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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

A reflection on a project to introduce self-medication on an acute medical ward

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Abstract

I have undertaken a reflection of self-medication, the action of patients carrying out their own administration of medications whilst in hospital, using Driscoll's 'What?' model of reflection (Driscoll, 2007). The purpose of this is to reflect on how the process of introducing self-medication in hospital affected the team, and impacted on patient care and on my feelings at the time and now. Self-medication is considered in the context of a 28-bed acute medical and respiratory ward within the local NHS general hospital, the East Sussex Healthcare NHS Trust, on the south coast of England.

Reflection improves practice by facilitating understanding of the world of nursing and enhanced care, where developments may not necessarily be as influential as hoped, requiring adaptation and refinement, which reflection can help bring about.

Implications for practice:

- There needs to be an inclusive approach to changes in medicines management
- Participating staff must be included from an early stage to ensure their concerns over devolved responsibility are addressed
- Formal patient feedback would be valuable in optimising self-medication

Keywords: Self-administration of medicines, acute hospital environment, nursing practice, reflection

Introduction

Self-medication is a programme of administration of medicines whereby individual patients take responsibility for administration of their prescribed regimen following initial assessment and consent, together with ongoing assessment (see Figure 1). The process involves careful selection of patients in terms of cognitive ability, manual dexterity and knowledge of the drug regimen (Vilasuso and Barnett, 2007). Self-medication is not a new concept; however it has had limited success within the acute hospital environment. I have chosen to reflect on the introduction of self-medication within our area at a time when it is not widely used, increasing awareness of its role within medicines management and of the suitability of patients.

Figure 1

SELF-ADMINISTRATION OF MEDICATION ASSESSMENT FORM									
Patient's name:					Date of birth:				
Ward: (or attach label)					Hospital number:				
Completed by (name)			Pharmacy:						
			RGN:						
			Date of assessment:						
<p>1. Does the patient administer their own medication at home? YES / NO</p> <p>2. Is the patient orientated to time and place? YES / NO</p> <p>3. Can the patient open the bottles/blister packs and self-administer the medication with/without reasonable adjustments, eg an aid or training? YES / NO</p> <p>4. Can the patient read the labels? YES / NO</p> <p>5. Can the patient explain the name of the medication, why they are taking it, the dosage and the main possible side-effects? YES / NO</p> <p>6. Does the patient have a history of drug/alcohol/substance abuse or self-harm? YES / NO</p>									
<p>Must answer YES to 1-3 to be considered for self-administration.</p> <p>If NO to either of 4 or 5, or YES to 6, then the patient is not automatically excluded but support/education needed to facilitate self-administration will need to be identified.</p> <p>I am satisfied to the best of my knowledge that the above named patient is competent to self-medicate.</p>									
<p>Level of administration: 1 2 3 (please circle)</p>									
Signature of assessor:					Name printed:				
DATE									
QUESTION Y/N									
1									
2									
3									
4									
5									
6									
Signature									
Continue Y/N									
If no, new level (1,2,3)									
Controlled drug count									
Signature									

My ward is a 28-bed acute medical ward, specialising in respiratory patients, with a mix of patients with acute illness and exacerbations of a chronic illness, primarily chronic obstructive pulmonary disease. I volunteered our ward to be part of the self-medication project due to my interest in medicines management and my status as a nurse independent prescriber.

Practice development seeks to improve patient experience through new and effective person-centred ways of working but it is strongly influenced by local factors within the team and organisation (Canterbury Christ Church University, 2012). Reflection involves intellectual and affective activities to examine experience and clarify meaning (Sherwood and Horton Deutsch, 2008). Within nursing, Gibbs (1988) and Johns (2002) are two popular models of reflection but I consider that these focus upon individual experience, rather than on the reflection process within a wider context. Therefore, I have chosen the 'What?' model of structured reflection by Driscoll (2007), (see Figures 2 and 3, below). I recognise though, that reflection is a personal journey on a continuum of growth and development, which blends theory and practice.

Figure 2: The 'What?' model of structured reflection (Driscoll, 2007)

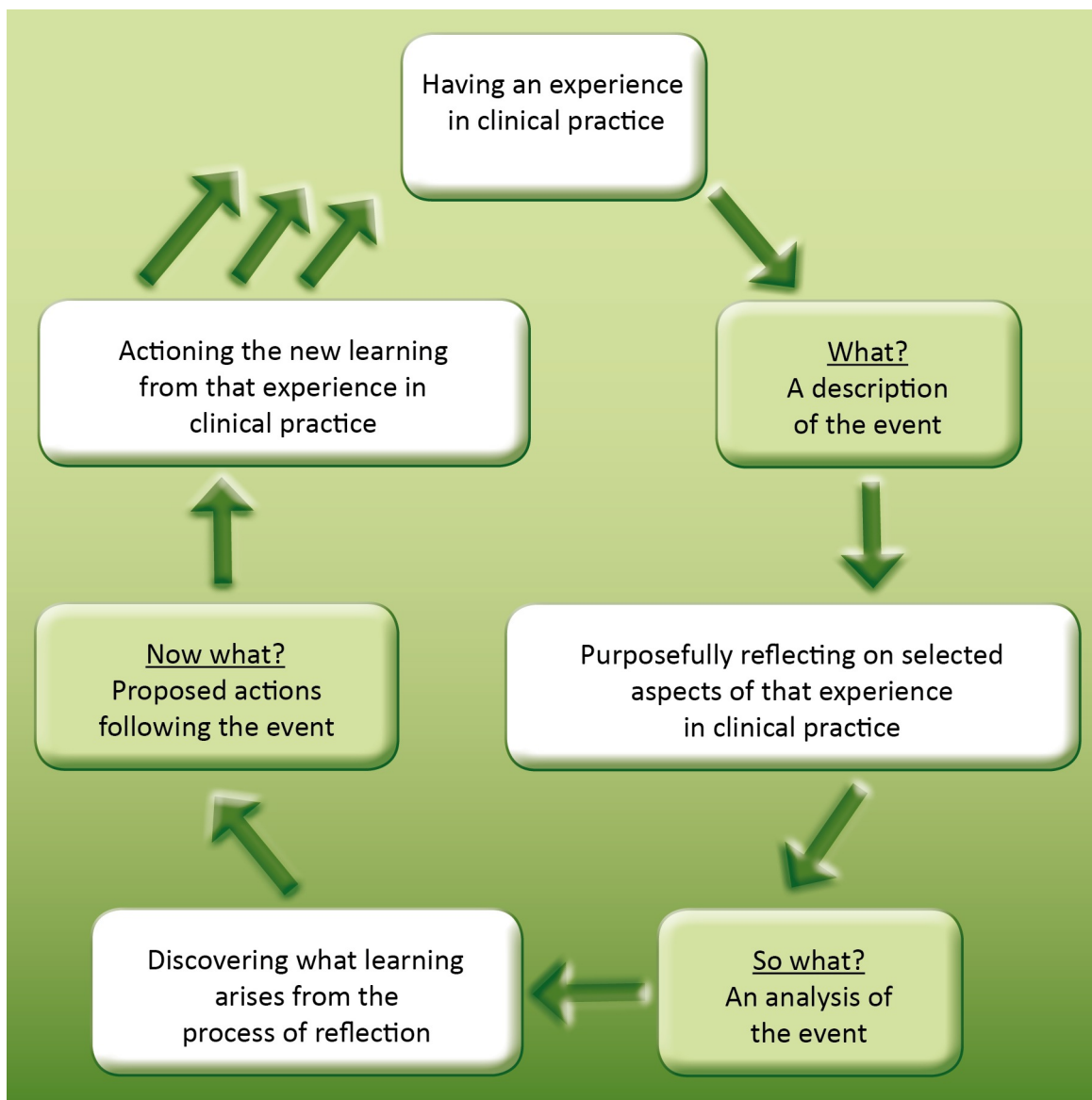


Figure 3: Trigger questions for the 'What?' model of structured reflection (Driscoll, 2007)

1. A description of the event
What? trigger questions <ul style="list-style-type: none">• is the purpose of returning to this situation?• happened?• did I see/do?• was my reaction to it?• did other people do who were involved in this?
2. An analysis of the event
So what? trigger questions <ul style="list-style-type: none">• How did I feel at the time of the event?• Were those feelings I had any different from those of other people who were also involved at the time?• Are my feelings now, after the event, any different from what I experienced at the time?• Do I still feel troubled, if so, in what way?• What were the effects of what I did/did not do?• What positive aspects now emerge for me from the event that happened in practice?• What have I noticed about my behaviour in practice by taking a more measured look at it?• What observations does any person helping me to reflect on my practice make of the way I acted at the time?
3. Proposed action following the event
Now what? trigger questions <ul style="list-style-type: none">• What are the implications for me and others in clinical practice based on what I have described and analysed?• What difference does it make if I choose to do nothing?• Where can I get more information to face a similar situation again?• What help do I need to help me 'action' the results of my reflections?• Which aspects should be tackled first?• How will I notice that I am any different in clinical practice?• What is the main learning that I take from reflecting on my practice in this way?

