

Reflective Practice

Fenech, Sharon. & Micallef Cann, Rodianne. 2018.

“Experience is not what happens to man; it is what a man does with what happened to him” (Huxley, 1932, pg112). In order to achieve meaningful learning in life, it is not sufficient simply to go through an experience as this may be easily forgotten, but one has to engage in reflection.

The aim of this paper is to address key issues associated with reflective practice and how to write a reflective practice account. Reflective practice has been identified as one of the strategies to keep up with the ever growing information within the health care sector.

Professional reflective practice has been defined ‘as the ability to reflect on one’s actions so to engage in a process of continuous learning’ (Schön, 1983). Maltese registered nurses and midwives have an ethical and professional responsibility to engage in lifelong learning to maintain their professional expertise. One way this can be achieved is through reflecting on practice in a critical and focused way (Nicol & Dosser, 2016). This is done through engaging in deliberate questioning of one’s practice in order to identify ways and means to improve.

Reflective practice can take place before, during and post action. For it to be meaningful reflection must have conclusions and actions to improve practice. Reflective practice entails a conscious analysis of emotions, experiences, and responses taken and adds them to one’s existing knowledge in order to reach a higher level of understanding (Paterson & Chapman, 2013). This leads to identification of either positive outcomes which may be reapplied, or in improvement or a change in practice. Therefore, it is a means to help practitioners to make cognizant decisions and avoid repeating any errors or mistakes.

Reflection has been viewed as a very personal thing; however the trend is to move away from individual reflection towards more collaborative workplace reflection (Prilla, Herrmann, & Degeling, 2013). Indeed most of our practice occurs in settings where a number of healthcare professionals work together to perform their duties to achieve the best outcome for the patient. Therefore, reflection can be done in groups as well. This will not only enhance the individual practitioner but assist in the development of the team, overall organisational learning and ultimately patient care. There are various frameworks which can facilitate and guide learning through reflection including Boud’s Model, Gibb’s Model, Atkins and Murphy and Johns’ Model of Reflection amongst others. The choice of models remains a personal one as it must appeal both to the professional as well as to the situation being reflected upon.

Hereunder, one finds a set of general questions which can be addressed during a reflective exercise. These questions are based on Boud’s reflective model

- a. Description of the experience? - A short and brief write up of the experience upon which you are reflecting.
- b. What did you learn from the experience? - An interpretation of the description. It needs to include emotions, actions, feelings, knowledge, and your interpretation of them such as why was it meaningful, important and relevant. One may add any realisations or questions posed on the experience.
- c. What was the outcome on your practice? – This could be a change or improvement or a continuation of the current practice in terms of self, team. One needs to write in terms of what was improved or developed such as skills, understandings, knowledge or ability. Finally it must include what will be done.

Example of a Reflective Account

It was in the early hours of the morning when we were notified of an admission of a young adult following an MVA. The patient was in a very bad state and upon admission to ITU arrested for the second time. The patient was bleeding profusely however, surgical intervention was not being considered as the patient was very critical and unstable. The whole team was working with the patient to ensure that we keep him alive. In the meantime the relatives were outside the unit and after an hour or so we heard quite some loud and aggressive sounds coming from outside the door. A security came in through the internal door and advised that it would be better if someone comes out and explains what is happening before the family knock the door down and someone gets injured. At the time everyone was focused on the patient and we told him that we will speak to them as soon as the patient is stabilised. The consultant and the nurse in charge spoke with the family after 2 hours. When they eventually asked for the closest family, there was quite a scene and I feared for their safety.

I found myself reflecting upon this case as sometimes we tend to focus our priorities and all our energy on the patient and forgetting that someone is out there waiting to hear how their loved one is doing. Although we couldn't just leave the bed side, there were other nurses and doctors who could have dedicated their time to speak with the family whilst care was still being delivered. The questions that I was asking myself were numerous but mostly where concerned on the number of people assisting during admission, and the time taken to speak with the family. I felt very saddened and frustrated thinking back on the whole experience. If one of us had kept the family updated with some information maybe the situation would not have escalated so much. The patient had survived as it could have been much worse if patient had died before the relatives were notified of the patient's condition. Therefore, I decided to discuss this occurrence with my head of shift and also the whole team.

Following a good discussion and group reflection we came out with tangible conclusions and guidelines for future occurrences. In fact it was decided that the number of people assisting would be directed by the head of shift following assessment of the case. This would create less confusion and duplicate of work because everyone will have a focus. The team would also be assisted with a runner. The head of shift took it upon him that he will be updating the family of any admissions every 15 – 30 minutes so that they will not be kept in the dark in this crucial moment. The

information does not need to be detailed but sufficient to keep family reassured that their presence is being acknowledged. Following the admission a full account is provided to the family by the anaesthetist in charge and head of shift. This was communicated to the whole shift so that in the absence of the head of shift the person replacing him will take over this role as well.

Bibliography

Gibbs, G. (1988). *Learning by doing: a guide to teaching and learning methods*. Oxford: Further Education Unit, Oxford Polytechnic.

Nicol, J., & Dosser, I. (2016). Understanding reflective practice. *Nursing Standard* , 34-42.

Paterson, C., & Chapman, J. (2013). "Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport* , 133-138.

Prilla, M., Herrmann, T., & Degeling, M. (2013). Collaborative Reflection for Learning at the Healthcare. In S. Goggins, I. Jahnke, & V. Wulf, *Computer-Supported Collaborative Learning at the Workplace. Computer-Supported Collaborative Learning Series*., Springer, Boston MA.

Schön, D. (1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith.