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Working with Complexity in Reflective Practice: Images, thoughts and feelings brought up in sessions

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Working with Complexity in Reflective Practice

Images, thoughts and feelings brought up in sessions

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In relation to this presentation I declare that I have no conflict of interest

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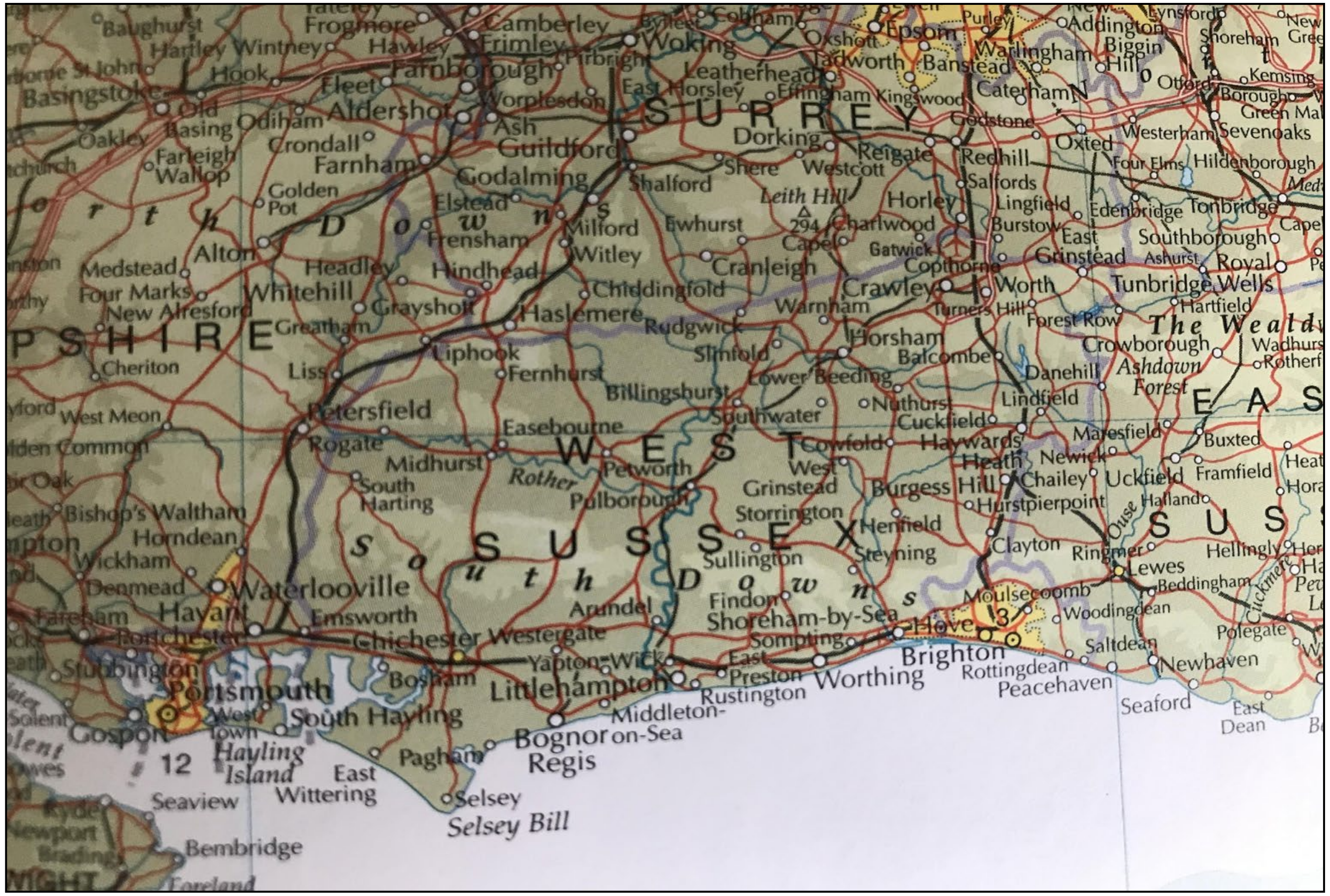
Pause

Aims…



Who are we?

