REVIEWS & DISCUSSION PAPERS

A nurses' guide to using models of reflection

AUTHORS

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ABSTRACT

Objective: This scholarly paper aims to discuss the importance of reflective practice in nursing, both theoretically and clinically, for undergraduate and graduate nurses. The article also aims to provide direction by comparing and contrasting four reflective models to provide a basis for self-reflection.

Primary argument: The Nursing and Midwifery Board of Australia requires nurses to be reflective practitioners. Gaining greater knowledge of different models of reflection may aid nurses, both undergraduate and graduate, to enhance their clinical and theoretical knowledge through reflection in their day-to-day practice. Registered nurses may develop their practice through reflecting on their actions, experiences, knowledge, feelings and beliefs to shape their ongoing education and practice.

Conclusion: There is an expectation from registering authorities for nurses to be reflective practitioners. This paper provides information on four different models of reflection, discussed in a systematic and logical order, with a view to highlighting the value of their use to support reflective practice. A comparative framework is provided to highlight similarities and differences. A personal reflection, based on a real-life event, using one of the models is included to provide an authentic example.

Keywords: Reflection, reflective practice, nursing standards, models of reflection, assumptions.

INTRODUCTION

Reflection has a long history and has relevance to many professions. Dewey, some 90 years ago, became a passionate advocate for education and the need to reflect.[1] He believed that reflecting on a person's own practice required courage and open-mindedness.[1] Reflection can be seen as a process of making sense of experience in order to move on and do better as a practitioner.[1,4,5] This is further reinforced by Marshall who provides the definition of reflection as "a careful examination and bringing together of ideas to create new insight through ongoing cycles of expression and re-evaluation".[6] Reflective practice is an integral aspect of nursing education and practice. Currently the Nursing and Midwifery Board of Australia (NMBA) encourages nurses to reflect on their experiences to improve and shape their practice, as does the Royal College of Nursing (RCN) in the United Kingdom.[2,3] The reflecting practitioner needs to be willing to take on board, and act on, constructive criticism. This belief is supported by Bulman and several colleagues who argue reflection can be used to inform and change future practice by reviewing, analysing and evaluating experience.[4,5]

Sources of reflection may include everyday events, positive experiences, negative experiences, eventful incidents, unusual incidents, routine activities, important events and meaningful events. Nurses experience many incidents and situations every day. Examples of this may include an incorrect drug administration, a lecturer being unhelpful, unconstructive criticism in essay feedback, supporting a family in need, a kind comment from a colleague, the birth of a new baby, or a rapid response. Each example is individual

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to the patient, the situation, or the experience of the nurse. By comparison, models of reflection have common themes generally including a description of the event, how the event made the person feel, an evaluation of whether it was a good or bad experience, analysing an area for learning, coming to a conclusion and considering changes that may need to be made. This is important because it aids nurses to think about, plan and deliver high quality and safe care to their patients.[1,2,8]

SELF-REFLECTION IN NURSING

Central to the discussion are the ramifications for nursing practice as well as providing evidence to the NMBA.[2] Self-reflection is an essential skill for all nurses to develop including nurse educators who are required to reflect on their teaching practice.[7] Self-reflection, together with confidence building, is considered a specific requirement for the advancement of educators, especially those who are new to the nursing faculty.[7] Skills for self-reflection include self-awareness which enables a person to analyse their feelings.[5,6] By necessity, self-reflection involves an honest examination of how a situation has affected the person and is intrinsic to enabling the nurse to process experiences, explore actions and evaluate their understanding of those experiences.[8] The person who is reflecting will need to be able to clearly describe the incident or situation. This involves the ability to recognise, and recollect accurately, significant events, and key features, of an experience to then give a more precise account of the situation. The nurse as a reflective practitioner should be able to analyse an experience which involves examining the components of the situation, identifying existing knowledge, challenging assumptions and exploring alternatives. [8] A critical analysis of knowledge needs to be undertaken which involves examining how relevant knowledge is to an individual situation. The integration of this new knowledge with previous knowledge is called synthesis.[6,8] It can be used in a creative way to solve problems and predict likely consequences of actions. Finally, the event or experience needs to be evaluated enabling a judgement to be made about the value of something. Synthesis and evaluation are crucial to the development of a new perspective.[1,2,6,8]

MODELS OF REFLECTION

Many models of reflection have been developed over the years but due to the need to be succinct only four will be discussed. The models were chosen because they employ different approaches but allow the reflective practitioner to follow the steps of self-awareness, description, critical analysis, synthesis and evaluation. The models are presented in a comparative framework below to juxtapose their style and content. The four models chosen are known as the Gibbs Reflective Cycle,[10] Kolb's Reflective Cycle,[11,12] Atkins and Murphy's Model of Reflection,[13,14] and Borton's Framework for Reflection.[15,16] The four models are all relevant, logical and appropriate to current education and nurse education.[10,12,14,17,18]

Gibbs Reflective Cycle

Gibbs Reflective Cycle, developed in 1988, is a systematic, logical and cyclical process encompassing six stages which is demonstrated below. The example below provides a sample reflection, using the Gibbs' model, to highlight how a model can be used to foster self-reflection.[10] This reflective cycle uses its stages to encourage nurses to think methodically about the phases of an experience or activity.[10] Models such as Gibbs, and others discussed in this paper, have overlapping components which are all engaged in providing a platform for directing a reflective process. Education bodies may request the use of a specific reflective model, preferred by their institution. For example, The University of Edinburgh believes the Gibbs' model is an effective way to work through an experience, stating Gibbs' original intended use was for repeated situations however the model's stages also apply equally well to single experiences.[10] The first stage requires a **Description** of the experience, followed by the second stage, the person's **Feelings** and thoughts about the experience.[10] This stage is followed by an **Evaluation** of the experience considering both the good and bad aspects.[10] The fourth stage is the **Analysis** to make sense of the situation allowing the arrival at the fifth stage, the **Conclusion** where the reflecting person can consider what they have learned and what they could have done differently.[10] These five stages lead sensibly to making an **Action Plan** on how the reflecting person would address similar situations in the future, as well as changes they might make.[10] Implementation of the Action Plan can lead to future reflection and a return to the start of the cycle. For further depth, a helpful Reflection Toolkit, provided by the University of Edinburgh, is listed below.[10]

Kolb's Experiential Learning Cycle

In 1984, Kolb published his Experiential Learning Cycle which involves four stages, namely: **Concrete Experience, Reflective Observation, Abstract Conceptualisation** and **Active Experimentation**.[11,12] The first stage, **Concrete Experience**, begins with doing something whereby the individual, team or organisation are assigned a task which requires active/physical involvement. Kolb believes learning cannot take place simply by watching, or reading, but requires activities such as team games, practical exercises or discussion which may not work well for clinical reflection. This differs markedly from the Gibbs' Reflective Cycle where reflection can be based purely on observation.[10] Kolb's model would not support, for example, the situation involving a nursing student observing a wound dressing, for the first time, being undertaken by a more competent staff member. Observation is a safe and effective form of learning especially if the nurse who is attending the dressing explains the procedure, following the steps of

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the nursing process, and then directs the student nurse to specific learning materials.[8] The nurse who is learning can reflect on the process and apply critical thinking to what they have observed.[8] The second stage in the Kolb Cycle is **Reflective Observation.**[11,12] This means taking time-out from the activity, stepping back, and reviewing what has been experienced. Verbalising thoughts and discussing the given task is essential to the reflective process. The third stage, **Abstract Conceptualisation** is the process of making sense of what has happened and interpreting the events, as well as understanding the relationships.[11,12] The learner is required to make comparisons between what they have done and what they already know drawing upon theory from textbooks or any other knowledge that they have developed. The final stage, **Active Experimentation** is when the learner considers what they have learnt and how to put it into practice.[11,12] New understanding translates into what may happen next or what actions should be taken to refine or revise previous behaviour. This could apply to the student nurse who may ask to attend to a dressing under supervision, when due, or sooner if found necessary, following assessment.

Atkins and Murphy's Model of Reflection

The third model for discussion is Atkins and Murphy's Model of Reflection (1993)[13,14] which was specifically designed to be used in nursing practice. Given nurses face many varied, different and difficult situations, the model has been viewed as transferrable and has been adopted by other disciplines.[14] Atkins and Murphy state that people find it difficult to think about uncomfortable experiences but if they reflect on these events, they may find insight when faced with similar situations in the future.[13,14] There are five stages, the first requiring an **Awareness** of uncomfortable feelings and thoughts, an action or new experience. The second stage requires the nurse, or reflecting person, to **Describe the situation** including their thoughts and feelings alongside salient events and key features. This is followed by the third stage which is to **Analyse feelings and knowledge** relevant to the situation. This stage requires the reflecting person to identify their knowledge and challenge assumptions and in doing so, imagine and explore alternatives. The fourth stage is to **Evaluate the relevance of knowledge** which may, or may not, help to explain and solve problems which have occurred. The final and fifth stage is for the person to **Identify any learning**. The model provides detail and encourages the user to think deeply but may be more complex to use in practice and it is not as simple as other models,[15] such as Gibbs and Kolb.[10,11,12] Ball expands on this premiss stating the model presupposes a level of awareness, or unawareness, and presupposes the nurse has the time to analyse which may not be the case in a real-life clinical situation where a lack of time and resources do not allow a nurse to reflect in any depth.[16] Reflection may be something that is addressed much later when an immediate emergency or situation has been resolved.

Borton's Framework for Reflection

Borton's original Framework for Reflection **(What, So What and Now What)**[15] is very simple in its presentation (see the Framework below) but to allow for more in-depth reflective analysis it has been added to by Driscoll to include an array of trigger questions.[17,18] Driscoll also developed an experiential cycle.[17,18] The initial description of an event, the **"What"** uses trigger questions such as: What is the purpose of reflecting on, or returning to the situation, what happened, what did other people do who were involved in this, what did the reflecting person do or see, and what was their reaction to it? From a nursing perspective this would be invaluable in an emergency situation where honing future life-saving skills depends on the ability to reflect and consider what else might have been done. The second part is the **"So what"**. Driscoll asks the reflecting person to consider what they felt at the time of the event, whether their feelings now are any different from what they experienced at the time of the event, what the effects were of what they did, or did not do, to consider the positive aspects emerging from the event, reflect on their behaviour in practice by taking a more measured look at it and to consider the observers views to aid reflection of practice, actions and feelings.[17,18] The **"Now what"** has implications for clinical practice based on what has been described and analysed. Trigger questions include asking whether there would be a difference if the reflecting person chose to do nothing, what the main learning points are from reflecting on practice, what help might be needed to action the results and which aspects should be tackled first. Further trigger questions include where more information might be found to face a similar situation again and how practice could be modified if a comparable situation arose again.[15,17,18]

RECOMMENDATIONS

Nurses should be aware of the many sources or contexts which can be used for reflection in their everyday practice. They also need to be cognisant with the numerous reflective models that can be accessed to provide a basis for reflection. The four reflective models presented in this paper are examples of models that can assist personal and situational analysis so that the user may immerse themselves in a realistic, logical breakdown of how that specific situation has affected them, their work colleagues, their patients and their patient's family members. It is essential that nurses are enabled to process positive or negative experiences, explore their actions and evaluate their understanding of those experiences.

All experiences, whether positive or negative, should be embraced as they can provide meaningful learning opportunities. As promoted by the RCN, reflective practice can lead to revalidation of practice and an improvement in work behaviours.[2] Recommendations may include seeking, and reflecting, on any feedback from patients, and other

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service users, as well as accepting feedback from colleagues to identify areas for improvement in practice. Staff must ensure they take part in professional development activities to address gaps in knowledge which can be achieved through undertaking Continuing Professional Development (CPD) which ultimately ensures safety for the patients.[2,3,19] Most importantly, nurses must accept accountability for their professional development, maintain a portfolio and ensure there is evidence of reflection to provide a plan of how care can be enhanced, improved or done differently, if appropriate.[2,3]

CONCLUSION

Reflecting on practice is considered to be an important aspect of nursing.[2,3,7] The value of reflective practice is widely acknowledged due to its significant role in nursing education, clinical and theoretical nursing assessment and revalidation requirements.[7,20] Advocates of reflective practice understand that a competent reflective practitioner repeatedly reflects on experiences and continually learns from those experiences to the benefit of future actions.[2,19,20] Reflective practice is now a fundamental component of both theoretical course work and clinical practice for nurses and positively impacts on both personal and professional development. An integral part of continual, evolving nursing, both clinically and through education, is the need to evaluate and improve care in an ever-changing healthcare environment. Reflective practice can only enhance the provision of quality in healthcare ensuring future nurses become competent practitioners who can provide, person-centred, safe care, that is aligned with best evidence and clinical standards. The four models discussed provide a platform for nurses to reflect as they all provide a structure which clearly directs a systematic process from describing the experience to eventually giving true significance to it.

