

6

Thinking, Learning and Working Under Fire

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Chapter aims

- Describe the origins of reflection in nursing and the reasons for which nurses have not widely adopted critical thinking techniques.
- Outline a number of innovative approaches that seek to promote reflective practice in nursing, in a practical, realistic and creative way.

Introduction

In Chapter 2, the personal impact of nursing in contemporary healthcare and the effect of change were considered. Models of reflection have been used since the 1970s as a means of encouraging thoughtful analysis of nursing practice with only modest success. While there have been many positive examples of reflective approaches being adopted – such as the use of clinical supervision in mental health and health coaching in adult nursing – perhaps the problems associated with broader use has been the rigid, structured ‘model’ approach to promoting and teaching the skills of reflection and the difficulty in then using these models in a busy practice environment. That said, the value of nurses developing their reflective skills akin to Schön’s reflective practitioners ‘in action’ has been shown to correlate with the delivery of high-quality care, evidence-based practice and personal stress reduction.

The Origins of Reflection in Nursing and the Reasons Why Nurses Have Not Widely Adopted Critical Thinking Techniques

What do we mean by ‘reflective practice’ in nursing?

Boud et al. define ‘reflection’ as:

Reflection is an important human activity in which people recapture their experience, think about it, mull over and evaluate it. It is this working with experience that is important in learning. (1985: 43)

Bulman and Schutz describe ‘reflective practice’ as:

‘Reviewing experience from practice so that it may be described, analysed, evaluated and consequently used to inform and change future practice. (2013: 6)

Thus, it can be seen that ‘reflective practice’ can result in critical thinking about one’s clinical practice, skills and competency and the practice of other team members, the application of research and evidence-based practice and the delivery of high-quality care. Reflective practice is also concerned with trying to analyse and understand clinical problems that occur or, conversely, evaluating situations that achieved positive care outcomes.

Approaches to reflection can be informal, but it is the more formal models of reflection that have tended to be used within nursing, and specifically pre-registration nursing courses. The importance of reflection is reinforced within these initial education programmes, with students being expected to select and utilise a model of reflection (from the many options) in order to compile portfolios of their learning and skill attainment, use reflective diaries or employ a model for personal reflection within a written assignment. The difficulty with this strategy is that reflection tends to become an enforced approach that is then often not used after the student qualifies as a registered nurse. Nevertheless, continuing learning is a fundamental aspect of professional development and the contribution of reflection to this process is essential.

The models of reflection used in nursing

A basic search engine exploration using a ‘model + reflection + nursing’ format shows Johns’ model of reflection to be the most widely documented framework used within nursing by a considerable margin. This is followed by Gibbs’ framework, with Schön’s work close behind. Kolb’s (1984) reflective cycle is in fourth place, although it is still utilised quite extensively (Table 6.1).

Table 6.1 The models of reflection used in nursing

Model	Returned results
Johns + reflection + nursing	487,000
Gibbs + reflection + nursing	371,000
Schön + reflection + nursing	367,000
Kolb + reflection + nursing	225,000
Driscoll + reflection + nursing	157,000
Boud + reflection + nursing	50,700

Johns' (1995) 'Model of Structured Reflection'

This was initially proffered as a learning theory but has become more widely known as a 'model of reflection'. It uses cue questions to structure and help analyse an experience. This then enables us to break down our experience and reflect on the process and outcome. Johns' (ibid.) work uses Carper's (1978) four patterns of 'knowing' in nursing: empirical, personal, ethical and aesthetic, adding a fifth pattern of 'reflexivity'. This cyclical process follows five stages:

1. *Bringing the mind home*: Creating space for reflection.
2. *Description*: Summarising the incident.
3. *Reflection*: Thinking about the situation and what occurred.
4. *Alternatives*: Generating different ways of interpreting the incident.
5. *Changes*: Summarising the most workable potential solutions.

Johns' model is often utilised for written reflections on nursing practice in portfolios and as a structure for student assignments. The model's popularity seems to stem from the straightforward stages but, while being relatively easy to use, the potential number of suggested questions often has to be reduced so as to ensure that the reflective process is realistic. However, a central concept of the framework ('bringing the mind home') is often overlooked and, yet, it has potentially high relevance to more informal approaches to reflection. This first stage emphasises the importance of generating the 'mental space' for personal learning by creating time for reflection through such techniques as imagery and mindfulness.

