The Development of Critical Reflection in the Health Professions

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FOREWORD

'The Development of Critical Reflection in the Health Professions' is the fourth in the series of Occasional Papers produced by the Learning and Teaching Support Network (LTSN) Centre for Health Sciences and Practice (HSAP), soon to be under the umbrella of the UK Academy of Higher Education. These occasional papers are part of the work of the Centre, the remit of which is to promote good practice in Learning and Teaching in Institutions of Higher Education.

There are many aspects of learning and teaching, from the student experience, through the subject content, the mode of delivery and facilitation, to assessment. The Centre has consulted the Health Science and Practice community to find out the aspects of this process on which they would most like support. One of these was on placement education within which critical reflection has become an essential element of learning.

The philosophy of the LTSN Centre for HSAP is primarily to address the expressed needs of the constituency, rather than to adopt a top down approach about the requirements of Higher Education. In this case there is no conflict between these approaches as the expressed needs match the current benchmark standards for health care professionals as set out by the Quality Assurance Agency for Higher Education (2001) which all indicate that reflective skills are needed at the point of registration.

The Health Sciences and Practice Community is wide, comprising 31 disciplines and several other associated subjects that are primarily attached to other Centres. The range of experience is therefore equally wide and this provides an excellent opportunity to compare, within our community, the experience of different health professions in the development and use of critical reflection. In this volume we benefit from the reflections on reflective practice by practitioner educators in podiatry, physiotherapy, pharmacy, paramedicine, occupational therapy, nursing, midwifery, mental health nursing, dietetics, complementary therapy and teaching. These case studies are expertly introduced in Sylvina Tate's chapter which sets the scene by introducing critical reflection as a teaching tool with much useful background information about modes of learning, and some of the advantages as well as difficulties in this approach, such as assessment. The question of assessment is taken up in detail in the penultimate chapter by Stephanie Fade and useful, succinct conclusions are reached in the last chapter by Lynne Clouder.

As mentioned at the start of this foreword our aim is to promote good practice and a key question is always 'how do we know what is good practice?' when there exists very little evaluation of impact of various practices on learning. The exposition of these case studies however gives the reader a depth of understanding about the theoretical underpinning of critical reflection in professional learning, as well as the practical limitations and benefits. With this sharing of experience the formulation of what is good practice can fruitfully evolve.

As always, we welcome comments on our publications and look forward to hearing from you on www.health.ltsn.ac.uk

Professor Catherine Geissler
Director: LTSN Centre for Health Sciences and Practice

FOREWORD

Reflective practice is like a pool of blue inviting water. The pool has a shallow end where the bottom is visible and a deep end where the blue is deep and the bottom unknown.
We have read that reflection is a good thing because it is a path towards realising desirable and effective practice in meaningful and practical ways. More than that, it is a process of self-development, of becoming the sort of practitioner you want to be. It is also a way to value caring and honour self as caring. How alluring. Can we resist the pool? You see your reflection in the clear blue water. Is this who I am? Is this who I want to be?
Some people will always fear water and turn away despite our best efforts to engage them. They may dip their toes in the water but will resist no matter what you do. Such fears are deeply held and a mystery. Maybe they would prefer flying?
Others will slip cautiously into the water, others with gay abandon and immediately feel the pleasure and benefits of the soothing blue water. Not being out of one's depth is important as we move about the shallow end and learn how to swim guided by our trusted instructors.
Gradually we learn to swim and move into the deeper end submerged within the deep blue water. No longer can you feel your feet on the bottom. What depths must I go to touch the bottom… it is the same question as to what depths must I go to know myself? It is about letting go of fear and attachment to the sides- all those safe practices that keep us safe but also constrain us. And in no time you gather pace and swim easily in the depths, marvelling at the freedom, and choosing the places to visit. Each time you return you understand more about the depths and choose more wisely. Indeed, it feels like a spiritual experience for you to notice the way you hold yourself differently, stronger, more compassionate, wiser, more assertive and confident of your place in the wider world. People comment how different you are. What you read in the books now makes sense but you had to experience it for yourself to realise. Monsters met in the depths become companions on a seemingly endless journey.
And in the darkest depths you see the light of realisation, a light that pulls you inexorably closer until you merge with the light and become who you truly are, certain of your purpose in your professional practice.
The best instructors are those who have made the journey for themselves, who know from experience, who guide the person to find their own way to swim well. Rather than applying rigid techniques to swim, these guides enable each individually to find their own way, a balance of challenge and support to move to greater depths.

Well-worn paths are easy to follow but mould the person into the pattern of the guide rather than finding their own pattern. Techniques, like all tools, are useful for doing the job but are merely tools in wise hands. To practice well requires a strong sense of vision to guide us. We need expert clinical judgement – the ability to grasp and interpret what is unfolding, and skilful action to respond appropriately and effectively. We then need to evaluate and reflect in order to learn from the situation and apply such learning to new experiences within a reflexive spiral of being and becoming. That is professional practice. Within that spiral, we draw on relevant theory to inform us, theory that we then assimilate into our personal knowing. That is the swimming lesson and if we also enjoy it then how richer our lives are.

This book is a collection of fragments from different peoples' reflections on making reflective practice work within a curriculum. Fragments of uncertainty, hope, celebration, and commitment to making it work, for the effort is surely worth it, not just for ourselves as practitioners but also for the difference it makes to our patients and clients.

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CONTENTS

CHAPTER	TITLE	AUTHOR	PAGE
	Introduction	Sylvina Tate	7
1	Using critical reflection as a teaching tool	Sylvina Tate	8
2	Using reflective practice in the podiatry curriculum	Maria Young	18
3	Using reflective practice in the physiotherapy curriculum	Patricia White	24
4	Using reflective practice in the pharmacy curriculum	Judith Rees	32
5	Using critical reflection in the paramedic curriculum	Indra Jones	39
6	Reflective practice within the occupational therapy curriculum	Rebecca Khanna	47
7	Enabling learning through reflective tutorials in the nursing practice setting	Alison Clark	54
8	Reflective practice in the midwifery curriculum	Annie Powell-James	63
9	Reflection in mental health nursing	Janet Barker	70
10	Reflection in the Dietetic Curriculum	Stephanie Fade	76
11	Using reflective practice in an interprofessional complementary therapies programme	Sibyl Coldham	82
12	Reflective practice in teacher preparation	Helen Stanley & Charlotte Ramage	88
13	Reflection and assessment	Stephanie Fade	96
14	Conclusion	Lynne Clouder	101
	References		109
	Appendices		
Appendix 2	2.1 – Case One: Year 1, level 1 (4)		129
	2.2 - Case Two: Year 2, level 2 (5)		132

	2.3 - Case Three: Year 3, level 3 (6)	135
Appendix 3	3.1 – Extract from the physiotherapy professional portfolio guidelines	138
	3.2 – Example of a professional portfolio completed diary sheet	140
	3.3 – Marking guidelines and criteria for professional portfolio	142
	3.4 – Example of a half way completed student Continuous Practice Self Assessment (CPSA) form	145
	3.5 – Example of a completed Clinical Educators Continuous Practice Assessment (CPA) form	148
	3.6 – Example of a completed Significant learning Experience Report (SLER)	152
	3.7 – Descriptions of the characteristics of reflectors in professional practice.	154
	3.8 – Student feedback form	155
	3.9 – Guidelines for Clinical Educators	156
	3.10 – Interprofessional working	157
Appendix 4	4.1 – Self assessment form	158
Appendix 5	5.1 – ENB (1996) Ten Key Characteristics	160
	5.2 – A paramedic example (1) of reflective writing	161
	5.3 - A paramedic example (2) of reflective writing	163
Appendix 6	6.1 - Indicative content for the reflective essay	165
Appendix 7	7.1 – Abstract from assessment strategy diploma nursing students	166
	7.2 – Patient and public information: Adult branch themed placement	167
	7.3 – Learning summaries	168
	7.4 – Shades of competence	169
Appendix 8	8.1 – Examples of practice and integrated outcomes for a specific module	170
	8.2 – Module assessment table	172
	8.3 – Grading for module seminar assessments	173
Appendix 9	9.1 – Assessment – portfolio activity	177
	9.2 – Extracts from student's assignment	178
	9.3 – Assessment guidelines level 2 (5)	180
	9.4 – Extracts from a student assignment	182
	9.5 – Assessment guidelines level 1 (4)	187
Appendix 10	10.1 – suggestions for using a film clip	188

	10.2 – Prompt questions	189
	10.3 – Reflective questions to consider after an activity	190
Appendix 11	11.1 – Learning Outcomes for Levels 4, 5 & 6	191
	11.2 – Generic reflective Criteria	192
	11.3 – Marking grids for levels 4 & 5	194
Appendix 12	12.1 – Action learning set feedback form	199
	12.2 – Portfolio criteria.	201
	12.3 – Journal guide	204

INTRODUCTION

The seed of this occasional paper germinated at the Festival of Learning and Teaching organised by the Learning and Teaching Support Network (LTSN) for Health Science and Practice, held in Bristol in 2002. I was facilitating a session on teaching reflective practice attended by a number of teachers from differing professional backgrounds. It was apparent that there was much expertise within the room and that this sharing had been very beneficial to all who attended.

My enthusiasm resulted in me asking those present if they would be interested in sharing their knowledge with a wider audience. Their consent started the process, supported by Margaret Sills, which has ended with the production of this occasional paper.

The LTSN for Health Science and Practice provides support for teachers of nursing, midwifery and Allied Health Professions. Critical reflection is used to varying degrees, as a teaching tool by many of these professions, often as a result of their professional body requirements. However, each of the professions has differing experiences and expertise in using reflective practice.

The purpose of this occasional paper is to share those experiences with the aim of helping others to learn from our experiences. We are not suggesting that our experiences are representing best practice, only that we are committed to the use of critical reflection as a teaching tool. We have implemented it into our curricula and have, in some way, evaluated that process. The contributions to the paper have adopted one of two approaches; theoretical or experiential. Most contributions are experiential, drawing upon our individual experiences of incorporating critical reflection into a specific curriculum. Each of these chapters have the same framework but individual voices. In the spirit of reflective practice, which acknowledges the individuality of each experience, no attempt has been made to edit out different voices. The remaining chapters have attempted to synthesis theoretical aspects of reflective practice.

In chapter 1, I will provide an educational case for reflective learning before exploring the reflective process within health care education. The chapter will conclude with some of the issues for teachers of reflective practice. Chapters 2 – 12 are individual narratives of using critical reflection in a range of health care curricula. These are presented in reverse alphabetical order according to profession. In Chapter 13 Stephanie Fade, drawing on her PhD work, will explore some of the issues of assessing reflective practice. Lynn Clouder provides the final chapter in which she explores the similarities and differences between the differing approaches and makes recommendations.

Differing voices will emerge in individual chapters. However, to provide a sense of consistence in relation to academic levels, where contributors are still using '1', '2' and '3' to denote academic levels, in line with Quality Assurance Agency's new National Qualification Framework for Higher Education the newer levels of '4', '5' and '6' have been added in brackets during the editing process.

A final comment is necessary to explain the numbering of appendices. The number of any specific appendix indicates that it is the appendix to the chapter of the same number. Where appendix numbers are apparently missing this indicates that there are no appendices to this chapter.

It is hoped that you find our contribution helpful and that we can learn from the experiences of our differing professions. To this end each of the contributors is happy to be contacted via the email address at the end of their chapter.

CHAPTER 1

Using critical reflection as a teaching tool

Introduction

"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 practice" (Jarvis 1992).

Increasingly health care professionals are required to utilize reflective practice both within their initial training and continuing professional development.It is also seen as a Higher Education transferable skill, evidence of which is required by Quality Assurance Agency (QAA). Within this chapter I will provide an educational case for reflective learning before exploring the reflective process within health care education.

Within the article the terms 'reflection' and 'reflective practice' will be used synonymously. This is congruent with the findings of O'Connor et al (2003) who conclude that the terms are used interchangeably.

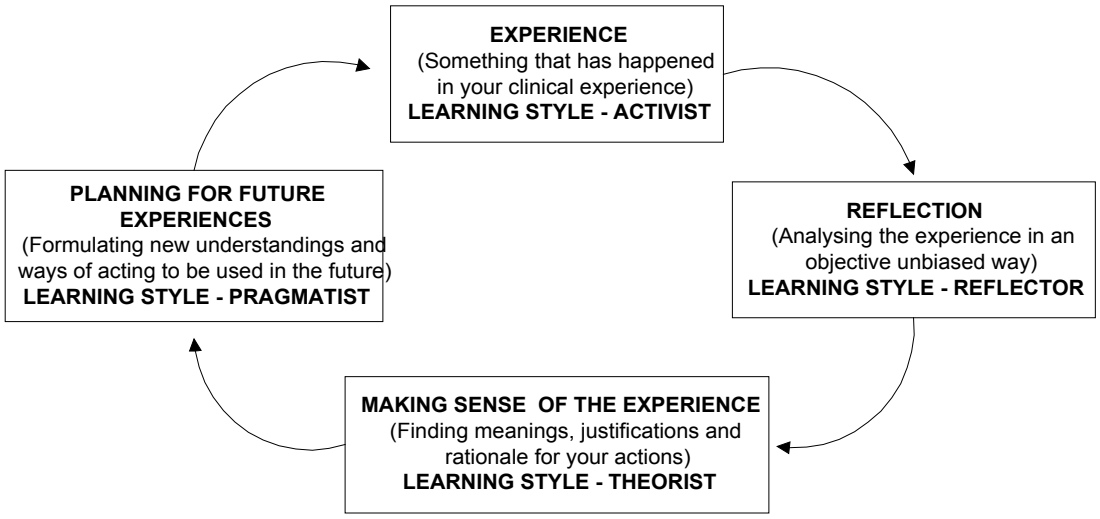
The case for reflective learning

Maximising student's learning, especially in the applied sciences, is an ongoing challenge for teachers and pedagogic researchers. Much has been written about the theory - practice gap, whereby students are taught theory in an educational establishment and find that in the 'real world' of practice, things can be very different (Salvage 1998). This is a particular problem for professional education. Part of this problem could be related to there being a difference between how novice and expert practitioners work. Benner (1984) found that while novice practitioners rely on theory based rules to direct their decision making, experts draw largely on intuition based on their past experiences. Learning from experience (experiential learning) is one of the aims of critical reflection. It seems appropriate therefore that student practitioners should be well grounded in this skill to maximise their learning both as a student and a professional.

For most of the last century psychologists have defined and redefined how it is that we acquire new knowledge, skills and attitudes. Early research (Pavlov 1927, Skinner1953) suggested that learning took place through the process of conditioned responses. Although there is still a role for such learning, for example in responding to a cardiac arrest, it is now acknowledged that in humans, learning is a much more complex and individual process. The role cognition plays in the process of learning was demonstrated by such theorists as Bruner (1961), and Ausubel (1968), who expounded the theory of 'discovery learning' and 'advanced organisers'.

Further advances were made by 'Humanists' such as Maslow (1962) and Rogers (1969) who recognised the affective domain to the learning process, thus recognising that for individuals to achieve 'deep learning' (Claxton 1988) they need to be engaged as a whole person. This includes the three domains of actions (behavioural), thoughts (cognitive) and feelings (affective). This has been supported by work into individual learning styles (Honey & Mumford 1986). They described four learning styles: activists, reflectors, theorists, and pragmatists claiming that each of us has a preferred style of learning. These fours styles fit very clearly with the stages of the experiential learning cycle described by Kolb (1984) (See figure 1.1). To maximise our learning it is suggested that we need to develop all of our learning styles. The focus within this chapter will be the exploration of critical reflection as the skill required to develop the learning style of reflector.

Figure 1.1 - The Experiential Learning Cycle (Adapted from Kolb 1984) with Associated Learning Styles (Honey & Mumford 1986)



Critical reflection (reflective practice)

The seeds of reflective practice can be traced back to the educational philosopher John Dewey (1933, 1938) who argued that the ability of an individual to reflect is initiated only after they identify a problem *as well as* recognising and accepting the uncertainty this generates. He claimed that reflective thinking requires continual evaluation of beliefs, assumptions, and hypotheses against existing data and against other plausible interpretations of the data. Schon (1983) in his book 'The Reflective Practitioner' further clarified this process. He categorised knowledge into two types: technical rationality and professional artistry. Technical rationality is the phrase he uses for scientific knowledge that has been generated by research and referred to as 'knowing that' (facts). In contrast professional artistry is intuitive knowledge derived from individual experience and referred to as 'knowing how'. Both types of knowledge are needed in becoming a practitioner. I personally like to view their interface as that of an artist. I imagine the artist's tools, the brushes, paints, canvas etc, to represent technical rational knowledge. However, how individuals use these tools will result in very different pictures. This is the professional artistry required of practitioners who aim to provide holistic patient-centred care. Their knowledge will be used in different ways in response to the differing needs of individual patients. Professional artistry is developed through the use of critical reflection and Benner (1984) identified this as a characteristic skill of an expert nurse. Part of this process requires us to develop awareness of our personal unconsciously held beliefs and values, often referred to as our tacit knowledge

Johns beautifully describes critical reflection as 'a window through which the practitioner can view and focus self within the context of her own lived experience in ways that enable her to confront, understand and work towards resolving the contradictions within her practice between what is desirable and actual practice' (Johns 2000:34)..

To maximise learning through critical reflection we need to contextually locate ourselves within the experience and explore available theory, knowledge and experience to understand the experience in different ways. Thus Boyd & Fales (1983) claim that critical reflection "is the core difference between whether a person repeats the same experience several times becoming highly proficient at one behaviour, or learns from experience in such a way that he or she is cognitively or affectively changed". Because of this critical reflection is viewed as transformational learning, which according

to Baumgartner (2001) '…..can occur gradually or from a sudden, powerful experience and change the way people see themselves and their world.' She describes Dirkx's (1998) four-lens model of transformational learning: consciousness-raising (Freire 1972), cognitive-rational (Mezirow 1981), developmental (Daloz 1999) and spiritual (Dirkx 1997, Healy 2000).

Freire (1972), a humanist, worked with the illiterate poor in Latin America to help them understand the sources of their oppression and, through consciousness-raising (or conscientization p13), work towards dismantling the societal structures of that oppression. He believed in the liberating power of education in which students and teachers worked together on the actual experiences of students. Through this process they came to see the world and their place in it differently.

The cognitive rational approach of Mezirow (1981) shares some of the same philosophical underpinnings as Freire. Both believe that knowledge is not 'out there' to be discovered but is constructed through the interpreting of new experiences. As such they both believe that education should be empowering. They differ in as much as Freire focuses on social justice while Mezirow's emphasis is on rational thought and reflection. This is characterised by the process of experiencing a 'disorienting dilemma' (Mezirow 1991a p 168), and reassessment taking place through reflection and the evaluation of assumptions. This may lead to a 'perspective transformation' (1981 p3), which is not complete unless action follows thought and the individual begins to live the new perspective.

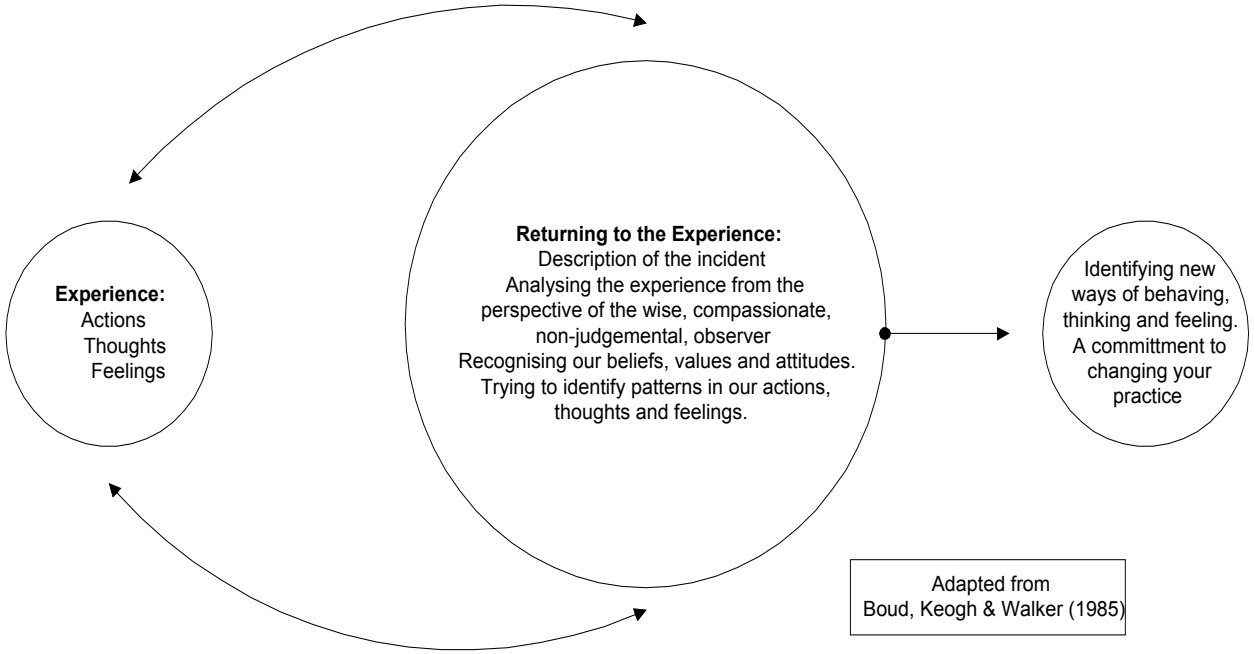
The third approach, that of Daloz (1999), uses the concept of development. He believes in the role of a mentor in guiding the learner on a journey that is affected by their social environment including family dynamics and social class. This often occurs as the learner tries to make sense of their situation. Their learning tends to be intuitive, holistic and contextual based with the learner in charge of the negotiated process. The four conditions that Daloz (2000 p112) suggests are particularly salient in facilitating the process are 'the presence of the other, reflective discourse, a mentoring community and opportunities for committed action.'

The final approach links spirituality and learning. Baumgartner (2001 p18) claims that 'both Dirkx and Healy make a case for transformational learning having a spiritual dimension. Dirkx (1998) speaks of the role of imagination in facilitating learning through the soul. He says that transformational learning goes beyond the ego-based, rational approach that relies on words to communicate ideas to an extra-rational, soul-based learning that emphasises feelings and images. Healy (2000) investigated the transformational learning process of those who practice insight meditation. He found respondents had an expanded self-awareness that simultaneously led to a deeper self-understanding and mindfulness in the present.'

It could be argued that each of these models may be more or less relevant at different stages within the professional career of any individual. However, the cognitive-rational approach may be most relevant during initial education with the development approach being more relevant within Continuing Professional Development (CPD).

Schon (1983) suggests that we can engage in reflection in one of two ways; either by 'reflecting on action', after the experience, or by 'reflecting in action', during the experience. The later is the more advanced skill while the former is the process more likely to be used when teaching student health care professionals.

Figure 1.2 The Reflective Learning Cycle



The reflective process

Various proponents have suggested a range of models and guidelines to facilitate reflection–on-action (Boud, Keogh & Walker 1985, Driscol 1994, Brookfield 1995, Johns 1995a, Moon 1999). All of these are very useful in providing structure for the process and I would advocate that students are exposed to a range of models then use the model with which they most connect. However, it is important to recognise that these are only 'models' of reflection, a representation of reality and that critical reflection can take place without the use of 'models'. Indeed in line with Benner's (1984) findings of the characteristics of an expert nurse I would suggest that 'expert' reflectors will not use the rules and steps described within the models. I will therefore, in describing the process of critical reflection draw on the work of a number of theorists to provide an eclectic illustration of the process.

There is a general consensus that when reflecting-on-action the first step in the process is the description of the incident (Figure 1.2). In recognising the inadequacy of memory, it is advisable that student health care practitioners keep a reflective diary in which they record details of incidents that either troubled or pleased them, recording details as soon after the event as possible. When describing the incident it is important that details of actions, thoughts and feelings are recorded. Feelings are important to learning as they affect both motivation and our ability to understand our experiences. This is what (Goleman 1995) calls 'emotional intelligence'. Having identified the incident the next step is to reflect upon it with the intention of coming to new understandings. In other words learning from the experience in such a way that one can act, think or feel differently in similar situations.

Figure 1.3 Advantages and Disadvantages of Different Method of Critical Refection

METHOD	ADVANTAGES	DISADVANTAGES
Unsupervised		
Individual	• Not threatening • Can be undertaken according to individual needs • May be able to be more honest • Concentrates on personal issues	• More difficult to challenge self • Have only one world perspective • May become negative • May self deceive
Pairs	• More than one world perspective • Can feel supported • Can provide a more objective view of the experience	• May collude rather than challenge • Need to consider another when engaging in the process
Group	• Many world perspectives • Have a support group when initiating action • Can learn from the experiences of others	• Need to consider others when engaging in the process • Others needs may be more urgent. • Personal needs may not be the priority for the group. • Need to adhere to ground rules • May be scapegoated • May develop 'cliques'
Supervised		
Individual	• Can be undertaken according to individual needs • May be able to be more honest • Concentrates on personal issues • Can be undertaken according to individual needs • Have the experience of a facilitator (see p 8 & 9) • May be more motivating for supervisee	• May respond to please the facilitator • Need to find a personal facilitator • Need to trust and respect the facilitator • May be costly
Pairs	• More than one world perspective • Can feel supported • Can provide a more objective view of the experience • Have the experience of a facilitator (see p 8 & 9) • May be more motivating for supervisee	• Need to consider another when engaging in the process • May respond to please the facilitator • Need to find a personal facilitator • Need to trust and respect the facilitator • May be costly
Group	• Many world perspectives • Have a support group when initiating action • Can learn from the experiences of others • Have the experience of a facilitator (see p 8 & 9) • Less costly than individual supervision • May be more motivating for supervisee	• Need to adhere to ground rules • May be scapegoated • May develop 'cliques' • Need to consider another when engaging in the process • May respond to please the facilitator • Need to find a personal facilitator • Need to trust and respect the facilitator • Participants may be at different developmental stages • Personal needs may not be the priority for the group.

This reflection can take place in a number of ways; individually, in a dyad or in a group situation. Each of these may or may not be facilitated and each has advantages and disadvantages (Figure 1.3) for the individual. Cost would be a major issue for any organisation, such as a University, which decided to provide facilitated opportunities for its employees/students to engage in the reflective process.

Regardless of how any individual engages in the reflective process, this next stage is crucial to the learning process. In returning to the experience (see figure 1.2), with or without the facilitator, one needs to engage in an analysis of the incident using a particular mind-set. The idea of becoming the wise, compassionate, non-judgemental observer of our own experience is a very helpful concept. It is important to aim to be kind with yourself and see your experiences as opportunities for growth and development rather than for 'beating yourself up' and engaging in self-deprecation. To do this one can ask a range of questions about the incident. Many authors have suggested frameworks for critically reflective questioning (Driscol 1994, Brookfield 1995, Johns 1995a, Taylor 2000). Some of these are presented in figure 1.4.

Figure 1.4 Examples of Questions For Engaging In The Process Of Critical Reflection

You may wish to explore some or all of the following questions*:*

What were your hopes for the outcome in the incident?

How did everyone else involved in your incident interpret their roles?

What did they seem to expect in the incident?

How were your hopes related to your own expectations?

What caused you to see other people's actions in the way you did?

What are the sources in your life and work for your ideas and values?

Are these ideas and values still appropriate for you at this stage of your life?

Why do you continue to endorse and act upon these ideas and values?

How did your interpretation of your role affect your relations with the people in the incident?

In what ways do you now act out these ideas and values in the way you communicate with others?

To what extent were social norms, or sets of expectations for behaviour, operating in the incident?

At this point it may be appropriate to explore the differences between the two terms 'reflection' and 'analyse' in an attempt to show that reflection is something more than 'navel – gazing' (a phrase that I have heard applied to reflection on many occasions). The Collins English dictionary (1998) defines 'analyse' as 'to examine in detail in order to discover meaning, essential features etc' and 'reflection' as 'careful or long consideration or thought'. I would like to suggest that in reality they are the same process with each belonging to a different paradigm. The term 'analyse' belongs to the technical rational model while 'reflection' to the professional artistry model (Schon 1983). When the term 'to analyse' is used it generally refers to a cognitive and/or behavioural process with the person undertaking the analysis adopting a position of objectivity and separateness. The purpose is generally to understand and advance theory. However, when the term 'reflection' is used the affective, as well as the cognitive and behavioural domain is part of that process. The person undertaking the reflection is actively involved as both researcher and researched. The main purposes are to understand self in a particular context and to apply theory to practice.

In order to become 'critically reflective' the individual needs to adopt the components of critical thinking. Brookfield (1987) describes these components as being able to identify and challenge assumptions; challenging the importance of context; trying to imagine and explore alternatives; leading to reflective scepticism. To become a critical thinker is challenging for some to achieve but in asking students to become 'critically reflective' this can be even more challenging as we are expecting students to question the beliefs and values which have made them the person they are.