What?

Returning to the process of self-medication is timely due to recent involvement with the Care Quality Commission within our trust and the enhanced awareness of medicines management.

The policy for self-medication was developed by a small group of nurses and a pharmacist. Relationships are a critical part of nursing and healthcare, and medicines management involves a variety of disciplines to ensure safe and effective practice. On reflection, it was perhaps an oversight not to include a physician, whose contribution would have offered a worthwhile and different perspective, particularly when administration of medicines may be seen as the domain of nursing. Since the inception of self-medication in our trust, the culture of healthcare has changed. There is greater input from users and their voice needs to be heard as the recipients of our practice. Retrospective evaluation and comments from past patients and relatives involved with self-medication might go some way to achieving this. It is important to recognise that practice developments must reflect advances in practice and the changing culture of healthcare.

I hoped that bringing the self-medication project to the ward would prompt staff to participate in a development that would be used throughout the trust, and also to use their skills of assessment, communication and knowledge of medicines to enhance a particular aspect of the patient experience. When a development is implemented in practice, staff need to be persuaded that it is worthwhile and that their involvement can help make it work. At the time, I considered myself a champion for self-medication, yet staff were less enthusiastic, contending that it would involve more paperwork and saying 'they had enough already' and 'we don't have the time'. They felt they lacked control within the sphere of medicines administration and expressed concern that they would remain responsible for any errors. Although this reaction was disappointing for me, I managed it by talking through the process and reassuring staff, explaining the patients' responsibility for safe management and staff responsibility for carrying out assessments, which would protect them in the event of an error. We also reflected on what would happen if a patient was to self-medicate without the appropriate process and assessments having taken place, underlining staff responsibilities relating to medicines. I recognised that, as with all changes, ongoing encouragement and facilitation would be required, including identifying suitable patients and opportunities to assess patients' self-management in order to pinpoint issues and optimise health outcomes. I recognise I was considered the advocate of self-medication on the ward, although through collaboration and participation, self-medication does continue to be a small part of our ward culture.

So what?

Drug administration errors account for more than half of all incidents reported to the National Patient Safety Agency (Thapar et al., 2011). Fulman et al. (2011) found that hospital dispensing schedules caused delays in delivery, for reasons such as the nurse being busy elsewhere or dispensing from pharmacy. Contributory factors to nursing medication errors are manifold and include both individual and systems issues (Kletsiou, 2011). Self-medication, when appropriate, may go some way to addressing some of these issues.

I felt positive about introducing self-medication to the ward as part of practice development, team participation, enhancing medicines management and using nursing skills. I was making a contribution to policy making and also working with the pharmacist as a different approach to medicines management. However, I felt frustrated by some of the nurses' negative responses and lack of motivation for change. As well as concerns over time constraints, they were apprehensive over who would be responsible for risks from other patients. Staff accepted the concept in principle but were unsure how it would actually work in practice, and had increased anxiety relating to 'what if...?' With regard to the frequently cited worries about lack of time, I wondered whether this is always a valid excuse or whether we are just so used to saying we have no time, especially for innovative ideas that challenge the way we practice. Staff were encouraged to talk through these

feelings, think through how accurate assessment would provide a framework for the 'what if...' and to try self-medication in practice.

I now consider that self-medication does have its place within healthcare, although in a less prominent role than I first thought. Healthcare has changed, with a focus on reducing length of inpatient stay, providing more care in the community and prioritizing acutely unwell patients for hospital beds. I also feel, as a result of my own personal development, that I could have asked other staff members to join me as key champions of self-medication, to help support other staff, share skills and values and seek opinions; I could have trusted staff to deliver the standards required in a more collaborative way. These concepts are all central to practice development and are aspects I have become increasingly aware of in my own clinical and managerial practice, through clinical supervision.

However, whilst self-medication may have a less prominent role than I'd hoped within my environment, there are areas where this role can be enhanced, such as community hospitals and rehabilitation areas. Whatever the setting, staff must fully recognise the implications of patients self-medicating without following due process and their own responsibility and accountability for self-medication in the patients for whom they care.