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COMPARATIVE FRAMEWORK

Model	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Gibbs (1988) Reflective Cycle[9]	**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 have been done?	**Action Plan** If it arose again what would you do?
Kolb (1984) Experiential Learning Cycle[10,11]	**Concrete learning** Doing/having an experience	**Reflective observation** Reviewing and reflecting on the experience	**Abstract conceptualisation** Concluding/ learning from the experience	**Active experimentation** Planning/trying out what you have experienced		
Atkins and Murphy Model of Reflection[12,13]	**Awareness** of uncomfortable thoughts and feelings, actions or new experiences	**Describe the situation** Include salient (most noticeable or important), feelings, thoughts, events or features	**Analyse feelings and knowledge** Identify and challenge assumptions. Imagine and explore alternatives.	**Evaluate** the relevance of knowledge. Does it help to explain/resolve the problem? How was your use of knowledge?	**Identify any learning** which has occurred?	
Borton's Model of Reflection[14,15]	**What?** What have I learnt? What did I hope to learn? What surprised me?	**So What?** So, what is the importance of this learning? So, what more do I need to know about this? So, what have I learnt about this? So, what was different to what I knew previously?	**Now What?** Now what can I do? Now what do I need to do? Now what might I do to improve or enhance the care I give to my patients? Now what might be the consequences of this action			

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A PERSONAL CLINICAL EXAMPLE

using Gibbs Reflective Cycle as part of the reflective process required by the NMBA and RCN.[2,3,10]

Description	I was the Nursing Unit Manager (NUM) on a seven-bed busy Intensive Care Unit (ICU) and received a male patient from the Emergency Department (ED). The patient had been lying, unfound, on his front porch for 20 minutes, having cardiac arrested on a cold winter's day. The neighbour had walked out of his front door and saw the patient collapsed on the cold cement porch. The neighbour ran over and commenced resuscitation. He shouted until help came whilst also managing breaths and cardiac compressions, to the best of his ability. The paramedics arrived another 20 minutes later. The patient was transported to ED, 10 minutes away. The patient arrived on ICU two hours post cardiac arrest and then cardiac arrested again 30 minutes later. The ICU staff commenced resuscitation but by this time I had made the assumption that the patient was probably already brain-dead. I was undecided and conflicted as to how much help he should receive given there were six other critically ill patients on differing levels of life support and staffing was stretched to the limit. The doctor-in-charge asked everyone if we should continue and we all agreed we should keep trying but all of us had a failing belief it was the right thing to do. We were successful in resuscitating the patient however all signs of brain viability were not good at that point. However, after the first 24 hours, the patient started to improve. Much to everyone's disbelief the patient walked out of the hospital five days later with only mild short-term memory loss.
Feelings	Following the resuscitation in ICU I felt very distressed as the patient had been without oxygen for a long time prior to the hospital admission. I knew I had an ethical obligation to the patient but I now felt I had participated in a resuscitation that would likely leave the patient with brain damage and little quality of life.[21,22] At the time, I considered the whole situation to be a lost cause. I turned my attention to helping six other staff members, and their ventilated patients, seeing them as my priority rather than the patient just brought in. I felt very uncomfortable and under pressure to do the right thing for all patients in the ICU, but I was feeling too stretched mentally and physically, and well out of my comfort zone.
Evaluation	The experience was ultimately beneficial for the ICU staff, as well as personally, as it became apparent that nurses should not make assumptions about potential patient outcomes. Individuals will respond in differing ways. The experience was also a negative one because it made most of us, especially me as the NUM, feel I was not able to perform my job to the best of my ability and I had made assumptions that were not in the best interest of the patient.
Analysis	Despite our concerns the team continued to act as advocates for the patient and the successful resuscitation was ultimately in line with our required duty of care.[21,22] I, however, made negative assumptions, as did other staff members, but as NUM and Team Leader it was up to me to remain positive and focused. As NUM I was required to support all patients and staff on the floor. I could have embraced the role of advocate for that particular patient equally as well as I did for the other six patients.[21,22] Research suggests hypothermic patients can avoid brain damage.[23,24] Our Code of Ethics requires us to follow our ethical principles. I had a duty of care to uphold beneficence (to do good) and non-maleficence (to do no harm).[22,25]
Conclusion	The Code of Conduct requires nurses to be a patient advocate whatever the circumstances.[22] Our personal beliefs and judgements should not influence patient care. This was one of the most valuable experiences of my life. On reflection I should have asked for support from the Hospital Coordinator. I should have remained the patient's advocate at all times and not allowed assumptions to cloud my judgement.
Action Plan	In a similar situation, in the future, I would remain vigilant, focused and ensure I receive physical support to reduce fatigue but also gain support from management to keep team spirit intact. I will continue to read around the topic of cardiac arrest, and sudden death, and further develop aspects of my knowledge. I will ensure I pass my knowledge on regarding hypothermia and preserved brain function.[23,24] I have learned that assumptions are inappropriate, and I will remember a very old phrase that "assumptions make an ass out of u (you) and me".[26] I am aware that the quality of healthcare may be undermined if nurses do not understand the full scope of their responsibilities.[27]

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