The amount of understanding and learning that takes place as a result of this process depends therefore upon the amount of self-awareness, honesty and openness to feedback of the individual. However, critical reflection is a process, a journey, and learning through this process is iterative. Thus one must accept that there is very rarely a 'right or wrong' solution for any given situation. Indeed if an individual reflected upon an incident at a later date, almost invariably the solution would be different. However, for any given individual, there does need to be an acknowledgement of some change in their actions, thoughts or feelings that could be utilised in a similar situation. It is suggested that within an academic framework, any change needs to be embedded in theoretical analysis, thus using the rational cognitive approach described by Mezirow (2000). If over time one can look back on the process and show awareness of how one has changed as an individual, this is generally referred to as reflexivity (Gadamer 1975).

Conditions for effective learning through critical reflection

In order to engage effectively in the critically reflective process, John's (2000) suggests the engagement of the 'ten Cs of reflection' (p36) (See figure 1.5). It is suggested that for novice reflectors some of these characteristics can be very challenging, especially if their educational background has been more factually based. This may account for the resistance expressed by a number of students new to critical reflection as a learning method. The role of the facilitator is crucial in minimising this resistance.

Figure 1.5 The Ten C's of Reflection

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.
CARTHARSIS	Working through negative feelings
CREATION	Moving beyond self to see and understand new ways of viewing and responding to practice.
CONNECTION	Connecting new insights within the real world of practice; appreciating the temporality of experience over time
CARING	Realising desirable practice as everyday reality
CONGRUENCE	Reflection as a mirror for caring
CONSTRUCTING PERSONAL KNOWLEDGE IN PRACTICE	Weaving personal knowing with relevant extant theory in constructing knowledge.

Some issues for the teacher of reflective practice

Role modelling

There is a wealth of information from a variety of sources demonstrating the importance of role modelling. The importance of congruency in what we say and what we do, was investigated by Bandura (1977). If our words and actions are not congruent then action is given greater value, such that students will replicate what we do rather than what we say they should do. This is supported from communication theory (Argyle 1983, Hargie et al 1994), which indicates that non-verbal behaviour has more weight than verbal, and again, if there is any dissonance between the two then the nonverbal message is more likely to be believed.

The implication of this for teachers of critical reflection is very clear. If we tell students of the importance of critical reflection but do not engage in it ourselves then we are contradicting our message. Students will not value it nor believe in it. It is important therefore that we role model not only critical reflection but the philosophical underpinnings whereby students are valued as individuals on a personal journey, where process is of equal or more value than outcome.

One of the first implications is that the teacher of critical reflection needs to adopt the role of the 'guide on the side' rather than the traditional role of 'sage on the stage'. According to Brockbank and McGill (1998) "The relationship required to nurture critically reflective learning, is mutual rather than one way, open to difference and uncertainty, rather than tied to inflexible outcomes, able to accommodate the questioning of established ideas, connected to the other virtue of dialogue, rather than estranged, and, recognising the existential reality of social and political context, rather than losing the value of tacit and personal knowledge in students."

To achieve this it is essential that teachers should engage in their own critical reflection in order to 'hunt assumptions' (Brookfield 1995). He suggests that as critically reflective teachers we particularly need to illuminate the dynamics of power that permeate all educational processes and uncover our 'hegemonic assumptions'. Hegemonic assumptions are "those that we think are in our own best interests but that have actually been designed by more powerful others to work against us in the long term" (p15). One such example is the assumption that good teachers meet all students needs all of the time and when this does not happen we blame ourselves. Brookfield suggests that this assumption is guaranteed to leave us feeling incompetent and demoralised.

By engaging in our own critically reflective process, not only do we develop as teachers, we will also have greater empathy and understanding with our students and be in a better position to support and guide them on their journeys.

Assessment

In the previous section I stated that 'students are valued as individuals on a personal journey, where process is of equal or more value than outcome'. It therefore becomes apparent that for those of us working in situations that require us to assess student's work and then award it a mark, there is a point of conflict. As will be explored later in chapter 14 by Stephanie Fade, reflective assessment can be used in two ways: to assess students reflective ability or to assess specific competencies using critical reflection as the format. Each approach will have its own particular issues but in general terms it can become a major problem for teachers of critical reflection when we adopt the apparently conflicting roles of facilitator and assessor.

As facilitators of the reflective process, we are trying to develop a relationship of trust and support which has the potential to assist people to become aware of their taken-for-granted ideas about the

world (Shor 1987). As assessors we are trying to objectively assess a piece of academic work that is based on students personal experience. From a staff perspective, it can be very difficult to phrase constructive feedback in a situation where a student has written a deeply personal paper that does not follow the guidelines. A person critical incident may help illustrate the dilemma.

I personally have experienced much resistance from a minority of students to the idea that a mark will be awarded. I can understand their anxiety, some students can view awarding a mark and providing feedback as a personal judgement. In my own module I am marking students ability to reflect. I make much effort to explain that we mark process rather than outcome, providing students with marking criteria and the opportunity to undertake formative assessments. However, one very vivid experience stands out in my memory of a mature student who used the essay as a cathartic opportunity, pouring out onto the page a life time of untold personal secrets. Although a powerful and emotive story, the work demonstrated only description with no evidence of reflection or personal learning. I therefore had to fail the essay as it did not meet the module criteria. This I did with great sorrow and pain, as I completely empathised with the student's story. I tried very hard to give sensitive, supportive and constructive feedback and invited the student to talk to me about it. This they did and I spent a very difficult hour with an angry student who had felt personally judged and attacked. As a result of this I tightened the essay boundaries, requiring students to reflect on class based experiences. Many subsequent students found this constraining and limiting.

Most texts on critical reflection provide little guidance to help resolve this type of problem. I was able to reflect upon the experience with my team of facilitators and work through my own issues to achieve a way forward. However, each year the process of assessing critical reflection creates some new learning opportunity, perhaps demonstrating very clearly the need for me as a teacher to engage in my own critical reflection to help me grow and develop as I engage in my own personal journey.

As a teacher, it is important to consider the pros and cons of both highly structured and non-directive guidelines for reflective assessments. A compromise may be to provide guidelines that are prescriptive as to process and ask for a demonstration of learning in relation to the module syllabus content.

Covert messages

When incorporating critical reflection into the curriculum, it is essential to recognise the messages that the wider (hidden) curriculum can give to students. Is critical reflection an add on concept or is it embedded into the wider curriculum? Each approach will give a differing message to students. It is suggested that critical reflection needs to be embedded within the wider curriculum including the personal tutorial system, personal and professional development portfolios (student and staff), staff peer observation, staff clinical supervision (if appropriate) and peer reflective groups. If students are required to become reflective practitioners then we as teachers should also be reflective practitioners. To achieve this critical reflection needs to be embedded not only into the curriculum, but also into both staff and student support and professional development systems.

Conclusion

Using reflective practice as a method for learning can be both rewarding and challenging to both the student and the teacher. It may be helpful to listen to the advice of Meyers (1987) who states that "in the reflective classroom, both teacher and student will appreciate the fact that some problems may forever remain a mystery." Reflective practice is predominantly about 'process' and therefore may be very challenging to those who are 'outcome' orientated. However, its advocates see it as a

very powerful tool to link theory to practice, using it to continually expand their own personal and professional comfort zones

Biography

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CHAPTER 2

Using reflective practice in the podiatry curriculum

Context - The Course
In the early 1980's the initial education award for the majority of professions allied to medicine, including podiatry, was the diploma. The diploma course was primarily developed as a training course and therefore concentrated on the accumulation of knowledge and the acquisition of practical skills. In 1989 the School of Chiropody of Brighton Polytechnic, now the Division of Podiatry at the University of Brighton, validated the first full-time degree for the award of podiatry in the UK, adding honours to the award in 1992. Unlike the diploma this course was designed to provide an education in healthcare with podiatry as the focus. Subsequently, the course has undergone two further validations, converting it to, and developing it as, a modular programme. Like the majority of programmes educating health professionals, the course is now subject to a national benchmarking process.

The responsibility for funding podiatry programmes has recently moved from the Department of Education's Higher Education Funding Council for England (HEFCE) to the local Health Service Workforce Confederations of the NHS. Home and EU students receive a bursary to pay for course fees, with UK students also being eligible for a means-tested grant.

More than 400 students have now successfully graduated from the course, with the award of BSc(Hons)Podiatry.

The Profession
Chiropody and podiatry are used synonymously, the latter being adopted from the early 90's as a means to improving professional recognition and gaining protection of title status. There still remains much confusion with regard to this change of professional title, not only from the point of view of the service users, the public, but also within the profession itself. Professional registration carries the title State Registered Chiropodist (SRCh) whilst all undergraduate courses and subsequent awards have the title BSc(Hons)Podiatry.

The award of the honours degree provides the podiatry graduate with eligibility for membership of the professional body, the Society of Chiropodists and Podiatrists, and for state registration under the rules of the Health Professions Council. It also qualifies them for certification for access and supply of prescription only medicines, and for certification for the administration of local anaesthesia.

Podiatry as an Education
There are fundamental differences between the diploma and the degree courses in terms of the nature of curriculum delivery, the type of student learning and desired outcomes at graduation. Time for on-the-job training is now very limited and graduates are expected to be capable of being effective practitioners at graduation (Katz 2000). In 1999, Ball and Price were commissioned by the DfEE to ascertain what it was that employers were looking for in graduates applying for their first job. The results yielded a list of seven attributes, all of which were based on the acquisition of transferable skills, the actual practical skills of the profession being taken for granted. This project also sought to identify the defining characteristics of a degree level education. The results lead the

authors to identify characteristics such as the development of a student's creativity and innovation, critical and analytical thinking, and problem-solving skills.

Katz (2000) stated that the desired outcome of any undergraduate course in healthcare, is the ability of the student to be self-aware and self-directed, having the personal skills and emotional maturity to take responsible actions with regard to both colleagues and clients. The podiatry course team therefore aim to facilitate the development of the undergradutate, preparing the student for professional practice by developing their ability to become a reflective practitioner.

The Need for Reflection

Whilst it is unclear where the notion of reflective practice originated, it is now a widely held belief that it will somehow lead to enhanced patient care through more effective professional practice. Although research continues there is currently little or no evidence for this assumption (James and Clarke 1994). Reflection is an integral part of experiential learning, an element central to a theory by Kolb (1984), which advocates a need for experience before reflective learning and critical thinking can take place. Reflection is also inherent in the development of practical knowledge; knowledge being acquired, according to Durgahee (1996), when the practitioner reasons logically and critically about a situation experienced, gains insight into the issues it has posed, and uses this as a basis for sound deliberate and purposeful healthcare practice.

As the profession of podiatry has evolved, the demands placed upon podiatry education have increased. An important element of these increased demands is the fact that there are now a number of 'masters' to satisfy: the statutory and professional bodies, the fund-holders, the employers and the government. One thing that these masters have in common is the goal of improving patient care. The consensus of opinion is that this can best be achieved through the development of a practitioner's skills of reflection and ability to engage in life-long learning. It is therefore the responsibility of the podiatry course team to help meet these goals through well-considered degree programmes that incorporate effective learning and teaching strategies, that facilitate the development of reflective practice, together with appropriate assessment techniques that can demonstrate the acquisition of these skills at graduation.

The Curriculum

The structure of the course reflects the course teams' belief in the importance of developing the reflective practitioner. The intention is that the students graduate as reflective practitioners whose practice is based in evidence. To do this the reflective skills that must be acquired at each stage in the curriculum are explicit in the aims and learning outcomes of all the clinical modules. The assessment requirements necessary to demonstrate these skills are also explicit.

Students are first introduced to the notion of reflection through an induction programme. Time is spent detailing the learning and teaching strategies, and allowing the student space to explore their own needs and fears at this early stage. They are then introduced to Kolb's Experiential Learning Cycle (1984) in order for them to identify their own learning style and think about how this might have influenced, either in positive or negative terms, their learning to date. The very nature of this task exercises their powers of reflection.

Subsequently level 1 (4) modules are used to develop the students' understanding of the concept of reflection. This is first achieved by exposing them to additional models of reflection: Schon 1983, Boud et al 1985, Johns 1995b. This provides the student with the theory underpinning the learning and teaching strategies employed by the team to facilitate the development of reflective skills.

One of the learning outcomes for the second semester of the course is 'to enable students to develop reflective skills'. The assessment of level 1(4) reflective skills is achieved using a **clinical learning journal**, where students are expected to write a journal applying these skills of reflection to the early stages of their own clinical practice. They are also required to demonstrate self-evaluation by identifying their own strengths, weaknesses and clinical needs. For a case study mapping how these skills are fostered through level 1(4), the reader is referred to appendix 2.1.

The outcomes for the two clinical modules at level 2(5) are:

- to develop self awareness as a practitioner
- to demonstrate reflective practice in podiatric clinics

Demonstration of successful achievement of the former (semester three of the course) is through a presentation. This is based on a written reflection undertaken by the student in relation to their ability to perform an informal clinical assessment of the lower limb. Demonstration of the latter, in semester four, is via a **clinical learning file**. Students are asked to define reflection within the context of clinical learning, then apply the skill throughout the file. For a case study mapping how these skills are fostered through level 2(5), the reader is referred to appendix 2.2.

At level 3 (6), the concept of reflection is further developed by encouraging students to use reflection on their past clinical experience to inform current clinical practice. Submission of a clinical evidence file is required, which should show regular documentation of reflections on specific episodes of patient treatments in both their own podiatric clinics, and within a number of specialist podiatry and multidisciplinary clinical environments.

The final learning outcome of the course is designed to encourage the student to bring together the entire practical, theoretical and transferable skills learnt during the course:

- to continue the development of the student into an autonomous reflective practitioner with demonstrable skills that are required for the ever changing healthcare practice in the U.K.

The final **clinical evidence file** (CEF 2) provides the student with the opportunity to present evidence that they have developed as a reflective practitioner, and includes statements about their own personal development. Appendix 2.3 maps how these level 3 (6) skills of reflection are nurtured through the final year of the course.

Action Learning to Underpin Reflective Practice

The main strength of the undergraduate podiatry course is that it integrates theoretical knowledge with podiatric practice. Schon (1983) explored the theory that reflective practice involves two constituent elements: practice and action. He asserted that competent practitioners not only think about their experiences, but use those experiences as the basis for the development of innovative and creative actions. Boud et al (1985) detailed three stages to a student's reflective process: the anticipation of the experience and any mental preparation; exposure to professional practice and linking it with the academic content of the course being studied; making something of the experience by carrying out an action. With this in mind the course team has embraced the concept of action learning (McGill and Beaty 1995). Action learning serves to underpin the course philosophy of a student-centered approach and the nurturing of the life-long learner. It also satisfies the action element of reflective practice. Reflection is a cognitive skill; action is the link between theory and practice (James and Clarke 1994).

Lessons Learnt

Probably the single most enlightening lesson is that there is no absolute definition for reflective practice. Attempts at defining the nebulous concept inevitably produce more questions than answers. However, the podiatry course team has been asking students at level 2 (5) and as an

element of their written assessment, for definitions of reflection in a clinical setting. This requirement perhaps needs to be revisited in view of the lack of an actual definition

A number of 'journal-style' assessment strategies have been adopted throughout the course to allow the student to demonstrate their achievement of the learning outcomes. The question has to be just how appropriate has this been? There are many arguments both for the use of reflective journals and against them. In support, Shields (1995) suggests that writing can distance a student from the experience thereby allowing more objective reflection, that revisits can be made and that these can take place many times, even years later. Jasper (1999) wrote of written reflection that people change and develop as they gain an awareness into themselves, greater insight into their own personalities and greater confidence in their own abilities. Heath (1998) quotes from L'Aiguille (1994) "I have probably learned more about myself than about nursing. However this knowledge has transformed my practice more than I could have thought possible at the outset." Authors presenting arguments against reflective journals include Richardson and Maltby (1995) who suggest students may not write honest and open accounts for fear of poor marks. This is supported by Greenwood (1993b) who states "there could be an element of writing what is perceived as required by the assessors, rather than what actually happened." Other proponents (Burrows 1995 and Burnard 1995) consider journal writing to be time-consuming, repetitive and superficial in content.

A review of the current podiatry assessment tasks perhaps needs to be undertaken. It has been suggested that a wider array of strategies should be considered in order to provide the student with a greater opportunity to demonstrate their reflective skills.

At present, the year three students are required to write their reflections on any clinical visits they make. This contributes to their summative assessment. However it is suggested by Stoddart et al (1996) that students who often find themselves in new environments feel like 'outsiders' and have to make considerable efforts to re-establish themselves in their new social situations. This takes effort and focus, and therefore could be detracting from the student's 'space' to reflect. The course team needs to consider this aspect of clinical visits when writing marking guidelines for this type of work.

Implicit in a course incorporating reflection as an outcome is the notion that anyone can become a reflective practitioner; that it can be taught and the skill acquired. There is no evidence for such an assumption, but vast implications if it were found to be untrue. For instance, would students who cannot reflect be excluded from a course? And what of educators who have been unable to experience reflection themselves before teaching it? Stoddart et al (1996) suggests that this assumption goes further; that all tutors are reflective practitioners and that they would be capable of fostering reflection in their students.

Even when a method of assessment has been designed and implemented, there is a further difficulty; that of setting a mark to it. Assessing reflection is problematic. There are no measures by which to compare standard, and again, no definition with which to apply to the result. The assessors are assumed to be competent in reflective practice themselves, and the students are assumed to have written down all their reflective practice issues. In truth, none of this may be the case. As James and Clarke (1994) identify, in everyday practice proficient healthcare professionals make innumerable judgements of quality for which they cannot justify, and display skills for which they cannot state their rationale. This does not mean they are poor reflectors, or flawed practitioners.

Student Feedback
The following are transcripts from two recent graduates about the use of reflective portfolios in the BSc(Hons)Podiatry. They are representative of the issues identified in this section with regard to the lessons learnt.

Student 1: The School-leaver

"In the first year, the concept of reflection was very new to me and I was not very successful in developing reflective skills. By the end of year two I was able to reflect on my own practice and the situations I found myself in. By the end of the course I was beginning to enhance my practice in light of my past experiences.
I have now been working in the NHS for a year and am aware that I critically reflect on my own and my colleagues' professional practice. The process of reflection introduced to me by the university has been a steep learning curve, but I now see its relevance and it has enabled me to be conducive to change."

Student 2: The Mature Student

"At first the process of information-gathering was both useful and informative, but I tended to do all my reflection verbally. I didn't particularly like communicating my reflective skills by writing them down; I didn't find my education was enhanced any more than my informal discussion with friends had done. However the course has taught me how to reflect, and I can see that I have developed the skills of reflective practice over the three years. Writing these journals has also made me think very closely about my experiences on placement, both in intra- and inter-disciplinary settings."

Future Plans
The course team has recently re-evaluated the role of the final level 3 (6) clinical evidence file (CEF 2) in fostering the reflective practitioner. They have now devised and implemented a new proposal to prepare the graduating student for professional practice.

The new assessment strategy replaces the existing clinical evidence file with a **practice-based portfolio**. This final piece of written clinical assessment is modeled on the Continuing Professional Development Portfolio that practitioners are expected to produce to maintain their registration. This new portfolio should provide the student with the opportunity to demonstrate their development as a reflective healthcare practitioner over the last few months of their pre-registration training, and bring together all of the practical, theoretical and transferable skills learnt over the entire 3-years of the honours degree course

In addition, the demand of the level 2 (5) clinical learning file, in terms of asking the student to define reflection, will be revisited. If there is no suitable definition within the quantities of literature on the subject of reflective practice it seems hardly justifiable to ask our students to write one, or our educators to assess them fairly.

Conclusion
The requirement to develop the reflective practitioner is now an accepted condition for all institutions providing education in healthcare. The necessity for it to be fostered at an undergraduate level is undisputed. For the course team in podiatry education at the University of Brighton, the preparation of the reflective practitioner for the workplace is at the heart of their philosophy. They produce graduates of the highest caliber; evidenced by their excellent employment record following graduation, the numbers of graduates who return to undertake and are successful in higher degrees,

and the reports by the various standards assurance agencies. It is unclear whether their strategies of reflective portfolios either develop or promote reflective skills among the students, but it can be said that they are highly educated graduates in podiatry with well-developed transferable skills. There is much anticipation for the results of work investigating the link between reflective practice and enhanced patient care and even more for evidence that shows that institutions are being effective in their attempts to foster reflective skills.

Biography

Maria became an RGN in 1988, then graduated with a First class BSc (Hons) Podiatry in 1995. Subsequently she was employed by the University of Brighton as a graduate Clinical Tutor in Podiatry and eight years later she remains at the Leaf Hospital, now a Senior Lecturer. She obtained a SEDA accredited Postgraduate Certificate in Learning and Teaching in Higher Education in September 1999, and an MSc Podiatry in September 2001.

Maria's main teaching responsibilities are for lower limb structure and function (holding a licence to perform human dissection on the premises), general medicine, minor podiatric operations and final year clinical podiatry. Her main interests are Action Learning, Reflective Practice, and low level laser therapy.

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CHAPTER 3

Using Reflective Practice in the Physiotherapy Curriculum

Introduction

Reflective practice is more that just' thoughtful thinking' and refers to "the higher order intellectual and effective activities in which physiotherapists engage to critically analyse and evaluate their experiences in order to lead to new understanding and appreciation of the way they think and operate in the clinical setting"(Donaghy and Morss, 2000, p13)

Reflective practice therefore enables the reflector to analyse their clinical practice, reinforce and/or modify future actions and generate new knowledge. A recurrent theme in most of these chapters relates to the fact that there are many conceptualisations of reflection in the literature and that each profession places a different emphasis on it. This has created problems as it has resulted in the meaning of reflection being confused with its use (Mackintosh 1998) whilst the interchangeable use of the terms 'reflection' and 'critical reflection' has created conflict between the different ideologies which underpin reflective practice (Ecclestone 1996, p. 150).

For the purpose of clarity this chapter will focus on critical reflection. Critical reflection has been defined as an activity that takes place when a practitioner's knowledge and experience is used to relate research findings to practice and one which requires the utilisation of both the narrow rigorous approach of evidence based practice and the reflective skills to put that evidence into context (Clarke and Croft 1998). The development and utilization of reflective practice can be traced back to the third century B.C. (Houston 1988) yet some physiotherapists are still wary of it because more evidence based research needs to be done and possibly because its roots lie in phenomenology (Dewey 1933) – a philosophical concept relating to personal perceptions rather than hard science.

The physiotherapy profession historically chose to emphasise the positivistic and empirico-analytical approach to research and evidence based clinical practice because it generated repeatable and reliable results that were easily applied to physiotherapeutic assessment, problem solving and clinical reasoning/treatment. We felt comfortable with quantitative research and considered it to be more 'scientific' than the 'touchy feely' research generated by qualitative and social science methodologies (Ritchie 1999). With time this empirical bias led to the 'art' of physiotherapy being tacitly acknowledged, because of its 'obvious' contribution to the efficacy of clinical practice, but underrated because it was difficult to define and measure (Peat 81, Pratt 89, Parry 94, Grant 95). Polit et al (2001) recognize that despite the development of numerous new measurement tools available to choose from 'measurement' still poses the most challenging problem to the researcher

Polit et al (2001) define research as a systematic examination that uses scientific methods to answer questions or solve problems and regard the scientific approach to generating knowledge to be the most sophisticated method humans have developed. Hek (2000) takes a more guarded view and considers that scientific knowledge has the ability to inform health and social care practice provided that problems are solved in a logical, systematic and rigorous way. She warns that no scientific method is infallible and recommends that the strengths and weaknesses of scientific knowledge be identified through critical appraisal. Donaghy and Morss (2000) stress how important it is to link reflection to higher order cognitive process i.e. memory schema, illness scripts and clinical

knowledge and consider that the physiotherapy profession should move away from an 'approach' which encourages reflection on beliefs, values and attitudes to one that links more closely to systematic critical enquiry, problem-solving and clinical reasoning. I shall discuss the contribution that critical reflection can make to clinical knowledge later in this chapter.

Health care professionals, and physiotherapists in particular, have developed a 'hierarchy' of evidence-based practice, which evolved in response to the notion that some approaches/research designs, particularly those using quantitative methods, provided more scientifically robust i.e. better, evidence of effectiveness than others. The qualitative approach became the Cinderella of research in physiotherapy and was considered to be unscientific because outcome measures were often presented without statistical analysis. Attitudes towards qualitative research have begun to change since critical appraisal and statistical analysis has been applied to it and this has helped physiotherapists to embrace the concept and worth of critical reflective practice and encouraged many of us to contribute to the growing body of knowledge related to it. Despite this change I feel some concern that random controlled trials (RCT) may still be considered to be the most valuable and scientific approach to effective research – a view that infers that scientific rigor and qualitative research are mutually exclusive.

Heck's (200) hierarchy of evidence of effectiveness could be seen as a case in point as it places evidence from personal, professional and peer expertise, together with experience, at the bottom of the ladder of effectiveness and evidence from systematic reviews of multiple, well designed RCT's at the top. This hierarchical arrangement can be looked on as a challenge, and not a threat, to the development of qualitative research. I am optimistic about the future and wholeheartedly agree with Hek *et al* (2002 p. 19) who recognize that scientific knowledge may not always be the most appropriate source of information on which to base practice but consider that the use of scientific enquiry will establish the best basis for care.

This chapter will discuss how reflection is being promoted and measured in undergraduate physiotherapy education at The University of the West of England (UWE) and demonstrate that reflective practice and critical reflection are educationally sound, clinically relevant and quantifiable.

Can reflection be taught and measured?

The ability to reflect critically on one's experience, integrate knowledge gained from experience with knowledge possessed, and to act upon insight is considered by some adult educators to be a distinguishing feature of the adult learner (Mezirow 1991, Ecclestone 1996; Brookfield 1998) but an interesting question to ask is can this ability be 'taught'? The answer to this question is unclear (James & Clarke 1994, Graham 1995, Ecclestone 1996, Mackintosh 1998). Some consider that reflection can be taught because it is a learning strategy that utilizes tools such as diaries (Heath 1998) and autobiographical stories (Brookfield 1995) and others believe that it can be 'learnt' through action learning groups etc (Williamson 1997).

At UWE action learning, in the form of role-play, is utilized to provide first year students with opportunities to begin to develop the ability to reflect in action, a skill that is often only achieved by experienced clinicians. Some, more reflective students, initially find the experience difficult whereas the more activist and pragmatic students enthusiastically engage in role play but find the reflective 'de-brief' part, after the activity has taken place, to be tedious. This could suggest that a student's preferred learning style (as determined by Honey and Mumford's evaluative questionnaire (Honey and Mumford 1992) could potentially block their ability to reflect in and/or on action. With guidance and support the students are encouraged to identify and develop their least preferred

learning style so that they can become a more ‘rounded’ physiotherapist as a result. An appreciation of a student’s preferred learning style helps both the student and clinical educator to understand, negotiate and meet the needs of the student on clinical placement and provides a platform on which the student can reflect and build, to develop their strengths and address areas that need to be developed e.g. self confidence, clinical reasoning, practical skills and time management.

An appreciation of the student’s preferred learning style alsohelps when the student presents a significant learning experience report (SLER) to their personal tutor. As I will explain later in the chapter the students are required to document a critical incident that occurred on clinical practice after every clinical placement. The report, based on Gibbs (1998) reflective cycle is word processed but aurally presented in a one-to-one tutorial. This activity provides students who have poorly developed writing and/or reflective skills to receive guidance and identify and address areas for improvement. The presentation and ensuing discussion also provides an opportunity for critically reflective student to reflect-in-action-on-action and is an opportunity for reflectors and non-reflectors to develop their levels of reflection, as formulated by Mezirow et al (1990).

Reflection has been related to different levels of attainment and/or willingness to change (Wellington 1996) and it has been suggested that the learner's cognitive ability (James and Clarke 1994) and/or willingness to engage in the process (Bright 1996; Haddock 1997) can affect it. Williamson (1997) is a great advocate of action learning and believes that reflection can actually be ‘learnt’. I agree and consider that a great deal can be learnt through role play but recognize that it asks a great deal of Level one(four) students especially as it uses clinical scenarios just before they go on their first clinical placement and that it takes place within practical groups of about 22 students, many of whom do not know one another well enough, at this stage, to take the risk of getting into role.

There are divergent opinions relating to the assessment of reflection. Williams et al 2000 recognized that despite extensive discussion on the 'concept' of reflection and the extent of its use reliable and sensitive methods to assess if reflection has taken place, and at what level, have been lacking. Some tools lack reliability (Richardson et al 1995, Wong et al 1995, Sumison and Fleet 1996) and others lack sensitivity (Hatton and Smith 1995. Wong et al 1995.). Progress has been made by Williams et al (2000), who have developed five criteria for assessing reflection. These are derived from the criteria developed by Boud et al (1985 to evaluate the level of reflection in journals. However more work into measuring depth and outcomes of reflection is required.

