



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

A reflection on nurse advocacy for the person experiencing dementia whilst an in-patient in the general and acute sector

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Abstract

Background: With the increasing older population it is recognised that the incidence of dementia is dramatically rising and subsequent to this is a higher incidence of people experiencing dementia needing care in the general and acute sector, as physical compromise is part of the aging process.

Aim: This research aimed to examine the role of one community mental health nurse (the author) acting as an advocate for the person experiencing dementia whilst an in-patient in the general and acute sector. Challenges encountered were explored with a view to improving practice and the patient experience.

Method: A reflective journal was used for data collection and four pieces of evidence were selected using an inclusion and exclusion criteria. Stephenson's critical reflective framework was used to explore, analyse, interpret and test theory of my own practice.

Findings: Critical analysis revealed emerging themes which identified areas that challenge practice:

- The need for increased understanding in dementia care
- The need for improved effective communication
- The impact of emotions on practice

Interpretation of the outcome of the findings in relation to broader research, evidence and practice context initiated recommendations which were significant to a personal development plan. The process of changing practice was discussed whilst giving consideration to potential barriers and the benefits of using a clinical practice improvement model.

Conclusion: The impact the research had on my own practice is discussed and recommendations for change were made that would impact positively on practice and the patient experience.

Implications for Practice:

- Identify the possible impacts of critical reflection on professional practice
- Recognise the potential neglect of the needs of the vulnerable client and my priorities for practice
- Develop insight into how effective liaison can impact on the patient experience
- Challenge my own assumptions in practice

Keywords: Critical reflection, dementia, nurse advocacy, general and acute setting, working in partnership, person-centred care

Background

As a community mental health nurse (CMHN) for older people, working in a non-National Health Service (NHS) setting, my role is described as autonomous within the realms of a multi-disciplinary team. My work involves supporting older people with various mental health needs within the community setting enabling them to maintain independent living. Much of my work is devoted to the client experiencing dementia and their carers. An important part of my role as care co-ordinator is comparable to that of a dementia advisor, whose responsibility is to act as advocate for the individual experiencing dementia (National Dementia Strategy, 2009); supporting them through care pathways they may have difficulty in accessing themselves. Collaboration with other health and social care professionals and active development of these partnerships is essential in order to maximise the outcome for the person with dementia.

The Dementia UK (2007) report describes dementia as a collection of symptoms including a decline in memory, reasoning and communication. In conjunction with cognitive failure there is a parallel decline in function and skills required to carry out routine daily activities. These symptoms are a direct result of structural and chemical imbalances in the brain caused by physical diseases such as Alzheimer's Disease, vascular dementias and other forms of dementia. Dementia is progressive and unrelenting regardless of chemical intervention (National Dementia Strategy, 2009). As the disease progresses, the person experiencing dementia becomes more vulnerable and their needs often complex which requires appropriate care management (Kitwood, 1997). It is inevitable that physical decline will accompany the aging process and this may result in possible admissions to the general and acute sector (National Dementia Strategy, 2009; National Service Framework for Older People, 2001; Care Services Improvement Partnership, 2008). The Royal College of Psychiatrists (2005) state that the person experiencing established dementia is at an even greater disadvantage as their condition dictates they have a decline in memory, reasoning and communication which may delay treatment for a physical problem resulting in an admission into the general and acute sector. In order for the client experience whilst receiving care in the general and acute sector to be positive, it is important that the CMHN monitors the admission closely (McCallin, 2001). Acting as the clients' advocate, the CMHN is in a favourable position both to inform colleagues of the holistic needs of the client and offer advice accordingly. The outcome of this practice is that staff, feeling reassured and supported, are better equipped to deliver a person-centred approach to care. Brooker (2007) suggests that person-centred care means getting to know the person and then thinking about how their dementia is affecting them. In Standard Two of the National Service Framework for Older People (2001), it is suggested that a person-centred care approach should be demonstrated within the NHS and social care settings in order to meet the individual needs of the older person (National Dementia Strategy, 2009). It is crucial that the CMHN acting as the clients' advocate invests time and commitment towards working collaboratively with colleagues within the general and acute sector in order to enhance the patient experience.

With existing pressures for staff within the general and acute sector, there is evidence to suggest that the main aim is to treat the condition which, whilst being essential, does not always encompass a person-centred approach to care, which may result in a poor experience for the person with dementia (National Dementia Strategy, 2009). Neglect of the overall health and wellbeing of the client with dementia is not deliberate, but through lack of essential knowledge and skills the potential exists for an admission into the general and acute sector to have adverse effects for the client, and indeed impact on their recovery and subsequent outcome. It has become apparent to me in practice, that a lack of understanding exists in the general and acute sector about dementia and the problems the disease poses for the person in relation to their experience whilst in hospital. Caring for the person experiencing dementia is challenging and requires a creative approach in order to address individual needs. For the person experiencing dementia who may no longer have mental capacity to make informed decisions, it is vital that they are advocated for by someone who knows

them well. Gates (1994) suggests that in these circumstances the nurse befriends the client in order to represent, protect and promote their interests. He compares this relationship to that of a relative and describes it as a true partnership which is the essence of person-centred care.

