, in other words amongst A&E practitioners, should be supportive and not laying blame. Reflective practice is time consuming and opportunities to gain new knowledge and understanding must be created and planned for.

5.3.3   Theme 3: The structured reflective tool

The attributes of the structured reflective tool also conform to the objective:

- Describe the components that need to be incorporated into the structured reflective tool to enhance continuous professional development

The participants of the focus group initially had the idea that the structured reflective tool would be a control list of activities, but after the discussion it was clear that this could not be the case. The structured reflective tool has to be holistic and universal in order to apply it in any situation. The participants of the focus group suggested a list of questions that will assist the A&E facilitator to structure reflection. The list of questions will not only assist the A&E facilitator, but A&E practitioners will know what to expect from the reflective session and guide critical thinking and evaluation of the experience. The main focus areas include: description of the experience, analysis of the experience, evaluations and conclusions (see Table 4.5).

5.4   RECOMMENDATIONS REGARDING THE DEVELOPMENT OF THE STRUCTURED REFLECTIVE TOOL

The findings of the study generated the following recommendations to A&E facilitators who want to implement a structured reflective tool in their daily facilitation process:

- Even though reflection of A&E practitioners has not received the same attention as under graduate studies, it was deemed important by the focus group participants. Reflection is important and its use should be implemented and investigated in the A&E environment
- All stakeholders involved in the reflective process need to be made aware of the advantages that reflection has for their organisation
- The structured reflective tool must be marketed amongst the stakeholders involved
- There must be a dedicated A&E facilitator driving the reflective process
- The A&E facilitator needs to be a dynamic and skilled reflective practitioner
- The questions recommended by the participants of the focus group, as seen in Table 4.5, should only serve as a guide as the A&E facilitator is required to adapt it to different experiences and individuality of the A&E practitioner

5.5 REFLECTIONS

In this section the researcher discusses the affective experiences encountered during the research process.

5.5.1 Methodological reflections

The study focused on the identification of components for a structured reflective tool to enhance the continuous professional development of A&E practitioners. The research is significant as the demand on A&E practitioners is increasing due to the fast changes in clinical practice. The researcher could not find explicit evidence in the literature that reflection was used as a learning strategy for A&E practitioners. To overcome this limitation the researcher followed a qualitative approach.

The research design was complicated and it did not fit into any of the pure research designs detailed in research textbooks. Objectives were achieved by taking advantage of the qualitative research characteristics of holism and flexibility.

The population for the study was small and it was interesting to establish that clinical facilitators in the A&E environment are a scarce commodity. The participants of the focus group, though very small, were highly knowledgeable and willing to share this wealth. The exposure to the experts in reflection may very well serve as an inspiration and stimulation of reflection in the A&E environment.

5.5.2   Study specific reflection

A&E practitioners work in a fast changing and demanding environment and need to engage in continuous professional development. Although the focus group participants predicted resistance to the structured reflection tool, the importance of continuous professional development was accepted.

Reflection leads to learning in the cognitive, affective and psychomotor domains. During the reflective sessions A&E practitioners should be assisted to relate their experiences and ideas without all the negative connotations of debriefings.

5.6   LIMITATIONS OF THE RESEARCH

The limitations of this research were as follows:
- A small sample was used due to the small population of A&E clinical facilitators
- The study aimed to identify components for a structured reflective tool to enhance the continuous professional development of A&E

practitioners. The other categories of nursing practitioners working within the A&E environment were not within the scope of this research
- The execution of the structured reflective tool could not be done and monitored
- The sample size was very small

5.7   RECOMMENDATION FOR FURTHER RESEARCH

The study lends it self to open doors for further research. The possibilities include and are not limited to the following:
- Apply this research to more categories of nurse practitioners
- Explore practical solutions to overcome management and time constraints
- Investigate reflection in the expert nurse practitioner's field
- Implement the structured reflective tool in practice and evaluate the effectiveness thereof

5.8   CLOSING REFLECTION

The aims and objectives of this study were reached and so much more. The participants of the focus group did not only express their views on reflection and describe the components for a structured reflective tool, but also discussed the logistics regarding the implementation of a structured reflective tool.

