

Reflection, not rumination: why headspace matters in nursing practice

Welcome to the second issue of 2026! I can't believe that we are already halfway through spring – time seems to be flying by! When I talk to colleagues across different areas, there is a shared sense of how busy everyone is, and how increasingly difficult it has become to find some headspace to reflect on practice and services.

I am always inspired by those who can do this, which made me think about how important reflection is – even more so when there is increasing demand on our time, both at work and at home. In the past, I have claimed to reflect regularly on my practice. However, in hindsight, I was sometimes confusing reflection with overthinking and rumination. It was only after discussing reflection with a new member of the team that I realised I was no longer reflecting on and reviewing situations for improvement next time; instead, I was replaying a negative loop repeatedly that only made me feel worse, not better. It is difficult to move away from that passive, repetitive, negative thought cycle, especially when you are under pressure.

Having dedicated headspace to reflect on nursing practice is not just a “nice-to-have” – it is critical for mental health, growth and safe care. Nursing is fast-paced and emotionally charged, and it is easy to feel overwhelmed. I have certainly felt this at times.

Generally, the articles we receive at the journal, and many papers and posters I see, start with some degree of reflection on a practice or service, which then expands into ideas for improvement. Some people may call this a “light bulb” moment, but I believe that it comes from having the headspace to reflect, allowing us to move from narrow, task-focused thinking to turning often chaotic information into insightful ideas and solutions.

One such article is featured in this issue. [Samantha Kelly](#) and colleagues describe how a framework to support DSNs acting on prescribing recommendations from non-prescribing colleagues

was developed after a GP asked why the diabetes team itself had not made the requested changes to a prescription. It is a very valid question. The idea was likely born out of having the space to reflect critically and ask that same question of themselves.

Samantha describes how this led to a model that encourages a supportive approach for the non-prescribers and prescribers. Listening to this simple comment by the GP, and reflecting on its impact on timely access to medicines and prescription changes, ultimately led to a shift in the whole team's philosophy and generated interest from outside their own speciality. Seeing a development you have successfully implemented within your own team adopted across other services, within and beyond your organisation, is true praise and something to be very proud of.

Reflection can also happen at a national level, shaping how we develop and support the workforce. Some of you may have read the recently published [consensus statement](#) on a National Competency Framework for the training and assessment of knowledge and skills in diabetes technologies for healthcare professionals. A considerable amount of work has gone into developing this four-level “Novice to Expert” framework to support staff involved in delivering services for people using diabetes technology. I am sure we all agree that a confident and competent workforce is essential to deliver the NICE guidance associated with diabetes technology consistently across the country. However, that level of consistency may not be evident yet in user education for technologies such as hybrid closed-loop (HCL) systems.

In her article, [Jennifer Skivington](#) describes that despite NICE recommending that people moving onto HCL therapy are offered structured education before starting, there is currently no nationally approved structured education programme for children and young people. As this group is considered a priority, paediatric diabetes teams will need to decide how to provide it.



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Structured education is essential for the safe and effective use of HCL systems in this population. Although HCL technology automates insulin delivery, users still need accurate carbohydrate counting and exercise adjustments to achieve the best outcomes. Good training also helps families set realistic expectations, reducing the risk of frustration (and, potentially, early discontinuation), and supports the translation of clinical benefits into everyday practice. Jennifer’s article covers a great deal, including educational theory, current approaches in practice and the existing resources available.

The Diabetes UK Professional Conference takes place next week in my home town of Liverpool. I am fortunate to be attending and am looking forward to seeing the innovation, “light-bulb” moments and service developments in diabetes care that will be presented there, including the poster presentations, which is one of my favourite parts. I hope to see some of you there – please do visit the OmniaMed Communications stand (JDN’s publisher) and, if you see me, please come and say hello. We also have a JDN group on [LinkedIn](#) – it would be great if you gave us a follow. ■