

Reflection on a Significant Incident from Practice

Introduction

The intention of this written essay is to demonstrate an understanding of my views on the art and science of reflection and the issues surrounding reflective practice. It is based on a significant incident from my own area of clinical practice as a state registered paramedic employed by a large provincial Ambulance Service N.H.S. Trust within the U.K.

There is a discussion appraising the concept of reflection both generally, and in my particular area of practice. This is followed by an analysis of the incident using The What ? Model of Structured reflection suggested by Driscoll (2000). A rationale is given for the selection of this particular incident and also for the selection of the chosen model as a framework.

It will show how the model has been used to reflect on the incident, what has been learnt, and the outcome on both current and future practice.

Reflection is an active process of witnessing one's own experience so that we can take a closer look at it. It has its foundations in the discipline of experiential learning. Dewey (1939 cited in Rolfe, Freshwater, & Jasper 2001) claimed that we learn by doing, and realising what came of what we did.

“Reflective practice is something more than thoughtful practice. It is that form of practice which seeks to problematise many situations of professional performance so that they can become potential learning situations and so the practitioners can continue to learn, grow and develop in and through their practice” Jarvis P. (1992) pp174 -181.

Johns, C (2000a) pg 34, describes reflection as a window through which the practitioner can view and focus self within the context of his own lived experience in ways that enable him to confront, understand and work towards

resolving the contradictions within his practice between what is desirable and actual practice.

All professionals experience physical, “hands on” , doing parts of their roles, but unless they search for the knowledge that comes from realising what came of what they did, then the standard of their practice can stand still. In other words if you always do what you have always done you will always get what you have always got.

Roth (1989) summarized the basic elements of a reflective process as follows,

- Keeping an open mind about what, and how we do things.
- Awareness of what, why and how we do things.
- Questioning what, why and how we do things.
- Asking what, why and how other people do things.
- Generating choices, options and possibilities.
- Comparing and contrasting results.
- Seeking to understand underlying mechanisms and rationales.
- Viewing our activities and results from various perspectives.
- Asking “What if?”
- Seeking feedback and other people’s ideas and viewpoints.
- Using prescriptive (advice) models only when carefully adapted to the individual situation.
- Analysing, synthesising and testing.
- Searching for, identifying and resolving problems and result limitation.

As a guide to its essential nature, reflection can be viewed as ten C’s of reflection. Johns.C (2000b)

- Commitment – believing that self and practice matter; accepting responsibility for self; the openness, curiosity and willingness to challenge normative ways of responding to situations.
- Contradiction – exposing and understanding the contradiction between what is desirable and actual practice.

- Conflict – harnessing the energy of conflict within contradiction to become empowered to take appropriate action.
- Challenge and Support – confronting the practitioner’s normative attitudes, beliefs and actions in ways that do not threaten the practitioner.
- Catharsis – working through negative feelings.
- Creation – moving beyond self to see and understand new ways of viewing and responding to practice.
- Connection – connecting new insight within the real world of practice; appreciating the temporality over reality.
- Caring – realising desirable practice as everyday reality.
- Congruence - reflection as a mirror for caring.
- Constructing Personal Knowing in practice – weaving personal knowing with relevant extant theory in constructing knowledge.

Reflections can vary in their details and their complexity. Two main levels of reflective enquiry have been identified; either practitioners engage in deep and potentially meaningful inquiry, or they opt for superficial problem solving according to tradition or pressure of work. Burnard P. Chapman C.M. (1988)

Reflection can be facilitated in a number of various ways. In the narrative, through reflective writing, this may be in the form of analysis of a significant incident from the writer’s area of practice. Through poetry and journal or diary entries and in the context of a portfolio.

In clinical supervision, which has been described as “an exchange between practising professionals to enable the development of professional skills”. B Procter (1989) pg 23, it can be expressed through dialogue and it has a vital part to play in sustaining and developing professional practice.