From the data analysis it is clear that reflection is perceived to be a valuable approach to learning, but the practical implementation needs to be investigated.

Annexure A

Ethical approval: University of Pretoria
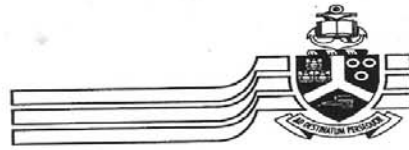
University of Pretoria

Faculty of Health Sciences Research Ethics Committee
University of Pretoria
Tel: (012) 339 8619   Fax to E-Mail: 086 6516047
E-Mail: deepeka.behari@up.ac.za
Date: 18/04/2007

Soutpansberg Road   Private Bag x 385
MRC Building   Pretoria
Room 2 - 20   0001

Number	:	S1/2007
Title	:	The development of a structured reflection / self assessment tool for accident and emergency (A&E) nurses in a private hospital group
Investigator	:	C J Filmalter, Department of Nursing Science, University of Pretoria (SUPERVISOR: TANYA HEYNS)
Sponsor	:	None
Study Degree:		M Cur (Clinical)

This Student Protocol has been considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 18/04/2007 and found to be acceptable.

Advocate AG Nienaber	(female)BA(Hons) (Wits); LLB; LLM (UP); Dipl.Datametrics (UNISA)
Prof V.O.L. Karusseit	MBChB; MFGP (SA); M.Med (Chir); FCS (SA): Surgeon
Prof M Kruger	(female) MB.ChB.(Pret); Mmed.Paed.(Pret); PhDd. (Leuven)
Dr N K Likibi	MB.BCh.; Med.Adviser (Gauteng Dept.of Health)
Dr F M Mulaudzi	(female) Department of Nursing
Mrs E.L. Nombe	(female) B.A. CUR Honours; MSC Nursing – UNISA (Lay Member)
Snr Sr J. Phatoli	(female) BCur (Et.Al) Senior Nursing-Sister
Dr L Schoeman	(female) Bpharm, BA Hons (Psy), PhD
Prof J.R. Snyman	MBChB, M.Pharm.Med: MD: Pharmacologist
Dr R Sommers	(female) MBChB; M.Med (Int); MPhar.Med;
Prof C W van Staden	MBChB; Mmed (Psych); MD; FTCL; UPLM; Dept of Psychiatry
Prof TJP Swart	BChD, MSc (Odont), MChD (Oral Path) Senior Specialist; Oral Pathology
Dr AP van der Walt	BChD, DGA (Pret) Director: Clinical Services, Pretoria Academic Hospital
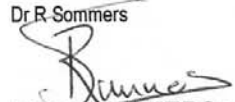
Student Ethics Sub-Committee

Prof R S K Apatu	MBChB(Legon); PhD(Cambridge)
Dr A.M Bergh	(female) BA (*cum laude*), Rand Afrikaans University BA (Hons) (Linguistics), University of Stellenbosch Secondary Education Diploma (*cum laude*), University of Stellenbosch BA (Hons) (German) (*cum laude*), University of South Africa (Unisa) BEd (Curriculum Research and Non-formal Education) (*cum laude*), University of Pretoria PhD (Curriculum Studies), University of Pretoria
Dr S I Cronje	DD (UP) – Old Testament Theology
Dr M M Geyser	(female) BSc; MBChB; BSc HONS (Pharm); Dip PEC; MpraxMed
Mrs N Lizamore	(female) BSc(Stell), BSc (Hons) (Pret),MSc (Pret) DHETP (Pret)
Dr S A S Olorunju	B.Sc Hons; M.Sc; Ph.D
Dr L Schoeman	(female) Bpharm, BA Hons (Psy), PhD
Dr R Sommers	SECRETARIAT (female) MBChB; M.Med (Int); MPharMed

DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
SECRETARIAT of the Faculty of Health Sciences
Research Ethics Committee
University of Pretoria

DR L SCHOEMAN; Bpharm, BA Hons (Psy), PhD
CHAIRPERSON of the Faculty of Health Sciences Research
Students Ethics Committee – University of Pretoria

Annexure B

Ethical approval: Private hospital group

NETCARE
Training Academy

Private Bag X 34
BENMORE
2010
Tel (012) 664 8731/2
Fax (012) 664 8738

e-mail; research@netcare.co.za

NATIONAL OFFICE
Research Administration

Ms C Filmater
POBox 194
THABA TSWANE
0143

March 2007

Cc: **Unitas Hospital**
Nursing Manager: Mrs N Bronner

Dear Ms Filmater

RESEARCH: THE DEVELOPMENT OF A STRUCTURED REFLECTION / SELF-ASSESSMENT TOOL FOR ACCIDENT AND EMERGENCY NURSES

It is with pleasure that we inform you that your application to conduct research on The development of a structured reflection / self-assessment tool for accident and emergency nurses at Unitas, Milpark, Sunninghill and Pretoria East Hospitals has been successful, subject to the following:

i)   All information with regards to Netcare will be treated as confidential.

ii)   Netcare's name will not be mentioned without written consent from the Academic Board of Netcare.

iii) Where Netcare's name is mentioned, the research will not be published without written consent from the Academic Board of Netcare.

iv) A copy of the research will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.

v) All legal requirements with regards to patient rights and confidentiality will be complied with.

We wish you success in your research.

Yours faithfully

DR CW FöLSCHER
Duly Authorised
Research Administrator
NETCARE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Annexure C

Focus group: Participation leaflet and informed consent

Dear Participant

RESEARCH TOPIC: The identification of components for a structured reflective tool to enhance continuous professional development (CPD) of accident and emergency (A&E) practitioners

Thank you for your willingness to participate in the focus group interview regarding the above-mentioned topic on **15 August 2007** at Netcare Unitas Hospital, Pretoria. The total time scheduled for this group interviews is two hours, starting at **10:00**.

I am presently studying for the M Cur Clinical Degree at the University of Pretoria.

The purpose of this research is to identify core components of a structured reflective tool to enhance CPD that can be utilised by clinical facilitators to improve the professional development as well as the critical thinking skills of the A&E nursing practitioner. The tool may also enable the A&E nursing practitioners to identify their individual learning needs and make them aware of their shortcomings within the clinical setting.

Data will be gathered:
- To obtain the views of the clinical facilitators', A&E lecturers' and expert nursing educators with an interest and/or experience reflection regarding the value of reflection and structured reflection
- Identify the components that need to be incorporated into the structured reflective tool to enhance continuous professional development
- To make recommendations regarding the development of the structured reflective tool

A structured reflective tool may enable the A&E nursing practitioners to identify personal learning needs, address these needs, engage in professional development and enhance critical thinking skills; which may result in an improvement in quality service delivery within the A&E unit.

The following questions will serve as a guide only, during the focus group interview:

1. What are your views on reflection as a learning strategy to facilitate CPD of A&E practitioners?

2. What should be included in a reflective tool as a learning strategy for A&E practitioners?

The researcher aims, with your help, to identify the core components for a compile a structured reflective tool. Your expertise and insight regarding the research topic are truly valued. Your participation will help to ensure that A&E nursing remains a highly professional and desired profession by ensuring that individual needs are identified and shortcomings are addressed to the benefit and advancement of this profession.

Permission for conducting this research has been granted by the relevant authorities. Your participation in this focus group is voluntary and you can refuse to participate or stop at any time without stating a reason. Attending and participating in the focus group implies that informed consent has been obtained from you. The only discomfit that one will experience while undertaking this study will have to sit for a prolonged period. Data that may be reported in scientific journals will not include any information that identifies you as a participant of this study. As all information or data is anonymous, you must understand that you will not be able to recall your consent, as your information will not be traceable. All information supplied during the course of this research will remain strictly confidential.