I believe that reflection it is an intellectual skill, acquired through practice and step-by-step guidance and that can be learnt/facilitated but not taught. The practice comes from self-evaluation and analysis and the guidance comes from the educator whose role is that of facilitator rather than teacher. Some students are more or less reflective than others whilst others have the ability to express themselves without being particularly reflective but, in either case, I regard the educator's role to be pivotal to the intellectual development of the novice reflector. The educator requires a working knowledge of the reflective process and skills to lead the student, in a Socratic manner, through the steps that challenge assumptions and initially lead to unsettling doubt. With practice, and application, comprehension and understanding are eventually attained through a process that creates, rather than transfers, knowledge and understanding and generates positive outcomes, rather than the negative ones that novice reflectors so easily seem to generate

Physiotherapists are now beginning to appreciate the contribution critical reflection can make to bridge the theory practice gap and its contribution to Continuing Professional Development (CPD). The Chartered Society of Physiotherapists (CSP) Continuing Professional Development policy

statement (1998) acknowledges this and states that "day-to-day reflection on practice, along with self and peer review are central to the development of individual practice, the enhancement of patient care and the continued growth of the profession"

How critical reflective practice is being developed in undergraduate physiotherapy education
Physiotherapists and other health care professionals are in the process of developing and refining new methods to promote and assess reflection and have been challenged by the fact that reflection, as with any phenomenological experience, varies between and within individuals and is difficult to measure. We have come to recognize that certain attributes, such as cognitive maturity, are required for reflection to occur and that support and guidance, combined with practical experience, is essential. To this end the CSP stipulates that undergraduate physiotherapy students have to complete one thousand hours of supervised clinical experience prior to graduation.

The University of the West of England Undergraduate Physiotherapy endorsed this requirement and, along with incorporating Interprofessional Education at all levels (see appendix 3.10 for details) has developed a Professional Practice Portfolio (PPP) that has been designed to promote the development of a critical approach to experiential and self-directed learning. The PPP aims to integrate theory with practice, and theory from practice, in an iterative reflective cycle. It achieves this by cataloguing the continuum of practical experience and develops reflective practice by providing the means for the students to document their ongoing self-assessment of professional competence, personal goals, learning outcomes and reflections on clinical experience.

The portfolio states that reflective practice requires …

'a conscious analysis of what has happened and why. This analysis of clinical experience will encourage the student to monitor and develop their professional practice and self-assessment skills'.

The portfolio asks the student to:

- Identify and evaluate personal goals for each placement – self analysis (see appendix 3.1.)
- Keep a weekly log of what went well and what did not go so well on clinical placement (see appendix 3.2.)
- Complete a half way self-assessment and discuss the report with the Clinical Educator at the 'half-way' feedback meeting (see appendix 3.4)
- Give the Continuous Practice Assessment to your Clinical Educator for them to complete at the end of the placement (see appendix 3.5)
- Write a 500 word reflective report documenting a significant learning experience from clinical placement (see appendix 3.6)
- Discuss the SLER report with their personal tutor

Relevance of reflective practice

The introduction of the Commission for Health Improvements, the National Institute for Clinical Excellence (NICE) and the advent of Primary Care Trusts (PCT) have created a demand for Evidence Based Practice within the National Health Service (NHS). Health Care Professionals are required to continuously review and reflect on their practice in a critical and analytical way. These bodies require that outcome measures, relating to clinical decision-making and the factors that influence clinical reasoning, be evaluated. This has not been an easy task for clinical decision-making is inextricably linked to therapist/patient interaction and the reflective/analytic phase of clinical reasoning which takes place during and after contact.

The association between the split second clinical decision-making undertaken by experienced clinicians (reflection in action) and the more retrospective and discursive aspect of clinical reasoning (reflection on action), which students engage in with their educators when they discuss their assessment findings prior to formulating treatment plans, relate well to one another as the former involves diagnostic considerations whilst the latter relates to hypothetico-deductive reasoning, problem-solving and the interaction between theoretical knowledge and practical experience. An understanding of the clinical decision making process is helping to move the physiotherapy profession away from its reliance on the quantitative random control trial model of evidence based practice which, according to Sackette et al (1996, p.71), has been considered to be the gold standard of research. This is being achieved through the development of a methodology that embraces both the 'art' and science of modern physiotherapy practice (Barnard, 2001, p. 115) as evinced by professional craft knowledge.

Professional craft knowledge is but one component of clinical knowledge which Higgs and Titchen (1985) consider to fall into three groups. These are propositional knowledge, which is derived from research; professional or craft knowledge, which is derived from practice and finally personal knowledge, - derived from the self. They claim that professional craft knowledge, when combined with propositional knowledge, can be valued as more than simply just 'expert opinion', an opinion, considered by Greenhalgh (1997) to lie at the bottom of the hierarchy of knowledge. Higgs and Titchen (1985) claim that professional craft knowledge can be seen as a form of 'single case methodology', which incorporates the formation of a hypothesis which is tested after the application of treatment.

It has been claimed that clinical reasoning can also be divided into three components: namely: knowledge, cognition and metacognition and that reasoning is not effective without the last reflective component – metacognition i.e. 'thinking about thinking' (Higgs and Jones 1995). Physiotherapists are now beginning to agree that metacognition/reflection, or whatever other terminology is applied to it, is an important element in the development of sound practice and that it can enrich experience through the development of personal growth and clinical expertise.

A growing body of opinion within the health and social care professions emphasises the importance of metacognition and accepts that monitoring of one's own thinking helps to craft the fabric of a sound knowledge base. This base enables us to identify where learning has taken place to examine our beliefs, values and attitudes and to take our learning forwards. The PPP, and the student's interaction with it, have been designed to reinforce this. The phenomenological work in clinical reasoning undertaken by the Occupational Therapists (OT's) Mattingly and Fleming (1994) shows how their approach to clinical reasoning is subtly different from that of physiotherapists but that their conditional reasoning is similar to metacognition as it is attained by the step by step working through of procedural and interactive reasoning. The OT's subdivide reasoning into three groups namely: procedural reasoning - hypothetico-deductive, cue identification, hypotheses generation

and evaluation; interactive reasoning - during the encounter between the therapist and patient and finally conditional reasoning - a multidimensional process involving the therapist's reflection upon the clinical encounter from both procedural and interactive views.

Most health care professionals quickly learn to use this multidimensional process and develop a spontaneous kind of professional 'knowing' which, according to Schon (1983) utilizes a process that generates reflection *in* action ('online' reflection) and reflection *on* action ('offline' reflection). The former is brought about by thinking about how to shape an activity whilst it is underway and the latter occurs after the activity, when it is interpreted and analysed.

Reflection *in action* is a process that consists of thinking on one's feet simultaneously as practice occurs and requires an understanding of the phenomena & development of 'tacit knowledge' (Schon 1983, p51) and how thinking about the activity while it is underway reshapes, and develops, new strategies of action. Reflection *on action* relates to the retrospective thinking about an experience that leads to problem solving, theory building and a re-appreciation of the situation. As stated above, reflection is an area that was once undervalued by physiotherapists but has now been given recognition for its contribution to clinical reasoning and decision making. This has been achieved by the amalgamation of empirical and phenomenological philosophies and the development of critical reflection.

Implementation of reflection - the portfolio and its assessment

The professional physiotherapy portfolio (PPP) contains the guidelines and all the assessment documentation required by the six clinical placements in the course. The documents include documentation for personal goals (see appendix 3.1); weekly reflective diary sheets (see appendix 3.2.); example of marking guidelines and criteria for assessment (see appendix 3.3.);the half-way and continuous practice assessment (CPA) forms (see appendices3.4.), and a significant learning experience report (see appendix 3.6)

The halfway self-assessed CPSA is completed by the student and their self-assessment is discussed with the clinical educator to facilitate a mid way dialogical reflection and an opportunity to develop metacognition (Higgs and Jones 1995), that reflective element which enables thinking about thinking to occur. The CPA is completed by the supervising clinical educator(s) on the penultimate day of the placement and reflects the complete period of the placement. It uses elements from both norm-referencing and criterion-referencing assessment models - judgment of 'normal' levels is gained by experience and all assessors are expected to seek regular guidance from the allocated visiting faculty lecturers to ensure that norms are established and maintained (see appendix 3.3).

The elements assessed are:

Interpersonal skills and professional behaviour
Organisation and management skills
Patient/client examination and assessment
Implementation of physiotherapy practice
Learning behaviour

These elements entail both formative (on-going/informal) and summative (formal/marking of achievement) methods of assessment but only the summative method is used to decide the outcome of the module – pass/fail. The formative assessments are used to help the student reflect on their own progress and enable the visiting lecturers and personal tutors to facilitate this. This formative feedback is highly rated at interview as it reflects clinical, rather than academic, ability.

Weekly reflective diary sheets and SLER documentation are included in the PPP. The former provide the student with the opportunity to record what went well and what did not go so well during the week whilst the SLER asks the student to write about an incident that made some form of impression on them whilst on clinical placement. It follows the Gibbs (1998) reflective cycle that is made up of the following sections:

Description of the incident
Explanation - how did it feel?
Evaluation – what was good or bad about the experience?
Analysis – what can you learn from the event?
Conclusion – could you have done anything differently?
Action plan – if it happens again what would you do?

Lessons Learnt
There was a need to evaluate how effectively the PPP had been used and so an audit tool was developed (Gordon and White 2003) (see appendix 3.7.). Analysis of the audit enables student to know how effectively they have used their portfolio and which areas need to be addressed before the next clinical placement. It also indicates if the student has fallen into the non- reflective, reflective or critically reflective categories (see appendix 3.8).

Some students are naturally more reflective than others but some, highly reflective students, fall into the non-reflective category because they have difficulty expressing themselves on paper. The SLER provides the opportunity for them to talk through their chosen experience and to get feedback on their writing and analytical skills.

Staff have different reflective and facilitatory skills which cause clinical feedback and the SLER tutorials feedback to vary considerably. This is recognised by Benner (1984), Melia (1987) who suggest that reflection needs to be coached and guided but that not all practitioners have the skills to facilitate reflection in their students. To this end UWE provides clinical educators with a reflective practice development day to explore the concept of reflection, discuss their own SLER, which is related to a critical incident that occurred during clinical supervision of a student, discuss how reflective practice can be facilitated in their students and how they use their PPP

Care has to be exercised over the development of reflection for novice reflectors tend to dwell on the negative aspects of experiences, even with qualified staff who have not used reflection to analyse their performance before. The SLER tutorial for students provides the opportunity for dialogical reflection i.e. talking about thinking and metapractice i.e. thinking about clinical practice and for students to be given feedback on which of three levels of reflection (Mezirow 1990) they had attained.

Features of non-reflectors
Descriptive eg" I ended up spending the whole day on ward 1'
Makes assumptions without testing validity eg "The patient was very bad tempered".
Straightforward and unaware of contextual factors eg "I told my supervisor that my patient was lazy as she refused to get up and walk".

Features of reflectors
Attending to feelings eg " I was aware of the fact that my patient had just been given a suppository so I suggested that I helped her with her leg exercises without her getting out of her chair".

Association eg "I knew how she felt because I had had tummy problems when on holiday in Spain!".
Integration eg "I will explain to her that drinking more water and that mobilising regularly will help reduce constipation and the need to keep having suppositories".

Features of critical reflectors
Iterative eg returns to experience in the discussion " I felt concerned when she refused to get up but once I understood why she did so I was able to work round it".
Ability to frame the problem in context e.g. " I will try not to alarm the patient and get the nurses to encourage hydration and mobility to reduce the constipation and need for repeated suppositories".
Adventurous in method and amenable to change e.g. "I will ask her relatives to help her order lots of roughage and refer her to the dietitian if this problem carries on. I will consult with staff around the effects that her medication is having and perhaps be able to get it changed if it seems to be exacerbating the problem".

Conclusion

The physiotherapy profession has now begun to recognize the contribution that critical reflection can make to the body of physiotherapeutic knowledge, especially to the trial and error and intuitive interventions often used to treat patients who do not respond to treatment in 'predictable' ways. Reliable results have been generated by regarding each treatment as a 'single case study' in which a hypothesis is formulated and then tested, both subjectively and objectively, after treatment. The application and efficacy of intuition, that 'sixth sense' often used by experienced practitioners when reflecting in action is an area that physiotherapists are beginning to develop and produce robust evidence of effectiveness i.e. what works. There is still a great deal of work to be done into evaluating the contribution that intuition, for example, makes to holistic care and how intuitive knowledge might be linked to the development of personal knowledge through reflective practice.

In the past physiotherapists did not fully acknowledge the worth of 'trial and error' and the efficacy of acting upon 'gut feelings' but now, due to qualitative and phenomenological research methods, we have begun to do so. Not only this but we are also generating credible evidence for what we 'do' in practice and have, as a result, been able to 'prove' the worth of the 'art' of physiotherapy (which was used extensively but only tacitly acknowledged). Critical reflection has enabled us to appraise and develop the theoretical basis of out 'art' and verify what we actually do- as opposed to what we have been trained to do or even what others, such as educators and researchers, might think we do. It has also made the art of physiotherapy more scientific and thereby more valued.

I agree with Polit et al (2001) that measurement is the key to the research process. As for deciding which is 'better' than the other I consider that neither quantitative nor qualitative research is better than the other, but consider that one might be 'better suited' to certain types of research. I will therefore conclude with Clarke and Croft's recommendation that critical research into reflection and reflective practice requires "the utilization of both the narrow rigorous approach of evidence based practice and the reflective skills to put that evidence into context." (Clarke and Croft 1998)

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CHAPTER 4

Using Reflective Practice in the Pharmacy Curriculum

Introduction to the education/training of pharmacists
The normal route to becoming a pharmacist in the UK, involves the successful completion of a 4year Master of Pharmacy degree followed by a preregistration training year then obtaining a pass in the Registration examination (www.rpsgb.org.uk). A couple of universities offer a 5 year sandwich Master of Pharmacy degree which includes the preregistration training. The professional and regulatory body for pharmacy, the Royal Pharmaceutical Society of Great Britain (RPSGB), is involved in all stages of the educational process. It accredits, on a 5 yearly basis, the Master of Pharmacy degrees offered by a relatively small number of universities. Only those students with accredited degrees can proceed to preregistration training. The preregistration training year is the responsibility of the RPSGB, which seeks to ensure that developmental objectives are met by defining the expected outcomes (performance standards and knowledge requirements) of the trainees learning. Each trainee has an accredited pharmacist tutor and must satisfactorily complete the training year in an accredited training site, usually a combination of hospital and community pharmacy practice. The Registration examination is taken at the end of the preregistration year or immediately after graduation for sandwich course students. Thus, in pharmacy the undergraduate education and the professional training/registration are separated and concomitantly the responsibilities. This situation presents a fairly unique position in the training of health care professionals.

Reasons for the need to develop reflective practice skills in the education and training of pharmacists.
Reflective practice skills development is required in both the undergraduate degree programme and the preregistration training for the following reasons.

Firstly, the undergraduate education of pharmacy students is the responsibility of the awarding university, however, the universities take cognisance of the need to produce graduates that are aware of the professional responsibilities and roles of pharmacists and capable of completing the preregistration training. Therefore undergraduates are not taught in total isolation from the profession and teaching and learning opportunities will include modules explicitly for professional development and sessions in practice situations. The QAA subject benchmark for pharmacy(www.qaa.ac.uk) includes two statements relevant to this chapter:-

- 'The activities of pharmacists are underpinned by the development of a high level of interpersonal skills, which are ……and reflective'
- pharmacy related cognitive abilities and skills include 'the ability to contribute to the development of health care through reflective practice, enquiry and innovation'.

Thus it is incumbent on the universities to address the development of reflective practice skills by their students.

Secondly, in the preregistration training, although the emphasis is on developing and demonstrating competence to performance standards, towards the end of this training year trainees are required to reflect on their experiences and think about their immediate development needs. The reflection required is presented as a structured form with a number of questions to be addressed.

After registration as a pharmacist, reflective practice skills are needed to meet the requirements of the pharmacists Code of Ethics to maintain competence and effectiveness as a practitioner. The RPSGB recommends (to be mandatory after 2004) pharmacists to plan, undertake and record their own continuing professional development (CPD). The CPD process suggested by RPSGB depends heavily on a reflection stage to help individuals identify their own learning needs. Documentation provided by RPSGB details the reflection process and gives examples of situations in which pharmacists use reflection to identify their learning needs. Additionally RPSGB provides master record sheets for pharmacists to record 'learning that starts with reflection'. The format of these sheets consists of a series of questions related to reflection, which guide the pharmacist in the recording of their own reflections. RPSGB also provide pharmacists with a Personal Development Plan (PDP) form. The PDP is designed to structure the reflective process by a series of questions to be answered by the individual pharmacist in order to link individual development, career and business plans to service needs and delivery through CPD.

From all of the above it can be seen that reflective practice skills need to be developed throughout the undergraduate education and pre registration training of pharmacists in order to underpin the abilities of pharmacists to undertake CPD using a reflective practice approach and process.

Incorporation of reflective practice skills into the undergraduate curriculum

Whilst the RPSGB accredits pharmacy degree programmes, each university's curriculum will be unique. Each curriculum will contain the required components of the RPSGB indicative syllabus but can contain other subject material, the teaching and learning strategies and delivery may differ, the order and methods of presentation need not be the same and the emphasis placed on individual subjects may be different. Thus the introduction and methods of development of reflective practice skills will differ between university providers and so this chapter will describe what is happening in some not all of the schools of pharmacy.

At Manchester University School of Pharmacy the approach to including reflective practice into the curriculum has been to pilot the introduction of reflective practice in a stepwise fashion to small discrete professionally based modules and to evaluate each pilot before deciding to subsume the reflective practice element into the formal curriculum and proceeding with further developments.

A reflective practice workbook was introduced into a 4th year professional practical module. The workbook consisted of an introduction explaining reflective practice and a completed examplar together with sheets for students to self-record their progress followed by space for writing reflective statements on their performance in the practical class. Each worksheet was required to be completed on a voluntary basis at the end of each class and was not assessed. Prior to this introduction students had received didactic teaching on reflective practice and its place in learning. Over 80% of students returned the workbooks. Analysis (Rees et al 2003a) of the completed workbooks and evaluation of this pilot showed that the students' written statements were mainly short and straightforward with only a few being longer and more reflective. The statements could be classed as either pertaining to personal development needs or module content/methods of teaching. The personal development needs could be further categorised as statements of future action e.g. 'need to do….', statements with reasons e.g. ' X is tricky, must learn X better' and confessional statements e.g. 'I should do more study'.

However, although students stated their development needs few indicated how they would go about meeting these needs. Therefore for the following academic year the format of the workbooks was

changed to a more prescriptive style and each worksheet contained a series of questions designed to guide the students in their reflective practice e.g.,

- What problems occurred?
- What did I learn from them?
- What went well?
- What did I learn from this?
- How can I improve myself?
- How will I do this?
- What further work do I need to do now?

Again completion was voluntary and the workbook was not assessed. Halfway through the module approximately half of the students were verbally asked by an independent researcher for their comments on the workbook and reflective practice. These comments were analysed and used as the basis of an evaluation questionnaire for completion by the students at the end of the module. Analysis (Rees et al 2003b) of the questionnaire revealed that students considered reflective practice to be good in theory but not in practice, a way of highlighting their weaknesses, good points and errors, helpful in making them think about what they are doing and in planning future tasks. However, although the workbook was easy to understand, the process of reflection was considered to be time consuming, tedious and repetitive. In a similar vein, students considered the process of completing of a CPD portfolio would be tedious. Despite these comments it has been decided to continue with the reflective practice workbook in the same format for the next year group of students.

Concomitant with the introduction of the more prescriptive workbook to 4th year students, reflective practice has been introduced to all years of the degree programme. First year students attend a 2 hour non assessed workshop delivered by the Centre for Pharmaceutical Postgraduate Education on reflective practice and its place in professional practice. They are required to complete a reflective practice worksheet at the end of each class in a professional practical module. The worksheet is individualised for each class and is a series of questions, which are answered by a combination of free responses and completing a rating scale. Again the worksheets are not formally assessed but are collected for evaluation purposes.

Reflective practice skills are further developed during second year by students completing a self directed learning package, which involves them in interviewing family and friends about minor ailments and preparing a written record of the interview, completing an interview evaluation form, evaluating their skills development and reflecting on their performance and knowledge base in each interview by rating themselves against set criteria (see appendix 4.1).

In the third year, students further develop their reflective skills and develop peer reflection at the end of two different types of interview situations. Firstly students undertake interviews with patients during hospital visits and secondly they are video recorded counselling/advising a simulated patient about their medicines. At the end of each of these two types of interview students complete a reflective practice worksheet self-assessing themselves against set criteria and a similar set of criteria are used for peer reflection of a student's performance. Evaluation of the worksheets for years 1, 2, and 3 is being undertaken currently.

At London University School of Pharmacy, reflective practice has been introduced in a similar way into professionally orientated modules. In a practical professional module, students have to complete a reflective proforma at the end of each class. This involves each student reflecting on

whether the objectives of the class had been achieved, what went well or didn't go well etc. These reflections are freestyle comments and are not assessed.

In another module held at the university, each student undertakes an interview with a visiting patient, whilst another student observes. Prior to the interview students are provided with examples of reflective self and peer assessment. At the end of the interview, the 'student interviewer' self assesses and completes a reflection on their own performance, whilst the observing student provides feedback in the form of reflective peer assessment. Uniquely the patient also provides feedback to the student. A further module introduces students to reflective daily diaries. These diaries are required to be completed whilst the student is spending several days undertaking a ward-based hospital experience. Again the reflective diaries are not assessed, but are used in the development of reflective skills by students and to underpin good professional practice.

There is anecdotal evidence from the tutors that students are reflecting and changing the way that they carry out clinical practice tasks as a result of completing the reflective diary.

At Bradford University School of Pharmacy reflective practice will be embedded from September 2003 in a number of modules as a development tool for deeper learning. The first year Professional Practice and Personal Development module will require students to reflect on their performance in a number of tasks designed to develop their key skills. For example students will be asked to reflect and devise a development plan based on the results of calculation tests, an IT examination, a presentation assessment, a mock summer job application form and a mock dispensing examination. These reflective statements will be recorded in the students' progress files. Following a second assessment in these areas, students will be asked to write a statement outlining any improvement made.

Third year students on the 5-year sandwich programme will undertake a 6-month period of professional practice in a hospital or community pharmacy. As part of the 3rd year Professional Practice and Personal Development module students will be expect to reflect upon a number of experiences encountered during this period of professional practice, critically appraise their performance and identify strategies to improve their performance. On their return to University in fourth year, students will present a reflective statement based on their learning from experiences of professional practice.

Third year (non sandwich programme) students do not undertake a period of professional training but are exposed to practice through structured visits. Students will be required to reflect on the experiences of a number of these clinical visits to hospital, community and General Medical Practitioners and where necessary on their performance in simulated pharmacy scenarios.

A large part of the final stage of the programme is dedicated to the teaching of the management of medicines whereby students will be presented with case studies and be expected to critically appraise a medication regime and formulate pharmaceutical care plans which demonstrate the most appropriate, effective and safe use of medicines in a practical setting. Students will be expected to use their skills in reflective practice in order to identify gaps in their knowledge, review their personal performances and plan their learning needs in order to become reflective practitioners.

Throughout the Bradford programme, students will maintain and contribute to a progress file that is designed to capture and record evidence of achievement and of reflective learning and identification of learning needs. By the final stage of the programme students should be able to identify, plan,

participate in, record and evaluate their own learning in preparation for continuing professional development and lifelong learning post-graduation.

Lessons learnt

Some of the developments in the three Schools of pharmacy are described above, but what are the observations, feelings, and reflections of the academic staff involved and what lessons can be learnt? Firstly all the novel ways of introducing reflective practice into the curriculum are aimed at helping the students towards becoming reflective practitioners and to underpin their future participation in CPD. Have we been successful? To some extent only time will tell. What is certain is that students do regard reflective workbooks as helping their learning (Rees et al 2003a) and they support the concepts of reflective practice and CPD but do not like the actual process. Maybe students find the process time consuming and tedious because we expect too much and introduce reflective worksheets/diaries into already crammed sessions. Alternatively perhaps we need to allow students to acquire more practice and so gain more confidence, which in turn will enable them to speed up and develop their reflective writing skills. For this reason, reflective practice has been or is being introduced to first year students and will be continued throughout the remaining years of the degree programme in two of the three universities referred to in this article.

One related and common criticism of pharmacy students is their poor ability to write reflective prose. Students are able to adequately describe situations or write short statements but find it more difficult to reflect on their part in the situation or their (lack of) abilities and/or skills with respect to the situation. Again although examplars are provided for students, the ability to reflect and to write down reflections is a skill that needs to be developed and perhaps as academics we are not addressing students needs and preparing them sufficiently for reflective practice. However some of the approaches used in schools of pharmacy have been to provide proforma with questions for students to complete as a way of directing their reflective thinking, particularly in the early years of the degree programme.

In this initial stage of introducing reflective practice to students some thought needs to be given to the teaching staff? Do we totally understand reflective practice and could we write adequate reflective prose? Certainly we are beginners at teaching reflective practice skills. And, as always, there is a small number of staff that are sceptical about new approaches to teaching. The issue of staff training in reflective practice will need to be addressed by most Schools of Pharmacy, especially for the non pharmacist staff who will not participate in the RSPGB scheme of CPD.

Another issue mentioned anecdotally by some tutors, was that students did not always display candour in their reflections, for example, students who appeared very nervous, whilst conducting a patient interview, claimed in their reflective write-ups to be very confident. Similarly peer assessment sometimes followed the same trend with students giving very positive reflective comments to their peers, which did not match and describe the situation as viewed by the tutor. As tutors we do not wish to undermine students self esteem and confidence and yet we need to develop ways of persuading students that acknowledging weaknesses is the first stage to overcoming them and that peer assessment should likewise be upfront but not destructive.

Another major issue is the question of whether or not to assess reflective practice. At the present time it would appear that schools of pharmacy are still at the early stages of introducing reflective practice and that students are requested to complete various reflective worksheets/diaries, which are reviewed by tutors but not formally assessed or awarded credit. Of course there is the perennial problem that students want credit for work and are less likely to put major effort into assignments that are not assessed. Surprisingly in the pilot schemes that have been introduced the majority of

students have completed most if not all of the reflective worksheets. However there is a minority of students that don't complete any reflective worksheets or only complete to a very basic minimum standard. In the present 'voluntary' scheme there are no penalties for such students, indeed it could be said that they have more time to spend on other assessed parts of the course. The opposite is true of students who complete reflective worksheets to the best of their ability; if the scheme is 'voluntary' then there is no formal reward for trying and they may have disadvantaged themselves by limited time for other assessed work. The challenge to academics is to engage the students with reflective practice so that students can see the benefits and are willing to put in effort even where no formal recognition or credits are given.

Yet another issue is ethical practice- do we as academics have the 'right' to see a student's very personal reflective thoughts? Some tutors feel uncomfortable, almost prying, reading students personal reflections. Perhaps students knowing that their reflections are going to be viewed by others decide not to be totally open –it's a brave person who reveals their innermost thoughts to the world! There needs to be explicit trust between students and tutor. I would suggest that this area needs to be explored and perhaps we need some ethical debate on the subject.

One surprising result of our evaluations on students' reflective freestyle statements was the way students would reflect on their own performance but in the same piece of work would comment on the course structure, content, organisation and the abilities/skills (good or otherwise) of the academic staff. Such comments cannot be truly described as reflection and are more akin to feedback. However as a by-product of reflective practice they have been used to modify course contents and delivery of some modules. It has also been useful to the individual tutors, who either modify their teaching style or congratulate themselves on unexpected praise!

Conclusion

In conclusion, pharmacy undergraduate education is in the developmental stages of introducing reflective practice to the curriculum in order to underpin professional requirements. A number of universities are piloting or introducing in a limited way reflective practice exercises to their students. Much work still has to be accomplished in developing reflective practice skills in both students and academic staff. Similarly much thought needs to be given to how to address the thorny topic of assessment and contribution to credit ratings. I consider that in the next few years we will see a rapid increase in the number and ways of recording reflective practice in the pharmacy undergraduate curriculum in response to the current developments and the needs of the profession.

My thanks are due to Rita Shah (School of Pharmacy, University of London) and Simon Tweddell (School of Pharmacy, University of Bradford) for their information on reflective practice in their respective undergraduate courses. Also my thanks go to my co workers at Manchester, namely, Judith Cantrill, Ian Smith and Clare Watkins.

Biography:

Dr Judith Rees is Senior Lecturer in the School of Pharmacy and Pharmaceutical Sciences at the University of Manchester. She is also a registered Pharmacist. Dr Rees has considerable experience in both teaching pharmacy and in research on the delivery of pharmaceutical education. Together with Prof. Collett, she received a National Training Award for the development, assesment and evaluation of a programme of structured work based learning for pharmacy undergraduates and a Partnership Trust award for Developing and assessing communication skills. She has been involved in inter university and local educational research programmes. Recently she was project leader in the introduction and evaluation of reflective practice to all four years of the undergraduate pharmacy degree at Manchester.

