Reflection as an integral part of professional practice

Experience, Personal Experience

The healthcare profession is an emotionally demanding career and because academic learning alone does not prepare individuals for the complex and daunting challenges they face during their practice, the need to continually assess oneself and look back at previous events or incidents to learn from them in order to make provision for a better outcome in the future has become an essential part of professional practice (Jasper, 2003). This means reflecting on emotions and exploring how to deal with them in the future which ensures that practitioners are learning on an ongoing basis in so as to make improvements in their roles (Boud et al., 1985). This is referred to as reflective practice and according to Schon (1983), it is the process of learning through and from experience in order to gain new insights of self and/or practice. Duffy (2008) agreed and described reflective practice as an active and a deliberate process to critically examine practice, where an individual is challenged to undergo the process of self-enquiry as this allows us to look at an experience and how it makes us feel and react, asking what is good and bad, and what can be learned (Gibbs, 1988).

The purpose of this essay is to explore and discuss reflective practice as a key to professional learning and to critically discuss how this applies to my practice. I will discuss an incident that had occurred at my workplace during one of my shifts and through reflection, I will examine and evaluate the effects and contributions this incident had on my professional development as well as on the services provided by my employer. There are different models of reflection but to critically reflect upon this incident, I will use Gibb’s (1988) cycle of reflection as it allows a systematic and structured analysis of an event. This model is cyclical and it encompasses knowledge,

emotions, and actions and also advocates that experiences are repeated (Boud et al., 1985). According to Cherry and Jacob (2005), It is one of the most widely used models of reflection in the healthcare profession and It is also been quoted by The Royal College of Nursing (2012) as being the model of reflection which emphasizes the role of emotions and acknowledges their importance in the reflection process. The framework of Gibbs reflective cycle as in Gibbs (1988) is as follows:

1. Description; What happened?
2. Feeling; What were you thinking and feeling?
3. Evaluation; What was good and bad about the experience?
4. Analysis; What sense can you make of the situation?
5. Conclusion; What else could you have done?
6. Action Plan; if it arose again what would you do?

I work for a healthcare organization that provides supported living for people having learning difficulties and mental health issues. My role as a support worker requires me to support five residents with day to day activities including personal care, housekeeping, medicine administration, dinner preparation and community engagements. One of our residents whom, for the purpose of data protection, I will refer to as John, have learning difficulties and mental health issues. John had been risked assessed of having the capacity to access the community independently without any support and he will often go out to socialize, but according to his care plan, he needs to come back home before 8 pm every day in order to take his evening medication. This medication helps John control his challenging and

aggressive behaviours and it is therefore very important that he does not to miss them. Because John had physically assaulted other residents in the past, his risk assessment emphasized that staff should be present whenever John is in the company of other residents so as to minimize the risk of violence.

Description:

On this particular day, John came back home very late, two hours after his medication was due. There should have been two staff on duty but due to staff issues, I had to work on my own for the whole shift. I followed company procedures of phoning NHS Direct for advice on John's medication and was told that a doctor would ring back within four hours. During this period, John went to the kitchen to make some food but another resident whom I will refer to as Peter, was also in the kitchen at the same time making a drink. I immediately joined them in the kitchen because of John's risk assessment that he should not be left alone with other residents. Whilst the three of us were in the kitchen, the phone rang in the lounge and I knew it was the call I was waiting for from NHS Direct. I left John and Peter in the kitchen and rushed to the lounge to answer the phone and about two minutes into the call, I heard a scream in the kitchen. I panicked and suddenly put the phone down and went back to the kitchen to investigate but by this time, John had already rushed back to his bedroom. I asked Peter what had happened and Peter alleged that John had just hit him on his neck. I could see visible red marks on Peter's neck and chin. I reassured Peter that everything would be fine and managed to encourage him to sit down in the lounge whilst I went to speak to John. John denied doing anything to Peter as he usually does and

knowing that John’s presence in the lounge at the time would have been threatening to Peter, I advised John to stay in his bedroom until after I get back to him. Peter was clearly shaken, agitated and looked confused, but I managed to provide him with enough reassurance and he eventually became calmed and looked okay. The marks on Peter’s neck were visible but did not look any serious. At this point, I remembered that I was in a middle of a conversation on the phone, so I rushed and picked up the phone but NHS Direct had already cut off the call. The fact that I was working alone and fearing the likelihood of violence against myself, I decided not to go back to talk to John. I then phoned the on-call, which is the emergency line for our services, and explained what had happened and sought some advice.