Gibbs' (1988) 'Reflective Cycle'

This also evolved as a learning theory but was then utilised in a structured way as a debriefing framework or cycle. It is a frequently used model within pre-registration

nursing courses and is often utilised to structure reflection in professional practice and for critical incident analysis. The framework is particularly useful in helping students reflect on the merits of an experience and their learning styles, and so is often considered easier to use than Johns' model. The model uses a similar series of steps:

- *Description*: What happened?
- *Feelings*: What were you thinking and feeling?
- *Evaluation*: What was good and bad about the experience?
- *Analysis*: What sense can you make of the situation?
- *Conclusion*: What else could you have done?
- *Action plan*: If it arose again, what would you do?

Schön's (1983) 'Reflection-in-action'

In Schön's (1983) influential book, *The Reflective Practitioner*, the philosopher comments that practice presents problems that are inherently 'messy, indeterminate situations', which are characterised by 'uncertainty, instability, uniqueness and value conflict' (ibid.: 20). Here, Schön was referring to the process of reflection in professional education, and so his ideas became hugely significant in many professional curricula. He considered experiential learning to be the cornerstone of effective education, and so this may well explain why his work has become so influential in nursing. Schön's approach celebrates the intuitive and artistic styles that can be brought to uncertain situations. These can be seen in the two central components of the model:

- *Reflection-in-action*: Thinking about one's practice while doing it.
- *Reflection-on-action*: Thinking about an experience after the event.

Arguably, it is Schön's concept of 'Reflection-in-action' that is critically relevant to nursing. Schön viewed this as an essential characteristic of 'expert practitioners' who can test out their ideas while directly engaged in an experience: 'Our thinking serves to reshape what we are doing while we are doing it' (1987: 26).

Schön (1987: 13) further describes the process of reflection in action as:

The art of problem framing

Surprise triggers reflection, directed both to the surprising outcome and to the knowing-in-action that led to it. It is as though the performer asked him/herself, what is this? And at the same time, what understandings and strategies of mine have led me to produce this?

The art of improvisation

The performer restructures his/her understanding of the situation-his/her framing of the problem s/he has been trying to solve, his/her picture of what is going on, or the strategy of action he has been employing.

The art of implementation

On the basis of this restructuring, he/she invents a new strategy of action. S/he tries out the new action s/he has invented, running an on-the-spot experiment whose results s/he interprets, in turn, as a 'solution,' an outcome on the whole satisfactory, or else as a new surprise that calls for a new round of reflection and experiment.

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Activity 6.1 Examining Professional Practice Using Schön

Identify an example of health-related 'good practice' that you have seen (as a colleague or a patient). This can be anything that you thought was good, well done, impressive, helpful, etc.

Thinking about Schön's work, reflect on your 'story' and consider:

- How the person responsible for the 'good practice' identified that there was a problem to be solved (the art of problem framing).
- How he/she tried different approaches to solving the problem (the art of improvisation).
- How he/she put into practice their chosen action that led to the good outcome (the art of implementation).

What common themes developed from your reflection? Do you think that these themes would be the same across all professional groups? Perhaps share your observations with a work colleague?

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Why nurses do not always use structured reflective techniques in their practice

Given the strong evidence base, it is surprising to note the lack of consistent application of approaches to critical reflection within nursing to date. Why might this be the case? A poll conducted by the author of a group of qualified adult and mental health nurses attending a mentorship seminar elicited the following reasons:

- Reflection has become too formalised.
- Pressure of time owing to the intensity of clinical work.
- The excessive requirements of documenting care events.
- The emotions attached to a situation require quiet reflection rather than a structured approach.
- It is inconvenient to assign time to write up reflections.
- It is preferable to talk and unburden to a colleague.

- Some issues are too personal to document.
- Reflecting in a planned way does not match real-life reflective thinking.
- There is a need to consider individualised approaches to reflection.

The above reasons correlate with the evaluative work undertaken by Barksby et al. (2015), who cite problems with the practical use of staged models and apprehensions regarding who might see the reflective writing. Oelofsen (2012) also underlines the vast number of reflective models available and the need for simplicity of same in practice. While Jasper (2013) explains that, although the techniques to support reflection in nursing are widely known, initiating action needs to become more of a consistent response. Significantly, de Vries and Timmins (2015) claim that ineffective reflective practice can even contribute to poor quality of care. To help counteract this, de Vries and Timmins (ibid.) further call for greater understanding of the impact of the processes associated with reflection such as removing obstacles. Once the barriers have been identified, it then becomes necessary to remove these before reflection can be undertaken (Caldwell and Grobbel, 2013). With this point in mind, the procedure for dealing with barriers as advocated by Boud et al. (1985) is useful:

1. Acknowledge barriers.
2. Name the barriers.
3. Ask how the barriers operate and their origin.
4. Work with the barriers.