With the aging population and the increase of dementia it will be essential for staff engaged in the general and acute sector to be equipped with the skills to care for this client group effectively. The Nursing and Midwifery Council (2008) code of professional conduct states that the profession has a duty of care to patients, who are entitled to receive safe and competent care. Whilst there is evidence of pressure from identified stakeholders to improve the care of the older person across health and social care services both nationally and locally, there persists a lack of knowledge and understanding with regard to the care of the person experiencing dementia whilst being cared for in the general and acute sector which presents challenges for me acting as nurse advocate. On these occasions I find myself feeling frustrated and disappointed with the outcomes. These and other observations in practice have inspired me to investigate further the challenges of my role as nurse advocate in order to improve my practice and the patient experience. Therefore the aim of my research is to inquire into the challenges for the CMHN acting as advocate for the person experiencing dementia whilst an in-patient in the general and acute sector.

It is evident from previous study, reading and my reflective practice, that the role of nurse advocate for the person with dementia whilst an in-patient in the general and acute sector is an important one. Indeed, the intention is that critical reflection will identify challenges I face as nurse advocate with the aim of improving my practice. The nurse advocacy role has the potential to improve practice in accordance with key components of clinical governance (Royal College of Nursing, 2007) and could potentially demonstrate improved education, learning and development and effective collaborative working between the Community Mental Health Team (CMHT) and the general and acute sector resulting in an enhanced patient experience.

Methodology

For the purpose of my research I chose the practice inquiry methodology. This process sits in the qualitative paradigm and includes approaches such as ethnography, phenomenology and grounded theory. These approaches contribute toward the holistic exploration of peoples' behaviours, lived experiences, cultures and consider the individual as unique which is pertinent to the focus of this research. Practice inquiry is practitioner-centred and is an inquiry unique to the practitioner focusing on his/her individual practice within specific clinical settings. Rolfe (1998) describes practice inquiry as a systematic process of generating knowledge, theory and practice focused on oneself which is disseminated to a wider audience. However, Parahoo (1997) suggests that there can be different interpretations of the same phenomenon and indeed this applies to the reflective practitioner who has developed his/her own scientific, practical and experiential knowledge. In order to exclude bias and for the process to be honest, valid and trustworthy, it was essential that I as the practitioner reflected on myself analytically, which at times I found to be challenging (White et al., 2006). Within the practice inquiry route there are two approaches available; narrative inquiry and critical reflection. I will discuss the approach of critical reflection which was the process I used in my research.

Critical thinking has been encouraged in the nursing profession since the late eighties and continues to be a significant aspect of nursing practice (White et al., 2006). Indeed Jarvis (1992) urges the need for reflective practice within the nursing profession in order to enhance a holistic approach of care to individuals. Bulman and Burns (1994) suggest that the use of critical reflection in nursing can be likened to researchers generating theories which Rolfe (1998) endorses when he refers to practitioner-centred research. Duffy (2007) supports that the concept of critical reflection encourages the practitioner not to accept practice issues as tradition, but to question, review and

consider their practice, with a view to improving the care environment for themselves, colleagues and most importantly for the client (Nursing and Midwifery Council, 2008). In order to critically analyse a situation we must first reflect on it, which Jarvis (1992) states is a learning experience and not just thoughtful practice. Whilst analysing the attributes of personal knowledge, ethics, aesthetics and empirics as described in Carper's 'Ways of Knowing' (Carper, 1978), critical reflection encourages the practitioner to uncover assumptions about oneself, other people and the workplace (Brookfield, 1988). I did in fact hold initial assumptions about the practice focus which is further justification for my choice of approach as it will allow me to challenge these assumptions. Critical reflection is as Schon (1991) states, a continuous process of learning through and from experience. It encourages the practitioner to think in new ways and promotes creativity when problem solving (Mezirow, 1991). The process involves critical analysis and synthesis of the evidence. Data is systematically analysed and connections are made in the findings leading to the development of themes which can be examined and have the potential to promote improved practice (Dewey, 1933). Mezirow (1990) suggests that transformative learning involves the practitioner becoming more reflective and critical, more open to the perspectives of others, less defensive and more accepting of new ideas.

Reflective practice is core to the process of critical reflection and evidence generated in relation to the focus is by observation and documentation. Boud et al. (1985) suggest that reflection encourages analysis of clinical practice and helps the practitioner to develop knowledge and acquire a deeper understanding about the complexities of nursing practice which contributes to the development of clinical competence. Similarly, Avis and Freshwater (2006) state that the critical reflective process provides the opportunity to integrate practice, theory and research. This process is performed with the use of a chosen theoretical reflective practice framework of which there are many models offered by theorists to choose from (Mezirow, 1981; Goodman, 1984; Gibbs, 1988; Burnard, 1991; Driscoll, 1994; Johns, 1994;) who Burns and Bulman (1994) identify as recognised frameworks. The framework allows the process of reflection to have structure and provides logical steps from contemplation to transformation (White et al., 2006). Osterman and Kottcamp (1993) suggest that learning and professional development become a successive and connected action through the cyclical nature of the reflective process.

In previous reflective work my preference has been Johns (1994) and although his framework is influenced by Schon (1987), Carper (1978) and Mezirow (1981), Rolfe et al. (2001) argue that John's (1994) structured framework lends itself to a situation that has been resolved and does not make provision for the question 'How can I take this forward?' Rolfe et al. (2001) consider this stage of reflection to potentially make the greatest contribution to practice. Previously, I have viewed Stephenson's (1994) method as having a tendency to concentrate on the practitioner's perspective which is likely the result of Stephenson herself, reflecting on her own practice as a student nurse over a period of four years. However, in this instance I believe this perspective to be pertinent to the focus statement. Therefore, my choice of framework for the exploration, analysis, interpretation and theory testing procedures of my own practice in this research, was Stephenson's (1994) theoretical reflective practice framework.