Feeling:

Initially, I felt worried and helpless because I knew I had to deal with the situation on my own. As the incident unfolded, I became increasingly unsure about the right thing to do and was constantly thinking about what John might do next. I felt bad that I had to leave John and Peter together in the kitchen but equally, I was frustrated that I had no choice otherwise. I was also considering the consequences of my actions and judgment, including what was going to happen if John did miss his medication. The degree to which Peter was hurt was also a concern and I kept wondering if it was necessary to call the ambulance or not. I felt betrayed and was upset towards management, thinking about why a single staff should be left to deal with such a situation. Also, putting the phone down rather than asking NHS Direct to hold on to the call whilst I investigated what happened made me

felt unprofessional and I contemplated what they would have been thinking of my professionalism.

Evaluation:

The good thing about the incident was that nothing very serious happened apart from the bruises endured by Peter. In addition, the fact that John listened to my advice and stayed in his bedroom after the incident helped eased the situation because Peter seeing John around him would have been very threatening. Though Peter was very shaken and looked confused, I was able to calm him down by displaying good communication skills. Effective communication is essential for healthcare professionals especially during crisis in order to provide the best care for the people we look after (Fook and Gardner, 2013). A different reaction from Peter would have made the situation much harder to control and maybe I would have had to phone the ambulance or the police. It was also good that John heeded my advice by staying in his bedroom because he might have become aggressive towards my self. In contrast, it was bad that there was only one staff on duty to handle such a situation. I also did not handle the phone call very well since I panicked and immediately put the phone down without asking NHS direct to hold on to the call whilst I find out what happened. An essential quality of a healthcare professional is to always remain calm especially in the midst of a crisis and on this occasion, I failed to do so (Wondrak, 1998). In addition, being unable to finish the phone conversation with NHS Direct made me having had to restart the whole process again which took another four hours and eventually, John missed his medication. Acting in the best interests of

the people we support is part of my role, and on this occasion, John and Peter were not provided with the care they deserved.

Analyses:

Healthcare workers owe a duty of care to the people they support and this includes safeguarding their health and well-being. The Social Care Institute for Excellence (2012) described Duty of Care as a legal obligation to act in the best interest of individuals and not act or fail to act in a way that results in harm. Likewise, Safeguarding means protecting people's health, well being and human rights, and enabling them to live free from harm, abuse and neglect (Royal College of Nursing, 2012). These are fundamental to creating high-quality health and social care and it places upon me personal responsibility and accountability for actions I take and do not take (Hay, 2007). During this incident, deliberating on my duty of care to the people I supported contributed to my nervousness and anxiety because I kept thinking about the consequences of my actions and its broader implications. For John to have missed his medication was really bothering me as well as how best to deal with the injuries sustained by Peter. My employers also have a duty of care to ensure that working conditions are safe and suitable and this was not the case as I was the only staff on duty (Social Care Institute for Excellence, 2012). Having been on duty alone and having to choose between either picking up the phone in the lounge or staying with the residents in the kitchen meant that we as an organization have really failed in providing the best care to the people we supported. The care provided should have been holistic and geared towards providing a comprehensive package to everyone we supported (Brooker and Waugh,

2013). I therefore found the incident upsetting to witness, as I was convinced it could have been totally avoided.