Activity 6.2 Examining Professional Practice Using Schön (*cont.*)

Consider repeating the poll that I conducted with mentors, with nurses from your clinical team, and then try to think creatively about how you and your clinical team can work on removing these barriers.

Innovative Approaches That Seek to Promote Reflective Practice in a Practical, Realistic and Creative Way

Caldwell and Grobbel (2013) conducted a literature review on the importance of reflection in nursing. The outcome of this review identified four themes:

- *Development of practice* – Reflection has the potential to enhance nursing practice.
- *Emotional impact* – Reflection provides a safe opportunity for nurses to explore their feelings and emotions.

- *Mentor support* – With support from mentors, students can partake in expressive reflection.
- *Barriers* – Acknowledging the barriers will assist in making the required changes for reflection in practice.

Thus, it is evident that reflection can help to reduce anxiety or feelings attached to stressful events or challenging situations encountered in clinical situations. With the potential benefits of reflection in mind, the following questions were posed to a group of final-year work-based learning student nurses in a supervision session:

- How and when do you reflect?
- Do you prefer formal or informal techniques?
- What advice would you give to a new nurse about reflection?

Reflective writing, using some of the techniques outlined in this chapter, are built into the work-based learning pre-registration nursing course. The feedback received seemed to demonstrate that reflection was relatively widely used. The emotional labour of nursing was clearly identifiable and the importance of critical thinking as a means of helping to cope with such stressful situations was evident. It was further apparent that a range of methods was utilised with many being informal. Yet, formal methods were also seen as necessary, with reflection being recommended as an essential learning tool. The responses further provided some suggested options for reflection such as note-taking, supervision, group debriefings, reflecting on events, returning to personal reflections, peer reflection and contemplative activities. The requirement for a supportive structure was also mentioned and as was the need for colleagues to give and be receptive to constructive feedback.

Comparable feedback on critical thinking was documented by Tashiro et al. (2013), who conducted a thematic analysis and then described the attributes, antecedents and consequences of reflection in nursing. One of the aims of this review was to help nurses enhance their reflective skills. The authors describe how, through reflection, nurses develop self-awareness that then expands care skills and promotes excellence and professionalism. Communication with service users and team members is also enhanced, and self-directed learning improved.

Similarly, a particularly useful way of dealing with some of the pressures implicit in clinical nursing practice is striving to attain the high level of 'reflection-in-action' embodied in Schön's 'reflective practitioner' framework. Schön's 'excellent practitioner' is perceived by nursing students (as cited to the chapter author) as a nurse who has maintained their enthusiasm and motivation to provide high-quality care and who utilises both structured reflection approaches and 'reflection-in-action'.

With this observation in mind, and given the strong evidence base for the use of reflection in nursing, one way of dealing with the pressure of working in contemporary healthcare could be by using the strengths of models of reflection, self-reflection and reflection-in-action in a more integrated, realistic, usable, creative and practical way. How might such an aim be achieved? The following suggestions outline some options that could be tested by the practitioner in the clinical setting. Many of these are based on ideas put forward by registered adult and mental health nurses and so are currently being utilised in their clinical roles.

The opportunity for a carefully considered personal review and application of some of these approaches seem to have been presented by the reflection strategy that is now an expectation of the revalidation process by the Nursing and Midwifery Council (NMC). The approach adopted for revalidation appears to exemplify the very structured procedures used to date by being based on evidencing five reflective pieces of work. While 'PREP' (Post-Registration Education & Practice) and the 'ENB (English National Board) portfolio' did not have a good record of success, the new NMC method provides an opportunity to embed reflective practice in nursing practice. Nurses are often now overheard saying, 'Note that for your portfolio,' and potential topics are also frequently explored in mentor updates as a basis for triennial review. Similarly, the NMC (2010) standards for pre-registration nursing education require nurses to be self-aware, evaluate their care and, importantly, learn by reflection as part of their personal and professional development. The Code 'will be central in the revalidation process as a focus for professional reflection'. (NMC, 2016: 6).