From the patients' perspective, they were receptive to the idea when approached. They understood the paperwork and none expressed concern at having to sign consent. Participating patients' own drugs were kept in a locker with the key given to the patient to keep and a sticker placed on the drug chart and handover sheet. The patients appeared to appreciate the control element and the trust we had in them to take their medications. This may in part be due to their expectation that they would simply be given their medication by nurses in hospital rather than being invited to participate. The patients did not seem concerned about other patients being nearby and, although safety issues were explained, perhaps they did not consider that anyone would take another person's drugs. Nevertheless, it was important that our assessments accurately reflected not only the individual who was self-medicating, but also the environment. Ongoing assessment and discussion not only involves the patients – a current national theme in healthcare – but also ensures optimal drug therapy in a supportive environment. However, I recognise that although self-medication was well received by participants, there was no formal evaluation of the project by patients and, therefore, assessment was based on our judgement. Whilst the project has been going for some time, I consider formal evaluation would be worthwhile and would perhaps reaffirm or challenge my assumptions.

What learning emerged?

Nursing takes place within a given context and medicines management will continue to be an integral part of nursing care. The use of practice development processes to discover assumptions, values and beliefs regarding the purpose of self-medication would have been valuable from the outset to encourage more enthusiastic staff participation.

For me, the learning points that emerged were the need to be collaborative and inclusive throughout the process (McCormack, 2010); and the need to spend more time promoting the concept of self-medication. Learning was evidenced through the completion of daily assessments, communicating with the patients involved and understanding what the project aimed to achieve through discussion. I felt staff were able to verbalise their feelings, whilst recognising that more preparation by way of working through the associated paperwork and the rationale for introducing the project would have enhanced learning. This may have helped to allay some of the fears expressed regarding accountability, responsibility and 'what if...?' However, learning is also about recognising that there is always potential for things to go wrong.

Self-medication has continued, albeit on a small scale for the reasons mentioned, which has ensured ongoing learning, greater understanding and the sharing of values by staff – underpinning the practice development principles of being efficient, effective and appropriate. I have also valued the promotion of the core nursing skills inherent to the project through assessment, being with the patient and enhancing the team ethos of patient-centred care.

Throughout the project I realised that the overriding obstacle to implementation was the time and effort required to sustain self-medication. As such, the assessment was made as simple as possible and time given for explanation and support. However, I accept that this aspect was underestimated due to my own enthusiasm and is a factor to take forward when considering practice developments together with group dynamics.

Reflecting upon learning, I would suggest that some of the potential benefits of a systematic, continuous and facilitative process of practice development have been achieved (McCormack et al., 2004). These included team effectiveness, cross-boundary working and enhancing the knowledge and skills of the nurses. It is imperative that practice developments are demonstrated to be effective and meaningful within the context in which they occur (McCormack, 2010).

Now what?

Whilst advocating the implementation of self-medication, I concede that there appears to be little conclusive evidence of its benefits, particularly within the acute hospital environment where demands are continually being placed on nurses at the front line of care (Desborough et al., 2009). I would suggest that self-medication has failed to become the norm in acute hospital wards due to: constraints on everyone's time, not just that of nurses; the pace of activity on acute wards; the acutely ill patients who may not be well enough to self-medicate; and the focus on length of stay. Thus, practice developments should consider the wider context of the environment and the culture within which they are being undertaken.

An alternative approach may be to have individuals who promote medicines management as a whole across all settings and who would, as part of that broad role, facilitate self-medication processes. This would widen communication about what could be achieved, and encourage multidisciplinary inclusion and formal evaluation of efficiency and effectiveness, without which self-medication will remain almost invisible in acute care. Identifying what is meaningful and valid will empower nurses to facilitate change and improve the patient experience. Another option would be promotion of self-medication through roadshows, posters and screensavers in areas such as longer stay wards, rehabilitation areas and community hospitals, and with carer involvement. Changes to medication regimes and failure to involve hospitalised patients in medicines management may result in errors at home following discharge, patients may be challenged by changes to multi-drug regimens and nurses are in an ideal position to identify and challenge polypharmacy. However, Wright et al. (2006) found that there was inconclusive evidence that self-medication improved compliance and errors still occurred.

Reflecting on the project has allowed me to conclude that, in future practice development projects, it would be beneficial to have personal feedback as to my behaviours and management of change through my manager and clinical supervisor. The nature of human interaction in practice is complex and consideration needs to be given to receptiveness, leadership styles, boundaries and team working, together with individual and group values, in the context of a long-term vision for growth and learning to facilitate patient-centred care (Rycroft-Malone, 2004).