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CHAPTER 5

Using Reflective Practice in the Paramedic Curriculum

Introduction

This chapter describes and discusses a unique example of reflective practice (RP) implementation in an undergraduate paramedic curriculum. It is not intended to debate the various theoretical and conceptual dimensions of RP as this is widely published elsewhere. In particular it will explore some of the emergent issues pertaining to teaching, learning, assessment and evaluation of RP based on my personal experience over the last seven years. The overall approach to RP adopted during this time is closely aligned to Moon's (1999a) simple definition of reflection but emphasises experience as the basis for learning.

Currently RP remains a relatively limited concept in development and application to UK paramedic practice compared to other health care disciplines such as nursing where it has become a well recognized model for professional development. The conspicuous dearth of RP literature available to paramedic practice does appear to indicate a global gap in this area. As such the development of reflective practice in the paramedic curriculum at the University of Hertfordshire (UH) is regarded as an example of curriculum innovation and indeed was highly commended by the Quality Assurance Agency (QAA) subject review three years ago for its initiatives in this area.

However, from my personal experiences the continued embedding of reflective practice for learning, teaching and application to practice remains challenging; not least because it is often misunderstood and resisted by many practitioners. More pertinently it also questions the technical rational model traditionally associated with paramedical practice (i.e the use of scientifically /medically based practice protocols for guiding practice similar to the " instrumental problem solving" described by Schon (1991 P21)). Though the stringent protocol approach and its many benefits have long served paramedic practice well (Jones and Cookson 2000) there are many instances where following protocols habitually have not proved to be the best course of action for both patient and practitioner. Additionally paramedics are increasingly confronted by unexpected non-trauma cases for which there are no protocols. So what are the alternatives to technical solutions for non – technical problems? The current shift from protocols to 'guidelines' implemented by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC 2001) strongly suggest that without the legal cushion that protocols provide paramedics necessarily need to develop more flexible thinking skills for complex decision making.

According to Light and Cox (2001) it is in such situations that reflective practice enables practitioners to select and apply professional knowledge and responses appropriately.
It is my contention that this can best be developed through higher educational processes.

Background/Context

In 1996 the University of Hertfordshire became the first UK higher education Institution to host the inaugural Certificate of Higher Education in Paramedic Science. Developed and led by the Department of Nursing and Paramedic Sciences in partnership with the London Ambulance Service (LAS), the emergence of the certificate in higher education programme was in direct response to national demands for paramedic education and training to be recognised professionally. Previously the only route to higher education by paramedic practitioners wishing to pursue graduate status was through access to generic health based courses. However, the driving forces for a specific pathway

for paramedic science within higher education were compelling both within the service and externally.

Rapid and ongoing changes in health care delivery, political and technological advances necessarily demanded more advanced knowledge and skills to underpin paramedic practice than the traditionally protocol based approaches. The need for paramedics to be explicit in considering the psychological and social needs of patients, and not just medical needs were clearly outlined in the Wells (1995) report suggesting that a protocol based approach to practice was no longer sufficient for contemporary practice. Similar concerns had also been highlighted in USA (Janning 1994).
The emerging consensus indicated that a more holistic approach to contemporary paramedic practice could be enhanced and developed if practitioners had a more comprehensive and critical understanding of the rationale and knowledge about protocols to inform their practice. The case for higher education was established and at UH we considered reflective practice ideal for promoting a critical thinking approach to practice.

As a starting point to curriculum development, in 1995 UH first granted academic accreditation at level 1 (4) to the LAS in-house paramedic training programme. For the first time in the UK this provided qualified paramedic practitioners the opportunity to complete two additional academic level 1 (4) modules (one being reflective practice [RP]) to be awarded the Certificate of Higher Education in Paramedic Science. This was an historic landmark for UK paramedic education and training. Subsequently a number of undergraduate programmes, both full and part-time, continue to be successfully developed and implemented in partnership with various National Health Service (NHS) ambulance trusts. Throughout this time reflective practice has achieved and retained subject status alongside the traditional health and human science subjects such as psychology and sociology with significant impact on practice. As a direct result of the UH initiatives a number of ambulance services are now implementing the use of written reflective journals and practice portfolios in the workplace for continuing professional development. This is clearly a positive curriculum outcome.

Reflective Practice in the Undergraduate Curriculum At UH (How we do it)

Learning and Teaching

From the outset of the curriculum development and subsequent implementation, the concept of a reflective practitioner in paramedic practice had been identified as a fundamental aim for graduate practice. Interestingly this was not solely an academic initiative but equally service driven and resulted in significant contributions to the content and structure of courses by ambulance personnel.
The structure we adopt to learning and teaching to all our programmes is largely congruent with Moon's (2001) input/outcome model of reflection for both full and part time modes of study.

The part-time route for the Bachelor of Science (Hons) award is designed for paramedics who are already qualified and wish to obtain graduate status, with exit options at certificate and diploma level status. For these students RP is driven by experience as the basis for development. The full time route, first implemented in 1998, is designed for pre-employment students who at the end of three years (if successful) obtain both qualified paramedic status and graduate status. RP underpins the achievement and assessment of professional practice competencies.

But what are the implications for reflective teaching and learning and how should it be organised taking into account the novice as well as expert practitioner? Reed and Procter (1993) identify a number of pertinent issues in particular the concept of coaching in RP development.

One of the key issues in Schon's (1987) view of the teacher is that of coach. This does not at first glance sit comfortably with the concept of traditional classroom teaching and the teacher-student relationship (See Tate chapter1). For us effective coaching and Schon's concept of the 'practicum' extends to the classroom, simulation laboratories and the clinical settings so that students can gain maximum benefit from theoretical and practice expertise in more than one way. Additionally providing opportunities for reflection *before* practice as well as during and after is something that the pre-qualifying paramedic students especially seem to benefit from.

Crucially, as part of the partnership agreements with service providers, teaching and assessment is jointly shared between clinical ambulance staff and academic staff. The main contribution to teaching from clinical staff is concerned with the supervision of the full-time pre-qualifying students. Throughout the three years of undergraduate study, identified clinicians act as practice supervisors to students. They are responsible for the assessment of their practice competencies, as stipulated by the Institute of Health Care Development (IHCD) and also have active link roles to the University to ensure continuity with professional competency achievement and reflective learning. What is particularly notable here is that this group of clinicians have themselves experienced RP learning and teaching at the university. Consequently they are able to promote the values of reflective learning equally, if not more effectively, than the academic teacher. Understanding and valuing reflection (Gillings 2000) and providing guidance (Johns 2000) by clinicians appear to have a positive influence in reflective learning and teaching.

For the pre-qualifying students the professional practice competencies are designed around the former English National Board's (1991) ten key characteristics (Appendix 5.1) for continuing professional development. Adopted from the pre-registration nursing degree pathway this framework provides a structure for reflection on practice that paramedic students can also use to examine experiences in a focussed way whilst demonstrating progression over three years. This necessarily involves written reflective accounts for selected characteristics within a practice profile for individual clinical placements. Reflective writing remains a contentious issue and our experience at UH with paramedic students is similar to those described by Rolfe et al (2001) i.e reluctance to write. Some of the reluctance appears to stem from the long established practices of ticking boxes in standard pro-forma. Some students see this as a pure academic exercise whilst others have genuine writing difficulties. My personal view is that it does encourage them to think deeper about issues that relate to their day-to-day practice.

As a way of promoting and supporting writing formative opportunities are provided at each level of the course .We also recommend the use of reflective frameworks for getting students started - a kind of stabiliser effect. Admittedly getting the balance right remains problematic. Although most students find popular frameworks, such as Gibb's (1988) reflective cycle, useful for structuring reflective learning, from my personal experiences it often results in no more than parts of a narrative under different headings. By default it might be argued that the continued use of the same framework by some students throughout the three years of study does highlight a ritualistic, superficial approach to reflective learning. However, reflective writing like any other skills need to be practiced if it is to be mastered and this is what we encourage and promote with our students with pleasing results. (See appendix 5.2 for example)

Reflective writing is not the sole method for developing reflective thinking skills as we include other strategies such as simulated learning, seminars, problem–based learning (PBL), and scenario based learning. Scenario- based approaches to teaching and learning in pre-hospital emergency care has been shown to enhance students' critical thinking skills (Janning (1997). Within the last two years we have also been using our intra-net system to facilitate more reflective discussions with the

hope that this will encourage further interests and motivation. Given that students have different learning preferences reflective practice, like other subjects, needs to be delivered in a variety of different ways in order to engage all students. Dedicated time on a weekly basis, away from practice is also devoted to students' development of RP in whole group sessions jointly facilitated by UH and clinical staff. This provides added opportunities for paramedic students to focus on discipline specific issues outside common multi-professional modules shared with undergraduate nursing students. The other intentions are to promote the broader concepts and benefits of reflective practice within a safe environment without the constraints of summative assessments.

The Assessment of Reflective Practice

The overall curricula aims and learning outcomes for the two graduate routes are similar, however, the methods of assessment vary depending on the mode of study. Assessments inevitably become a pre-occupation for many students and RP is no exception. It is also one of the most contentious issues (Nicklin and Kenworthy 1995). Debates about whether reflective learning should be assessed (Reed and Procter 1993) and difficulties with the assessment of reflective material (Moon 2001) are particularly interesting for paramedic education. My shared view (Jones and Cookson 2001) is that it should be assessed if it is to be accepted as a valid subject for learning and practice otherwise it will remain consigned to the simplistic view of casual thinking.

It is suggested that informal methods of reflective practice in paramedical practice such as critical incident debriefing and case review methods very rarely lead to measurable outcomes. That is not to say that such strategies are without value. Students are given clear assessment guidelines within which to structure their reflective learning and clarify the learning outcomes to which they apply. Progression and achievements are assessed by set criteria appropriate to the required level of reflectivity prescribed within learning outcomes for each year of practice.

From academic levels one (4) to three (6) the emphasis of reflective practice learning is on depth of learning: hence the use of higher order learning objectives derived from Bloom's (1956) taxonomy for assessment purposes. Summative assessments include essays, and reflective accounts of professional practice competencies

One of the summative essays at level two (5) for the part time students is linked to the area of paramedic clinical assessments. Linking reflection to the area of patient assessment was identified by service as an urgent practice need. Patient assessment is a key process that underpins practice and has profound implications for novice and expert practitioners in following prescribed protocols in complex emergency situations.

We have found that providing students with clinical assessments as a focus for reflection to be highly beneficial for sharpening decision making skills and for highlighting 'grey' areas of practice not resolvable by protocols. Examples of non-protocol based clinical assessments ranges from simple baseline measurements such as blood pressure and temperature monitoring to the more complex such as pain assessment, monitoring, witnessed resuscitation, accidental elderly falls and mental health assessments. These examples are derived from students' critical incidents, written reflective accounts and seminar presentations, and demonstrate that reflective learning can highlight gaps
in day to day practice not previously addressed through ambulance service policy.

However, the reality for practitioners instigating active change to practice derived from reflection is at times complex and can cause conflict. Ambulance service priorities are often different to areas

that the practitioners identify and needed changes are sometimes out of the control of their individual practices. Frequently change lies within the remit of other pre-hospital and hospital services such as primary care, the other emergency services and accident and emergency departments. Some students conclude that reflection therefore can be a frustrating process given that action and active experimentation are considered essential to reflective learning. I propose too that not all reflective learning, as suggested by popular theories for example, Kolb (1984) require overt action. It is also a process of confirmation and re-affirmation of effective practice, for example where paramedic protocols and guidelines work effectively and remain the best course of action.

Evaluation of RP in the Paramedic Curriculum

As with other subjects reflective practice teaching and learning is evaluated a part of institutional policy at the end of every academic year via student feedback questionnaires. Although the results have been consistently positive and achieve high scores it is not without subjectivity. Encouraging results from a pilot study I conducted two years ago showed that over 85% of the 130 paramedic students strongly agreed that reflection is important to learning and practice. A more in depth study is currently in progress to explore further this as well as other teaching, learning, and assessments issues.

In addition we use other free forms of qualitative forms of evaluations such as graphic representations and collages to further inform our developments. The following range of edited students comments gives some useful and interesting feedback.

Linking experience with RP

"As paramedics have become more experienced using reflective practice it has shown protocols to be restrictive and it does not always meet the needs for which they were developed"

Using Frameworks for reflection

"Gibb's cycle allows practitioners to use a structured model. This is very useful for helping paramedics in teasing out the very chaotic nature of practice which can often lead to distortion of facts after the event".

"Knowing how to analyse the facts of a situation and learn from them are essential skills for professional paramedics".

The Need for Reflective Practice

"It is essential that paramedics who practice in an ever diverse world, reflect on their practice if mistakes are to be corrected but also to see where positive things have occurred".

"By using reflection a paramedic can get both good and bad feedback about his practice and show how to improve in the future".

"Paramedics might choose only dramatic cases to reflect on and forget the day to day things that they deal with which are just as important".

Protocols versus Guidelines

"The problem with protocols is that it doesn't encourage you to reflect because it is always there. Guidelines will force you to reflect which is not a bad thing. It will force people to make the best choices and this depends on experience and reflecting back on those".

"Reflective practice must be more widely introduced in the service if guidelines are to be the way forward".

Ways of Reflecting

"Reflection does not occur just by knowing about it. It depends on many other things such as writing in diaries and portfolios and clinical supervision practice. It can happen with or without the use of a model".

The Need for Change

"Paramedic training has concentrated on medical science far too long with little attention to reflection. We need to change to keep up with nursing and other health care workers who are ahead of us with reflective practice."

Benefits to Patients

"If the paramedic learns from reflection then surely the patient must benefit".

Teaching and Learning

"The best way to learn about reflective practice is not to frontload it with theories, but to start with what we do in practice"

Lessons Learnt

Over the last seven years the development of reflective practice in the undergraduate paramedic curriculum at UH has evolved in an incremental way. Without a blueprint to follow this seemed daunting but it has also been an advantage. Interim evaluations from students, the ambulance service and our own reflections at each stage of development helped to shape RP as a subject in its own right .The full benefits are yet to be determined. However, throughout this time some important lessons both positive and sobering have been learnt.

Firstly that the partnership approach with service colleagues in the ongoing development of reflective practice has served to establish a credo for reflective practice in paramedic education and training. This strategy offers greater opportunities for unifying theory with practice and vice-versa. Collaboration has also strengthened the case for reflective practice though not before some significant initial resistance to the concept. Gradually the myth that reflection is a "nursing thing" is being successfully dismantled.

So what has influenced this change? From my personal reflections of using different methods to teach RP I have found that students are generally more receptive to the idea if it is introduced within the context of 'ways of thinking and learning' rather than beginning with popular definitions of reflection. Popular definitions nearly always elicit responses of "we automatically reflect after a job anyway". It is useful to build on the student's own definitions as a starting point. In our experience this is best done by immediately engaging the students with practice examples rather than by introducing theoretical aspects of the subject.

Additionally, engaging students with a specific focus for reflective practice, such as patient assessment and professional competency achievement, provides them with a clear sense of what could be realistically accomplished and learned. This strategy definitely weans our students away from the superficial cursory approach of writing "on reflection" etc. to more focussed in depth, objective writing. It also overcomes the common student problem of not knowing where to begin.

Creating extra opportunities for discipline specific reflection for pre-qualifying students is further necessary. Joint sessions with nursing students can sometimes limit deeper exploration of paramedic issues and vice-versa. Hence peer reflection in multi professional situations is not always sufficient and needs to be considered in the planning of such courses.

Conversely for the qualified paramedic part time students, the need for extending reflection to multi-disciplinary teams such as accident and emergency nurses, mental health nurses and general practitioners emerges strongly. The corollary of this is that RP as a curriculum concept depends on students' needs and experience, which has to be consciously nurtured for it to become internalised and applied in meaningful ways.

Reflective writing is a common problem for both pre and qualified paramedic students. At UH we have consistently and deliberately used the term 'journal' to differentiate between personal diaries and professional journal writing. Although students are encouraged to keep written professional journals, it is not compulsory and the proportion that does so is negligible. Despite the identified benefits to paramedic practice (Lord 1998), on the whole reflective journals are seen as an onerous paper exercise rather than a developmental concept. Students highlight a number of reasons, for example lack of motivation and difficulty in writing Burns & Bulman (2000). Some of the more recent literature promoting reflective practice (Rolfe et al 2001) has been helpful in overcoming this resistance.

In my experience the most significant reason for the general unwillingness to consciously commit reflective learning to journal writing appears to be because it is seen as extra non-assessed work.

In relation to written reflective accounts of practice an ongoing issue for the majority of students relates to writing in the 'first' or 'third' person. The position we adopt with writing in the first person for developing reflective writing is informed by literature e.g Crème and Lea (2000) who recommend a judicious approach to the use of 'I' and which does not obscure the essence of reflectivity.

Contention about the use of frameworks is also ongoing. Although the use of cyclical approaches is recommended (Bulman 2000), often they promote a non-reflective approach to writing. From my personal experience it is increasingly evident that for many students some popular reflective models, by default encourage non -reflective, repetitive approaches to writing. Similar to findings by Burnard (2000) these are used in a prescriptive way and hamper reflective thinking rather than promote it For some paramedic students the more pragmatic guides to structure reflective thinking, e.g Driscoll (1994) and Peters (1991), have some appeal possibly because of similarities to the protocols/ guidelines approaches to paramedic practice. They do seem to encourage a more analytical approach to writing.

Conclusion

The introduction of reflective practice within the Bachelor of Science programme over the last seven years has been a significant milestone in the history of paramedic education. The last two years have produced a number of successful diplomats and graduates from both the full and part-time schemes. However, the extent to which the reflective practitioner has emerged and what fully influences reflective learning is yet to be determined and is currently being addressed via empirical research.

Currently within UK ambulance practice there is a rapid movement away from stringent protocols approach to ***guidelines*** allowing more flexibility for practice. This will necessarily involve a greater reliance on professional judgement, hence the prediction that RP will become even more significant. The movement to state registration for paramedics (SRP) since 2001 and Quality Assurance Agency (2001)education benchmarks for health care professionals already allude to this

The re-validation of existing schemes is in progress as well as the development of new schemes such as the Foundation Degree that commenced in September 2002. Reflective practice continues to remain an integral part of all developments. Embedding reflective practice in the paramedic curriculum is not a static process at UH. We are actively modifying and exploring different methods for further integrating RP into the curriculum taking into account the lessons learnt.

Biography

Indra Jones is currently a Fellow in Learning and Teaching at the University of Hertfordshire. Her academic work centres around the teaching and curriculum development of reflective practice for a variety of undergraduate and post-graduate courses in nursing and allied health disciplines .She also contributes to staff professional academic development.As well as leading RP developments over the last ten years she initiated the research programme into the application of reflective practice in the paramedic curriculum particularly the use of structured methods and has achieved international publications in this area. Her other scholarly interests include Problem based Learning, Learning Styles and academic levels of assessment. Indra has a background in both critical and Primary Health Care hence the strong interest in the pre-hospital emergency care interfaces. She remains strongly committed to reflective practice in all curricula developments but especially in paramedic education which is rapidly changing its approach to practice.

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Chapter 6

Reflective Practice within the Occupational Therapy Curriculum

Introduction

Occupational Therapists need to be able to sustain themselves today on an ever-challenging professional tightrope. They are required to balance the demands of patient led services and development of evidence-based practice, within the complex environment of health and social care. Reflective practice offers a means to improve clinical care whilst providing an invaluable anchor for professional accountability and personal development. Although the capacity to be a reflective practitioner is a central tenant with the profession there appears to be lack of discussion regarding the development of reflective skills within undergraduate Occupational Therapy students. This article is written in an attempt to gain some understanding into the importance of reflective practice within the Occupational Therapy curriculum from a theoretical and practical perspective and, in addition, to promote debate.

The Concept of Reflection within the Occupational Therapy Curriculum

Within the curriculum of undergraduate Occupational Therapists reflective practice is an essential component (College of Occupational Therapists, 1998; QAA, 2001; WFOT, 2002). The development of reflective practice is core to the philosophical framework as it underpins the tripartite requirements of '*fit for purpose, fit for practice, fit for an award'*. Capacity for critical, reflexive thinking is central to the student's experience as the development of evaluative and analytical skills are fundamental to professional practice. At the same time, we must readily acknowledge the longevity of this initial learning experience since we can no longer assume, what we have learnt today will serve us adequately for all future situations (Burnard, 1989; Moon, 1999a; Boniface, 2002). In the experience of the author and her colleagues, incorporation of reflective practice into the curriculum is as much about engendering an approach to working as a reflective practitioner, as it is to learn the skills of reflection. This underpinning approach not only facilitates the act of learning itself (Saylor, 1990) but designates the curriculum with a long lasting quality of promoting 'critical beings' (Barnett, 1997) who have the capability to practice in the evolving socio-political environment of health and social care (Brockbank & McGill, 1998).

Theoretical Considerations

Although the concept of reflective practice has been open to many interpretations (Boud et al, 1985, Schon, 1987; Dewey, 1993; Reid; 1993, Spalding, 1998) its place within the educational framework of student Occupational Therapists holds an unreserved position for several reasons.

Primarily, it is anticipated that students by engaging in reflection are able to link theory with practice (Parker et al, 1995; Ghaye & Lillyman, 1997). This reflective synthesis on learning enables critical appraisal of old and new knowledge (Atkins & Murphy, 1993).

Intrinsically it is also concerned with a higher order of meta-learning involving the ability to doubt the present reality of knowledge and reconstruct it into a changed perspective (Bateson 1973, Argryis & Schon 1974). Rolfe et al (2001) conceptualise this stance, by stating that through engaging in reflective practice students are afforded a learning map. Indeed, it is through this changed outlook that the facility for self-critique and development are afforded (Williams, 2001). Surely, what we are about as educators is to develop learners who have the capacity for self-monitoring therefore opening up their professional practice to positive change and development. In other words, as Candy et al (1987) propose, an outcome for the educationalist is to make oneself

redundant, as students succeed their mentors in becoming autonomous, reflexive clinicians themselves.

A second theoretical premise for inclusion of reflective practice in the undergraduate curriculum is that the rapid pace of modernisation within health and social care creates an imperative for practitioners to adapt and re-interpret their practice, assisted by a critically reflective approach. Clearly healthcare professionals do not work within a vacuum therefore, reflection on the context in which they work is vital if challenging influences are to be moderated and optimised. Harvey & Knight (1996) identify the product of this capacity to shift viewpoints, as the development of 'transformative agents' who are critically reflective learners able to cope in a rapidly changing world. Our intentions for the student experience is to facilitate movement from a paradigm of self-perception to one in which students distinguish themselves as therapists in the wider clinical context.

A final principle for incorporating reflective practice into the educational framework rests with its influence on evolving personal development, professional practice and the influence this has on the therapeutic relationship for people that access our services. The ability to be reflective has been advocated as essential for a positive rehabilitation process between therapist and patient (Jenson & Denton, 1991; Mattingly 1991). In Occupational Therapy establishing a therapeutic relationship is crucial (Lloyd & Maas, 1994). Reflection can increase awareness of self and so is an essential part of using oneself in the therapeutic liaison.

Implementation of Reflective Practice Within the Curriculum

Implementation of reflective practice within the curriculum is underpinned locally by the principles of self-awareness, personal development and empowerment throughout the course (Occupational Therapy Subject Group Coventry University, 2000). It is anticipated that as reflective skills develop this will lead to greater individual responsibility for learning, which we believe also prepares students in their endeavour to become life long learners. The capacity for reflection is developed in both university-based practice and fieldwork education experiences.

Reflective Signposts Within University Based Studies

Locally the development of reflective skills within university-based work is supported by the expectation that students will engage in continuing professional development and a journey of personal profiling (Heames, 1992).

The concept of profiling encourages explicit links between theoretical based studies, practical experiential learning, personal and professional development. Each student develops an individual profile through the duration of the course as part of an iterative process, which is as much about development of thinking, as well as recording thinking (Wellard & Bethune, 1996). Students engage within three central activities: the development of a continuing professional development portfolio, which enables connections to be integrated between university based achievement and fieldwork education experience, personal profiles completed at academic milestones and fieldwork education assessments from practice.

Key to this connective learning is the relationship between students, fieldwork educators and members of our course team, notably professional development tutors. We accept that experience is insufficient in itself unless complimented by mental space to reflect on what we are doing in a critical way (Pearson & Smith, 1987). To this end individual meetings between students and staff involve an ongoing reciprocal dialogue, normally preceding and following a period of fieldwork education. In this way, the experience of reflection is supported and not deemed to be an isolating,

disconcerting process as some writers may have suggested (Brookfield, 1995; Burns & Bulman, 2000). Students are assisted by tutors to capture learning experiences, be they academic or personal, resulting in rich potential for the integration of new insights into professional practice (Boud et al, 1985; Castle, 1986)). It is clear that the quality of undergraduate education of healthcare professionals is grounded in practice (Eraut, 1995) and the next section of this paper is based on an account of how reflective skills are promoted within professional development in practice modules.

Reflective Practice A Means to Closing the Theory Practice Gap?

Within the undergraduate course, referred to by the author, students undertake three periods of professional development in practice during each year of study; this amounts to periods of seven, ten and twelve weeks of placement, respectively. The approach by the course team to developing reflective practice during fieldwork education placements is centred on the following principles:

- Reflective practice in fieldwork education placements are characterised by 'reflective spaces' associated with deep learning (Entwistle & Ramsden, 1983), which allows students to actively capture and integrate their experiences.
- The student experience of reflection is an individual journey, which may begin from different starting points, yet is normally concluded by a commitment to action (Ghaye & Lilleyman, 1997)
- Increasing the capacity to be a reflective practitioner is a developmental process and involves moving from personal ways of seeing oneself to broader contextual viewpoints (Brockbank & McGill,1998)
- Opportunity for reflection on practice empowers students to identify and deconstruct norms, values, and assumptions reconstructing these into a changed perspective of seeing themselves within the environment of health and social care (Brookfield, 1995)

The work of Mezirow (1991a) on transformative learning provides the basis for our principles on reflection within professional development in practice. This learning journey is informed by meaning schemes (Mezirow, 1991a) or how we make sense of events, based on our expectations, knowledge, beliefs and past experience. Such a journey is not linear and is characterised by students challenging, usually subconsciously, their assumptions or perceptions of professional practice. This thinking becomes enlightened through the experience of reflection. From observations of undergraduates on our course the development of a changed perspectives appears to be a developmental process, which increases over time during the programme. This view is endorsed by Kitchener & King (1990) who provide evidence that reflective judgement increases with experience and education. We would anticipate preparedness for professional registration is characterised, not just by academic achievement and proficient professional skills, but also through maturity as reflexive critical beings (Barnett, 1997). Within this dimension students have developed the capacity to tolerate perceptions differing from conventional experience with preference to an approach, which is broad and inclusive (Knox, 1977).

Within each level of the undergraduate course and particularly fieldwork education the development of reflective skills is promoted using several different learning tools. The framework below (fig.6. 1) provides some exemplars of this pathway and proposes that narrative reflection forms the basis of past, present and current learning experiences. Although not limited to students in level one (4), we have found predominantly students at this level demonstrate reflexivity within practice by describing retrospective events – their narrative. These findings concur with Williams (2001) who identified that the preliminary thoughts of nursing students are associated with 'content reflection' or description of an issue or problem.

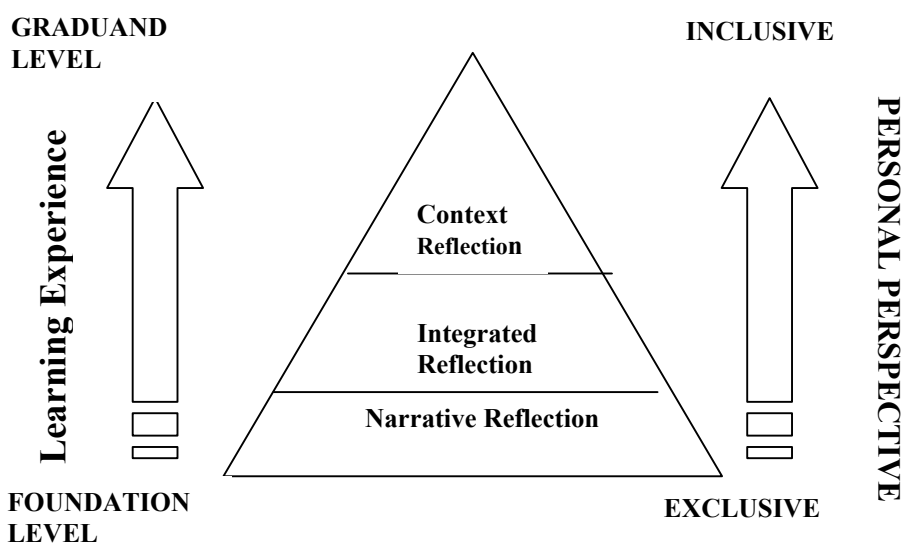

Fig 6.1 Development of Reflective Skills Within the Undergraduate Occupational Therapy Programme at Coventry University

Within level one (4) the capturing of reflective learning from professional development in practice is organised around Gibbs's reflective cycle (Gibbs, 1988). Students are guided by structured prompts centred around describing the event(s), re-collecting feelings, identifying areas of achievement, aspects for improvement and finally eliciting a personal action plan arising from the experience.