Caseload

The caseload comprises of individuals who have lived experience of multiple and complex needs including:

- Substance misuse [alcohol, crystal meth, G, cannabis], mental ill-health, homelessness or a safe place to call home, non-adherence to medications, interpersonal difficulties and breakdown in relationships, domestic violence, lack of funds/poverty.

- Perhaps many of these issues attributed to complex childhood and/or adult trauma.

This caseload of patients *may* not have had their needs fulfilled in childhood, therefore to be shown they matter, to learn and develop functional capacities for self-soothing, to develop a trusting relationship with a professional other are important in the nurse/patient relationship.

Caseload

- All new patients to the service are assessed by the nurses, including a risk assessment and self report measures using PHQ-9 & GAD-7.

- Overall referrals come from secondary care, from both the HIV consultants and acute specialist nurses**.** We are hoping for more liaison with community services in order to increase referrals from GPs and primary care

- If referred for psychological assessment I like to keep in mind life history including childhood, support structures and risk to self or others both now and in the past plus what this individual sees as the problem and how they would like to work with me. I may ask patients to self report using an Adverse Childhood Events (ACE) score.

Reflective Practice

- Reflective practice sessions had been discussed at management level within the wider community Trust and other staffing groups had been encouraged to participate. A Reflective Practice Lead had been commissioned and there were regular reflective practice supervision for facilitators of sessions.

- The psychological intention is as a supportive team resource for thinking about problems, challenges & dilemmas faced when working with a complex caseload.

- New to post with my own caseload as well as offering staff support and training.

- What did staff *want* from reflective practice?
- What did staff *need* from reflective practice?

- Contract? What would this consist of?

Reflective Practice

- Nursing staff engaged in verbal discussion as to what they would like from reflective practice sessions.

- Initially it was suggested monthly reflective practice sessions for the whole team. However although we are one community HIV team we operate within three geographical areas with two bases so one team would have to join the sessions online.

- Due to the staff taking annual leave prior to April it was difficult at times to engage with all of the team members therefore we discussed twice monthly reflective practice sessions allowing all members of the team to contribute.