Action from learning experience and conclusion

Improving practice through reflection facilitates understanding of the world of nursing and enhanced care (Esterhuizen and Freshwater, 2008). Through reflection I have recognised that while this project was patient-centred, patients were passive as far as the development of the project was concerned. There is a need to focus on the purpose, what is to be achieved and whose voice needs to be heard. However, even when aiming to enhance practice through sustained effort, commitment and with an ethos of patient-centred care, developments may not necessarily be as influential as first envisaged and may require adaptation to the context and refined thinking. In this respect, effective leadership is essential.

I have recognised the need to promote myself positively, consider my personal behaviours and widen my horizons, with the support of my clinical supervisor and feedback. In this way, I can use the skills and knowledge that I have to enhance care through dissemination, locally or more widely through teaching and publication, becoming a champion for areas of care within my expertise, of which medicines management is one. Initially, I should direct my efforts at achieving a formal evaluation involving staff and patients to take forward the concept of self-medication appropriately.

My own personal and professional development has come about through insight into myself as a participant in the change process, and into my values and assumptions about how an idea will work and be applicable in practice and to the way I work. Such insight in itself is central to our competency as practitioners and has a beneficial influence on patient care.

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A commentary by John Driscoll appears on the following page

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COMMENTARY

A reflection on a project to introduce self-medication on an acute medical ward

John Driscoll

Although with the title, the author suggests this article is a reflection on a self-medication project, I would suggest it presents a complex synthesis of a number of reflections and discussions that happened throughout its development in practice on an acute medical ward. My first impressions were that, whilst there were a number of implications cited arising from the project itself – medication management, patient participation and devolved responsibility – there were likely to be further implications for practice. I am often struck in the reflective work of students, and in face-to-face reflections and/or clinical supervision, how the resultant actions (Now What?) can often be directed towards how ‘others’ (rather than oneself), need to improve from the learning that has taken or is taking place. The ongoing nature of the reflection process means this can continue some time after the event. For instance, what has happened with self-medication on the ward based on the new learning gained and having completed the writing of this article? I am sure that more specific actions as a result of the author’s effort and commitment in becoming published have since emerged that were not evident in the conclusion.

Perhaps it was no surprise that, as someone who was obviously knowledgeable as an independent nurse prescriber and had clear expertise in medication management, the author was instrumental in ‘volunteering’ the ward for the self-medication project. A possible consequence of this may have been rushing through the more facilitative aspects of the project, such as making an assessment of the workplace culture as part of the initial project plan and working with staff to bring about change in a time-pressured environment. I also wondered whether there might have also been a parallel process of working through staff anxieties and frustrations with the project and how any similar feelings were personally managed as the project lead. It would seem that carrying the ‘burden bag’ of managing a significant change in practice alone makes that bag even heavier. Whilst the author’s clinical supervision seemed a regular feature throughout the project, not so obvious was the practical managerial support needed not just to sanction the project, but to legitimise the intended changes in practice.

Significantly, it would seem that the specifics of practice development activities were written in hindsight, and it was not made clear what these processes were when they were cited as having contributed to more effective team working, cross-boundary working and enhancing the knowledge of self-medication both with staff and patients. Some interesting points were raised by patients themselves as a result of being involved with self-medication on the ward, such as feelings of being more in control at a vulnerable time and being ‘trusted by staff’ to self-medicate. Notwithstanding some of the challenges that were posed by patients self-medicating on a busy ward, the project did demonstrate the development of a more patient-centred approach to care. Whilst this also

presented a number of challenges to overcome, it did appear to counterbalance the ever-thorny issue of finding extra time that was a theme throughout the article.

Whilst a formal project evaluation was not undertaken in favour of a patient self-satisfaction survey, it might be that the project is seen as a baseline or a pilot study for broadening out to other acute areas in time. However, I am reminded that one of the attributes of a highly effective person (and perhaps a practice developer) is to 'begin with the end in mind' (Covey, 2007). This means that the project outcomes are identified at the beginning of the project, as far as possible, although it is a more difficult task to predict the process-generated outcomes often seen with practice development projects. Further direct involvement with service users from the project would seem to present a unique opportunity for a formal evaluation – not just to hear a patient voice about self-medicating, but to help drive and support a policy change.

Finally, the author and the team are to be congratulated on a worthy project of introducing self-medication into an acute arena despite the challenges and issues arising from this reflection. Having the courage to publish a project that disseminates but exposes further areas for improvement in the project design, as well as with personal reflection, would seem to complete the project cycle. However, the article probably leaves more questions than answers as well as perhaps a 'lingering uncertainty' that is the companion of the reflective practitioner and of the practice developer.

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