Reflective practice: a tool to enhance professional practice

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Reflective practice
Reflective practice is crucial in continuous development and re-assessment of skills when working in health care. A reflective practitioner:

- Reflects on feedback and integrates changes into practice.
- Reflects on how own perceptions, attitudes and beliefs impact on practice.
- Identifies knowledge deficits and seeks clarification.
- Ensures procedures for safety and quality assurance are implemented.

Interprofessional and client centred communication
The health care team consists of health professionals, the client and the family. The interaction within the health care team demonstrates:

- Communication is authentic, consistent and demonstrates trust
- Team members demonstrate active listening skills.
- Communication ensures a common understanding of decisions made.
- Trusting relationships with clients /families and other team members.
- Other disciplines’ roles are promoted and supported to client/family.

Team functioning
Professionals support a team approach by:

- Establishing and maintaining effective and healthy working relationships and team interactions.
- Respect team ethics and demonstrate trust and mutual respect for members of the team.
- Be an active participant in collaborative decision making.
- Be an effective and engaged participant in discussions and interactions among team members demonstrating open communication and attentive listening.
- Demonstrates respect for the knowledge and skills of the each team member.
Background

In 2007, the World Health Organization (WHO) found that tens of millions of people every year suffer lasting injury or even death as a result of preventable medical errors (World Health Organization, 2007). In 1999, the Institute of Medicine (IOM) released its report “To Err is Human” estimating that at least 44,000 and possibly as many as 98,000 patients die each year in the United States as a result of preventable clinical errors (Healey & McGowan, 2011; Kohn, Corrigan, & Donaldson, 1999). Alarmingly, the IOM findings indicated that more people die from medical errors than from breast cancer, road accidents or AIDS (Healey & McGowan, 2011; Kohn, et al., 1999). The 2008 National Healthcare Quality Report noted that since the IOM report, patient safety had actually gotten worse instead of better: one in seven hospitalised Medicare patients experienced one or more adverse events (Clancy, 2008). In Australia the findings are of equal concern with as many as 4,500 people dying each year in hospitals as a result of clinical errors (Armstrong, 2004), at a cost of approximately $2 billion dollars per annum (Ryan, 2008).

A considerable issue adding further to these statistics is that of under-reporting. Despite the frameworks which have been developed to prevent under-reporting, there is often a failure to measure the true extent of errors resulting in patient harm. This would suggest that the above statistics are probably much higher than reported (Wakefield & Jorm, 2009).

Reflection

According to Stein (2003), medical errors can be partly attributed to the failure of many health practitioners to reflect on their professional practice. Bengtsson, cited in Kinsella (2009), states that though reflection is the “buzz word” of today, there is a lack of consensus among educators, researchers and practitioners as to what reflective practice actually entails (Kinsella, 2009). Although there is little hard scientific evidence to support the fact that critical reflection reduces medical errors, “...there are theoretical bases to reasonably expect that reflective practice can reduce likelihood of failures in clinical reasoning for solving complex cases” (Mamede, Schmidt, & Rikers, 2006, p. 144).

With technology becoming more sophisticated along with an increase in patient acuity due largely to the aging population, there is a greater need for the practitioner to be able to think critically and independently (Sewchuk, 2005). According to Mamede et al. (2006), the ability to critically reflect on one’s practice is fundamental to developing and maintaining expertise.
In 2008, the National Institute for Clinical Excellence (NICE) in the United Kingdom used national standards to develop aims, objectives and measurable outcomes for reflective practice groups in order to improve psychological awareness of staff, with the aim of creating beneficial changes not only to an individual’s practice but also to practice and procedures on the ward (NICE, 2009).

The idea of reflection as a learning tool was first put forward by John Dewey, an educational philosopher. Dewey’s work in the early 1900’s explored the distinction between reflective thinking and thinking itself (Musolino & Mostrom, 2005). He describes reflective thinking as thinking that is purposeful and working towards a conclusion. Dewey found that reflection begins with an unexpected difficulty, challenge or problem. This then impels the thinker to examine the sources of, and evidence supporting, a set of beliefs or expectations surrounding a situation, and to search and enquire in an effort to resolve doubt (Musolino & Mostrom, 2005).

Reflective practice

Donald Schon (1983) expanded on the theory of reflection and developed the concept of reflective practice. Since then reflection has been incorporated into higher education at the undergraduate and postgraduate level as well as in the professional development of a range of health disciplines and social care professions. It is seen as a means of improving clinical practice and consequently quality of care, through exploring and evaluating one’s understanding of a problem rather than simply trying to solve it (Leung, Pluye, Grad, & Weston, 2010). The National Health Service (NHS) General Practice Nursing Toolkit suggests that engaging in reflection not only promotes autonomous, self directed practitioners, but also improves quality of care and helps close the gap between theory and practice (Working in Partnership Programme, 2006). To critically reflect empowers the practitioner “to see things from a different perspective and then gain insight that makes it an effective learning experience” (Ashby, 2006, p. 37). The benefits of reflective practice for practitioners include redefining their understanding of professional knowledge, expanding personal knowledge or self-awareness and evaluating the appropriateness of actions (Morgan, 2009). Morgan further states that it is a characteristic of professional practice and promotes the development of personal and professional growth and is also associated with improvement of quality of care (Morgan, 2009).
The Australian Physiotherapy Council (APC) defines reflective practice as “an intentional and skilled activity in which a person analyses and describes his or her thoughts, actions, feelings, and behaviours and makes judgements about their effectiveness” (Connaughton & Edgar, 2011, p. 89). Critical reflection need not only involve one person looking at him or herself independently but may incorporate another’s or a group’s perspective. Two or more people may witness the same event but view it quite differently. Stonehouse (2011) highlights the importance of the support of the act of reflection in the workplace, ensuring that the practitioner does not feel as if they are under scrutiny. Reflection ideally should be conducted in a safe environment encouraging self expression and an openness to share experiences among the participants (Castelli, 2011). Reflection should also be undertaken when something has gone well and not just be limited to a negative experience or an event that has had a less than successful outcome. This will enable the practitioner to recognise how such success can be repeated in the future (Stonehouse, 2011).