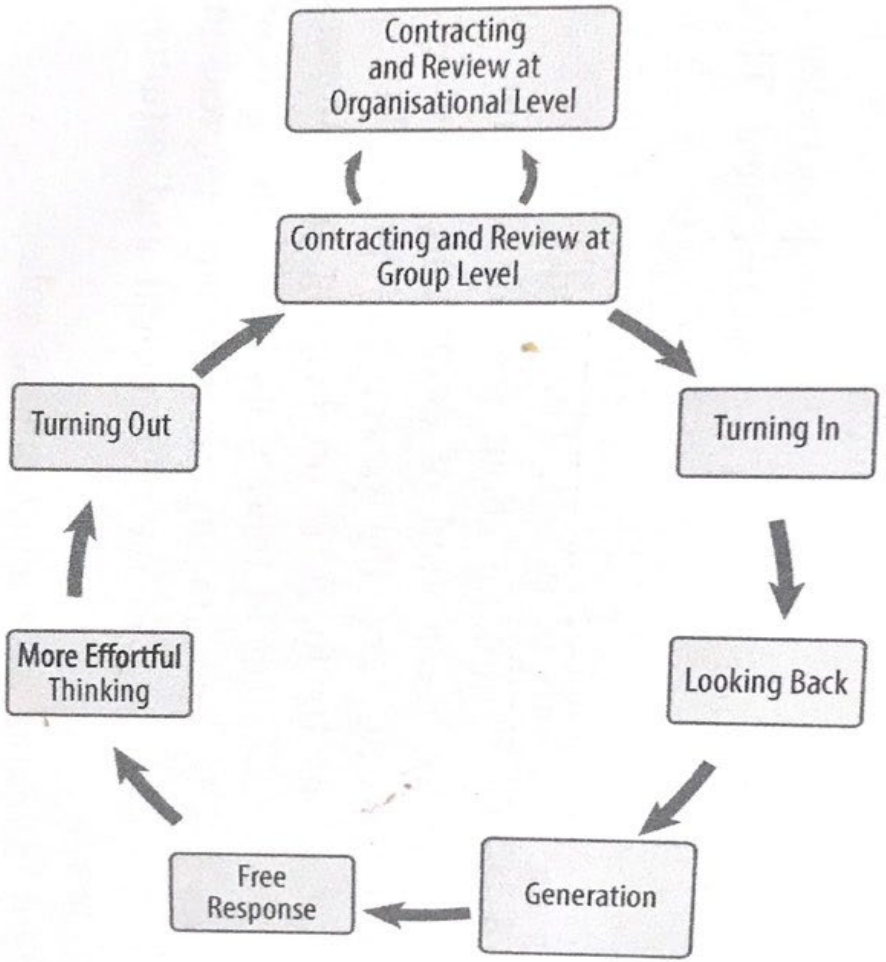
Reflective Practice

There are various models of reflective practice, perhaps the most popular being:

- The ERA cycle [Jasper 2013], Driscoll's What model, Kolb's Experiential Learning Cycle [1984], Gibbs Reflective Cycle, The Professional Nur.
- Kurtz's hearts & heads model to discuss individual cases which a nurse may be finding difficult to manage in some way.

- The model presented by Kurtz [2020] is an eight-stage intersubjective model of reflective practice for groups in healthcare. This model places an emphasis on looking at the feelings evoked in practitioners by their work.
- Use of this model involves a shifting from busy work mode to a reflexive stance [Kurtz, 2020., p10], and generating material for reflection from the lived experience of practice.

Kurtz model of reflective practice



Contracting and Review at Organisational Level
Liaising regarding aims at service level and practical support

Contracting and Review at Group Level
Agreeing aims within group and ways of supporting these

Turning In
Shifting from busy work mode to reflexive stance

Looking Back
Following up from previous meetings

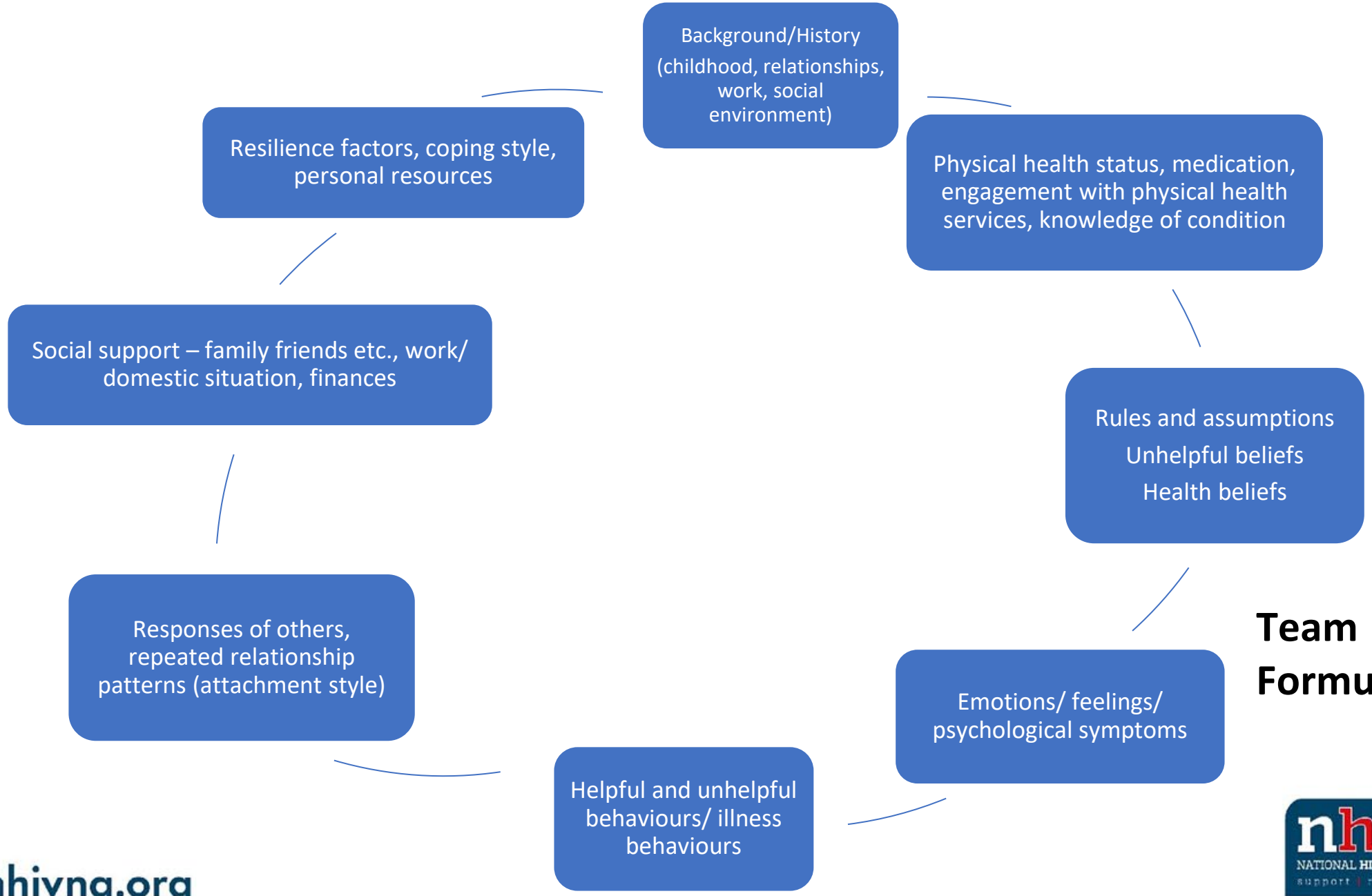
Generation
Producing material for reflection from lived experience of practice