Conclusion:

Looking back on the above incident in a holistic approach, it is apparent that a lot could have been done otherwise. The duty to look after and protect people we support at all times is the responsibility of all employers and their staff (Ghaye and Lillyman, 2000), and cases which could result in harm should have been dealt with very seriously. The evaluation and analyses above have revealed how my organization have failed in its responsibility to support both John and Peter and this incident would never have happened if there was an additional staff on duty at the time and such problems had been going on for a while but management failed to deal with them. This issue was highlighted in the Francis (2013) report which emphasized that tolerance of poor standards was a direct consequence of poor staffing, policies, recruitment, training, and leadership. I should not have had left John and Peter together in the kitchen without support but going to answer the phone in the lounge was part of my role and either way, I was trying to fulfil my responsibility which is to safeguard the people I was looking after. In addition, the telephone unit could have been a mobile handset rather than a wired one as this could have enabled staff to keep the phone with them wherever they happen to be in the building. Nonetheless, health professionals should not be left having to choose between doing one task or the other as the care they provide should be holistic and high-quality (Griffith, 2013). Care provided should be geared towards the needs, wishes and wellbeing of everyone we support and we should do all we can to protect

their best interests and not having to choose between caring for one individual or the other or having to decide which individual's needs are more important than the other (Barsky, 2010).

Action Plan:

Reflecting on this incident, my future plan focussed more on my responsibility of safeguarding all the people I look after, and this greatly requires courage. Courage enables us to do the right thing for the people we support, to speak up when we have concerns and to have the personal strength and vision to innovate and to embrace new ways of working (Maclean, 2012). Equally, commitment to the people we care for is a cornerstone of what we do. We need to build on our commitment to improve the care and experience and take action to make this vision and strategy a reality for all. Because of this incident, management has dealt with the issue of staffing level and have also provided learning activities and essential training for all employees. Training and learning activities improve our knowledge, skills, and understanding as they enable us to learn new skills and discover our strengths and weaknesses. They have given me the opportunity to network with other people who have had similar experiences and this is useful because it facilitates problem-solving which helped increase my understanding (Taylor, 2000). The more information you have the easier things become as you can pull from a bigger store of resources and knowledge to help you manage a situation. After the incident, A mobile phone was also made available so that staff could keep it with them at all times.

This essay has demonstrated how reflection is an integral part of professional practice. It helps one to learn from experience and it is a way of learning that recognizes and articulates what we learn on an ongoing basis (Bolton, G. 2010). The process of reviewing practice after it has occurred is an analytical process and it expands our learning and empowers us to make sense of what we have learned and the reason for learning it (Kolb, 1984). Jasper (2003) agreed that exploring situations from different perspectives challenges assumptions and adhered patterns of behaviour, and thereby encourages the adoption of different ways of seeing and doing things in the future. It has also assisted me in identifying my area of practice where I am good at, an area where I have made a mistake previously, and other aspects of my role in which I need to make improvements.

Since this incident, I have continued to follow Gibb’s 1988 reflective cycle to guide me through reflective practice and professional development. I began challenging poor practices whenever it occurred and this was important because management was obliged to listen thereby taking action when necessary.

Reflection had challenged me to look at the broader picture at my workplace and how these affect my ability to perform my role efficiently. It has become a key theme throughout my time working in any support or care setting and will underpin my future development and progression through education and employment. As pointed out in Fook and Gardner (2006), It has given me the ability to deal with situations in which I had no experience or where I find that behaviours and events are not happening as expected. The conscious

deliberate evaluation that is characteristic of reflective practice has enabled me achieve confidence, efficiency, and organization (Rolfe G. and Rolfe M., 2010). I am now able to understand a situation as a whole after perceiving its meaning in terms of long-term goals and how plans need to be adjusted in response to those events. This holistic perception of events has improved my ability to make sound decisions and judgments.

However, I am mindful of the limitations of reflective practice that every single incident or event is different and that even if I learn from an incident does not mean I will be able to deal with similar ones better in the future (Rolf G. and Rolf M. 2011). As the essay has highlighted, other issues including good management and sufficient resources will always be areas that need addressing if we are to provide the best services for the people we support. Wondrak (1998) discussed the need for more evidence to support the contribution of reflection to professional practice. Also, learning to reflect and learning from those reflections is a very individual process (Schon, 1983). Some people will find the process much easier than others and whilst some may focus on the positives, others will spend more time contemplating and overanalysing the negative aspects of an event and therefore sliding into self-conscious cynicism, isolated thinking, and self-absorption (Schon, 1987). Equally, service improvement will largely depend on other factors such as the attributes of the employees in question, their abilities, confidence, learning styles and commitment. It is also important to approach reflective practice without judgment or self-criticism, as there is no particular or right way of undergoing reflection (Kolb, 1984).