Method

The aim of the research was to identify the challenges I encounter in practice as a community mental health nurse, advocating for the person experiencing dementia whilst an in-patient in general and acute sector. I used a reflective journal as the strategy to collect data pertinent to the focus statement, which Schon (1987) describes in his theory of reflection as a means of reflecting-on-action, which was an appropriate form of evidence for this approach. Within the documented reflections, it was essential to consider and adhere to ethical issues pertaining to confidentiality and anonymity. The Nursing and Midwifery Council (2008) clearly state in the standards of conduct,

performance and ethics that the person's right to confidentiality must be respected. In accordance with this, my journal was kept under lock and key in a safe place in my home which only I had access to. All character entries were given pseudonyms and any identifying details such as gender were changed.

In order to condense the evidence to produce a desired focus and for the inquiry to be valid and trustworthy, it was necessary to have an inclusion and exclusion criteria. The inclusion criteria demands that there are essential characteristics present which I had identified as 'dementia', 'general and acute sector', and 'nurse advocacy'. As part of the exclusion criteria, clients with mental health problems other than dementia were excluded and practice situations other than in the general and acute setting were also excluded. Nurse advocacy featured as a recurring theme and was also part of the inclusion criteria as opposed to other disciplines acting as patients' advocate. On further reflection of my journal, it was apparent that much of my evidence related to challenges encountered in practice whilst advocating for the person with dementia in the general and acute sector and the emotional impact this had on me. Hence these additional features were selected as part of the inclusion criteria. However, in order to allow further opportunity for discussion and comparison, it was my intention to add to my inclusion criteria, a practice observation which presented no challenges and was an example of best practice.

Table 1. Inclusion and exclusion criteria

Inclusion	Exclusion	Rationale
Dementia	Other mental health disorders	In order to focus solely on the difficulties which are unique to the person experiencing dementia
General and acute sector	All other practice settings	To promote discussion which is specific to the general acute sector environment
Nurse advocacy	All other advocacy disciplines	To concentrate on the nurse advocacy role in relation to the patient
Stories that portray challenges to my role	Stories that portray no challenges to my role	To explore the trigger factors associated with the challenges
Stories that have an adverse emotional impact on me personally	Stories having no adverse impact emotionally on me personally	To explore the trigger factors causing emotional impact on me personally
One story as an example of best practice		To promote discussion and comparison

Analysis method

From my journal I selected four practice scenarios representative of other recurring themes and that support this analysis method. Their content was analysed separately using the chosen framework of Stephenson (1994).

Table 2. Stephenson's (1994) Reflective Framework

1. What was my role in this situation?
2. Did I feel comfortable or uncomfortable? Why?
3. What actions did I take?
4. How did I and others act?
5. Was it appropriate?
6. How could I have improved the situation for myself, my colleagues?
7. What can I change in the future?
8. Do I feel as if I have learnt anything new about myself?
9. Did I expect anything different to happen? What and why?
10. Has it changed my way of thinking in any way?
11. What knowledge from theory and research can I apply to this situation?
12. What broader issues, for example ethical, political or social arise from this situation?
13. What do I think about these broader issues?

Having analysed the scenarios collectively the next stage was to identify emerging themes through a process of reasoning. I had a hidden assumption that nurse advocacy would present as an emerging theme; however, throughout the analysis of my reflections it has become apparent to me that if the reflective practitioner has indeed been trustworthy in their reflective accounts and subsequent analysis, there may be a conflict between assumptions and realities. There could be initial disappointment in this discovery, which is yet another challenge for the reflective practitioner but is an important component of the continuing process of critical reflection. This discovery I believe to be described by Schon (1996) as a critical process in refining one's artistry or craft in a specific discipline. Whilst acknowledging the concept of critical reflection and adhering to a specific reflective practice framework the core of the investigation has by reflection discovered the true origin of the challenges within the context of the focus statement. Although the CMHN's role as patient advocate is indeed important and plays a part in all scenarios, the true essence of the analysis process has been to interpret the data and subsequently identify the challenges within this area of nursing practice in order to address the focus statement.

The chosen reflective framework helped guide me through each piece of work, enabling me to reflect methodically and with purpose and did indeed sit well with the critical reflective research process. This I believe is in accordance with Dewey (1933) when he described reflection as a form of problem solving that bound several ideas together by connecting each idea with its forerunner in order to resolve an issue. This process of reflection has allowed a greater understanding of practice, and the impetus to seek alternatives for future practice development. This requires brute honesty

about oneself which can be an uncomfortable experience but necessary in order to promote change. The outcome of the analysis has indeed challenged my own assumptions, but in doing so has enlightened me further of the true depth and power of critical reflection and the unconscious uncovering of assumptions, beliefs and values (Boud et al.,1985).