Reflections recorded each week, inform dialogue with fieldwork educators during supervision meetings. Generally our experience has demonstrated reflective practice of students in level one (4), tends to be from a narrow and exclusive perspective in relation to their environment, and is largely concerned with the desire and need for rules within practice. This paradigm of knowing can be linked to a novice (Benner, 1984) 'How am I doing?' and 'What should I have done?'

Progression from narrative reflection involves integrated reflection, which is a key theme at level two (5) in our course framework and links to the development of learning in the programme (Occupational Therapy Subject Group, Coventry University, 2000). This is characterised by the ability to combine theory with practice and evaluate this new perspective to inform development of future practice. Subsequently, the professional development in practice record of reflection documented by students is less didactic and they may also choose to record their reflections using free text style based on a reflective framework.

During debriefing from fieldwork, at this stage views concerned with the realisation that theoretical knowledge is influenced in practice by a multitude of moderating influences is not uncommon. This shift in personal perspective follows a developmental pathway characterised by a move from interpreting clinical scenarios, in a relatively structured manner, towards a growing need to cope with the dynamic reality where there is no 'one' right answer (Belenky et al, 1986 cited in Moon, 1999a). This insight is linked strongly to an awareness of reflection occurring, not just following action, but also as a preamble to future action and increasingly what the author understands as 'reflective self-talk' whilst involved within the clinical situation.

The fieldwork education placement at level two (5) is closely linked with a mandatory Clinical Reasoning module, in which students are introduced to the concept of gathering critical issues from practice. The framework for this analysis is based on the work of Boud, Keogh & Walker (1985) and provides a framework for students to present a clinical colloquia to peers and tutors, in which they integrate theoretical knowledge of clinical reasoning to inform new ideas and future practice. Witnessing this journey in our students concurs with the literature (Schon, 1991; Minghella & Benson, 1995) as their narratives move from fixed concepts based on individual reflections, towards an outlook grounded in the patient experience, driven by a process not purely of finding answers but a process of enquiry.

Lastly we arrive at the final undergraduate experience of fieldwork education, where students demonstrate critical reflective ability through identifying and analysing several critical issues from practice and formally presenting one of these to their fieldwork educator and colleagues. It is at this point that the author has witnessed a fundamental shift in the mindset of many of our undergraduates.

Although students are still concerned with self-evaluation, this viewpoint is progressively altered within the context of critical reflection as students articulate a concern based on the effect of themselves as therapists, and how the therapeutic relationship is influenced by dynamics within the clinical situation.

The demonstration of critical self-awareness in our students culminates in an independent study module, Critical Reflections on Professional Practice, which is complimented by formative feedback from fieldwork educators on the presentation of critical issues. In this module the reflective skills of students are assessed within a reflective essay based on their critical issue from practice. Use of critical issues from practice involves recognition of the wider environment in which Occupational Therapists work and a commitment to improving practice, systems of work and professional relationships. Because reflective writing can be challenging the link between verbal presentation and formative feedback from fieldwork educators provides a valuable anchor for this work. The indicative content aims not to be prescriptive but a focus for further discussion (appendix 6.1*)*. Support for the development of this reflective piece is coached and guided by tutorials and the use of an interactive discussion forum on WebCT. Within the Occupational Therapy programme at Coventry University promotion of reflection practice and its progression in fieldwork education can be summarised in the following framework (fig.6.2).

Reflective Learning Opportunity	Level One → *CHARACTERISTICS OF PROGRESS* → Level Three
Reflective Learning Agreements	Explanatory → Application → Evaluative
Student Stances in the Supervisory Relationship	Egocentric Perspective → Sociocentric Perspectives
Reflective Diary	Fixed – Specific Descriptive → Dynamic - Contextual - Critical
Development of Case Studies	Descriptive → Comparative → Critical

Figure 6.2 Reflective Learning Opportunities and Progression During Professional Development in Practice Modules in the Occupational Therapy Programme at Coventry University

Evaluating Lessons Learnt – Reactions from the Key Players

Within the course framework the position of professional development in practice is central to the undergraduate education of Occupational Therapists. The demonstration of reflective practice is made explicit within fieldwork education through reasoning dialogue with supervisors, negotiation of learning agreements and formal presentation of case studies - it is from this perspective that the student experience maybe best evaluated.

Following the progression of a cohort the author has witnessed a cumulative effect in the development of reflective practice skills; whilst facilitating and listening to student's narrative during debriefing following fieldwork education placements. It is interesting to note, albeit anecdotally, that student opinions concerning the development of reflective practice are largely silent until the initiation of critical issue analysis within the final year of study. It appears that critical reflection provided students with the emotional springboard to a higher level of learning. A central theme elicited from student feedback was the capacity of critical reflective practice to encourage insight into the wider picture of healthcare. As a course team we promulgate the view that knowledge, and indeed practice is not socially neutral (Barnett, 1997) therefore a valuable learning outcome was addressed. At the same time, learners expressed that this final presentation was richer than a case study as it provided good scope to consolidate and re-form knowledge. For many participants the process of sharing critical issues seemed almost liberating as they opened themselves up to new possibilities and their own potential, in effect masters of their own destiny (Boud et al, 1985; Moon, 1999a).

Despite prior agreement of expectations between student and fieldwork educator the power dynamic was evident as some learners became apprehensive about their capacity to be transparent. It was for good reason then that critical reflections were formatively assessed on placement. However, the influence of the student's critical issue presentation on their overall assessment cannot be underestimated. These trials of reflection and assessment in the literature where issues of emotional defensiveness (Alsop & Ryan, 1996) feelings of discomfort (Boyd & Fales, 1983) and reflection being inhibited (Richardson, 1995) are well documented.

Developing reflective practice in the undergraduate course is not without tension for fieldwork educators, which in many respects provides the influence to dissuade any inertia! Despite the tenet of reflective practice being a key principle within the Code of Ethics and Professional Conduct of Occupational Therapists (College of Occupational Therapists, 2000) the concept of critical reflection appears to be most demanding. A small number of practitioners felt uncomfortable by what they perceived as students challenging the way practice was delivered and organised. This feedback was valuable since it represents the enormity of our expectations and potentially a theory into practice gap. It was clear from students that some fieldwork educators felt less prepared to support learners in making connections between clinical practice and the influences of health and social care policy. Fieldwork educators also reported learning opportunities were inhibited by practical difficulties, such as, access to resources and lack of sufficient time for discussion. Clearly, reality for the majority of health care professionals is keeping pace with an endless stream of new policy directives, let alone explaining them to students!

Conclusion

The aspiration of improving professional practice through the development of undergraduate students as reflective practitioners holds a central position within the Occupational Therapy curriculum. At the same time reflection and critical issue analysis are fundamental to the agenda of clinical governance, to help elicit or resolve clinical concerns and share good practice. However, realising the full potential of reflective practice within Occupational Therapy is still in its formative stages compelling further research.

This chapter has aimed to convey the experience of tutors characterised as much by the development of reflective skills as engendering an approach to professional practice and lifelong learning. This new perspective requires all of us to reconsider the development of reflection as more than a discrete activity or collection of competencies to be acquired. Failure to engage with this challenge may compromise the development of clinical practice and possibly the longevity of professional careers.

Biography

Rebecca Khanna is a Senior Lecturer and Course Leader for the BSc (Hons) Occupational Therapy full time programme at Coventry University. For the last twenty years she has worked in a variety of clinical settings as a clinician and manager in occupational therapy services. Rebecca has a particular interest in evaluating the use of critical issues as an educational tool. She is currently researching the use of 'patchwork text' as means to support students in their reflective thinking and writing skills.

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Chapter 7

Enabling Learning through Reflective Tutorials in the Nursing Practice Setting.

Introduction

The notion of reflection and being a reflective practitioner is now a consistent theme that runs throughout diploma (Nursing and Midwifery Council (NMC) 2002), degree and master in nursing programmes. Evidence of learning through reflection, on practice, is one-way students can demonstrate achievement of theoretical and practice outcomes. Modular assignments require the students to be reflective (see appendix 7.1); sessions on reflection, which require the students to reflect on practice, are built into the taught elements of the nursing programmes. This paper focuses on my role, as a nurse lecturer, in facilitating reflective tutorials in practice placements. Several students have kindly agreed that work they have completed can be incorporated into the paper. The advantages of undertaking this role, and its challenges, will be outlined in relation to meeting the needs of the mentors and students. Writing the paper has been a reflective process in itself.

Background

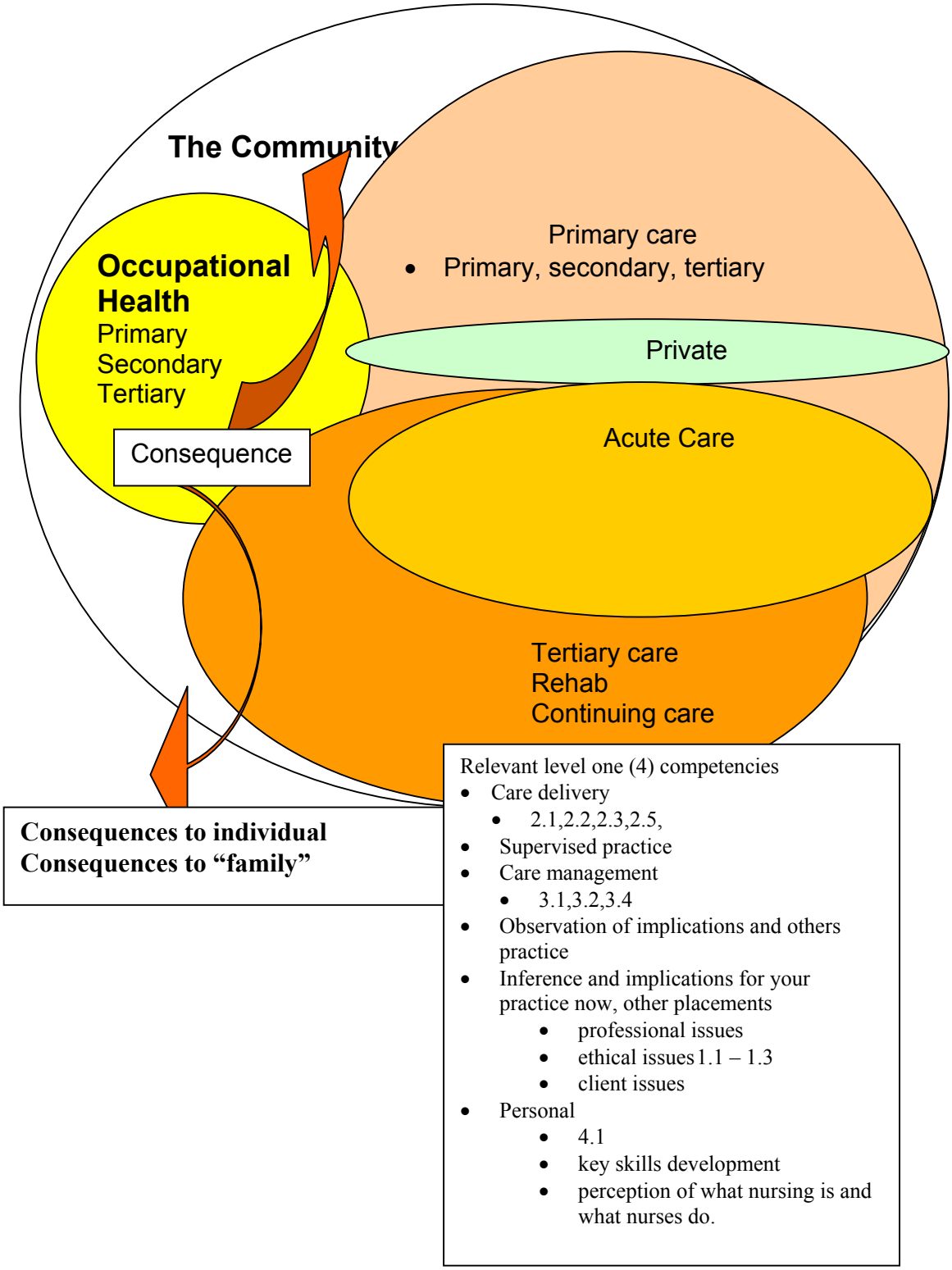
I first became interested in reflective assessment, and the processes it involves when supporting students undertaking a post-graduate diploma in education (Glen et al 1995). Since then I have focused this interest by developing reflective tutorials for pre - registration nursing students, and their mentors, as part of my role supporting a variety of practice placements. This paper draws on recent experience working with students undertaking their community placements in a wide range of health and social care settings. The students are at the beginning of their second year, just starting their adult branch component. Their placements are highly specialised settings each very different to the more general medical and surgical care settings they may be used to or expecting. As I too have only worked in acute care settings this was a new personal challenge. I wondered what I would have to offer students, and their mentors, other than being a point of contact with the school of nursing.

Making the initial link with the placements, and discussing its educational value with prospective mentors is a key factor to setting the scene for student learning in placement areas. The mentors and I have devised learning packages that translate the broad-based NMC competency framework into more specific objectives for the students to achieve in that specific placement (see appendix 7.2). I agreed to provide reflective tutorials for the mentors and the students at least twice, and preferably three times, during each student's period of placement. The purpose of these tutorials is to enable learning between mentors and students. It is a joint endeavour. The focus of the tutorials is to enable students to recognise and value their learning from practice. The vehicle for learning is the daily, lived experience of the student “at work". The process is one of sustained critical dialogue about practice events, utilising tools such as metaphors and concept mapping (Irvine 1995), as well as "testing" retention and application of factual knowledge required for safe practice (Glen et al 1995, Flanagan,

Baldwin, & Clarke 2000). The intended outcome is for students to formulate substantiated evidence of how they are achieving the practice outcomes. At the end of the placement students are expected to complete a " learning summary", connecting their practical experience and the theoretical component of the course in a meaningful way. The learning summaries then contribute to their portfolio evidence (See appendix7.3)
My role is about bridging the theory-practice gap for the students, and the mentors thus acting as an educational resource (Gibbon and Kendrik 1996). I help students to identify the relevance of "what they are doing in placement" to "what they are learning" from the community module content. For instance, this encompasses how the philosophy of community care fits to the context they are working in; what the issues are that are driving nursing and/or multidisciplinary practice in that setting (see diagram 7.1 - fitting occupational health within the context of community care) This helps students focus their assignment - a 1000 word report on why, and how, the service provides care in/to the community. Between us, the mentors and I, help the students to identify, through reflection, their strengths in practising fundamental health care skills; their needs in relation to enhancing their practical skills; and the implications, and the potential, this has for improving the experience of the client they are “nursing”. It offers the students an opportunity to see, for themselves, how well they are transferring core skills from placement to placement, and consolidating their skills, as well as identifying new learning. As the reflective tutorials are balanced where possible, by simultaneous feedback from mentors on *observed practice*, this enables the students to validate that they are achieving their practice competencies to the required level. Mentors and I often have interesting discussions on what they see students doing, and deem them competent, and what I see as competent in how much they need to know in relation to safe practice under supervision. I find myself reflecting on whether I "Am I going into too much depth, expecting too much of students", whilst the mentors are questioning whether or not they not going "into sufficient depth in explaining what they are doing and why".

Thus students begin to make meaningful connections (Chambers 1998, 1999) between their practice experience and the themes in the taught element of their programme (i.e. nursing and professional issues, promoting health, applied social sciences, applied biological sciences, communication and interpersonal skills, and ethical and legal issues). It can be deliberately focused around one aspect of nursing, or it can be multifaceted – encompassing knowledge, attitudes, affective disposition, intuition, psycho-motor skills, interpersonal and cognitive skills. It can be context specific. It can be adaptive, around strategies for managing and coping. It can focus on factors influencing clinical judgement (Swendsen Boss 1985). The intrinsic reward is a sense of knowing "where they are" and "what they have achieved" within the placement. The extrinsic reward comes from the mentors’ reinforcement of their learning, and provides students with a means of realistically assessing their performance, especially as many students will under value their achievement. It is about changing the "all I have done today is admitted a client…….. or played cards with some of the teenagers" feeling to one where the significance of these every day activities is converted to insight around the clients needs, and what is good practice. Professionally the tutorials seem to provide the mentors and myself with a tool for exploring fitness to practice, in a given context, at a given point in the students' programme, against given global outcomes.

Diagram 7.1
Fitting Occupational health within the community health context



Reflection.
No attempt has been made to précis the literature on reflection, learning from experience, or work based learning. This is well done elsewhere (Kolb 1984, Fish 1987, Boud, Keogh and Walker 1985, Gibbs 1988, Schon 1991, Glen, Clark and Nicol 1995, Johns 1995, Kitchen 1999). I continue to hold more or less the same opinion about the value of reflection as first indicated in Glen et al. This is - that reflection should focus on "converting a work experience with some learning into a learning experience about work" (p.66).

The vehicle for learning is a practice experience. The process of reflection is one of a sustained critical dialogue, between the students, the mentors and myself. It can move from a descriptive process - *this is what I did and what happened and it was ok* - to one of synthesis - *I can see now what influenced my actions, the clients actions, ... other staffs actions, ... I can understand how that might have been seen by/felt by others, I realise now that……, I can appreciate……, next time I will consider etc.* Thus the students move from a simple description of what they did to one where they start taking into account what happened before the event; at the time of the event; and subsequent to the event. Reflecting with others, who by simply offering different interpretations of the event, helps the student see the situation differently. This may influence the final perception of, and decision about the event (see appendix 7.2 and 7.3).

To supervise reflection requires a non-judgemental, but probing, approach by the facilitator (Glen et al, 1995, Schon 1991). Although non-judgmental it does not mean that it does not create discomfort for those concerned. It is an uncomfortable experience to explore practice /behaviour openly. I can see students getting uncomfortable; they shift in their chairs as they think the focus of attention is on them. This is made more difficult for students when the person facilitating their reflection (ie me) is an unknown factor. The students rarely have contact with me as a teacher in the common foundation programme (the first year of the course). On a few occasions they may have seen me during classroom, lecturing or facilitating group work before we meet in the placement. Rarely will they be my own personal students. The students, themselves, are often unused to visits from teachers (personal communication from all students). In addition, they have no expectations of why I visit them in practice. If the students are to learn, they have to feel safe to express themselves. When I start to "question" their practice, they may become defensive or "feeling inadequate and foolish" if they can't respond. The way the tutorials are handled, in an informal setting, appears to help students be more comfortable and less defensive. A recent peer review reflected that ***" It was clear from the student's responses that they felt valued and able to express their opinions at all times"(personal communication 2003)***. I must acknowledge the students bravery in offering to "have a go" at reflecting in front of their colleagues on something they have done that day. As this is also something I do in the classroom with students this could have one of two effects. It may either familiarise them with the process so its not an unknown, or it may create anxiety for the students knowing it's now their turn to be "put on the spot". It may be difficult for students to express themselves or find anything favourable to say about their own contribution to the situation, or if they are feeling bad about what happened, their perceived inability to deal with the situation (Newell 1992, Green 1997). What helps in this situation is the mentors and I freely

admitting to "not knowing" ourselves and then exploring with the students what we need to do collectively to obtain answers about practice. It means that on occasions, as so-called experts, we have to admit to getting information wrong ourselves This happened recently when I couldn't remember the mechanism for Vitamin B12 absorption and subsequently had to tell the students that I had my facts back to front.

Reflection needs structure, and assessment of progress needs criteria against which practice is explored (see diagram 7.2). As tutors there is a requirement to make tutorial notes when we see students in practice areas. These are sent to the student's personal tutors. I myself do not tend to do this. I prefer to give the students copies of notes I have made on the work we have done, and write witness statements they can show their tutors. These reflective tutorials do appear to work best with small groups of students. Large groups, and individual tutorials, seem to be more anxiety provoking for the students.

The process of instruction: simple frameworks work the best

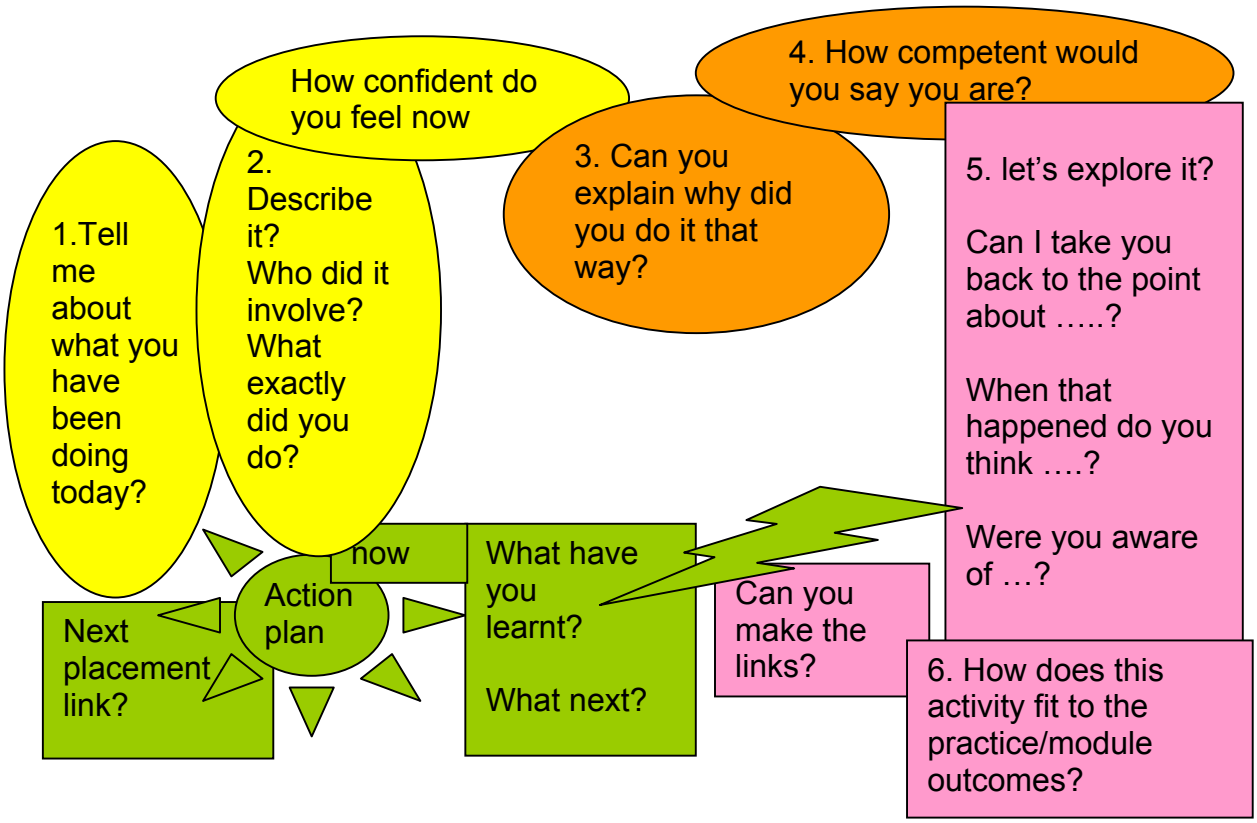
The process of recognising and identifying learning and building evidence of learning as part of practice seems new to most of the students I meet, despite the fact that they are now in their second year. Most of the students are still confused about reflection, although they have already submitted two assignments requiring some reflective activity (see appendix 7.1), and nearly all are still struggling with collating a portfolio of their learning. When I began to facilitate the reflective tutorials the mentors themselves often expressed surprise about what could be learnt from exploration of routine practice events. More importantly, they sometimes expressed concern that they had assumed levels of knowledge the students didn't have, or not explained something to students that had seemed obvious and routine to them. A good illustration of this was when we were talking about vaccination.

I had asked the students if they knew about the complications of vaccines. They knew anaphylactic shock could occur. They knew nurses giving vaccines had a "shock box" on hand when they were doing vaccinations. I asked if clients had to wait around in the clinic any length of time just in case they had a reaction? They didn't think so. "This is strange" I said "my practice nurse always tells me to wait 10 minutes." Another nurse listening in said she hadn't thought to explain this to students as clients are usually around the department for a while during the time of the vaccination so this wasn't usually an issue. The consultant nurse then added she wasn't sure it was valid anyway as anaphylactic symptoms could occur anytime in the 24 hours after a vaccination. I added then - well it's often the second dose that ???. The outstanding question for us all was; 'then what are the clients told to look out for, and to do?' So whilst the students were saying they were confident giving intra-muscular injections in the arm, using giving hepatitis "jabs", I was asking how competent were they if the injection being given is a vaccine (or an antibiotic), and who is taking responsibility for ensuring client safety and safe administration of drugs and vaccines.

The above episode also illustrates the difference in levels of competence between being able to do a task, and know what you are doing each time you do the task (Girot 1993).