Free Response
Sharing feelings, spontaneous reactions and associations

More Effortful Thinking
Stepping back to think about what is happening

Turning Out
Adapting ideas to the real-world situation

Diagram of the Intersubjective Model of Reflective Practice Groups



Team Formulation

Reflective Practice

- Individual nursing staff were able to feel contained within the sessions whilst discussing thoughts, feelings and bodily sensations in a non-judgemental, confidential setting where they felt supported.

- There was discussion on how the work impacted them as individuals as often this work was stressful and it was difficult not to hold patients in their minds when away from the work environment. The team were able to think about use of the self when discussing patients, what images were evoked in them and why this may be so.

- The team were also able to generate ideas for how they would work in a more constructive/assertive way that would be good for the team.

Reflective Practice

- We discussed unconscious communication– what was triggered for the nurse when working with individual patients? Disowned [perhaps split off] feelings that someone may find difficult to acknowledge about themselves. Risk & safety issues, dissociation.

- moral injury /trauma informed care.

- Casement [2008] suggests “members of the healthcare team have a particular need to be professionally ‘held’ whilst they learn about their patient and their response to that patient.

- Holding of caseload, ‘feeling held’ perhaps for the 1st time [patients], holding of space for staff, holding of space in supervision for psychologist.

- Reflective practice *can* be seen in a supervisory context or ‘holding’ where the facilitator or supervisor of the team believes in the nurses ability to be in tune with the patient”.

Themes and issues

Using data generated from the reflective practice sessions the main themes that emerged were:

- use of boundaries both with other healthcare professionals & patients
- thoughts/feelings brought up in sessions
- coping skills, moral injury, the ability to care for the self/team-care.

Issues: Wide geographical area, poor attendance at times due to other commitments.

Verbalised thoughts & feelings

- “We hold our caseload and worry even when off sick or on AL and then worry another healthcare professional [HCP] may judge me because I am unable to see this patient.
- “We never hand over everything; we are always sitting with them”
- “We are with our patients in a long-term relationship, not friends but whatever that may look like”
- “We care about the patients meaning discharge is difficult and we always expect a reaction from them [abandonment issues, own thoughts the patient will be alone]
- “I really gained confidence from talking about this patient and of the power dynamics being played out working with him”
- “Sometimes it feels like borderline burnout not being able to offload”
- “Why use the words reflective practice, can’t we change this to something else?”
- “I have learnt something about myself and when to step back”

Conclusion

At the end of the day, it's not about what you have, or even what you've accomplished…it's about who you've lifted up, who you've made better, it's about what you've given back…

Denzel Washington

Thank you for listening

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