Findings

Whilst initially my journal entries were diverse in content, it became apparent that I only recorded entries of significance which were causing me to question my practice. I noticed that my entries were related to specific situations. Practice situations of greater significance were associated to the person experiencing dementia and more specifically, to situations when they were at their most vulnerable. Another recurring theme appeared to be the vulnerability of clients with varying mental health needs whilst requiring treatment in the general and acute sector. Moreover, nurse advocacy was a continual feature of many of the journal entries. This led me to question why these entries were of a greater significance. I revisited the significant entries to explore their importance in greater depth. The entries varied in content and outcome and there were many examples of good practice which had proved to be gratifying entries to record. However, on reflection of personal thoughts and feelings, some entries had left me feeling disappointed, discouraged and frustrated. In order to reflect with a view to improving my own practice, it was essential to explore these particular practice situations in more depth. This combination of data was evolving into a focus of 'dementia', 'general and acute sector' and 'nurse advocacy'. Analysis of the scenarios demonstrated the CMHN's role as advocate for the person experiencing dementia whilst an in-patient in the general and acute sector.

After careful analysis of four documented practice situations adhering to the Stevenson (1994) framework and whilst examining alternative perspectives of the evidence, three themes emerged:

1. The need for increased understanding of dementia care
2. The need for improved effective communication
3. The impact of emotions on practice

Theme 1: The need for increased understanding of dementia care

There is supporting evidence within the analysis that emotions play a significant part in all scenarios. The evidence supports that the route of expressed emotions is strongly related to personal dissatisfaction with the outcome for the client. Here, the significant and emerging theme is the need for increased understanding of dementia and the care required in order to meet the individual needs of the person experiencing dementia. However, the evidence does illustrate a recognition and desire to become more informed of the complex needs of the person with dementia.

Journal reflections

'When I inquired about his current status the nurse informed me that his diabetes was unstable, he was not eating or drinking and was 'aggressive' towards staff on any intervention'

'I was unable to hide my disappointment and upset with regard to my findings of Mr R's present state and certainly the staff nurse was defensive with regard to her role in this scenario'

'I was becoming frustrated with the staff nurse's lack of insight into the person-centred care approach to Mr R's specific needs in relation to his dementia'

'I was upset at witnessing Mr D's distress which I believed could have been avoided by a more rigorous assessment taking into account his specific needs'

'He stated that he had tried to explain his mobility problems to the staff but because of his communication difficulties he had been unable to express his needs adequately. As a result of this he had now been provided with incontinence aids and was distraught, feeling both embarrassed and humiliated'

'My disappointment was now turning to frustration at the lack of insight shown not only by nurse X but by all staff who had been involved in his care and had made incorrect presumptions about his needs which had proved detrimental to him'

'It was apparent that nurse A was both frustrated and at a loss of how best to approach the problem and appeared relieved at my arrival to the ward. She admitted that her knowledge of dementia was limited and was unsure of the appropriate approach in this instance. I was able to share my knowledge of Mrs F's needs with nurse A both from a holistic view and in respect of her dementia'

Theme 2: The need for improved effective communication

Further investigation into analysis reveals that a recurring theme within all the scenarios is evidence of ineffective communication and the need for improved effective communication between colleagues is significantly highlighted. Examples of effective communication and colleagues working in partnership is demonstrated and should be both recognised and built upon.

Journal reflections

'At this point the staff nurse once again excused herself and continued with her duties elsewhere despite my efforts to engage with her. I felt helpless in a situation that I knew could have had a more pleasing outcome had the staff nurse allowed me to discuss Mr R's complex needs with her'

'As there is no access to shared documentation for colleagues in the acute sector with regard to individual needs, it relies on the CMHN to facilitate this essential information in order to aid a positive experience for the client'

'However, the occupational therapist and physiotherapist remained adamant in their opinion and communication between us was not effective. At this point I was feeling frustrated and attempted to encourage the two team members to view the case holistically and that if Mrs H was not given the opportunity to return home it would have a devastating impact on her'

'I had brought with me a completed needs assessment document which I felt would be beneficial to the staff in meeting Mr R's mental health needs which I was aware may be challenging for them on occasion and likely to be further exacerbated by his unstable diabetes. I offered to go through the document with the staff nurse but the ward was obviously busy and she was unable to give the time but agreed to look at it later. I advised her that it would be beneficial for both Mr R and the staff if she ensured that she and her colleagues familiarised themselves with the document as it would indicate his specific needs in relation to his dementia'

'I felt I had fulfilled my role as nurse advocate for Mrs F and that together nurse A and myself had communicated effectively and overcome what might have been potentially a difficult situation'

Theme 3: The impact of emotions on practice

Whilst reflecting on the scenarios it became apparent that emotions have played a significant role throughout the interpretive procedure and are certainly a factor in all themes in some respect. There is evidence in all the scenarios of the impact both negative and positive emotions have on situational outcomes.

Journal reflections

'...there was an uncomfortable atmosphere developing during the meeting'

'I was upset at witnessing Mr D's distress...'

'I was unable to hide my disappointment and upset...'

'I was at this stage feeling disgruntled that the nurse appeared defensive and was unwilling to make time in order for me to inform her of Mr R's needs on his behalf as he was unable to do so'

'The sight of Mr R's distress angered me even further and I immediately searched for the staff nurse'

'The visit to the ward had a pleasing and satisfying outcome for all concerned. Mrs F had received the prescribed treatment successfully and staff were now better equipped to meet her physical needs'

whilst taking into account her mental health needs. Nurse A now felt more confident in caring for Mrs F'

Discussion

Having reached conclusions based on written reflections of observation of practice, I then needed to interpret the outcome of the findings in relation to broader research, evidence and practice context. This is consistent with using theory testing procedures, the third phase of the concept of critical reflection as a research process (Avis and Freshwater, 2006) and can be useful in supporting recommendations for practice change.

Theme 1: The need for increased understanding of dementia care

Whilst appreciating that the priority for colleagues within the acute sector is regarded as being to assess and treat the clients' physiological complaint (Young and George, 2003; Lewis, 2004) it is essential for staff to have an understanding of the person's individual needs in respect of their dementia in order to ensure a positive patient experience (National Dementia Strategy, 2009). My data reflected a number of key findings already present in the literature. For example, Dewing (2001) highlights the need for staff in the general and acute sector to have an understanding of dementia in order to respond to the clients' needs effectively, which is consistent with findings in the analysis of the data. Harrison (2007) makes reference to the fact that a lack of understanding can limit access to certain services and individual treatments for the person with mental health needs which may impact on their recovery. Brinn (2000) reinforces this view when he implies that nursing and medical staff often feel ill-equipped to respond to the mental health needs of patients. I found that knowledge of dementia is limited. This is consistent with Tabet et al. (2005) when they state that dementia education is low profile in both nursing and medical curricula. Priest and Holmberg (2000) argue that this lack of knowledge can generate negative behaviours in staff and unmet patient needs (Hanks, 2008). I also observed this. These statements reinforce the importance of the nurse advocacy role in respect of this client group who Mallik (1998) refers to as vulnerable patients who have been recognised as a causative factor in nurse advocacy. Furthermore, Dewing (2001) suggests that the approach taken by staff caring for the person experiencing dementia is an important element to their recovery. Harrison and Zohhadi (2005) and Ekman et al. (1991) recognise the potential for negative views with regard to this client group and argue that many general and acute sector nurses may not regard mental health care as part of their role. These actions are not deliberate and Harrison and Zohhadi (2005) confirm this when they state that nurses in the general and acute sector feel a sense of professional failure and frustration when caring for this client group because of lack of skilled knowledge. In summary this deficit in knowledge and skills has the potential to allow the possibility of exclusion for the person experiencing dementia who may have difficulty in communicating or making their needs known. This position is a positive indicator for change. Increased knowledge and skills would improve staff competencies and promote confidence with regard to the care of this client group and subsequently impact positively on the challenges encountered as nurse advocate.

This increased knowledge amongst colleagues would promote confidence with regard to the specific care needs of this client group and subsequently impact positively on the patient experience. An increased understanding of dementia care within the general and acute sector would have an encouraging influence on interpersonal relationships and collaboration and significantly reduce the current challenges encountered within this area of practice, as staff would be collective in their goals for this client group.

Theme 2: The need for improved effective communication

My findings make it apparent that there is a need for improved communication between disciplines and there are continuous efforts to address the need for more effective communication within

nursing practice nationally (Nursing and Midwifery Council, 2008). Whilst recognising collaborative working as a challenge, Arnold and Boggs (1995) describe effective communication between all disciplines associated with the clients' care as being the foundation of nursing practice. Gray, B. (1989) discusses the benefits of professionals combining resources and information in order to meet the individual needs of the client. With the advances in nursing practice and the introduction of multi-disciplinary collaboration, the focus is on improved patient care. However, in order for collaborative working, which is described by Match (1978) as providing separate but related services, to be effective there must exist strong communication channels and it is suggested by Bailey and Baillie (1996), that effective communication and development of interpersonal relationships are essential features seen in skilled and competent nursing practitioners. Pollard et al. (2005) state that interpersonal working relationships are approached with some degree of anxiety. This anxiety possibly originates from the different cultures between general and acute sector nurses and mental health nurses. Tummers et al. (2000) discuss these differences when they state that mental health nurses have more autonomy than general and acute sector nurses and are less dependent on colleagues than their counterparts. Since their role dictates a different level of nurse-patient interaction, their interventions are less controllable than that of the general and acute nurse who practices within the constraints of their environment (Dallender et al., 1999). It is possible that these differences in practice, unless fully appreciated, may cause negative emotions and subsequent outcomes (Goleman, 1998). Gray (1989) suggests that an increased understanding of roles enables the provision of consumer satisfaction and positive patient experience.

Furthermore, it could be argued that general and acute sector nurses do not have a clear understanding of the role of nurse advocate as role conflict has been apparent in the data. On the other hand it may be that the differences in cultures of the mental health nurse and the general and acute nurse is indeed the origin of conflict. Poor communication is identified as one of the barriers of effective collaboration between disciplines (van Eyk and Baum, 2002) which adds a further challenge to my role as advocate for the person experiencing dementia. The importance of nurses engaging collaboratively or working in partnership with other professionals in order to provide high quality patient care is recognised within both national and local policies respectively (Care Services Improvement Partnership, 2005; Royal College of Nursing, 2007; Health and Social Services Business Plan, 2007; Nursing and Midwifery Council, 2008; States of Jersey Health and Social Services, 2008). Part of my CMHN role, acting as advocate for the person experiencing dementia incorporates frequent visits to the acute sector, which places me in a suitable position to build on increased effective communication by working in partnership with colleagues in the general and acute sector. This has the potential to impact positively on inter-personal relationships and the patient experience.