The process I utilise to help the students reflect is, very simple, and won't be unfamiliar to readers. It takes students around a circuit of questions for learning (see diagram 7.2). It is directive because I am the one instigating the reflection. However, it is also facilitative in that it allows the students to wander around issues and make their own sense of their experience. The breadth and depth of learning depends on the links the students' make between practice and theory in the curriculum (appendix 7.3: learning summary 1 and 2 for how two students made sense of the same session). It requires a process of unpicking and sifting through their existing knowledge base, and their previous practical experience. A sort of patterning occurs for students, some are linear, and some are circuitous (Carr 1996). One student in fact had no problem telling me she preferred to write down her ideas in a list like format, whereas I tend to use somewhat chaotic spider diagrams and concept maps. Some students are still quite concrete in their learning (I've *done this already - I don't see the point of going over it again).* This happened with a student who had been a moving and handling trainer in her previous job, and couldn't see why she had to reflect on moving and handling issues in this placement even though she knew what to do. Some are able to take a more in depth look at what they are doing and the factors influencing it

Diagram 7.2. The frameworks for working with the students is therefore simple:



I coach the students in the process of learning from practice (Schon 1991) One student (K) described this process, from a previous occasion, as *"Alison opened our brains and broadened our thinking by asking questions and playing "devils advocate" ...we*

could add more ideas and thoughts as they arose" (personal witness statement from student). The process of critical thinking and critical dialogue is modelled for them by the discussion they see between the mentors, their own contribution, and myself to the tutorial. What is achieved is limited by the fact that we only have a maximum of three tutorial sessions over the six-week placement. The focus of the students is partly skewed by the major concern of getting their assignments out of the way. This could detract from the content of the tutorials if they are only assignment led. However, because we pick different practice experiences in each tutorial, the students can explore practice at three levels; doing a task, nurse - client interaction and situational analysis, and professional practice and policy. (See diagrams 7.3 and 7.4). The outcome of the reflective tutorials is recognition of personal learning and about becoming a professional. It can balance workplace and academic competencies for the student (Swendson Boss 1985). It helps the students see their learning in the context of the curriculum parameters they are trying to fulfil (see appendix7.3 and diagram 7.1)

Diagram 7.3 Student directed reflection:

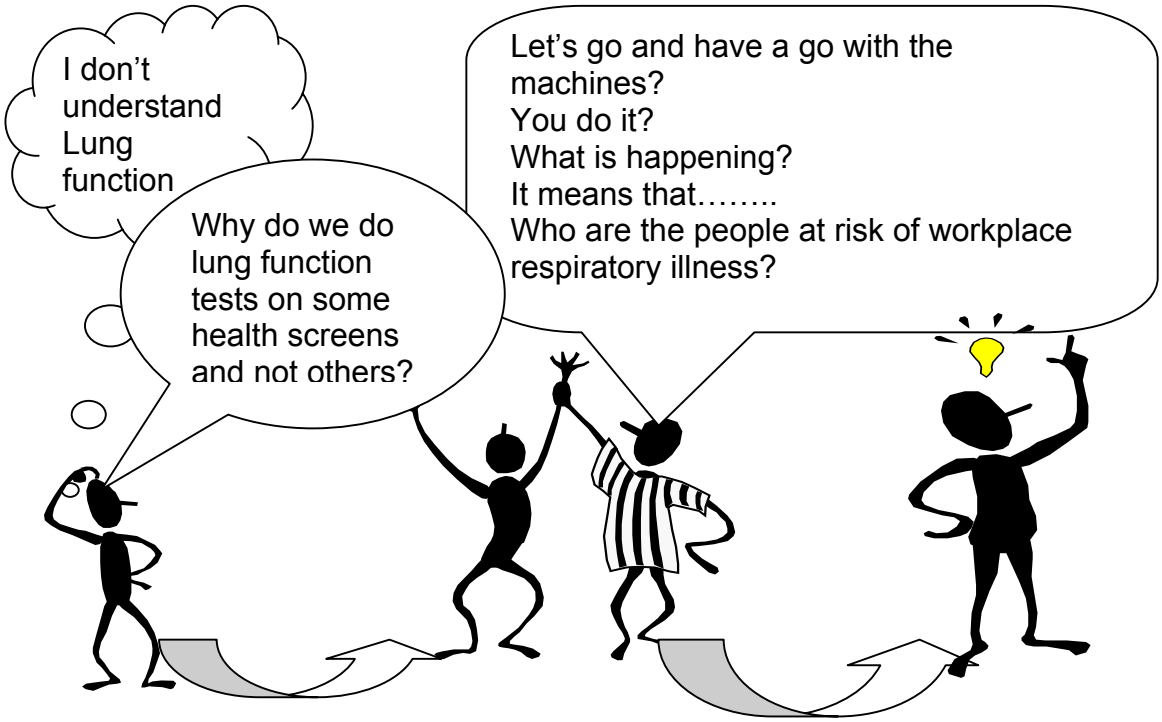
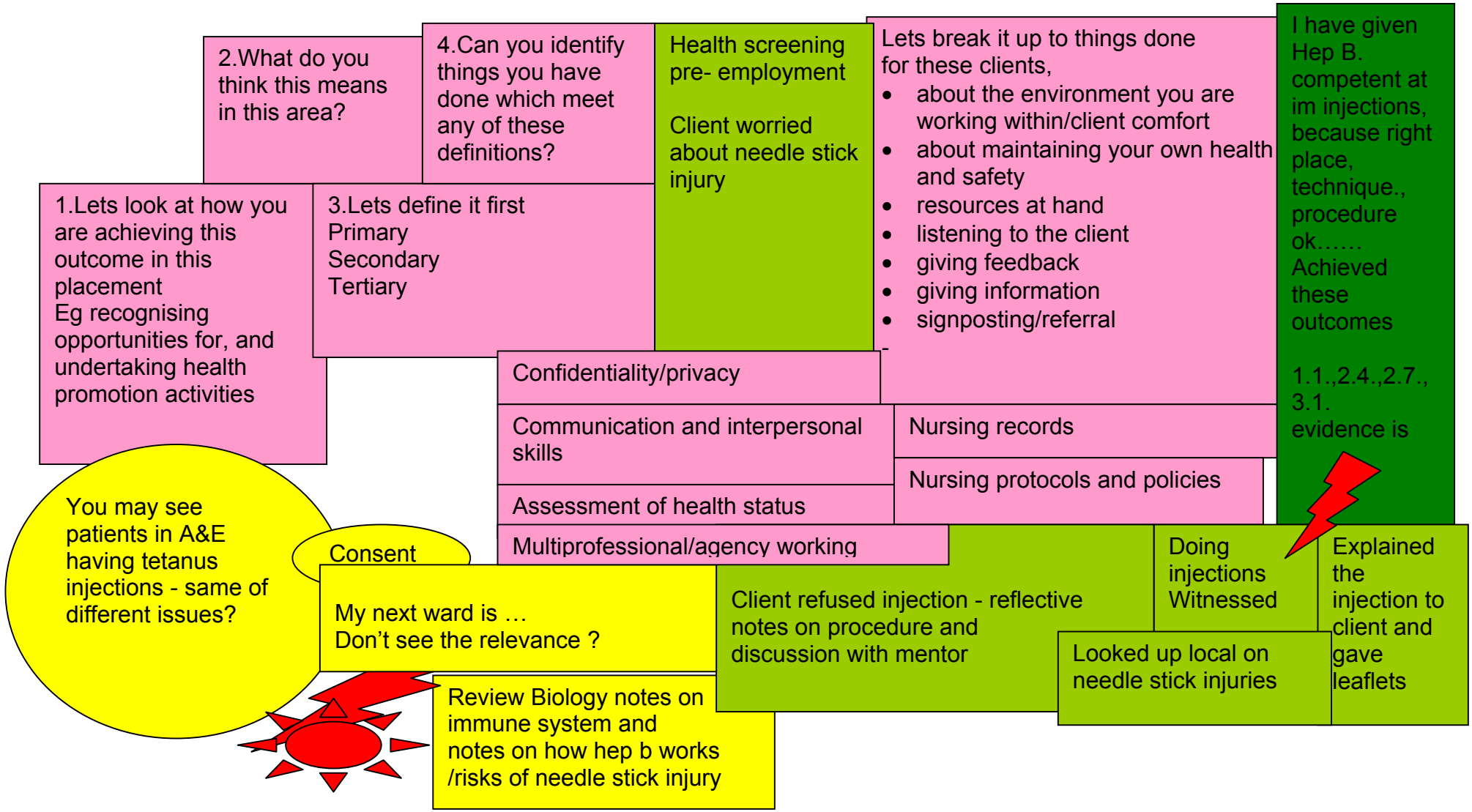


Diagram 7.4 Outcome directed: building the blocks - complex activity



Conclusion.

Reflection requires a framework, structure, process and a perceived outcome, which is of value to the student (Glen et al 1993) Reflection can cross different paradigms within practice, and be at different levels of analysis, depending on the event and the purpose of the reflection. It is a complex process to sort out in relation to assessing competence (see appendix 7.4 for "doing it" defined stages for students to assess competence on a more rule of thumb measure). It can be formative or summative. Its purpose must be known and it will have outcomes and those outcomes will have consequences at personal and professional levels. Mutual understanding of what reflection is, the processes that enable it, and the outcomes that can be expected from reflection are needed between education and practice settings. Whilst the ability to be reflective is emphasised in learning outcomes how this is reflective of their ability to practice safely is still a mute question. It was, and still is, the concern of the author that evidence supporting reflection only does so as a theoretical learning tool. It identifies students ability to discuss a situation, but not necessarily perform safely (Glen et al 1993), unless validated externally though other supporting assessment tools ie mentor feedback from observed practice or through direct observation in what are often unpredictable clinical environments (Benner 1982, Wood 1986, Glen 1993, Hardcastle 1999). Also being reflective has, as yet, to be seen to improve the health outcome for the patient or client. Nevertheless, with these cautionary notes in mind, the point of the paper is that reflective processes can enable learning from practice, and more importantly enable students to recognise the depth and breadth of their learning.

Reflection requires a structure, a process and a purpose. It is a communication process and needs to be proactive as well as reactive, witnessed, confirmed, and validated. It can be deliberately focused around one aspect of nursing, or it can be multifaceted, encompassing knowledge, attitudes, affective disposition, intuition, psycho-motor skills, interpersonal and cognitive skills, context specific, technical, interactional (Daly and Carnwell 2001), perceptual, adaptive, be around strategies for managing and coping, and focus on clinical judgment (Swendsen Boss 1985). It enables the students to identify the relationship between theory and practice and vice versa, it can offer them insight into themselves and their practice, it can enable a transfer of learning between practice experiences; it can offer a tool for problem solving, and be a means of needs assessment for future learning. For me becoming reflective is a process that involves coaching the students until they achieve mastery of their own ability to appraise their progress (Schon 1991).

Biography

I have been a nurse teacher/lecturer in 3 major teaching hospitals/trusts. My interests are now in health psychology and health promotion, with a particular interest in surviving cancer and other long term health problems. My past nursing experience has been mainly in head and neck/ear nose and throat nursing. Part of my current post as a health lecturer at Nottingham School of Nursing involves supporting students in their practice placements. This role is a crucial one, I think, in enabling educational support for mentors in order for them to provide support for students, but also in enabling students to express and substantiate what they are learning in and from practice. Reflection as a learning tool has been a specific interest for the last 15 years.

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CHAPTER 8

Reflective practice in the midwifery curriculum

"Reflective practice may be difficult, because to be critical of your own practice can be hard." (quote from student evaluation)

Introduction
The aim of this chapter is to provide an overview of reflective practice in the BSc(Hons) pre-registration midwifery curriculum at St. Martin's College incorporating methods of reflective learning within a complex, profession-based curriculum.

Our curriculum was developed from a former Diploma level programme, with Beattie's 4 fold curriculum framework, (1991), encompassing what were considered the four necessary spheres of development required by students in order for them to be able to fulfill the role of a midwife at the end of the programme. The four areas for development are new knowledge; new skills; personal development and engagement with relevant social issues.

The BSc(Hons) Midwifery Pre-registration [Shortened] Programme was developed during 1999-2000 following extensive consultation between midwifery practitioners, midwives in education, users of maternity services and management representatives from both NHS Trusts in the area, and the college itself.[1] The students who are recruited to the programme are registered adult branch nurses, some with several years experience as qualified nurses, and many having personally experienced midwifery care. The key educational approaches within our programme aim to make full use of students' experiences as a basis for learning. This can then facilitate the integration of theory and practice and foster lifelong learning skills, in keeping with policy recommendations, for example D.F.E.E. (1997) and E.N.B. (1997), as well as findings from educational research (Stuart 1997, Cheetham and Chivers 1999, Pryce 2002). As part of the application and selection process for this programme, it is required that applicants submit a reflective essay with their application, to demonstrate that they already have some skills of reflection from practice experiences. As the programme has evolved, its development has been very much influenced by ongoing evaluations from students, midwife teachers and midwifery practice mentors, and through discussion at curriculum development meetings.

As a concept, reflective practice has become more popular in midwifery education and in other areas of higher education in the past decade or so. This has enabled us, the midwife teachers, to use relevant literature as well as experience to inform our own learning and teaching strategies and methods for undergraduate midwifery. Reflection is being increasingly viewed as a valuable learning method for qualified and experienced midwives too, throughout their continuing professional development programmes and activities, and through supervision (Price 1998; Jackson 2002; Pryce 2002; Hansom and Butler 2003). At the very least, contemporary midwives are encouraged through the professional literature to maintain a reflective journal or diary of their midwifery practice. Furthermore, in recent years it has become necessary for midwives to maintain

[1] It should be noted here that St Martin's College and its partnership Trusts serve a very diverse geographical area, from Lancaster in the south, up to Penrith and Carlisle in the north, and Barrow in Furness and Whitehaven in the west. Consequently, our maintenance of link roles, and communication, is particularly important when compared with more centrally located 'schools'

a reflective professional development portfolio in order to be able to remain on the professional register, and therefore able to continue in professional practice (UKCC 1995).[2]However, what reflection actually is, and how it can be used for learning, is not always clear. Since the idea of experiential learning began to be discussed early in the 20th century, myriad interpretations and definitions of reflection have emerged. The concept as a learning method has largely been embraced in recent times within the midwifery profession (Stuart 1997, 1998; Price 1998; Miller 1999) as well as in other professions, for example nursing and teaching (Atkinson and Claxton 2000). It has been suggested by Stuart (1998) that by using critical reflection, "midwives can show that their clinical expertise is the crucial element that separates evidence based medicine…..and the mindless application of rules and guidelines." (p.644).

Reflection has often been viewed as synonymous with critical thinking, as indeed it is implied in the student quote at the beginning of this chapter, and is sometimes described as 'critical reflection' (Price 1998). It is important to note, however, that reflective practice as a learning method has also been subject to criticism in professional education. For example it is suggested by several authors that during the process of reflection, though ensuring that the professional becomes more aware of her feelings about incidents, the client focus may be neglected in favour of a focus on 'self'. There may also be bias in the memory of incidents (Reece-Jones, 1995; Kirkham, 1997). It therefore seems necessary to acknowledge the limitations reflective practice may have as a learning/teaching approach, whilst optimising its benefits.

How we use reflective practice in the BSc(Hons) Pre-registration Midwifery [shortened] curriculum.

The programme consists of 6 modules, each of which has 2 sets of specific learning outcomes to be achieved during the time the module is undertaken (see Appendix 8.1. for the outcomes of module MID 221 as an example). The assessment strategy, which will be discussed later, broadly consists of weighting of practice 50% and theory 50%. (see appendix 8.2.). The mentored practice contributes to the assessment of 'A' outcomes. The reflections undertaken and recorded by students contribute towards the assessment of theory/practice integration, and therefore the 'A' and 'B' outcomes. Because the programme carries both professional and academic awards, it is deemed appropriate that students are assessed not only on what they are able to do, but also on the knowledge, skills, attitudes and understanding that inform, and are informed by, what they do in midwifery practice.

The students are given a 'guide' document before they commence the course, in which information about course structure, assessment, time-tabling, module outlines and other guidance are detailed. In addition, the guide contains information about the learning and teaching strategy of the programme, our rationale for it, and further information on how to maintain a reflective portfolio during the programme, including brief guidelines on reflective practice itself. The portfolio consists of three parts. At the outset of the programme, Part one consists of details about each module's outcomes and relates to the assessment of practice. It also contains practice assessment documents. The student will collect evidence during each module that relates to the practice outcomes, for example undertaking aspects of midwifery care and being observed by their mentor and another midwife. The midwives need to agree and sign that each 'A' outcome has been achieved. The student may include, as evidence, cross-referencing to reflections from during the module placement experience and/or to statutory practice achievements in part three of the portfolio. This part of the assessment

[2] UKCC as regulatory body not in existence since 2002. The Nursing and Midwifery Council has taken this role, details can be viewed at www.nmc.org.uk

of practice contributes 25% of marks to the overall mark of the module. Part two of the portfolio, at the outset of the programme, is empty and is to be used by the student to store their written reflections from practice and other experience, as evidence towards the practice 'A' and integrated 'B' learning outcomes. These reflections need to be cross-referenced to the outcomes in some way in order to be sure that there is clear evidence of learning towards each outcome. In addition, each class-based session will be able to be cross-referenced to module learning outcomes. During the reflective process for each 'incident' or topic from practice, students are encouraged to collect additional sources, for example articles of relevance, and of course documented further reflection, thus completing the 'cycle of reflection that occurs in so many models.

"Reflection does help you to learn because you can go away and think about the incident and how things might have been done differently or better. If you come across something in practice you don't understand you can find out using the library, or the internet then add it into your portfolio as a reflection on learning." (student midwife)

Although formal taught sessions on reflective practice are not time-tabled, students are continually discussing their own methods and processes of reflection, with their midwife mentors, and especially with their link midwifery tutors whom they have regular meetings with for that purpose. During class-based teaching, active use is made of student reflections in many sessions, thus encouraging peer learning and support. However, it may be that some students need more structured guidance from the beginning, on reflective practice and its benefits for learning and improving practice, as suggested by this student,

"It is an ongoing process, my reflections are becoming easier, no longer need to consult frameworks – have developed my own way. More guidance initially on the process may help, especially for those who haven't done it before eg examples from others' portfolio with their permission." (student midwife)

The third part of the portfolio at the outset of the programme is empty, and is used for recording by the student, and subsequent verification by their practice mentors, their evidence of achievement of statutory professional requirements, for example numbers of births attended and numbers of postnatal examinations of women. The portfolio as a whole must be available for midwife teachers and external examiners to view from time to time, the exception being any sections of Part Two that the student wishes to keep private. To this end, we ask that students maintain their portfolio in organised sections, where individual pieces can be removed as required. As the course progresses, the large volume of work produced in the portfolio has meant that students have sometimes kept the three parts in separate folders for their convenience, though all three parts relate closely to one another and are cross-referenced. It is our experience as midwife teachers that students often have very diverse ways of maintaining and using their reflective portfolios, and indeed using and documenting their reflective processes. As with all other areas of learning and teaching, some students find using reflections from experience valuable from the beginning, and some need guidance to enable them to make good use of their practice experiences to learn. For example,

"I didn't enjoy 'reflection' learning at the start of the course because I hadn't used it before. There are no guidelines on how to use it or do it 'properly'. Another problem I find is motivating myself to do it sometimes. Never short of things to reflect on or learn about and quite enjoy using it now." (student midwife)

Reflections from experience

In this programme, although reflection forms a central part of the learning and teaching strategy, in the light of multiple models of 'reflection' in the literature, we do not wish to prescribe the way that reflections are carried out by students. However, some students will have already had experience of using reflective practice in their nursing practice, and some may not. To this end, we provide some initial guidance on portfolio compilation in the guide document. Some of this guidance is as follows:

"You should briefly describe the experience – what was done or found. Look through your description and try to find words or phrases that require further exploration: your link teacher will help you with this exploration at first. Then carry out the exploration and include sources of evidence. The rationale for what was done or found needs to be given, along with sources of evidence. Where there is controversy about what was done or found, provide the rationale and sources of evidence for both sides of the argument."

In the student guide, we also make explicit that though it is acknowledged that the group all have diverse educational and life experiences that can be effectively used for learning, there is also a need for flexibility where practice and the curriculum meet. It is not possible to control the issues that will emerge from practice experience in order to make sure that they will be relevant to each module's outcomes and content. Learning relevant to other modules is bound to occur in unpredictable practice settings, and this can be documented in the portfolio by students, perhaps to be explored again later in the course, or brought to classroom-based sessions for further discussion in the peer group.

Reflective portfolio assessment

As already stated, by using the reflective Part Two of the portfolio the student is able to provide evidence of learning toward their practice assessment. This is carried out as a series of two *formative* tripartite interviews, and a final *summative* tripartite interview between student, midwife mentor and midwife teacher (link tutor). The practice-based mentor midwives all must have undertaken a teaching course, and have attended a 2 day preparation course for this programme. They attend annual updates and are thus able to remain on a mentor register. This ensures that the students will have well prepared mentors and will be well supported in practice. Their evaluations, and those of midwife mentors, confirm the value of preparation. The employing Trusts of the midwives contribute to the success of this innovative assessment of practice by encouraging midwives to attend preparation, and to maintain their mentorship skills.

The second part of the portfolio is also used to assess the student's ability to integrate theory and practice via the use of an outcome-based seminar presentation towards the end of each module (see Appendix 8.3. assessment criteria for seminar presentations). Each student is sent one 'B' outcome to focus upon, *one week* before the presentation date. The purpose of the course leader waiting until so near to the assessment date, is to ensure that the students do not focus their reflective learning activities around a limited field of module content during their practice placement. Some students may be tempted to do this anyway, as suggested by this student,

"Using reflective practice can be very useful for identifying gaps in knowledge and ethical dilemmas or situations that need further thought. There is though the temptation to reflect on demand, I know I have to reflect on something, anything! – rather than wait until I come across something worth reflecting on." (student midwife)

In addition, because each student is normally presenting a different outcome, the whole group benefits from the assessment session itself - it is a valuable group learning opportunity. In the seminar presentation each student is required, using *at least* one reflection from experience, to fulfil the assessment criteria (see Appendix 8.3). The assessment is conducted with the group as audience/participants, and two midwife teachers to assess. An external examiner is present at least once during the programme. The seminar presentation assessment contributes 25% of marks to the overall module assessment. The remaining 50% of marks towards the overall module mark is undertaken with a written essay assignment.

Lessons we have learnt, or, 4 years on!

In this section I intend to discuss some of the strengths and potential areas for improvement that have emerged with reflective practice in our curriculum as it has been implemented and used for 4 cohorts of students. During the past four years, each module has been evaluated by students using a modified nominal group technique whereby students themselves agree on a number of issues and then cast votes according to how important it is for them (Wells 1987). Reflective practice itself is rarely brought up in the evaluations as a major problematic issue, though the time required to undertake documented reflection, and it's usefulness as a learning method, is frequently discussed at evaluation times. For example,

"I feel reflection on practice is always helpful and it makes me query in my own mind how I acted in a certain situation and whether or not I would do anything differently next time. However, I feel the reflective portfolio adds pressure when the time needs to be used for essays and presentations." (student midwife)

Some students develop their portfolios even further than required in order to make full personal use of the process, and intend to continue beyond the programme into their professional career, for example,

"Reflective practice has helped with my learning and development because it is personal to me. I use reflection as a way of changing my practice through analysis or building on my practice if I do something well."

As a team, we have always given written responses to the students following their module evaluations. In addition, practice-based mentor midwives are given information about the evaluations, and are given the opportunity to, firstly, update annually amongst other mentors at 'away-day' events, and secondly contribute to curriculum development directly by attending curriculum development meetings that are ongoing. Each practice learning environment is subject to an annual audit, between practice-based midwives, and link tutors. Mentor midwives and students have opportunities at the end of each placement to contribute written evaluations of the learning environment, including possible learning opportunities that are/were available, and link tutor support. During the past four years, two of the six members of the midwifery teaching team, myself included, have themselves undertaken programmes of education using reflective practice as a learning and assessment method. The following comments about using reflection to learn were given to me recently by my teaching colleague;

"it was extremely time consuming, it always took more time than I had allocated. The most difficult aspect of the whole process was the integration of reflection and module/course outcomes. As lecturers I don't think we should underestimate the enormity of the task when we ask students to undertake reflection."

I agree with her comments, and would emphasise that at the outset of the programme, students are encouraged to plan their time to ensure there is enough available for reflections to be fully 'worked upon'. There is time 'built in' to their working week whilst on placement in order that this can be undertaken, and as already stated, the link tutor visits students in practice areas regularly for outcome-based-reflection discussions. These discussions are in addition to, not part of, the tripartite practice assessment process and offer the student further opportunities to address difficult issues that they have reflected upon, for example,

"Reflective practice is a good way of looking back and seeing if there are any issues which need to be addressed, good or bad. It can also be a way of venting your anger at a bad experience" (student midwife – other students have also mentioned 'venting anger' in their evaluations of using reflective practice)

It is important that we acknowledge that the programme is complex and that some students will need more support than others to develop both the skills needed for effective reflection *and* for the documenting of experiences. One of the most prominent findings from evaluations overall in the past 4 years has been that reflection has mostly been viewed as an effective learning method by students and by teaching staff and midwife mentors, though that is clearly not the whole story!

My teaching colleagues have recently given me their personal evaluation of supporting students' learning via the reflective portfolio, and some interesting issues have emerged, although as we conduct ongoing evaluation and dialogue, some issues are less than surprising. One of the major issues that occurs with each cohort, is the difficulty for students of observing such widely differing midwifery practices, and relating those practices to theory – the so-called theory/practice gap (Kirkham 1997). An interesting aspect for us as midwife teachers on the programme, as mentioned earlier, is the range of abilities in relation to reflective practice that students demonstrate in their reflective portfolios and indeed in their assessed presentations. It is clear that some at the outset have well-developed critical thinking and reflection skills, and others take time to develop these. Likewise, some students seem to require quite directive guidance on reflection whilst others prefer to devise their own most effective methods. The students who seem better able to undertake reflective practice also seem more likely through their reflections to challenge contemporary midwifery (and medical!) practice, which may be difficult and frustrating for the students if they see 'bad' or 'non-evidence-based' practices continue. In addition, although they may be forthright with their challenges about practice during class-based sessions, and confident in their findings following reflection, it is sometimes more difficult for them to share their reflections with midwife colleagues if the issues examined are controversial or challenging. My colleagues and I agree that as a learning method, reflective practice has merit, and clearly most of the students are, or become, well motivated to use reflection as a learning tool. However, as one colleague has pointed out, **"Some want to investigate each issue so thoroughly and can get stuck with one reflection, gathering enough material for a dissertation sometimes!"**

Conclusion

The midwifery curriculum upon which this chapter was based is due for revalidation in 2005, and so we are already considering what changes need to be made to develop it into a more effective programme for professional graduate midwifery. At this stage it seems likely that reflective practice in some form will be a part of the new curriculum, and we will continue to evaluate its effectiveness throughout subsequent cohorts on the present programme. It does appear that for the most part reflection is effective in helping students learn, using their experiences from midwifery practice, both their own and others'. A further issue for us as a team is that we have also been using

reflective practice in the 'Return to Midwifery' curriculum for the past two years, and although numbers of returning midwives are small, they are increasing. It appears that evaluation of reflection as a learning approach for them so far is also good. I would therefore be very grateful for ideas or suggestions for reflective practice in any midwifery curricula from colleagues in other institutions, and will reply to any correspondence I receive about this.

Biography

Annie Powell-James has been a midwife for 21 years and has developed a strong interest in reflection and reflexivity since studying feminist research in the 1990s, gaining a BSc(Hons) First Class in 'Applied Social Science and Independent Studies', and an MA in 'Society, Science and Nature' from Lancaster University. She has been in her present post as midwifery lecturer for 5 years and has many interests related to health professional's education. She completed the CiLTHE course in 2002 by which time her interest in reflective practice had increased through the teaching of reflective practice in the undergraduate Midwifery programme, and through her study of the literature on learning, teaching and reflection. As well as this, she has developed ideas about reflection in day-to-day life that she believes contributes to her personal development and her parenting role. Indeed she uses these ideas for her major pieces of work for the CiLTHE assessment, looking at reflection and identity. She aims to continue developing reflective practice within her role as health professional educator.

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CHAPTER 9

Reflection in Mental Health Nursing

Context of Reflection in the Mental Health Nursing Curriculum

The current education agenda in relation to health care professionals working in mental health settings is driven by the need to produce clinicians able to practice effectively within the Government's modernising agenda for health care delivery. The National Service Framework for Mental Health (Department of Health (DOH), 1999) outlines the services required to meet the care needs of adults with mental health problems between the ages of 18 and 65 years. To ensure that a workforce is created to implement these initiatives and provide effective care a 'Framework of Capabilities' – the skills, knowledge and attitudes required by mental health practitioners – has been proposed to promote best practice and guide curriculum development. Here the term 'capability' is defined as having 5 dimensions relating to performance, ethics, evidence-based practice, lifelong learning and reflective practice stating that "the capability framework combines the notions of effective practitioner with that of the reflective practitioner" (Sainsbury Centre for Mental Health, 2001, p2).

The current emphasis on clinical effectiveness and evidence-based practice within health policy (DOH 1997) has also promoted the use of reflective approaches in practice settings (McSherry and Haddock, 1997; Cranston, 2002) and hence its inclusion in pre-registration education. Evidence-based practice is viewed as not only encompassing the use of appropriate research and literature but also critical reflection on activities and thus is a prerequisite to mental health nursing practice.

Reflective practice has been a central tenet of mental health nurse education for the last two decades. Education strategies promoting critical reflective thinking became a requisite part of the curriculum with 'Project 2000', a radical overhaul of nurse education intended to produce a new generation of nurses (United Kingdom Central Council (UKCC) 1986). Prior to this initiative pre-registration nurse education was of an apprenticeship type with student nurses forming part of the workforce. Following registration to practice, few education programmes were available for nurses and generally though unnecessary. Project 2000 set out to provide nurses with a broader and deeper knowledge in relation to both pre-registration programmes and Continuing Professional Development. These changes were driven by a variety of issues not least of which was the rapidly changing face of health care which required the creation of nurse practitioners able to gather, analyse, synthesise and evaluate information. Whereas previously students of nursing were viewed as vessels to be filled with knowledge which would sustaining practice throughout their career, now there was a need to teach nurses how the learn, to imbue them with a life long learning ethos. The intention was to provide a 'knowledgeable doer' a self-directed, autonomous practitioner "with the tools to evaluate their own practice" (UKCC, 1986, p20). Thus reflective practice became a fundamental aspect of nurse education. Recent changes in the nurse education provision (DOH, 1999; UKCC 1999) have further emphasised the drive towards reflective practice. Identifying the aspects essential to the education of nurses for practice the UKCC (2001, p7) highlight the centrality of "reflective capabilities…to complex professional practice".

As various commentators claim, (Burrows, 1995; Durgahee, 1996; Heath, 1998b; Heath and Freshwater 2000), reflection is at the very heart of professional practice. Nurses as a profession are expected to engage in reflective activity and provide reflective accounts of their practice as part of the evidence required for registration as qualified nurses and for continuance on the nursing

register. Thus within mental health nursing the impetus to produce autonomous, reflective practitioners is at the forefront of the minds of those involved in health policy and nurse education initiatives

How we do it

I intend to discuss the development of mental health nurse's reflective practice within a new curriculum launched in September 2000. This is a three year Diploma in Higher Education course preparing nurses for registration, which in many ways is fundamentally different from previous curricula. The School of Nursing is based on five geographical sites, having two intakes a year with a total of approximately 1000 students per year. Of these 170 are mental health students who are placed for clinical experiences across the five sites, but whose mental health specific content is delivered in only two of the five education centres. Whilst I have an overview of activities in all centres, my own experience relates specifically to one of these.

The first year of the course is known as 'Common Foundation' with students spending half their time in the classroom and half in clinical practice. All students irrespective of their chosen branch of nursing share 'common' theoretical input, however a larger proportion of their clinical experience is in their own branch area - here mental health - with shorter 'insight' placements in the other areas of nursing (adult, learning disabilities and child). The second and third years are again half theory, half practice, however all practice is in mental health settings, some theoretical modules are 'shared' with nurse from other branches, others are specific to mental health.

Critical reflective thinking is a theme that runs through the whole curriculum utilising enquiry-based learning, portfolio and practice based learning approaches to develop reflective abilities. Students are introduced to the concept of reflection and reflective models in the first two weeks of the programme in what is known as 'Foundation Studies' where issues such as study skills, working in groups and key skills are also addressed.