**Reflection in action**

When discussing reflection, much of the literature mentions ‘reflection in action’ and ‘reflection on action’. ‘Reflection in action’ is the act of making sense of each new situation as it occurs by applying personal knowledge and constructing a plan of action, testing that plan and modifying it as necessary (Kumar, 2011; Schon, 1983). It involves examining one’s own behaviour and that of others during a situation or event. Each situation must be assessed as new and complex while the practitioner is simultaneously aware of their own reasoning, influences, and assumptions which may affect that process. Similar prior experiences and/or the context in which each experience may have occurred, together with various social, cultural and psychological forces may have shaped an individual’s values and assumptions thereby affecting the way they may perceive and react to a situation (Mamede, et al., 2006). Schon states that “reflection in action is the hallmark of an experienced practitioner” (Somerville & Keeling, 2004, p. 43). Fisher-Yoshida states that “if we are not familiar with our core values and why we think and act the way we do, then we are destined to be reactive rather than reflexive ...” (Castelli, 2011, p. 18). Ashby (2006) goes so far as to say that it is potentially dangerous for any practitioner to not critically reflect, as practice becomes task orientated, routine and ritualistic.

**Reflection on action**

‘Reflection on action’ is probably the most common form of reflection and consists of similar reasoning as involved in reflection in action, however it is retrospective. Reflection on action
occurs after an experience or event has taken place and involves going over that event in your mind and developing more effective ways of dealing with a similar situation in the future. This sort of reflection often focuses on the negative aspects of what has occurred. Alternatively Somerville & Keeling (2004) stress the importance of identifying and valuing strengths in order to be able to develop these and become better professionals.

**Models of reflection**

Reflection may be an informal private exercise, or alternatively be more formal and structured employing a model to provide a framework in which to examine and learn from an experience. The use of a model to structure a person’s thoughts and feelings prevents that person from just describing an event without any further analytical thought (Hood cited in Stonehouse, 2011, p. 299). There are several models of reflection but the two which are most commonly used today are Kolb’s Experiential Learning Cycle and Gibbs Reflective Cycle.

**Kolb’s Experiential Learning Cycle**

Kolb’s Learning Cycle (Kolb, 1984) is described as an experiential model where the learner has a concrete experience that is transformed through reflective observation. The model consists of a learning cycle comprising four different stages which can be entered at any point. The learner will undergo an experience, and in the period of reflection following, the learner gains a general understanding of the concepts involved in the experience. Then, in the light of previous knowledge, the learner gains new insight and is able to utilise these concepts to develop an intelligent plan of action which can then be applied to or tested on new situations (Sewchuk, 2005).

*Source: (Davies, 2011)*
Gibbs’ Reflective Cycle was developed in 1988 (Gibbs, 1988) and is similar to Kolb’s Learning Cycle but it expands on the principles. Each step in the cycle begins with a description of the event, and involves reviewing and reflecting on the experience then continuing on to formulate a plan to deal with any similar experience which may occur in the future. Gibbs’ cycle consists of six steps where the practitioner is required to answer a series of questions each leading on to the next, encouraging a thorough examination of an event and provoking critical thought. New meanings are attained leading the learner to develop a positive plan of action (Forrest, 2008).

An event can be reviewed and learned from in a structured debriefing using Gibbs’s reflective cycle:

**Stage 1:** Describe the event in detail, including who was there; what were you doing; what happened; in what context did it happen; what part did everyone involved play in the event.
Stage 2: Describe own feelings, thoughts and perceptions. Think about how the event made you feel; how do you think the others involved felt; how were you feeling prior to the event; how do you feel about the outcome.

Stage 3: Evaluate the situation. What was good or went well; what was bad or what didn’t go well.

Stage 4: Analyse the situation. What sense can you make out of the experience; if things didn’t go so well how did you or others contribute to this; why did things not turn out as perhaps they should have done; what questions have been raised from the encounter.

Stage 5: In this stage conclusions are drawn from the information that has already been analysed. It is here that self-awareness and insight into own and other’s behaviour expands. Think about what you or others have done to contribute to the outcome of the event and what could have been done differently.

Stage 6: Develop a plan of action for the future should a similar situation occur again. Think about whether or not you would act differently.

Conclusion
Although there is insufficient empirical evidence to prove conclusively that reflection and reflective practice can help reduce clinical errors or improve clinical outcomes for patients, it is a logical conclusion to draw (Mamede, et al., 2006). Engaging in reflection promotes critical enquiry encouraging the practitioner to learn through analysis and evaluation of an experience thereby preventing practice from becoming habitual and task orientated (Stonehouse, 2011). Critical reflection helps practitioners focus on improving their knowledge, skills and behaviour ensuring they are able to constantly update their practice and meet the complex demands of patients in the health care setting (Somerville & Keeling, 2004).