If you have any further questions, you are welcome to contact or approach me.

Yours sincerely

Celia Filmalter

CONFIRMATION OF CONSENT

I _____,
have read the letter and consent to my participation in the study
conducted by Ms C.J. Filmalter.

_____   _____

SIGNATURE OF SUBJECT   **DATE**

_____   _____

SIGNATURE OF RESEARCHER   **DATE**

_____

PLACE

Questionnaire to participant

I value your feedback. Please share your experiences of reflection as a learning strategy for A&E practitioners.

What are your views on reflection as a learning strategy to facilitate CPD of A&E practitioners?

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What should be included in a reflective tool as a learning strategy
for A&E practitioners?

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What should be included in a reflective tool as a learning strategy
for A&E practitioners?

Annexure D

Meeting: Ground rules

FOCUS GROUP AGENDA

1. Welcome and introductions.
2. Goal of the meeting.
3. Purpose of research and obtaining consent.
4. Ground rules, including tape recording of session.
5. Questions and answers.
6. Wrap up.
7. Closing the session.

Prompts:

- How do you practice reflection as a learning strategy (structured reflection – reflection guided by a facilitator)?
- What is important to you when you use reflection as learning strategy?
- What do you view as the value of reflection as a learning strategy?
- What is currently working for you in terms of reflection as a learning strategy?
- What challenges do you experience with when you use reflection as a learning strategy?

Agenda	
Welcome and Introduction of moderator, co-moderator and group members	
Goal of the meeting: • Purpose of meeting: two fold – generating data through a naïve sketch & focus group interview Time – naïve sketch: 15 minutes Focus group: 45 – 60 minutes • Consent and explanation of the research aim and objectives, as well as the context	R R C
Conducting the naïve sketch (15 minutes).	R
Conducting the focus group: **Outcome**: • To bounce ideas about your views on reflection as a learning strategy for A&E practitioners, as well as *to explore components that needs to be included in a reflective tool. This tool will ultimately be used to facilitate CPD of A&E practitioners in this context...no right or wrong answers...* • **Role of moderator**: To focus the conversation – might re-direct the conversation as part of focusing • **Role of the co-moderator**: Taking notes and operating equipment • **Introductions of group members**	R

• **Ground rules**: What would allow you to share freely in this room? Keep focused and get closure on questions • Questions 1: What would are your views on reflection as a learning strategy to facilitate CPD of A&E practitioners? • Question 2: What should be included in a reflective tool to facilitate CPD of A&E practitioners? • Wrap up and closing the session	

Annexure E

Focus group: Ground rules

The identification of components for a guided reflective tool to enhance continuous professional development (CPD) of accident and emergency (A&E) practitioners   **- C.J. Filmalter (2008)**

Please complete the following information:

Demographic data:

Academic qualifications	
Current post held?	
What is your field of speciality?	
Years of experience utilising reflection as a learning strategy?	
Are you a clinical facilitator in A&E nursing?	
Are you an A&E lecturer	
Are you an expert within the field of nursing education with a interest and/or experience in the use of reflection?	

Please disclose any other information you regard as important:

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Data analysis summery

Question one
What are your views on reflection as a learning strategy?

Data collected

Theme one: Reflection

	Agree	Disagree	Comments
Reflection is viewed as a valuable and effective means of deep learning			

Question two
What should be included in a reflective tool as a learning strategy for A&E practitioners?

Data collected
Theme two: Pre-requisite for implementing the reflective tool:

	Agree	Disagree	Comments
Buy-in form stakeholders Management • Performance management			
Facilitators • Drive process • Guide reflection			
A&E practitioners • Personality traits • Resistance			

Theme two: continue	Agree	Disagree	Comments
Setting: Environment			
Relationships • Support • Team orientated			
Logistics • Time set aside • Enough staff			

Theme three: The tool

	Agree	Disagree	Comments

Attributes:
     Discussion
     Written accounts
• Holistic
• Universal			

Questioning			
Describe the scene- What happened?			

Knowledge component-
  What do you know about…?
  What did you not know?
  What do you need to know in future?			

Theme three: continue	Agree	Disagree	Comments

Skills component-
    What skills did you display?
    What skills did you not display?
    What skills do you require?			

Affective component-
    How did you feel at the time?
    How do you feel now?
    What has changed?
    What has stayed the same?			

How would you use this new understanding in future?			
What has been the value of this experience?			
Conclusion			

Additional Comments:

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Annexure F

Focus group: Extract from transcripts

Focus group interview

Facilitator: In terms of the outcomes of the focus group um... basically it is about ideas on the main focus of Celia's research. The research focuses on the tool specifically so we have questions for you.

What I will do I'm going to present the questions to you one by one to make uh... it easier to focus. In terms of ground rules um... I would like to suggest that we stay focused on the question and that when we talk about a specific question um... we try to complete the discussion regarding that question so that we don't um... do walk abouts. That will also assist with um...uh... coding of the data ultimately.

The research question then is:

What are your views on reflection as a learning strategy? Anyone can start.

Participant D: It is very important if a person grow and develop in the same mouth that is one of the most difficult justence as well to um... it, it is not easy just very important

Facilitator: Participant D so if you say very important, um... why do you specifically belief it is important?

Participant D: Hg...hg... I see learning as change and if you can't reflect on something and if you are unable to "create" your own, not only your own knowledge and also your emotions too.

You can't um... actually change your-self or your own view if something or... on a specific topic then learning is flat then it is short-term memory and after a week you don't remember anything at all um...
You scan a book you write a test you do well and you think backwards... um... you don't know anything.

But with reflection um... it is really deep learning that take place. Change that takes place, and that is actually when you really learn. You are not going to exactly remember the words as you have learned it but you will be able to translate it into something useful.

Participant A: If I can come in when I did my own research hg...hg... um... with specifically our interviews on reflection and guided reflection the one thing that strucks me was the amount of concerns that come out of the

students. Which we usually not see at that level and the amount of guilt feelings the student experience is very, very a... severe and I don't think there is an easy way to deal with that.

By reflection you can deal with that feelings and that feeling that sort of reflect the issue um... um... don't, it's not only learning the theory but many experiences in practice that can correlate the theory and practice and also the affective component through the theory and the practice so it makes it more holistically – structured tool or uh... reflection.

Facilitator: Participant A you mentioned guided reflection what do you mean by that specifically?

Participant A: Um...for a lay reflectioner it is very difficult to reflect because not all people know what is reflection so you have to guide them how to reflect um... after the question. I use a specific tool which help me to guide the prospective learner how to reflect and that all that came out of that is that um... reflection then focus on practice and affective component that enriched.

Facilitator: And reflection specifically how would you define reflection then as you say that people find it difficult to reflect?

Participant C: Uh…uh… can I say something there I wasn't very sure about reflection just when you went out we asked somebody so we know what you are talking about but if I listen to it, um… the reflection that, that we would explain going to be a structured thing that you can do with your students.

I don't know I feel that we've been doing it all the time we do it in practice everyday its part of what you do, but you don't know that, that it is reflection. So now you're actually just giving a name to something that you always do, cause you always think ok did I do it right must… maybe I should have done it like this and the students from um…um…um… my side. My students like to come to me and discuss the patient that they did and what do I think did they do… do it right did they do it wrong and in a way that is actually reflection and that if you see a thing and you experience a thing you remember it better.

So you can take the theory and the practice and correlate together like, like she says by...by... using experiences that they have lived and I don't actually know that's its reflection. But we do it everyday so now we just giving a name to it I think we have been practically unstructured reflection for a long time now.