Using mnemonics and abridged models of reflection

Given the relative success of the use of mnemonics in clinical practice, such as the VERA communication framework in dementia care (Hawkes et al., 2015) and the adoption of the 'PICO' concept in research question formulation, the embracing of reflective techniques could be similarly aided by simplicity combined with approaches to reflection that are easy to learn and apply. Indeed, the limitations of staged models of reflection are acknowledged by Barksby et al. (2015), who instead advocate the use of the mnemonic 'Reflect' as a new model of reflection on action for clinical practice. Use of the mnemonic makes it easier than more traditional models of reflection (Table 6.2).

Similarly, Oelofsen (2012) proposes a 'reflective cycle' that has three simple stages:

- Step 1: *Curiosity* – This step involves noticing things, asking questions and questioning assumptions.
- Step 2: *Looking closer* – This step involves actively engaging with the questions from step 1.
- Step 3: *Transformation* – This phase is all about turning sense-making into action.

This framework was developed by the author when working with clinicians in different care contexts and from an interprofessional perspective. This approach can be used in facilitated groups or by individual practitioners in order to promote valuable reflective opportunities.

Another reflective technique – based on an abridged form of a model that could be utilised as a template – that provides simplicity and might be comparatively easy to use is the 'What?', 'So what?' and 'Now what?' process developed by Driscoll in 1994 (Table 6.3).

Table 6.2 'Reflect' as a new model of reflection on action for clinical practice**STAGE**

(The REFLECT model comprises seven stages)

R – RECALL the events (Stage 1)

Give a brief overview of the situation upon which you are reflecting. This should consist of the facts – a description of what happened

E – EXAMINE your responses (Stage 2)

Discuss your thoughts and actions at the time of the incident upon which you are reflecting

F – Acknowledge FEELINGS (Stage 3)

Highlight any feelings you experienced at the time of the situation upon which you are reflecting

L – LEARN from the experience (Stage 4)

Highlight what you have learned from the situation

E – EXPLORE options (Stage 5)

Discuss options for the future if you were to encounter a similar situation

C – CREATE a plan of action (Stage 6)

Create a plan for the future - this can be for future theoretical learning or action

T – Set TIMESCALE (Stage 7)

Set a time by which the plan outlined in Stage 6 will be complete

By remembering the key questions in this way, this strategy promotes critical thinking in action on care situations aligned with the potential to make brief notes as soon as the opportunity becomes available. This approach can be useful as a structure for serious incident debriefing, biographical work, learning seminars or for clinical supervision.

Table 6.3 'What?', 'So what?' and 'Now what?' process, developed by Driscoll (1994)**Reflective Log****What?**

(A description of the event)

So what?

(An analysis of the event)

Now what?

(Proposed actions following the event)

Re-conceptualising reflective practice by applying ‘black box’ thinking to clinical nursing and service improvement

The importance of ‘black box’ thinking, based on the systematic method of investigating airline disasters, has recently been documented in a book by Syed (2016). The ‘black box’ refers to the plane’s data recorder that is used after a crash in order to help investigate the cause. Syed (ibid.) states that aviation has an excellent safety record because, rather than being concealed, mistakes become learning opportunities. He explains that the concept is not concerned with literally creating a black box but, rather, with the ‘willingness and tenacity to investigate the lessons that often exist when we fail, but which we rarely exploit’ (ibid.: 165). He further describes how it is also about ‘creating systems and cultures that enable organisations to learn from errors, rather than being threatened by them’ (ibid.: 116). To emphasise his concept and the importance of resilience, determination and conceptual thinking, Syed describes how Sir James Dyson developed 5127 prototypes before his vacuum cleaner was finally ready to go on sale! He also explains how an anaesthetist worked with a nurse to overrule a surgeon who was incorrectly convinced that a patient was not experiencing an allergic reaction to latex and how junior Korean pilots were reluctant for cultural reasons to challenge more senior pilots, hence creating opportunities for error. As Syed explains, ‘when we are confronted with evidence that challenges our deeply held beliefs we are more likely to reframe the evidence than we are to alter our beliefs’ (ibid.: 375) (Table 6.4).