Enquiry-based learning

Recent guidance on the development of nurse education (UKCC, 1999) advocated the use of problem/enquiry-based learning (P/EBL) within curricula. Superficial learning strategies found in traditional curricula based on knowledge acquisition positioned students as passive receivers of knowledge preventing engagement with knowledge that is viewed as essential to nursing practice. Strategies such as P/EBL have been adopted to facilitate deep learning, internalisation of the knowledge bases, and the development of new and critical ways of thinking about practice (reflexivity). EBL is proposed to place more emphasis on reflection and critical appraisal of the learning process than PBL and it is the former that we adopted.

Some nursing education institutions have developed curricula that are entirely P/EBL orientated. However we decide only to deliver certain modules using EBL. The practicalities of delivering a new curriculum based on methods that few teachers had experienced and in a School of this size, we thought too difficult. It was felt that as the curriculum progressed and gathered momentum, the skills and expertise required by the teaching staff would develop. A 'Nursing Enquiry' and two 'Evidence-based Practice' modules (delivered consecutively in the first eighteen months of the course), one of the shared module in year two and another in year three are delivered using EBL to all nursing students. Thus there is an EBL module in each semester of each year of the course.

The final mental health specific module, that commences six months before completion of the course is also EBL in approach. Here the intention is to prepare students for their role as qualified nurses encouraging evidence based practice, critical reflective thinking and problem-solving skills.

Having experienced EBL modules previously within the Common Foundation and the shared modules, students are well used to this format and have raised no concerns about learning in this way. The students are in the classroom for four weeks prior to going into practice. At the beginning of the first week a clinically orientated trigger is introduced. Students work in small groups (8-10 individuals) with a facilitator. Additional information is provided at the beginning of the second week and further issues are raised at the beginning of the third. Students are expected to draw on their own experiences in practice, identify what they already know and what they need to know to address the issues under discussion. Students seek out the additional knowledge bases, bring it back to the group for further discussion, consideration of the impact of the learning on their future practice and identification of further learning activities. In the forth week each group presents their discussions and findings to the other students in their cohort. Resource session and facilitated group sessions are also available throughout the time period.

Portfolios

Portfolios are a fundamental part of the curriculum allowing the student to demonstrate individual and professional development in a variety of ways. The portfolio is introduced at the beginning of the course and discussed regularly with personal tutors (each student is allocated to a tutor who has a background in mental health). The student is encourage to collect evidence of activities in both theoretical modules (e.g. formal assignment feedback, presentation resources) and practice (e.g. witness statements from clients, carer and colleagues); to produce reflective work giving insight into their personal and professional growth in relation to specific aspects of learning and practice; and to develop action plans through the use of SWOT analyses in relation to practice and academic goals. The portfolio requires students to reflect on their experiences throughout the programme encouraging the use of a reflective learning log. It is hoped this approach highlights for students the integral nature of reflection to professional practice and education. The portfolio itself, however, is not assessed which has implication for students' motivation to develop and maintain the document. To overcome this the portfolio is promote as a method of generating much of the material required as evidence for assessed components of the course such as module assignments and evidence of achievement of practice competencies.

Students are expect to achieve a number of practice competencies identified by the UKCC (2000), satisfying an identified clinical mentor of their ability to practice to the appropriate standard. Students are provided with an assessment of practice document that forms part of the portfolio and requires them to identify an action plan and person learning objectives for each period of clinical experience. The student and mentor discuss and document these at the beginning, middle and end of each placement. Within the practice record, the competencies to be achieved are identified, each one being expanded upon using positive and negative indicators, thus providing a guide as to what demonstrates achievement/non-achievement of competency. For each competency students must indicate, and at meetings with their mentor present/discuss, the evidence to support achievement. A range of evidence is expected and includes both direct observations by mentors, critical reflection on own performance and an expectation that students will share appropriate portfolio evidence with the mentor. One positive indicator in relation to the achievement of competencies concerning 'professional development…needed for safe and effective nursing practice' (UKCC, 2000) in semester 3 is the development of a portfolio with the student required to 'demonstrate the ability to reflect constructively'. By semester 6 it is expected that the student 'critically analyses and reflects upon own strengths and areas for improvement'.

Many theoretical modules are assessed through the use of portfolio exercises where evidence relating to specific activities is drawn upon. For example after the first 6 weeks of the programme students enter the clinical environment working with people in a mental setting. They are asked to

undertake a portfolio activity in which they reflect on an incident, interaction or experience using a reflective framework of their choice. The student is directed to focus on professional, legal or ethical issues associated with the incident and present this as the assessment for the 'Nursing Enquiry' module (see appendix 9.1 for assignment guidelines, appendix 9.2 for extracts from a student's assessment). A similar exercise forms the basis of an assignment in a year three mental health specific module (see appendix 9.3 for assessment guidelines; appendix 9.4 extract from student's work). In the final mental health module, students are asked to select a critical incident and analyse this in light of care management needs, professional responsibilities and current health policy, indicating their own learning and implications for future practice as a qualified nurse (see appendix 9.5 for assignment guidelines).

Practice-based learning

Also embedded in the programme is a theme of 'Practice-based learning'. Here students are encouraged to make links between theory and practice initially through specific 'teacher-led' sessions aimed at skill acquisition prior to clinical experiences; exploration of student experiences during practice (students return for study days during practice periods) and consolidation in the form of critical incident analysis following each clinical placement. As the student progresses through the course student initiated learning activities in the clinical environment become more common. To support such activities 'practice learning teams' have been developed to support groups of practice learning area. The 'teams' consist of representatives from the clinical environment; students and lecturers with the aim of developing learning packages to support practice based learning and the achievement of practice competencies. These activities are 'logged' and form part of the portfolio and record of achievement.

Lessons Learnt

The curriculum describe above has not yet run its full 3 year course and as such it is difficult to evaluate. However students are asked to evaluate both individual modules and practice experiences, which gives a flavour of how things are developing. When EBL was first initiated, students were critical of the triggers used and the facilitation of sessions but as resources were refined and teachers became more confident in this approach such modules have been well received. The issue of teacher time to facilitate sessions is a problem. Facilitating small groups in large cohorts of students is resource hungry and issues relating to staff development continue to be a concern.

Whilst P/EBL is well used in medical education these approaches are relative new in the nursing arena and the efficacy of these in instilling such characteristic as reflective practice in nursing students has yet to be fully evaluated. For some students this style of learning is either found to be too difficult or is intensely disliked and perhaps this is a justification for not moving to a curriculum entirely based on EBL. A mixed approach such as adopted here gives students time to gradually assimilate the skills required for a 'non-preferred' learning style. Never the less, for some students I am left feeling that EBL will never meet their learning needs whereas for other it opens the door to understanding and critical reflective thinking. The knowledge and information generated and the insights gained by the senior students and their teachers is truly phenomenal and as a participant in the EBL process I continue to be amazed by the breadth and depth of learning and reflective ability.

Our EBL resources still require 'fine tuning'. Student evaluation of the scenarios of the final mental health module identified that whilst this facilitated learning and encouraged reflection on practice, there is scope for making this more 'true' to life. The students suggest a need to provide information such as outcomes of risk assessments or impact of interventions at specific points of the activity. I intended to look for ways of developing such resources. However, having observed their assessment presentations I am impressed by the critical reflective skills demonstrated.

Portfolio work is advancing but there is a need for further developmental work with both students and teachers to ensure best use is made of them. The centrality of the portfolio to students learning experiences and the need for ongoing input is new to teachers and as such there is wide variation in portfolio formation, quality and student support from person tutors. Whilst the form of a portfolio is generally highly personal and therefore variable, the potential to facilitate the student learning experiences needs to equally valued by both students and teachers to ensure a 'quality' portfolio is generated. There is a general feeling that for some portfolios are seen as an 'extra', rather than an essential, with other activities and issues taking precedence when time – for students and teachers - is at a premium. There is a need to integrate the portfolio fully into all aspects of the student and teacher activity. Recent discussions have identified that as the assessment strategy for the course has been refined the ethos of the portfolio informing all assessments has become less apparent and there is a need to re-enforce this within assignment guidelines. Also whilst reflective elements are made explicit within many assignment guidelines this is not echoed in the generic marking criteria used for all assignments. It is envisaged that this will be addressed in the near future.

Facilitating effective practice-based learning requires further attention. The teacher-led sessions evaluate well with students feeling confident in their learning. However when it becomes more student-focused, students express concerns about what is required and how to achieve this. Positive evaluation is linked very closely to the practice placement experience and the practice learning team members. In some areas the practice learning teams function well and are highly motivated to develop packages for learning and facilitating reflective activities but in others development is ad hoc. There is huge capacity to use case review meetings, handovers and clinical discussion in a more focused way to develop reflective ability but again this requires time and resources.

Conclusion

Jarvis in 1992 suggested that in some ways reflective practice can be seen as a 'band wagon' on which various professions 'jumped' in seeking a rationale for their practice. To some extent nurse education can be viewed in this light. Reflection has been central to nurse education initiatives since Project 2000 but the effectiveness of reflection in facilitating improvements in the knowledge and practice of nursing has been questioned by some, yet placed at the heart of professional practice by others. However if mental health nursing is to meet the challenges and demands facing it and ensure that people with mental health issues receive the care they not only need but also so richly deserve the development of reflective practitioners is essential. The approaches identified above go some way towards encouraging the adoption of reflective approaches in daily practice and producing nurses fit for practice in 21st century. However these need to be taken further and fully evaluated to identify their efficacy.

Biography

Janet Barker is a Senior Health Lecturer responsible for curriculum development in relation to mental health programmes in the School of Nursing, University of Nottingham. Her doctoral thesis offers a post-modern interpretation of the nature of mental health nurses' knowledge, considering the power relations evident in the development and use of such knowledge. Janet's current interests lay in the use of Enquiry-based learning approaches within curricula and the development of critical reflective thinking within mental health practitioners.

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CHAPTER 10

Reflection in the Dietetic Curriculum

Introduction

Dietitians apply the science of nutrition to support the well being of individuals and groups in health and disease. Like other healthcare professionals we often find ourselves making decisions that cannot be predicted by simple "if-then" pathways and procedures. Critical reflective thinking is essential for making sense of the complexities of dietetic practice. The current curriculum guidelines for our profession (Dietitians' Board 2000) acknowledge this stating that students must be able to:

"Summarise what is meant by reflection on action and reflection in action and demonstrate each." (Dietitians Board 2000, appendix IV.)

Despite this there has been no published research regarding reflective practice in UK dietetics and a literature search using MEDLINE, EMBASE, CINAHL, the British Education Index and ERIC revealed only one published opinion piece about reflective practice in UK dietetics (Burton 2000).

What I will present in this chapter is my personal experiences of helping student dietitians develop their reflective skills in the context of their pre-registration practice placements.

How do we do it?

The inclusion of reflective competence in the new curriculum guidelines and practice placement learning outcomes (Dietitians' Board 2000) has highlighted a need for support materials for students and supervisors. To address this need I obtained a grant from the British Dietetic Association's Education Trustees to develop a self-guided learning pack . The aim of this project was to help student dietitians and their supervisors develop their reflective skills.

This pack (Fade 2003) has now been distributed to all dietetic practice placements in the UK and to all Universities offering degrees leading to State Registration in dietetics. An evaluation is being carried out but there is no data available to date. In this section I seek to present some of the learning activities included in the pack in order to illustrate how the development of reflective skills is currently being supported in dietetics.

Inter-professional collaboration

In developing the pack I was acutely aware that many other healthcare professions have a much longer history of using reflective practice and the advantages of a well-developed research literature and academic discourse on the subject. Dietitians and student dietitians have many questions about the theoretical work underpinning reflective practice and the practical difficulties associated with implementing it. The research literature although of varying quality is vast and I was keen to encourage dietitians to discuss reflective practice with colleagues from other professions who have contributed to the research effort and debate about reflection. For this reason users are encouraged to set up facilitated discussion groups to brainstorm the uses of reflection, the barriers to effective reflection and what could be done to overcome these barriers. It is recommended that an experienced reflective practitioner should facilitate these groups and users are encouraged to work with colleagues from other professions such as nursing, occupational therapy and psychology to achieve this where necessary.

The use of models

Van Manen (1977), Fish, Twinn and Purr (1991) and Durgahee (1996) have all described conceptual models that incorporate different levels of reflection. These are summarised in table 10.1. In my experience dietitians and student dietitians often struggle to move beyond the descriptive level (Fade 2003).

Table 10.1 Conceptual models of reflection.

Van Manen (1977)	Fish, Twin and Purr (1991)	Durgahee (1996)
Technical reflection - relates to a straightforward evaluation of performance against objectives.	Factual strand - descriptive and procedural.	Macro - involves accurate recall of an incident.
Practical reflection – relates to assumptions and a consideration of the possible consequences of different actions.	Retrospective strand - looks holistically at the incident being considered and draws out key themes.	Meso - identifies themes and interactions.
Critical – examines human concerns such as equity and justice.	Sub-stratum strand - involves a critical exploration at the level of thoughts, feelings, theories and assumptions.	Micro - attempts to make sense of the incident drawing on feelings, theories and personal views.
	Connective strand - draws all three previous strands together and formulates an action plan.	

Anecdotally students and supervisors report that following a model helps focus their thoughts and challenges them to move from description to critical exploration.

In the pack I offer models for prospective (looking forward), spective (looking now) and retrospective (looking back) reflection. However I am aware of the potential restrictions of models (Freshwater 2002) and I encourage users to search the literature for alternative models or to reflect without a model if they feel that they can achieve a deeper level of reflection this way.

Fish, Twinn and Purr's (1991) four strands model is suggested for prospective and retrospective reflection. I often hear dietitians rejecting reflection on the grounds that it is no more than "navel gazing" or because it is too "touchy feely". This model was chosen as it illustrates clearly how description can evolve into analysis and critical thinking incorporating ideas from the propositional knowledge base as well as personal knowledge in order to plan future action. However there is clearly a danger that the model might encourage dietitians to view reflection as a linear process particularly with the current emphasis in the NHS on care pathways and evidence based practice, which are underpinned by linear, hypothetico-deductive reasoning (Alsop and Ryan 1996). However I encourage dietitians and students using the model to apply it as a check after they have reflected on a critical incident to ensure that adequate analysis and comparison with previous experience has been included. In doing this they often notice how their reflective thinking jumps backwards and forwards through the strands rather than following a linear path.

Modifications of Schon's (1987) models of reflection in action are suggested to support spective reflection.

Dietetic practice is very cognitive and discursive and performing actions then stopping to discuss what is happening as suggested by Schon (1987) in his "Joint Experimentation" model is difficult. However where consultations split into an information collection phase and an advice giving or helping/counselling phase students are encouraged to stop after the information collection phase and summarise their plans for the supervisor before going on to the advice giving or helping/counselling phase. Dietitians and students have expressed concern that this might appear awkward and unprofessional in the context of a discursive consultation. However anecdotal reports indicate that patients feel re-assured by the open supervision of the session as long as they have been made aware in advance of what will happen.

The complexities of real life practice often make this learning activity impossible. To further support the development of the skills required to reflect in action CD film of five dietetic practice scenarios are included with the pack. These are accompanied by suggestions for points at which to stop the clip and discuss potential further actions with peers and supervisors. The skills used by the dietitian in the clip are linked to the practice placement learning outcomes to help the student understand the purpose of the activity in relation to developing their competence. One example is given in appendix 10.1.

Advanced students and registered dietitians seeking to develop skills in a new field of practice are encouraged to use Schon's (1987) "Hall of Mirrors" model. This works well in cases where the student/dietitian has to weigh up numerous factors before making a clinical decision. The following is suggested as a means of applying the model to dietetics.

1. Carry out a full assessment eliciting information from all relevant sources.
2. Discuss this information reflectively with your supervisor and come up with a range of possible action plans. Make sure you are clear about the rationale for each plan.
3. Meet with the patient, your supervisor and other members of the team and present the various options being sure to explain the rationale behind each one.
4. Weigh up the views of the patient and other members of the team and talk everyone through what it might be like to try out each option. As you do this people will be able to make comments and suggestions as you bring the different options to life.
5. Make notes about the pros and cons of each option as you go and summarise them for everyone at the end of the discussion.
6. Once you have done this make your recommendation based on everyone's views. You will obviously then need to seek the patient's consent following standard procedures.

The use of prompt questions

I have also included reflective prompt questions in the pack to help guide reflective thinking. Again these are only offered as suggestions and users are encouraged to develop their own questions once they start to feel more confident.

For example students are encouraged to prospectively reflect on what their practice placement might be like. CD film clips showing contrasting episodes of dietetic practice are given along with the prompt questions shown in appendix 10.2. to encourage reflection on the realities of the placement experience.

Users of the pack are also encouraged to take time out to reflect immediately after an activity and a series of reflective prompt questions (see appendix 10.3) are offered to support this. The idea is that

the student and supervisor should select questions from the list that they feel are particularly pertinent to the piece of practice they have just been involved in. The questions are linked to the learning outcomes so the student can contextualise his or her thinking.

Lessons learnt

As mentioned previously we do not yet have a formal evaluation of the self-guided learning pack. However I am currently researching the practice placement experiences of student dietitians and their supervisors and the findings of an initial study have illuminated some important issues in relation to reflective practice. These findings constitute part of my PhD thesis (Fade 2003) and I have drawn on them here to illustrate the lessons I have learnt about the lived experiences of dietitians and student dietitians who try to incorporate reflection into the practice placement.

Time

"I think it's something you can't always do (allow time for reflection) because I think sometimes you feel that the student has to see so many patients and has to get face to face contact, so it isn't always the case. It's not the best use of our time or the students time." (Quote from a Placement Supervisor, Fade 2003)

There are many factors that compete for a share of the time that students have whilst on their practice placements. In my study (Fade 2003) none of the supervisors expressed the view that reflective activity was something that should be prioritised.

An essential pre-requisite for reflective practice is experience and students need to see a variety of patients and clients in a variety of settings in order to support the development of their reasoning skills (Boshuizen and Schmidt 1995). However as Rivett and Higgs (1995) point out the processing of experience through reflection is also important for student development. Dietetic students may spend whole days observing practice or carrying out consultations in part or in full without taking any time out to reflect. Respondents in my study (Fade 2003) reported that dedicated reflective time was often restricted to a session at the end of the week by which time students and supervisors had forgotten the details of the critical incidents that had occurred. Students seemed to focus on mirroring the practice of their supervisors rather than developing individual approaches to practice.

Dietetic students are now required to collect evidence of their competence in assessment portfolios and although this is a continuous approach to assessment that might be seen to make additional demands on student time portfolios can also be useful reflective learning tools. Friedman Ben David et al (2001) suggest a number of educational advantages of portfolio-based assessment. They assert that the process of evidence collection enables the student to contextualise learning by linking it with personal experience and interpretation which in turn encourages dialogue between students and educators and a holistic and integrative approach to practice. However the students in my study (Fade 2003) tended to collect copies of as many work products as possible in an attempt to ensure that the final portfolio would meet the outcome statements. Evidence was placed in portfolios without any explanatory narrative describing why the student thought the evidence was suitable.

Lack of dedicated reflective time and the burdens of collecting evidence to demonstrate competence may well have blocked opportunities for reflection. However the supervisors seemed unable to support a more reflective approach to the placement experience and this warrants further exploration.

Supervisor commitment to reflection

"They (the students) need to be prompted to reflect."

"Well that's not surprising, so do we. We don't know about reflection it's not something we do." (Quotes from placement supervisors taken from a meeting called to discuss the preliminary findings of my research. Fade 2003.)

Like other healthcare professionals dietitians currently operate in an evidence-based culture which views knowledge as part of a reality that is separate from individuals and verifiable through scientific method. This very quantitative, positivist view of knowledge creation does not sit well with reflection, which is linked to a qualitative, naturalistic view of knowledge where knower and knowledge are interrelated and interdependent. In my study reflection did not seem to be part of day-to-day dietetic practice and this may be because it was not valued as a means of knowledge creation and may also reflect the fact that reflective practice was not mentioned in dietetic curriculum guidelines pre 2000. Consequently many supervisors have had no teaching about reflective practice and little or no experience of it. It is hoped that the self-guided learning pack will help address this problem.

The importance of facilitation

"We try to reflect but we don't have the skills and neither do the students." (Quotes from placement supervisors taken from a meeting called to discuss the preliminary findings of my research. Fade 2003.)

Schon (1991) stressed the importance of coaching for effective reflection and this has been echoed in the nursing (Johns 1995, Rich 1995), midwifery (Stuart 2001) and physiotherapy literature (Donaghy and Morss 2000).

When attempting to facilitate retrospective reflection supervisors in my study tried to use open questions that encouraged students to identify their own strengths and weaknesses. However the non-specific nature of the questions (students were most commonly asked: *"How do you feel that went*?"), the supervisors' difficulties with probing and the fact that the students found facilitated reflection threatening seemed to block critical discussions.

This struck me as surprising as effective communication and the ability to elicit relevant information are core skills of dietetic practice. Indeed in relation to clinical practice client/patient-centred approaches (Mearns and Thorne 1988) are commonly used. Helping relationships are underpinned by mutual trust and a sense of equality and these may be difficult to develop in a relationship that is short-lived (students spend just a few days with each supervisor) and where the stakes are high for both parties. Extending the time that students spend with each supervisor may help foster the development of more trusting relationships.

In the context of my own reflections I was also struck by the use in dietetics of the title "supervisor" where other healthcare professions may refer to mentors or facilitators. The title gives the impression of a monitoring role from a position of authority whereas the terms mentor and facilitator communicate a more supportive function. Whilst I accept that a change in title alone is unlikely to significantly alter the student experience it may help raise awareness of the students' needs. When attempting to help patients/clients dietitians may actively demonstrate empathy, acceptance and genuineness the conditions Mearns and Thorne (1988) describe as being essential for effective person centred helping relationships. A heightened awareness of these strategies may help "supervisors" develop trusting relationships with their students and these would be useful areas for supervisors to explore prior to taking on their role.

Conclusion

Although individual dietitians may have had considerable experience with reflective practice the concept has only very recently been formally introduced into the pre-registration curriculum. My profession is now faced with the challenge of developing its own research literature on the subject where relevant and working inter-professionally to further support and develop the reflective skills of practitioners.

Biography:

I have been a practising dietitian for the past 13 years and I am currently employed as Pan London Education and Training Facilitator for Dietitians. My work role involves supporting reflective practice in the context of student groups and facilitated CPD groups for dietitians. I have recently developed a self-guided learning pack to support a more reflective approach to learning and the assessment of competence in dietetics. I am registered as a PhD student at the University of East London and I am carrying out a qualitative exploration of dietitians' and student dietitians' experiences of assessment in the context of the pre-registration practice placement.

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CHAPTER 11

Using reflective practice in an interprofessional complementary therapies programme

Introduction

The form of reflective practice describe here is the approach used in the Complementary Therapies degree courses at the University of Westminster. The courses include acupuncture, homoeopathy, herbal medicine, nutritional therapy, bodywork and a generalist course in Complementary Therapies. In this chapter I will begin by outlining the background to the Westminster complementary therapies scheme, and the working environment that graduates move into. This should underpin discussion of the curriculum design in respect of our development of critical reflection, how it is integrated into clinical work and clinical supervision, and how the curriculum is used to develop inter-professional understanding and respect, and equip graduates to take a role in the rapidly changing workplace of complementary therapies. This will be followed by discussion of lessons learnt, before concluding with a brief account of the professional development facing graduates.

Background to the curriculum design

There have been five significant influences behind the way critical reflection has been developed in the University of Westminster programme. Two of these relate to the context in which Complementary therapies are practised. Others relate to the University context.

The working situation of most Complementary Therapists in the UK is that of self-employed sole practice and of working outside an hierarchical and/or collegiate support structure. This means that graduates move into practice with only their own resources to rely on. However, diagnosis and treatment planning for the therapies that we teach depend on the client's disclosing a very full picture of their physical and sometimes emotional life, which in a practice setting that is often conducive to a high level of disclosure, can leave both client and practitioner vulnerable. For this reason we have seen the need to develop practitioners who not only value ethical working but who can reflectively appraise their work from a range of viewpoints, and self-direct their own learning. Secondly, as the more mature professions work towards statutory self-regulation (acupuncture and herbal medicine) they are beginning to develop requirements for continuing professional development (CPD) using a self-directed learning framework. As there will be no line-management structure within which to develop understanding of this process we see it as a responsibility of undergraduate preparation.

The scheme of courses at Westminster is modular with approximately 50% therapy-specific components where the teaching staff are practitioners in that profession, built around a common spine of health sciences, research and practitioner development. The rationale for this was to build on best practice and to raise standards across the field, and the intention was to teach in interprofessional groups. Inter-professional working was itself a core value for the Centre where these courses were developed, although before now the experience was in primary and social care and postgraduate education (see Petroni, 1999). Within the practitioner development classes it soon became apparent that the diversity of the student group, both in terms of notable differences in how the therapy groups saw their roles and relationships and in terms of characteristics of the student intake, would need to be addressed in the curriculum design. In the early years of this work the impact of the student's developing professional identity on the group dynamic was not adequately

considered, and strong alignments and prejudices that resonate with observations about the tribal nature of the orthodox medical professions (Beattie, 1995) stultified the work.

The fourth, and in some respects most significant influence on the overall shape of the curriculum came from the recognition that we were offering education. Early influences on practitioner development within Complementary Therapies courses came from counselling and group therapy, where the requirement was stated in terms of attendance and there was no academic assessment. In the educational arena it was not sufficient to simply present a set of significant scenarios with no way of assessing how or whether the student processed them. Critical reflection offered both a tool for the student to process their experience as well as a method for demonstration of their learning, provided they were schooled in how to use it.

Finally, because the principles and processes of critical reflection and ethical working are developed initially in practical classes there needed to be some mechanism for transfer into the clinical setting. The approach we have taken to address both the "horizontal" (from class to clinic) and the "vertical" transfer from the nurtured development within the university to private practice and continuing professional development is to interweave the educational perspectives of self-directed learning (Boud et al, 1985, 2000; Brookfield 1987, 2000; and more recently, Lave and Wenger, 1991), and learning contracts (Anderson et al 1996, Stephenson & Laycock, 1993), with frameworks for reflection on self and other such as developed by Christopher Johns (2000)

Curriculum design

Within the Complementary therapy courses at the University of Westminster the concept and habits of reflective practice are developed in a staged programme of one module per year over the three years of the undergraduate programme. The Practitioner Development curriculum starts with exploration of self to underpin understanding of interpersonal communication, and then moves to professional communication and ethical working, with complex dynamics, facilitatory inquiry and supervision in the final year. Learning outcomes for the three years are shown in appendix 11.1. Critical incident reflection and self-directed learning are developed in the first year with assessment of structured reflective learning and learning contracts (Anderson et al 1996, Stephenson & Laycock, 1993). In later years students are expected to work with reflection and self-direction to focus and manage their learning within the module syllabus. Assessment at this stage asks for a reflective report of change in relation to the syllabus themes over a semester.

The programme is mainly delivered through experiential learning with outlines of theory sketched around the activities. This means that class contact time is prioritised for small group tasks, discussion and role-play that apply theoretical models, rather than the didactic delivery. However, keynote lectures are used in the first year, for both practical and pragmatic reasons. The person who was originally responsible for the first year programme came from a nursing background, and this was the model she was used to. However, the lectures also support the teaching staff in coping with a very wide-ranging syllabus. In second and third years all class work is experiential driven with only a brief introduction of the theoretical underpinning, leaving it as the students' responsibility to read and explore in depth and in relation to their personal needs an interests, which they identify through critical incident-based reflection on the classes. In this way reflective self-directed learning becomes generic rather than an additional skill.

In the first year the emphasis of the group work is on building students' self-awareness and their ability to talk about their perceptions and experience as personally located rather than as generalised judgements. In the second year, where the focus is interpersonal communication, feedback from role-play partners becomes a central aspect of the learning, and must be actively developed. Our

approach to this is to focus on feedback as the reflective position of the "other". We expect students to develop their own client roles from situations they observe in clinic, so that in any practitioner / client role-play exercise both roles are interactive. The potential for learning becomes obviously related to their level of involvement because they bring their clinical experience with them, and take their observational skills and ability to critically reflect and plan their learning back into clinic.

Once students engage with the process both role-play and discussion are enhanced by the fact that the students come from different groups and are preparing for different professions. Exit interviews with students regularly make the point that it is easier for them to work with people from different courses. Some say it just "makes it easier to do the work, because there is no history" with that person. Others find it helps to highlight the assumptions they make about what clients expect. Some students find the group size (15 – 20, depending on the year) difficult for full-group discussion. However, in first and second year much of the work is done in dyads and triads. I will discuss issues of safety under "Lessons learnt". The advantage of the interprofessional groups is the range of perspectives available to the facilitator and to individuals in the group, which can be explored reflectively as "other". The challenge is to enable the group to explore perspectives in their social and cultural context rather than extract and judge: to notice assumptions and consequences in actions and thought, without articulating personal judgement. One way to facilitate this process, which is in itself central to reflection, is to address the theory of knowledge construction as situated in social and cultural activity (for example, see Lave and Wenger, 1991) within the syllabus. Discussion that relates the client / practitioner inaction as a shared activity in knowledge construction can help students understand the need for reflection to help identify what they bring to the encounter. In this aspect of their work there is no right answer that is separate from the interaction, as there might be in their science modules.