Reflection can also be expressed using creative strategies such as music, poetry, modelling, art and collage.

There is a danger that personal reflection can focus on the negatives of a given incident, where it should involve balanced critical evaluation, focused on abilities and potential for growth.

In order to provide a framework for methods, practices and processes for building knowledge from practice there are several models of reflection available. All can help to direct individual reflection. Some may be particularly useful for superficial problem solving, and other better when a deeper reflective process is required. Reflective models however are not meant to be used as a rigid set of questions to be answered but to give some structure and encourage making a record of the activity.

The model I have chosen is Driscoll's What? model. The reason being that though it has a format of three simple questions – what? , so what?, now what? the added trigger questions give a deeper and meaningful reflective process by stimulating a more in depth enquiry leading to the formulation of an action plan for the future. It may be argued that reflective practice in my own area of clinical practice in the ambulance service has always been deployed whether through debriefing after a serious incident or the informal discussion in the cab of the vehicle.

I and my crewmate, an ambulance technician, received an emergency call from ambulance control just after midnight to respond to a road traffic collision between a pedestrian and a car. The location was given as a semi-rural area some 6 miles distance from our Ambulance Station, and we were quickly on the scene.

As we arrived on scene we first saw the car that had been involved in the incident and I made a quick mental note of the damage to the bonnet, windscreen and roof to assess the mechanism of injury to the pedestrian. The driver was still sitting in the drivers seat and although obviously distressed had no apparent injuries and was being comforted by a passer-by. This situation was left as it was; the primary concern was the pedestrian.

The pedestrian, a male in his early forties, was lying on the road some distance from the damaged car. There were three passers-by with him; one of them stated that the casualty was unconscious but breathing.

I carried out a patient assessment with a primary survey – a rapid in-depth survey of airway, breathing, circulation, disability, taking 60- 90 seconds. (Joint Royal Colleges Ambulance Liaison Committee. Pre-hospital Clinical Guidelines Manual.)

I immobilised the patient's cervical spine using a semi-rigid cervical collar and opened his airway using the jaw thrust technique. (Institute of Health and Care Development Ambulance Service Paramedic Training Manual). On assessing the airway I observed the patient's mouth and upper airway for air movement. There was obstruction due to blood and I removed this by aspirating with suction equipment, and then inserted an oropharyngeal airway in the patient's mouth.

Moving onto breathing assessment I exposed the patient's chest to observe chest wall movement and assess for chest trauma as a cause of breathing problems. Breathing was absent so I proceeded with resuscitation guidelines. Administering basic life support with cardiac pulmonary resuscitation

I asked my crewmate to fetch the trolley and the spinal board and we positioned the patient on to the spinal board ensuring that cervical spine immobilisation was maintained by using head blocks and straps. Once secured safely to the spinal board, placed on the trolley and transferred to the ambulance, whilst continuing Basic Life Support.

The patient was attached to the cardiac monitor which showed Asystole (no cardiac output) and advanced life support was commenced.

Intubating the patient was difficult, and it took several attempts to achieve, but eventually the endotracheal tube was in position and connected to the oxygen driven mechanical ventilator to allow artificial ventilation of the patient. The

next task was to gain intravenous access for the administration of drugs and fluids, and full advanced life support was commenced.

Whilst on The Reflective Practitioner Course I chose to reflect on this incident by writing a piece of poetry entitled 'Final-Cup Final' based on Gibb's model of reflection (see appendix 1). The feelings I had then was that I had done everything possible to save the patients life given the circumstances. But when using Driscoll's model (see appendix 2) , with the added trigger questions, a deeper and more meaningful reflection process occurred making me question my actions and leading to the formulation of an action plan for the future.

Final – Cup Final

I remember that warm summer's night so clearly,
the football cup final.
Most people would have watched it
just the same as you.

Our shift started at seven,
by the time we returned to base at midnight
five emergencies already,
I felt ready for a break.

I must have nodded off,
suddenly awoke with the ringing of the phone
"Emergency - between A and B
Pedestrian versus car."

Off we set all sorts of things racing through my mind.
Soon arrived on scene
and first saw the damage to the car –
Crumpled bonnet, broken windscreen, dented roof.
The driver sat there shaking,

terribly distraught.

Passers-by were with you,
not sure how to help.
Myself and my crew-mate did all we could,
used all the skills we knew,
Intubation, cannulation,
full drugs protocol
Nothing we did could save you
and my helpless feelings grew.

And now as I pass by the scene
several times each week
I often stop to wonder
is there more we could have done?

On careful reflection
there's nothing more we could.
And now I have to realise
nothing could have changed.
Negative thoughts turn positive –
look to the future
And learn from what has been.

Using The What ? Model of structured reflection suggested by Driscoll (2000) the incident can be analysed in the following way.

The purpose of returning to this situation is to review and reflect upon my experiences of this particular incident, and help make sense of what was a stressful, complicated and messy situation. I need to question if I made the correct decision as a paramedic to continue with resuscitation of this patient or if I should have certified fact of death at the scene.

The casualty was in respiratory and cardiac arrest and so cardiopulmonary resuscitation, basic, and advanced life support was commenced and the

patient rushed to the nearest hospital with an accident and emergency department.

My crewmate helped with clinical procedures on scene, i.e. cardiopulmonary resuscitation, assisting with intubation and cannulation and drawing up drugs. The casualty's friend and passers by, although in an emotional state of shock helped as much as they could by fetching and carrying when asked to and I think this helped them in the situation they found themselves in by giving some purpose of being useful.

At the time of the incident there was a reflection in action, where do we go from here? tuning in and going with the flow approach from both myself and my crewmate. There were two options available, either continue with resuscitation with full advanced life support or certify fact of death. The best approach at the time, and the one that I chose, even though his injuries were not compatible with life, was to continue with resuscitation. The main factor for this decision was by assessing the situation as a whole and considering the feelings of others. If resuscitation was not attempted the casualty's friend and bystanders would have thought that we were not giving him the best possible chance of survival, even though this chance was very remote. This had to be weighed up against the consequences of commencing resuscitation when it could be both futile and distressing for relatives, friends and health care personnel. Time and resources could be wasted in undertaking such measures.

Through reflection on action I have recognised that no guidelines can cover every situation that may arise. They are intended to provide adequate guidance for the great majority of circumstances. Not everything is black and white, there will be grey areas, and it is the individuals responsibility to act as he thinks appropriate at that particular time.

The implications for me and others when facing a similar situation again, are to recognise that there is sometimes a grey area when considering if to attempt resuscitation or not. This has to be assessed taking in to

consideration the particular situation and using professional judgement based on best evidence and up to date knowledge, and at times thinking beyond the guidelines, whilst remaining professionally accountable to the Health Professions Council.

I can use this learning experience when working with and mentoring trainee ambulance staff and discussing my feelings with them and how they may react and feel in a similar situation.

I can get more information and support to face a similar situation from my Clinical Support Manager, Ambulance Service Education department, Joint Royal Colleges Ambulance Liaison Committee Clinical Practice Guidelines manual and the Institute of Health and Care Development manual.

Conclusion

Reflection can range from deep and potentially meaningful inquiry, to superficial problem solving.

The care that patients receive has the direct potential to improve through reflective practice. Structured reflective practice also has the potential to develop staff and improve the implementation of professional standards. It has the following advantages to offer the health care professional; helps to make sense of complicated and difficult situations, a medium to learn from experiences and therefore improve performance and patient care, identify educational needs, identify workload stressors, highlight barriers to development and ways of identifying improvements, and provide evidence of continual professional development and life long learning.

In addition staff could become increasingly more motivated and empowered. Better critical thinkers and self-directed professionals.

References

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