Table 6.4 The four key concepts that underpin ‘black box’ thinking

The use of factors that give marginal gain	Marginal gain is not concerned with implementing minor changes but in deconstructing a major problem into smaller components to determine what is effective and what does not work
Learning from mistakes	Developing procedures and cultures that facilitate organisational learning as opposed to concealment
Learning from successful organisations and individuals	The ability to be open to ideas and critical feedback and to be willing to learn from or share the outcomes of successful projects
Avoiding closed loops	Closed loops mean that mistakes are overlooked or misconstrued, whereas an open-loop system ensures action and progress

The notion of marginal gain

The ‘notion of marginal gain’ was employed to good effect in the Rio Olympics in 2016 in order to achieve the highest number of medals ever recorded by Team GB. The subtle or marginal gain techniques used included the use of the best available

equipment and ergonomically designed apparel. Could such relatively minor changes have had a significant impact on athlete performance? It would appear so. It seems to the author that 'black box' thinking may well have potential relevance to healthcare and, hence, could be used for service improvement by following a similar methodical, yet reflective, structure. This method is not entirely dissimilar to established approaches to service improvement, whereby staff (often students) are encouraged to look for and highlight subtle changes in the care environment that could potentially have a significant impact on quality of care. Such changes or approaches to reflection have, for example, resulted in the more productive use of hand gel, which has reduced staff sickness rates, the provision of a clock in an operating theatre in order to ensure that hand-scrubbing conforms to procedures and Wi-Fi availability to promote the more efficient use of care plans in handovers.

The inability to learn from mistakes

The inability to learn from mistakes is based on cognitive dissonance, whereby, if errors occur, then these become difficult to admit to and so are often disregarded or subconsciously re-evaluated. Indeed, de Vries and Timmins (2015) have explained how poor practice, which they called 'care erosion', can result from a lack of effective reflective practice. To help overcome this phenomenon, they applied cognitive dissonance theory to several care situations. This theory explains how, when individuals become aware of inconsistencies, they experience discomfort (dissonance) between their thinking and behaviour. People are then motivated to react to remove the dissonance. De Vries and Timmins go on to explain how three focal points to address care erosion emerge from the application of dissonance theory:

- *Improve (or restore) the effectiveness of critical reflection* – By 'reflecting in a methodical way, aimed at practice improvement'.
- *Promote and maintain strong values and standards* – 'The nurse needs to become aware of the practical impact of strong values and their expression in practice and their potential to cause dissonance.'
- *Promote optimal care and awareness of signs of care erosion* – 'Care erosion can be avoided if early signs are addressed before contagion and conformity create its slippery slope.' (Ibid.: 7)

The 'ability to learn from successful individuals' is exemplified in the following case study, combined with the potential of the application of black box thinking to nursing.

Avoiding closed loops

Much of the published literature on communication in nursing is about using closed-loop systems so as to prevent unnecessary risks or misunderstanding. Therefore, a warning that consideration of the use of open-loop systems might cause

Case Study 6.1 Jamie's Story

Jamie was working as a newly qualified nurse in a community dementia team. The team already offered people recently diagnosed with dementia the opportunity to compile their life story. Because of the author's request to think about his reflective practice, 'J' noted that the uptake of life-story work by people with dementia had declined over the past year. 'J' spoke to clinicians experienced in life-story work and read publications by nurses who had compiled their life story and then shared this with relatives and service users before inviting them to develop their biographies. The impact of this was to demonstrate a commitment to the concept of life-story work and to show how powerful it could be. It also promoted a positive therapeutic relationship with the person and their family and an increase in the number of individuals undertaking life-story work. While not apparently a reflective approach, the careful use of evidence and consultation to re-evaluate a care strategy enabled an improvement in life-story uptake and potentially enhanced the quality of care.

cognitive dissonance! Syed (2016) explains that an open-loop system is concerned with implementing a strategy, then testing if it has been successful, working on any presenting problems, thereby enhancing the strategy.

Perhaps consider this idea in respect of your own health/social care organisation or NHS Trust and reflect on the structures that exist to support nurses to speak out about patient safeguarding concerns. Such a requirement is part of your professional code of conduct. Does your organisation facilitate such a culture? Are staff supported to raise concerns? Perhaps make notes on any examples of good practice that you come up with or, equally, any areas that require improvement.

Clearly, the notion of 'black box' thinking has resonated with the author of this chapter. I am of the view that the fundamental concepts outlined above have applicability to nursing and should be utilised and tested in the clinical setting. That said, often, the sheer pace of and pressures in practice, mitigate against taking time for even the briefest critical reviews of care situations. However, this chapter has established that the use of the 'black box' thinking phenomenon could help resolve some quality of care problems. One potential approach that could also be tested in such situations is an idea closely allied to the notion of marginal gain, namely 'one-minute' interaction analysis.

Activity 6.3 Reflective Exercise

Perhaps test this idea out. Take just a minute or two to step back from the intensity of your clinical role and observe an interaction between a colleague and a patient in your practice environment. What communication techniques is your colleague employing? Is the person being listened to in a meaningful way? What non-verbal signals are being given?

Creating opportunities for ‘bringing the mind home’

It seems to the author that removing oneself from stressful situations and taking the time to contemplate is essential. Is it similar to Johns’ notion of bringing the mind home by making space for reflection? While compiling this chapter, I spoke to a number of qualified nurses about how they create opportunities for reflection and have recorded below the ideas that they found to be both useful and efficient. Essentially, these strategies are concerned with opportunities for reflection in action, however, as has been seen, establishing a time for reflection on action can be equally important.

Activity 6.4 Reflective Exercise

Ask some of your practice colleagues if they reflect and, if they do so, how they go about it.

Emphasise that this exercise isn’t concerned with trying to catch them out but with documenting the creative ways in which reflection can take place. The approaches used by your colleagues may include making notes and thinking about everyday practice activities in a different way.

Make a bullet point list of the reflective techniques that they use. Are any of them useful for your own practice?

A popular method seems to be keeping a notebook to hand and then later using these records to make an entry into a personal journal. Both can take advantage of the abridged headings from established or new models of reflection. Some nurses have extended this idea by using a Dictaphone or audio device to record personal thoughts for a later discussion or portfolio entry, but, again, you may need to check local information governance procedures if you plan to use this approach. The logical progression from a journal is to consider the use of tablet computers, apps or other software, interactive whiteboards, work-supplied mobile phones or laptops. Again, information-governance procedures will need to be checked. These means are already being used to record care events, so why not use your mobile device to note your reflections? Meanwhile, Knight (2015) explains how a facilitated reflective practice group, based on containment principles, enables participants to express their thoughts in a form that is more meaningful and enduring. The structure of these groups is provided by agreeing on ground rules, promoting positive conversation and by broadly using the framework of a reflective model.

Some adult nursing colleagues cited the use of ‘bedside handovers’ as events for reflective practice and learning opportunities. Additionally, many mental health nurses spoke of the usefulness of clinical supervision as occasions for reflection. Most talked about the importance of individual supervision but a number mentioned group supervision because this was more realistic regarding resources. The use of recording

in the ‘first person’ in care plans was cited as a means of promoting care ownership by service users. In turn, this enables empowerment and contributes to recovery. Structured storytelling has been used to promote engagement. Brief seminars on clinical issues based on Driscoll’s work was also mentioned and so, too, was case formulation, which is a process that promotes reflective practice and critical discussion in mental health, which then increases clinician understanding of and empathy towards service users. The starting point for this is often the consideration of the person’s life story. Case Study 6.2 gives an example of how case formulation might be used to support reflective practice and so contribute to the professional revalidation requirements.

Case Study 6.2 Parveen’s Story

Parveen, an experienced charge nurse working in an acute mental health inpatient unit, found the pressure of working in such an environment demanding, particularly regarding finding the time to document care events and risk management. Parveen was aware of the value of reflection in terms of enhancing her use of evidence-based practice and the need for professional development. She suggested that a way of still meeting her personal aims of using an integrative approach to reflection was to utilise a case-formulation style within scheduled ward handover meetings. This consisted of using a personal biographical approach as a precursor to discussing service user needs. The outcome of this process was detailed written entries in care records, which then promoted a more meaningful and individualised dialogue with service users. This also provided the basis for entry into Parveen’s NMC revalidation portfolio.

Conclusion

This chapter has acknowledged the pressures inherent in contemporary clinical practice but has emphasised the positive personal and care outcomes of making time for reflection. The focus has been on describing a number of creative approaches to reflection that aimed to provide a chapter that you could ‘dip in and out of’. Many of these ideas have been suggested by clinicians, while some have been published in academic papers. The strategies for reflection include the use of mnemonics or abridged models of reflection-on-action, re-conceptualising reflection by utilising the principles of ‘black box’ thinking, marginal gain and cognitive dissonance theory and by outlining several approaches that create opportunities for ‘bringing the mind home’.

The author hopes that you will test out some of these ideas and incorporate them into your practice. It may be that you develop your own eclectic paradigm of reflection by taking the best parts of each approach or strategy to fit with the uniqueness of your experiences. Good luck with the methods that you use. Please bear in mind that reflection does not have to be on negative or difficult situations, reflect on the positive things, too.

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