Participant B: I think as a learning strategy in the accident and emergency (A&E) it is a very difficult thing we have type A-personalities who um... do not... view structured reflection as necessary it is a very skills orientated environment and emotions do not play a role.

In actual fact emotions should not play a role 'jy weet' most of the time in an A&E environment it actually doesn't matter how you feel as long as you make sure that you do the skills right and um... so... um... I think is a very difficult thing to do as a learning strategy and what I understand we are... your focus is on post basic people who are already trained so not learners, and that is another point if that for reflection as a strategy to enhance learning to maintain skills to work that person must be a life-long learner.

They must have the... the... willingness to want to be a reflective practitioner and the willingness to want to continue to change and that I found in our trained professionals is a quality that they don't always have and if they do not have that... that... trade in them this is not going to work. You first have to change their attitude before you can actually bring this in.

Participant D: I agree that... I also think that not everybody is able to be a reflective practitioner, I think that there are people whose willing and unwilling but I also think there are people that are unable to actually to... able to... to make use of clinical knowledge but the moment that emotions or affections or own experience or own...own ideas comes out they...

Participant B: Also being in the A&E environment it is make or break do or die um... and it is with a type A-personality I found it is very difficult for people to reflect and to... to... to... um... admit that they did something wrong and could've done something better. They don't respond positively.

Learners in a learning… in a learning time do but people who are not learners anymore… that are senior role models they don't respond well to or not all, but there is definitely a population in our environment that do not respond well and will not admit that they can actually, use this as a tool to enhance their skill or to enhance them to do better to make them better practitioners and their attitude.

Annexure G

Confidentiality agreement by coder

CONFIRMATION/DECLARATION OF CONFIDENTIALITY

I, _____

Confirm/declare that the information and data that I have analysed on behalf of S21261212 Ms C.J. Filmalter, whom is undertaking a MCur at the University of Pretoria, will remain confidential and I will not discuss the contents thereof with any other person/s.

Signed at Pretoria on the _____ Day of February 2008.02.12

_____   _____
CODER   Sr C.J. FILMALTER

Annexure H

Data analysis summery feedback

The identification of components for a guided reflective tool to enhance continuous professional development (CPD) of accident and emergency (A&E) practitioners   **- C.J. Filmalter (2008)**

Please complete the following information:

Biographical data:

Academic qualifications	
Current post held?	
What is your field of speciality?	
Years of experience utilising reflection as a learning strategy?	
Are you a clinical facilitator in A&E nursing?	
Are you an A&E lecturer	
Are you an expert within the field of nursing education with a interest and/or experience in the use of reflection?	

Please disclose any other information you regard as important:

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Data analysis summery

Question one
What are your views on reflection as a learning strategy?

Data collected

Theme one: Reflection

	Agree	Disagree	Comments
Reflection is viewed as a valuable and effective means of deep learning			

Question two
What should be included in a reflective tool as a learning strategy for A&E practitioners?

Data collected

Theme two: Pre-requisite for implementing the reflective tool:

	Agree	Disagree	Comments
Buy-in form stakeholders Management • Performance management			
Facilitators • Drive process • Guide reflection			
A&E practitioners • Personality traits • Resistance			

Theme two: continue	Agree	Disagree	Comments
Setting: Environment			
Relationships • Support • Team orientated			
Logistics • Time set aside • Enough staff			

Theme three: The tool

	Agree	Disagree	Comments

Attributes:
     Discussion
     Written accounts
• Holistic
• Universal			

Questioning			
Describe the scene- What happened?			

Knowledge component-
   What do you know about…?
   What did you not know?
   What do you need to know in future?			

Theme three: continue	Agree	Disagree	Comments

Skills component-
     What skills did you display?
     What skills did you not display?
     What skills do you require?			

Affective component-
     How did you feel at the time?
     How do you feel now?
     What has changed?
     What has stayed the same?			

How would you use this new understanding in future?			
What has been the value of this experience?			
Conclusion			

Additional Comments:

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