Theme 3: The impact of emotions

Emotions are an important part of one's personal identity and within nursing practice play a significant role in the commitment to caring (Arnold and Boggs, 1995). Nursing emotion work is defined by Dingwall and Allen (2001) as the management of emotions of self and other healthcare team members in order to improve care. It is apparent throughout the analytical procedure that my emotions, both positive and negative, are highlighted within the data analysis and have indeed been identified in the interpretative procedure as having significance for me personally in relation to practice outcomes with respect to the focus statement. Negative emotions, if not managed, can result in stress related problems which can impact not only at a personal level, but at ward and organisational levels also. There is evidence throughout the data analysis that emotions feature noticeably and the impact this has on practice is apparent to some degree within all the identified themes. Gray (2009) suggests that whilst many nurses have difficulty in accepting emotional work as part of the profession, in order for emotions to be managed in health care, they must first be

acknowledged. Miller et al. (2008) conclude in their findings that in order for nurses to engage in inter-professional collaboration effectively the issues of emotion work must be addressed.

As a CMHN, my role, whilst being part of a multi-disciplinary team is regarded as autonomous. Although this has its advantages there are fewer opportunities to engage in supportive interactions (Cronin-Stubbs and Brophy, 1985). Bush (2005) suggests that in order for nurses to appreciate and understand the aspects of patient care they must understand the emotional effects of caring. This he describes as part of the concept of clinical supervision (Bush, 2005). There is evidence to suggest existing strong links between clinical supervision and reflective practice. Clinical supervision will enable me to reflect on the impact of my emotions, which has been identified as a challenge to me in practice, in order to develop my practice further with a view to enhancing care delivery and the patient experience.

Limitations to the study

Whilst searching the literature I discovered that there appeared to be a lack of evidence to support my research with regard to intervention studies involving CMHTs in more significant ways in the general and acute setting. Also there was a deficit in evaluation of the CMHN acting as nurse advocate or advisor. This research has helped me inquire systematically into my current practice in relation to a specific focus and whilst it has facilitated the integration of theory and practice (Landeem et al., 1995), it is not without its limitations. Data collection has been dedicated to this specific area of my practice and does not consider other aspects of my role as a CMHN. In addition my data was relatively small. Reflection on self-practice is unique to the individual and cannot be generalised outwardly to the broader aspects of practice although practice can be influenced by example, role modelling and education. However I could have sought out some type of peer review from another practitioner with greater expertise in critical reflection.

Whilst findings throughout this inquiry are supported by broader research and evidence, it is subjective and this may limit practice development beyond my own. Furthermore, whilst consideration has been given to the benefits of reflection, the practice itself is not without limitations and the nursing profession has been criticised for actively embracing reflective practice (Jarvis, 1992). The reflective practitioner is at times challenged emotionally, and Rich and Parker (1995) suggest that reflection on negative situations may produce feelings of hopelessness and poor self-esteem. Unless the reflective practitioner is truthful and honest there is the opportunity for deceit and Mackintosh (1998) questions whether students reflect accurately or write what they believe their teachers want to read. Finally, Jones (1995) argues that reflection may be altered by the effects of hindsight bias which is to influence peoples' recollection of events once they know the final outcome.

This research has provided me with the impetus to question and reflect on my own practice in relation to the challenges I encounter whilst advocating for the person experiencing dementia when an in-patient in the general and acute sector. The process of critical reflection has enabled me to have a better understanding of the nature and boundaries of my role in practice and that of other professionals (Freshwater, 2002). It has led to an improved understanding of the condition under which practitioners practice and in particular the barriers that limit practitioners' therapeutic value (Johns, 1994, 1995).

Discussion and implications for person-centred dementia care

My local practice findings, supported by the published evidence, shows there is a need for change. This is further endorsed by national and local stakeholders. Practicing as a CMHN in Old Age Psychiatry places me in an advantaged position with respect to knowledge, skills, information and education, with regard to the care of the person experiencing dementia and I feel confident in

communicating the philosophy of person-centred care as part of my advocacy role. As my practice involves frequent and regular visits to clients receiving care in the general and acute sector, I have the opportunity to share this knowledge and experience with colleagues with regard to specific areas of dementia care.

A recent initiative within local Health and Social Services derived from the National Dementia Strategy (2009) to develop 'Champions for Person-Centred Dementia Care' can offer a strategic way to achieve this. I am a key member of this strategy group and will be leading on the training and education aspect. This places me in a favourable position to influence knowledge and awareness with regard to person-centred dementia care amongst my general and acute colleagues and sits within my practice context. I am hopeful that involvement in this project will promote self-development and complement my existing role in practice with regard to increasing the understanding of dementia for colleagues in the general and acute sector. This increased knowledge of the philosophy of person-centred dementia care will promote confidence and satisfaction among colleagues who will feel equipped with knowledge and on-going experience of meeting the needs of the person experiencing dementia. Furthermore this change in practice will impact positively on the patient experience. Equally important is the positive impact this recommendation will have in addressing the challenges I encounter in practice.

Working in partnership

Practice evidence concludes that a major barrier to collaborative working is the lack of effective communication. This is supported in discussion which also highlights the potential for less satisfactory patient outcomes due to a breakdown in communication between professionals. I have been able to identify proposed actions which have the possibility of improving effective communication between disciplines and subsequent patient experience. These proposed recommendations have the potential to positively impact on improved effective communication and collaboration between the CMHN and colleagues within the general and acute sector, encouraging a greater understanding and regard for one and others' roles. There is a further possibility for these recommendations to improve practice with regard to the person experiencing dementia when an in-patient in the general and acute sector. Also, recommendations with regard to person-centred care will complement improved communication efforts by further developing inter-personal relationships between colleagues and so reduce the challenges I encounter in practice.

Clinical supervision

During the reflective process it has become more apparent to me the impact emotions have on practice situations and how this may result in poor outcomes for staff and subsequent patient experiences. Throughout the analytical procedures, there is evidence of expressed emotion both positive and negative in relation to practice situations. Whilst I acknowledge negative emotion may be a response to a particularly difficult practice situation, I also recognise negative emotions to be a personal challenge for me in practice. Although there are many occasions of experiencing fulfilment whilst acting as nurse advocate, it is recognised in literature that the role of nurse advocate can provoke emotions such as frustration and anger (Mallik, 1997, 1998; Hellwig et al., 2003) as seen in the scenarios. Boud et al. (1985) stress the importance of focusing on positive emotions as well as trying to deal with negative feelings in order for the reflective process to be constructive. On the other hand Burns and Bulman (1994) argue that analysis of one's own feelings should not be a self-indulgent activity but a process that highlights practice situations which enhances learning from those situations. Clinical supervision will provide me with support and encourage me to channel my emotions in relation to difficult practice situations. It will foster an increased self-awareness of practice delivery and promote exploration of practice issues at a deeper level (Driscoll, 2000). All of these characteristics of improved individual performance will subsequently impact on identified

challenges within my practice role which has the potential to positively influence colleagues and the patient experience.

The process of change

Curtis and White (2002) suggest it is inevitable that there is resistance towards change as change will disrupt the balance within a group and reasons for resistance range from increased stress; denial; uncertainty; trust and ownership; motivation and personality. Strategies used for reducing resistance are slow introduction; participation; psychological ownership; education; facilitation and development of trust (Curtis and White, 2002). Although this research is an inquiry into personal practice development, subsequent recommendations and implications for change will impact on others and so the broader aspects of change must be considered.

Potential barriers and challenges to the proposed action plan

McCallin (2001) identifies teamwork as an essential strategy in the process of change. Whilst contemplating the possible barriers and challenges which may influence my action plan I have initially explored the culture of my own CMHT as it will be essential to enlist their support. The team networks well with other disciplines demonstrating efficient inter-personal skills. Communication amongst the team is effective and information is exchanged both formally and informally. Team members are supportive of one another which will enable me to fulfil my proposals and I feel confident that team members will both support and contribute towards recommendations constructively. There may of course be resistance to change from colleagues in the general and acute sector. Whilst the aim is to improve my own practice, it will be equally important for my colleagues in the general and acute sector to collaborate willingly in order for change to occur. Dissemination of information to colleagues with regard to the proposed changes will be essential.

Implementing change

Fowler et al. (1999) suggest that in order to achieve a relatively smooth transition when introducing change, it is advisable to work within a change management framework which allows guidance and structure to the recommended changes and monitors success. For the purpose of this research, I have used 'The clinical practice improvement model' (Langley et al., 1996) which is pertinent to the recommendations.

Conclusion

The purpose of this research has been to inquire, by the process of critical reflection, into an experience of my practice in order to describe, analyse and evaluate and so inform about practice. The process of this research has been a personal journey in self-practice development and at times has been both thought provoking and emotional at a personal level. My regard for the value of critical reflection in nursing practice has increased dramatically as a result of this research. Whilst I considered myself to be a reflective practitioner, the experience gained through this research has enabled me to reflect at a deeper level due to a new understanding of the process of critical reflection. Implications for practice change are supported by evidence and research and have the potential to address the challenges I encounter within practice and subsequently enhance the patient experience for the person experiencing dementia whilst an in-patient in the general and acute sector.

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A commentary on this paper by Abigail Masterson follows on the next page.



COMMENTARY

A reflection on nurse advocacy for the person experiencing dementia whilst an in-patient in the general and acute sector

Abigail Masterson

Reflective practice has been advocated for nearly three decades in nursing and has been a fundamental part of all pre-registration and most post registration programmes for nearly twenty years, yet it is rare for such reflections – particularly those of experienced practitioners - to be published and the insights derived therefrom made available for the benefit of others. My own clinical background is services for older people; I have been involved in debates about nursing roles since the early 1990s and I am currently undertaking a professional doctorate which is grounded in critical reflection on my own practice. I was therefore delighted to be asked to comment on this article in which a community mental health nurse for older people reflects on her experiences in acting as an advocate for individuals with dementia in the acute general hospital setting. The article provoked many questions for me related to the focus of the reflection, nursing roles and the experiences of people with dementia in general hospital settings, as well as the nature of the reflective process itself. I have used some of these questions to structure my commentary.

Is the notion of an autonomous practitioner helpful?

I was intrigued by the reference to autonomous practice in the first sentence, followed by a statement about mental health nurses being more autonomous than their peers in acute general hospital settings in the discussion about interpersonal relationships between the author and her counterparts in the general hospital, and finally the suggestion that the autonomous nature of her practice acted as a barrier to the author being able to access support. This intrigued me in that these references although brief, perhaps unconsciously, illustrated some of the challenges associated with the concept of autonomous practice in nursing and health care more generally. Autonomous practice was pursued almost as a holy grail in nursing in the 1980s because of a perceived association with it being a fundamental element of professionalism (Dickinson, 1982), and then since the late 1990s more divisively as an essential component of advanced practice and a means of differentiating between different levels of practice in nursing (National Organisation of Nurse Practitioner Faculties, 2011). Autonomy is commonly accepted to mean having the individual authority to make decisions and as a concept has latterly been subject to significant challenge in relation to all health professions by the patient safety movement, highlighting the importance of interconnections and team-based decision-making in ensuring safer and higher quality care and the patient self-advocacy movement seeing professional autonomy as a barrier to the implementation of truly person centered care supported by shared decision-making. Might therefore the author's belief in the superiority of being an autonomous practitioner undermine her relationships with ward nurses and indeed be antithetical to patient self advocacy?

What preparation and support do nurses need to work successfully in cross organisational roles?

There is growing interest in developing care pathways that span organisations and navigation/co-ordination roles that cross traditional organisational boundaries. Nurses are often suggested as the ideal care navigators. Much less consideration has been given to the preparation for and support required to undertake such roles successfully. This reflection begins to illuminate some of the difficulties involved in trying to influence the practice of peers without the assistance of line management authority, and demonstrates the significant emotional challenges to postholders these sorts of roles can pose, thus offering some insight into the knowledge, skills and support likely to be required for successful implementation.

Is advocacy a legitimate role for nurses?

This article is based on an unchallenged premise that nurse advocacy is a good thing and that it is a fundamental part of the care co-ordinator/care navigator role. Advocacy, much like autonomous practice considered above, is a highly complex concept which nurses have tended to claim somewhat uncritically. In the UK, 'The Code: Standards of conduct, performance and ethics for nurse and midwives' says "... you must advocate for those in your care, helping them to access relevant health and social care, information and support' (Nursing and Midwifery Council, 2008 p 3) which makes advocacy the responsibility of every nurse on the register yet in this reflective piece the author is often advocating for the patient against her fellow registrants, a position that is highly likely to result in the types of confrontations and conflicts described. There is also potential for disharmony between nurses and the other health professions if nursing and nurses promote patient advocacy as a particularly nursing role. In the professional and the patients' rights literature, questions have been raised about legitimacy and permission to advocate and an independent third party role has been suggested as a more suitable alternative. Patient representative groups have also raised concerns about nurses assuming an advocacy role rather than supporting self-advocacy and shared decision-making. The respective value of clinical advocacy i.e. advocating for individual patients in individual situations as opposed to organisational and/or system advocacy also merits debate which leads me on to my next question.

What is the appropriate service response to one in four patients in acute general hospitals having dementia?

Numerous reports have identified that at least one in four patients in acute general hospitals in the UK are likely to have dementia (Alzheimer's Society, 2012). Given this, is having a specialist care navigator for those patients an appropriate system response or would it be better instead to ensure that all staff working in acute hospitals understand that people with dementia are a core client group and that they seek and are given the appropriate training and support to care for this group appropriately? Similarly might the author have more impact working at an organisational level with clinical staff rather than fire-fighting individual cases?

How should we judge quality and ethical practice in critical reflection?

The author notes her desire to exclude bias and be honest, valid and trustworthy in her reflection thus implicitly offering us her criteria for quality. Are these the only or indeed the most appropriate quality criteria? In more traditional research, the quality parameters are well codified and accepted, the same is less the case in practice inquiry work of this sort. For example, is the desire to exclude bias and seek validity appropriate, feasible or coherent with the philosophical assumptions of critical reflection?

How to conduct practice inquiry ethically is also an underdeveloped area in the literature. Is ensuring that reflections are stored under a lock and key sufficient to preserve confidentiality, is changing the sex of those involved to maintain their anonymity ethical and or appropriate? How does presenting a man's experience as a woman's or vice versa fit with the intention to be honest and trustworthy?

What next for practice?

My experience of crafting this commentary, which I hope will resonate with your experience of reading it, has emphasised the value for me of such pieces of small, personally focused pieces of reflective inquiry work in highlighting important areas for further professional, practice and service debate and new areas of inquiry in the practice and methods of critical reflection.

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A response to the commentary by the author follows on the next page.



RESPONSE TO COMMENTARY

A reflection on nurse advocacy for the person experiencing dementia whilst an in-patient in the general and acute sector

Mo Boersma

I would like to thank the commentator for their commentary and welcome the opportunity to respond to some of the views expressed. I was pleased in particular that the commentator's background was that of care of the older person and indeed that they have a special interest in critical reflection and their acknowledgement that others in practice may benefit from my own personal experiences.

What must be taken into account throughout this paper is that it is an inquiry into my own experiences in practice and is therefore subjective. However, the process of critical reflection has enabled the exploration, analysis, interpretation and theory testing of my own practice and reference is made to research, literature and policy throughout.

Whilst I regard my role as autonomous it is within the realms of a multidisciplinary team and decision making is not achieved independently. Indeed collaborative working with colleagues in the general and acute sector is essential in promoting a positive patient experience/outcome and this is made reference to in my findings, when the need for more effective communication is identified.

I agree with the commentator, that advocacy is the responsibility of every registered nurse (NMC, 2008) and that self-advocacy should be supported and encouraged. However, for the person experiencing dementia who may no longer have mental capacity to make informed decisions, it is vital that they are advocated for by someone who knows them well (Gates, 1994). This patient right will be further enhanced by the recommendation for an improved understanding of dementia care.

Whilst practice inquiry is not, as stated, without its limitations which has been further endorsed by the commentator, it has provided me with a process of exploring my own practice at a deeper level with the potential of improving practice and the patient experience (Ponte et al., 2004).

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