Staff development

Many of the facilitators working on the practitioner development theme of modules have some sort of counselling background, some have experience of psychodynamically-based group relations workshops and some have trained "on the Job". All staff are expected to work reflectively themselves and as a minimal requirement facilitator teams at each level meet as a reflective supervision group each teaching week. This group acts both as a means of sharing practice and maintaining continuity across teaching groups at that level, and as debriefing and critical reflection on specific incidents in the group facilitation.

A more complex problem for us is the development of clinical staff who may not have had reflective practice as part of their own training. I will return to this in "Lessons learnt".

How critical reflection is developed and used in the curriculum

Critical incident reflection is introduced as a process in the first year, and in relation to that year's syllabus of developing self-awareness of how constructed our individuality is. Students work from incidents arising out of the class work, to personal reflective questioning to identify personal interests and issues for learning, which then direct their reading and further reflection on how to apply their insights in practice. Generic descriptors of the process for each level are given as appendix 11.2. We ask students to start their reflection from incidents in class. This can help them recognise the significance for learning of dissonance between their inner world and their perceptions, and it also grounds the work in the shared arena. However, this requirement is hotly contested by some students. Some see it as stifling their creativity, and therefore, because the work is assessed, their chance to do well. I will discuss this reaction further when I come to issues of assessment. The second aspect of process at this stage is to help students develop the confidence to talk in a group, to hear other opinions and experience, and to recognise the personally and culturally

located nature of perceptions and opinions. Group facilitators encourage people to talk about their own impressions rather than to offer judgemental comments about each other. We could not claim 100% success rate on this aspect, but most students do recognise the difference, and progressively become more confident when talking in the group and working with constructive feedback.

This process-work is picked up in the second year where peer feedback on feelings and reactions during the role–plays and case scenarios becomes one of the primary sources of input (together with their clinical experience) to the reflective process. By this stage it is assumed that students can work using reflection to manage their learning and so the only support to the process given in class is the allocation of time for journal recording. We offer a framework of self-observation that is derived from Brookfield (2000). Students are also encouraged to use their journal to record ideas from clinic, reading, and follow-up thoughts in relation to the in-class record, and to work with it to help them identify their patterns of behaviour and interpretation. The theoretical content for second year is the skills and structure used in the consultation, building to ethical awareness and ethical, patient- or client- centred practice. By this stage all students have relatively structured clinical observation, and take on peripheral roles in respect of patient/client care. This is the point at which the value of the different professional backgrounds can be used to broaden understanding of the issues. The clinical relationships in a contact therapy, such as acupuncture or bodywork, highlight different needs and ethical sensitivities than those for therapies such as homoeopathy, where the invasiveness is at the level of talk.

In the third year the theoretical focus moves to models of unconscious communication such as transactional analysis, and techniques for facilitating clients through different interventions and conceptual models. At this stage students have responsibility (under supervision) for patients and clients in the teaching clinic attached to the School. There is significant cross over between clinical work and this class-based work, and it is at this stage that the term “reflective practice” becomes more meaningful. All students present an issue from their clinical work to their group, who try to facilitate their deeper understanding through a peer supervision process.

The rationale at each level of the programme is to develop initial understanding and proficiency in the relatively safe environment of the classroom, but drawing on students’ observation and peripheral participation in clinic, before they take on higher levels of responsibility in the clinical setting. However the routine transfer of these processes into the clinical setting as reflective practice needs to be supported through overt incorporation into the clinical curriculum structures and assessment.

Assessment

Clinical assessment at each level includes some focus on critical reflection and self-directed learning related to personal observation and feedback from tutors. I order to support staff with structuring assessment guidelines and criteria we have develop generic criteria for reflectively learning at each academic level that can be applied to self, clinical learning and to some extent to research reflexivity (see appendix 11.2). We have taken this approach because it is congruent with our claim to students that it is the reflective process and the learning they present, both in their personal understanding of theory in terms of how they personally applying it, that is assessed. The difficulty is to facilitate students to understand that, although the focus of learning needs to be personal, assessments are about demonstrating learning of the topics in the module. Structured reflection inevitably precipitates powerful, and sometimes overwhelming, awareness, which may not be appropriate for the written assessment. Our approach to this is to help students to distinguish between their self-directed work for their own development, and their writing of an assessment to demonstrate how they have worked in relation to a specified chunk of the syllabus.

As a team, staff have debated the pro's and con's of highly structured and non-directive guidelines for reflective assessments (see appendix 11.3 for an example). At present we favour guidelines that are prescriptive as to process and ask for "demonstration of learning and change in relation to the module syllabus content". This seems to support students in keeping to the topic. It also helps staff to separate out any very personal disclosure that a student might make from the assessed work. All modules use a team of teachers who usually assess their own students' work and moderate each other's marking. The prescriptive guidelines provide both a marking scheme and a feedback framework for the staff. More significantly, they seem to help students remember that an assessment is a particular type of reflection with an overt academic purpose. This can help them maintain their own safety through not putting their most sensitive issues up to relatively public scrutiny.

Lessons learnt

Integration across the curriculum

We have found that students' integration of reflective practice across the curriculum depends on more than simply writing reflective components into assessments. Over the past year we have introduced reflective peer supervision groups for clinical tutors in an attempt to develop their insight into the processes that their students are working with so that they will better be able to model and facilitate reflection-in-action as part of students' clinical development. From the other side, and as mentioned above, we are working with staff to support a common approach to assessment, translating the generic criteria into assessment-specific descriptions.

Working from the student's perspective, we have also introduced reflective self-appraisal and personal learning plans through the pastoral tutoring scheme, and as the underlying structure to students' personal development portfolios. This development is not yet sufficiently advanced to evaluate, but tutors who use the framework report that they find it can offer a way into discussions about personal responsibility that help to shift the student into independent action.

Interprofessional facilitation

The curriculum as outlined above has been in place from the initial validation of the scheme. However, in some senses it has evolved dramatically since those first years. Initially, the interprofessional grouping became a focus for a considerable amount of dissatisfaction from both staff and students. Both groups felt that going uni-professional would dissipate most of the anxiety and confusion felt by many students, and make the curriculum more meaningful or relevant to the individual therapies. However, some positive effects of the group structure also began to emerge. Facilitators learnt how to use the different features of the therapeutic relationship and the methods of working as a resource, enabling the different therapy perspectives to structure discussion. This breadth of discussion, has fed the critical incident reflection format giving the impetus for self-directed learning and students' understanding of what they were seeing in clinic, which in this way has created congruence between the way students are expected to work and the outcomes that they want for themselves. However, in addition to this, taking students out of their specific therapy-groups has supported their understanding that in these modules the learning focus is aspects of the consultation structure and the therapeutic encounter, and not therapy-specific learning. This distinction is quite difficult for some students to hold onto.

Managing student anxiety in relation to personal development

Many students have said, in exit evaluations, that working with students from across the scheme of courses made the discussion and role-plays easier in that they could work with students they didn't know so well. However, in the early stages many students feel uncomfortable with the prospect of

discussing experiences and opinions that seem personal. It is difficult for them to understand the curriculum until they have used structured reflection to explore the significance of a piece of feedback or a new insight. For many people uncertainty leads to anxiety and so the beginning of the programme tends to be the most difficult time for both students and staff. Much of this difficulty stems from the problem of trying to describe a process in the abstract, but until a person has followed it, it can only be abstract. They make it meaningful for themselves. We have found that a short, early formative assessment helps to minimise this anxiety in so far as it helps students to concretise the process.

Module evaluations show that we have become more successful at containing anxiety around the group process. Relevant factors, as you might expect, seem to relate to building trust, setting ground-rules that include staying "on task" and encouraging people to speak from their own experience rather than commenting on others'.

Conclusions

The Complementary Therapies scheme at Westminster has developed it's own style of reflective practice, to meet the particular practice setting that most graduates will work in. We feel that, as independent self-employed practitioners, they will need the confidence to self-monitor with a critical perspective that enables them to realise their own solutions, but also identify those complex issues where outside facilitation may be necessary to enhance understanding. On another level, the professional organisations of the most well established therapies are beginning to introduce requirements for continuing professional development, and for some at least, this will be based on techniques such as critical reflection and self-directed learning.

Biography

Sibyl Coldham is a principle lecturer in the School of Integrated Health, University of Westminster, and is responsible for the curriculum development of what is there called "Practitioner Development", which is taught interprofessionally across a scheme of profession degrees in acupuncture, homoeopathy, herbal medicine, nutritional therapy and bodywork, and general studies in Complementary Therapies. The curriculum includes the development of client-centred communication skills and ethical working. The processes of critical reflection and self-directed learning underpin the curriculum by enabling students to develop professional autonomy within community of values and practice. Sibyl's educational interests include interprofessional teaching and learning, continuing education and workplace learning. She is current pursuing PhD studies researching the pedagogy of clinical teaching and learning.

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CHAPTER 12

Reflective Practice in Teacher Preparation

This chapter will give an overview of the use of reflection, reflective processes and reflective practice in the preparation of health professionals in health and social care education. The types of reflection involved included action learning sets, portfolio development, reflective diaries, illuminative expression and exploration of critical incidents. It is our belief that the use of a range of approaches serves to most effectively encourage student teachers within the health professions to reflect on their practice. This chapter is based on the experiences we gained through introducing and evaluating a range of reflective processes on a postgraduate course for the preparation of teachers.

The Course

The students involved were enrolled on a part-time, Postgraduate Certificate in Health and Social Care Education Course at the University of Brighton, leading to Institute of Learning and Teaching (ILT) membership and Nursing and Midwifery Council recording of the qualification as a Practice Educator or Lecturer. The students came from a wide variety of backgrounds, including nursing, midwifery, health visiting, medicine, occupational therapy, physiotherapy, and podiatry. The students were required to complete 200 hours of teaching practice, attend fortnightly action learning sets as part of the course and compile a portfolio reflecting on their teaching practice.

The course consisted of three 20 credit masters level modules, 'Learning, Teaching and Assessment – Theory and Practice', Course Design and Planning' and 'Developing the Teacher's Role through Reflective Practice'. This latter module spanned the whole year and included the action learning sets, portfolio and critical incident analysis within its substantive content and module assessment.

Course Evaluation

Little research had been undertaken into the use of groups and discussion to facilitate reflection (Platzer et al 1997) and even less into the complex role of the nurse teacher (Hakkarainen and Janhonen 1997). For this reason we considered it important to gain 'good feedback' (Knight 2002) from the students experiencing reflective strategies in use on the course in addition to the standard course evaluation using nominal group technique and individual module evaluations.

'Good evaluations' are those teachers would term as being useful and inspire teachers to continue to tinker at a programme due to a desire to do better (Knight 2002). Likewise formative feedback, evaluation that facilitates development whilst in the process of running a module or course, is most productive for students who can see that their input is actually valued and can reap the benefits of suggested changes whilst still engaged in the module / course (Rolfe 1994). In order to respond well to the concept of 'good evaluation' we decided to gather detailed information on one reflective strategy at a time. We focused our attention on action learning sets in years 2000/2001 and 2001/2002 and applied ourselves to the use of the portfolio in the last academic year.

We invited a lecturer who was independent of the course to gain feedback through interviewing the individual action learning sets. We felt that this method would yield more authentic data on the student experience. This proved to be the case as there were several comments that related to our facilitator style and the need for us to manage the group activity better. The data gained was then discussed with the group as a whole and changes were made in each year to the second semester that enabled the students to see that their opinions had been valued and action taken to respond to issues raised. Some changes though had to wait until the following year, for example, a three day

introduction to the concept of reflection underpinning the course was set up for year 2001/2002 in response to evaluations indicating the need for a more thorough grounding in the concept of reflection, reflective writing, action learning sets and portfolios.

We have now developed a specific evaluation form for action learning sets that has been in use this academic year (see appendix 12.1).

With regard to the portfolios a more detailed set of criteria was developed (see appendix 12. 2) to help clarify the course expectations and guide the student towards a better understanding on how to compile a portfolio that would meet the learning outcomes of the course and reflect their personal journey over the year. These changes arose from course evaluation, which alluded to the enormous amount of work for no academic reward. The portfolios are currently awarded 33% of the total marks for the Developing the Teacher's Role Through Reflective Practice Module. This is set to rise further to 50% in the year 2003/2004.

Reflection in Teaching and Learning

Scanlon and Chermonas (1997) consider that to teach reflectively we must be reflective ourselves. This involves thinking out our own teaching using reflective teaching strategies and using specific teaching methods that encourage students to be reflective.

In order that learning may develop from engagement with reflective teaching strategies there is need for the student to be self-aware, to be able to recall events with some clarity and articulate the issues effectively (Newell 1992). We became aware that the levels of reflection in students varied tremendously and related to Goodman's (1984) stages of reflection. Students could demonstrate simple problem solving, or they would use literature and theories to illuminate the analysis of the scenario under review, and others were able to critically consider the broader forces, of issues at play such as justice, emancipation and political factors on their event. This variance in student ability to engage in reflection is supported within the literature (Platzer 2000a). One study of novice teachers found that even when the conditions were right, some students did not know *how* to think about their teaching experience productively and this process had to be *learned* (Richert 1990). Personal experience would suggest that the use of reflective strategies in teaching and learning might not work the first time. In order to manage this experience we maintained a process of dialogic conversation between self, teaching colleagues, the students and the literature (Ghaye and Lillyman 2001). Through a series of formal and informal 'conversations' we identified several problematic areas arising from action learning sets, the use of reflective journals and the portfolio. This chapter describes this process alongside the discussion on how we managed to evolve the PGCHSCE into a dynamic curriculum to promote the effective use of reflective strategies throughout the course.

Action Learning Sets

Atkinson and Claxton (2000) suggest that reflection in isolation can not ensure learning, as it carries with it neither support nor challenge Shared reflection through group processes and group dynamics generates richer insights and understandings of complex professional issues through the challenge and support and feedback offered to the participants in the process (McGill and Beaty 1995). The vicarious learning from being within a group has been identified as a major benefit from action learning (Stockhausen 1994). Action learning sets were therefore chosen as a forum for assisting the development of the students on the PGCHSCE.

McGill and Beaty (1995:11) define action learning as

"*A process of learning and reflection that happens with the support of a group or 'set' of colleagues working with real problems with the intention of getting things done*"

Within the first three days of the course a whole day was set aside to introduce the concept of action learning, which was received positively and highlighted the need to actively prepare students for this type of reflection. Our experience revealed that students within an action learning set sometimes experienced difficulty in finding a language to talk about the self. This could delay the fundamental first stage in a group forming, that of 'getting to know' each other and developing trust so that the group could progress on to support 'learning talk'.

Influenced by the work of Spouse (2001), creative expression in the form of poetry, painting, music and sculpture was introduced into the curriculum. This acted as a medium through which the student was encouraged to express their feelings about being a novice teacher, being a student on the course and their personal aspirations. They used the product of the creative expression session to introduce the self in the first action learning set, and the session was again repeated at the beginning of the second semester. From the perspective of the action learning sets, groups formed quickly and progressed on to collaborative working at a pace not experienced in previous years. The experience for the student in many cases was profound and even those who were initially sceptical found it effective and fun. Expressing the self through creative artistry enabled the student to find an alternative language through which to explore an inner world of experience and describe it's meaning to the self and others. Within the context of the reflective element of the course, the introduction of illuminative expression appears to synthesise the cognitive and affective domains enhancing exploration of personal knowledge. Many of those involved in this experience have been encouraged to take this creative means of expression into their professional teaching role and a number have reported back of its effectiveness in engendering group cohesion and exploring role transition in health professional students.

For some students this was the first time they had disclosed their personal beliefs, opinions and practices to others, and usually there would be at least one student in a set who felt they should not feel forced to bring an incident, but agreed to engage in critical dialogue with other members of the set regarding their issues. Platzer (2000a) studied similar groups and concluded that the culture of nursing does not always foster the openness that shared learning requires. Therefore, it should not have been surprising that creating an environment that was conducive to reflection required more skill for some students than others, an environment that Haddock (1995:385) describes as "a setting which is a safe place to go to be 'human".

Richert (1990) researched novice teachers and found being overwhelmed with the demands of the job, fear of failure and vulnerability all contributed to their reluctance to look at their practice critically. We found that the problems brought to the groups were very real and most students had no trouble preparing something to discuss. In this context action learning became a very powerful tool for exploring ways of being in the workplace, and in order to move forward, it was sometimes necessary to challenge the most comfortable assumptions and to develop strategies that at first impression could be regarded as risky (Rosser 1995).

Some sets seemed to follow the group evolution stages of 'forming', 'storming', 'norming' and 'performing' (Tuckman 1965). We found learning in groups could be uncomfortable until trust, both between the students and between students and the set facilitator, and a sense of belonging, emerged (Franks et al 1994, Williams and Walker 2003). Through this experience some students became aware that learning through reflection was not necessarily an enjoyable experience (Platzer et al 2000b).

The students who seemed to benefit most from action learning sets were those that were already skilled at reflection, able to take responsibility for their own learning, and willing and able to change aspects of their practice (O'Hara et al 1997). Some students found it overwhelming to be amongst others who were in more senior positions and able to act autonomously. For others, the opportunity to offer a sanctuary in which to divulge the everyday conflicts that they were experiencing in their roles as novice teachers was almost more important that the learning taking place.

It seemed that most of the action learning sets were able to reach a high level of critical analysis of their teaching practice and this we termed 'learning talk'. Students were encouraged to bring critical incidents arising from their reflective journals to the action learning set. As with Richert (1990) we found, the reflective conversations provided the students with an opportunity to seriously explore their teaching experience and to delve deeper to achieve an understanding of their personal philosophies of learning and teaching. Glen et al (1995) demonstrated the importance of using critical incident analysis in a course of preparation of nurse teachers, as it not only challenges the roles of the teacher and student, but also encourages a perspective transformation of the problem discussed.

The outcomes from action learning are not easily quantifiable (Beaty et al 1997) but the students were able to describe increased self-confidence and empowerment through greater autonomy in their roles, which mirrors the findings of Platzer et al (2000b) and Williams and Walker (2003) in similar reflective groups. They enjoyed exploring difficult aspects of their role within a safe environment and welcomed the opportunity to develop their skills of critical thinking and reflection through being challenged by their peers and the set facilitator.

Creating opportunities through action learning sets to foster the ability to think critically is now essential as critical thinking has become a highly valued educational outcome from professional courses, especially at post-graduate level, creating skills that will offer a means of coping with relentless information development and change (Daly 1998).

Reeve (1999) argued that action-learning sets were more than excellent learning support groups because of the 'added-value' element that students gain over and above successful learning outcomes. An unexpected but pleasing outcome was the desire to use action-learning sets within the students' personal repertoire of teaching in the future (Pedlar 1991).

Reflective Journals

The use of a reflective journal was considered an effective strategy for assisting the students to reflect on their experiences throughout the course. The act of writing can help students to make contact with thoughts and ideas previously 'hidden' to them. It can also enable the expression and exploration of issues of which the student is aware but feels unable or unwilling to articulate and develop (Bolton 2001). Moon (1999b) considers all journal writing as creative as unexpected thoughts; meanings and insights can emerge from writing about anything. Gerrish (1993) and Callister (1993) found that students did benefit from the use of a journal as it helped them to analyse and evaluate their experiences and as such promoted learning through the act of writing. Platzer et al (1997), though questioned whether engaging in reflective writing through the use of diaries and journals did actually lead to learning.

Kuit et al (2001), suggested that reflection as an activity is hard to do in isolation and to prevent 'navel gazing' should involve engagement and pro-activity (Brown et al 1999). It is most effective

when undertaken with a group and can widen the experience of the reflection and reflexivity both politically and socially (Bolton 2001) and prevent the journal becoming a superficial record of daily events (Johns 1994). With this in mind the use of a reflective journal in the PGCHSCE has been closely associated with the action learning sets and the portfolio.

Linking the reflective journal to the action learning sets and the portfolio, however, had a variable rate of success in the early years as the student's willingness to engage in a reflective dialogue about their practice was directly correlated to their feelings of safety within the group, their understanding of the process of action learning sets, and their interpretation of what was considered 'acceptable' reflective writing in the portfolio. This latter point was more keenly noted when the portfolio became part of the summative assessment for the course. Lecturers will need to take heed of these issues when developing reflective strategies with summative assessment.

Our ability to develop a climate to facilitate the setting up of action learning sets was the key to enhancing the use of excerpts from the reflective journals. Journal writing works best in an atmosphere of trust. If the environment is not supportive then it is likely that the environment will become the topic of discussion (Moon 1999b), and we experienced this through students diverting attention away from themselves to criticisms of the course and their colleagues. The more speedy development of trust within the action learning sets through the use of illuminative expression did facilitate the process of students engaging in 'learning talk' and proactively bringing examples from their reflective journals to critically analyse and reconstruct within the safety of the action learning set.

Reflective journal writing can be quite freeing as it can liberate those who feel inhibited or self conscious about writing in an acceptable academic style (Bolton 2001), but students can have hang-ups about how to write having become constrained by the 'proper' way of writing in the form of an essay. Gerrish (1993) found students stated that diary writing was time consuming and that there was a lack of guidance as to how they were supposed to do it (Cameron and Mitchell 1993). Moon (1999b) points out the need to consider the purpose, and fit of reflective journals within a programme of learning. It is important to tell students why they are being asked to write, what they may expect to get out of the experience, and how the purpose relates to the format, design, guidelines and in particular any assessment tasks (Moon 1999b). Without guidelines students can feel they do not understand what it is they are supposed to write, although too tight guidelines can constrain the creative freedom of the student (Bolton 2001). We experienced greater acceptance of the process of journal writing once we developed clear guidelines for the portfolio and provided samples of ways of structuring journal entries (appendix 12.3). The latter guidance was not to restrict personal style in any way rather to facilitate those who wanted more guidance on how to begin the process of keeping a reflective journal.

There is some criticism of summatively assessing reflective writing as it may change the nature of the writing as students may launder their journals and write down what they think the teacher wants them to write (Moon 1999b). We feel that you cannot discount this as a factor that may be present in summatively assessed work. We do, however, hope that by engaging the students in an open discussion on their practice within the action learning set that having 'gone public' with their thoughts, concerns and ideas they may feel more comfortable in presenting authentic records of their reflection on their role and work experiences. We also put some of the control over to the student as to what they choose should be assessed by asking students to decide what aspects of the journal were to be marked. They could do this by selecting from their journal reflective pieces that

together gave a story of progression, of development on a journey to becoming a teacher. This is an appropriate strategy when personal development is a key aspect of student learning (Moon 1999b).

In summary the reflective journal has three purposes within the PGCHSCE; to facilitate the development of practice by bringing journal excerpts to action learning sets to open up a dialogue with their peers; to encourage personal and professional development by developing confidence through the process of finding that 'inner voice' through the reflective process (Moon 1999b); and to record progression through the development of experiences, in this instance the presenting of a story of the self through a portfolio and using the reflective excerpts to link together the elements of the portfolio into a more coherent presentation (Paulson et al 1991). This use of journals is supported by Crème (1998), who indicated that the level of integration of a journal within a programme influences the likelihood of its success as a reflective strategy to enhance learning.

Portfolio

Richert (1990), studying novice teachers, found that from the use of journal writing, portfolio development, discussion groups and reflective essays, the reflective conversations with teaching peers and the portfolio were strategies that assisted the teachers the most.

Karlowicz (2000:83) defines a teaching practice portfolio as:

"a purposeful collection of assorted work that represents a student's efforts, progress and overall achievements in a course or programme of study It is usually collected over time and presented in a chronological order".

In this course the portfolio was essential because there was a need for a method of recording the student's teaching hours and assessment of teaching to satisfy English National Board for Nursing, Midwifery and Health Visiting (ENB/DOH 2001) requirements for recording the qualification as a lecturer/practice educator. Baume (2001) would consider this a 'filing' aspect of the portfolio where students collect evidence of their work. We also considered it an important formative assessment tool because the student could collate ongoing critical reflections on their teaching and learning experiences which could be taken into their action learning sets and which together could help the student to synthesise the key aspects of their learning throughout the course. The analysis and review of experiences and evidence filed in the portfolio is the 'learning' element of the portfolio. Through this analysis the student can show what they learned, what capabilities they have developed and to what extent they have met the learning outcomes of the course (Baume 2001). Since 2002 we have introduced the summative assessment of the portfolio the rational for this will be discussed within this section.

The attraction of portfolios as a form of evidence for meeting learning outcomes in courses is their ability to convey progress and process (Simon and Forgette-Girpoux 2000, Baume 2001). A key element of any teaching portfolio is the evidence of a journey to competence, through a factual description of the student teacher's strengths, accomplishments and areas of development. Through the collection and analysis of evaluations, curriculum documents and teaching materials, an indication can be demonstrated of how a student teacher's performance has evolved over time (Nicholls 2002). This can prompt a spur to action within the supportive framework of a course (Cayne 1995). Another positive aspect is the provision of documentary evidence of complex sets of skills, not necessarily validated by other evaluation techniques (Karlowicz 2000). Baume (2001) considers the essential feature that distinguishes the portfolio from other forms of assessment is that it comprises a collection of items rather than a single piece of work.

As with reflective journals there can be some problems arising from the use of portfolios in the assessment of student teachers. There may be a lack of motivation to complete what can be a time consuming task and one that was initially formatively assessed in the PGCHSCE. There may be uncertainty in what was expected and clear criteria are needed to outline specific course requirements that are not so prescriptive as to prevent individuality and creativity (Snadden and Thomas 1998). We have devised criteria for the portfolio that fulfils this effectively, including quantitative and qualitative elements (appendix 12.2). Issues that should not be considered lightly are that portfolios may contain highly personal material, which may generate anxiety on the part of the student who may be reluctant to share private thoughts and feelings (Snadden and Thomas 1998). Making practice visible to others carries a degree of risk of criticism and challenge that may not have been experienced before. As stated in the previous section on reflective journals we manage this aspect within the PGCHSCE course by encouraging students to choose for themselves what aspects of their experience they want to make public.

There are very few examples of methods of assessing portfolios, however, more recent interest is becoming evident (Simon, and Forgette-Giroux 2000, Baume 2002, McMullan, et al 2003). We personally have found the work of Paulson and Paulson (1991) useful in portfolio assessment. Paulson and Paulson (1991) suggested three stages of reflection that can be captured in the portfolio; documentation, comparison and integration. Documentation involves justification of portfolio entries and comments on the relevance of these entries. Comparison encourages the student teacher to take stock of their learning and reflect on the differences and similarities among various pieces of evidence obtained from learning situations. Integration occurs when students recognise and describe their own personal teaching style and progress through the overall analysis and interpretation of all the portfolio entries. In the PGCHSCE, this is achieved through a final reflective account that synthesises the learning about becoming a teacher that has evolved over the year.

Our experience with the use of portfolio as a summative assessment tool supports the notion that its compilation by the student encourages personal and professional development. Cayne (1995:397) suggests the portfolio experience can shape the person and subsequently influence the professional practice they deliver. She felt the characteristics arising from this personal and professional development resembled Knowles' (1978) concept of the adult learner. The awareness of self concept, recognition and valuing of personal experiences, readiness to learn related to social and role competence, ability to be proactive and utilise problem-solving were all attributes promoted in portfolio development.

In summary the skills developed from portfolio experience include reflection, analysis, evaluation, research, writing and continued learning and professional development. Our view supports that of the more recent work of McMullan et al (2003) that the summative assessment of practice through portfolio is still evolving and issues of rigour still need to be addressed.

Conclusion

We have learned that introducing reflective practices into the curriculum does not bring instant rewards and that what works in one context may not always be transferable to another. We have, however, discovered through innovative practice and the use of formative and summative evaluations, that a range of reflective strategies and thorough orientation to the processes involved, have enabled the students to demonstrate greater motivation and interest in the subject of learning and teaching.

Biography

Helen Stanley is a Principal Lecturer and course Leader for the Postgraduate Certificate in Health and Social Care Education (PGCHSCE) at the University of Brighton. She has been instrumental in developing mentorship and teacher preparation programmes for health professionals since 1990.

Dr. Charlotte Ramage is a Principal Lecturer and co-ordinator of the Work-based Learning Framework of modules within the undergraduate post-registration programmes at the University of Brighton. Charlotte completed her PhD in 2000, an exploration of the link teaching relationship with clinical nursing practice. Her knowledge of role theory arising from this work has been used to encourage reflection in the developing role of the teacher in the PGCHSCE.

Together Helen and Charlotte have developed a range of reflective teaching strategies on the PGCHSCE to enhance the learning from experience achieved by the course participants. These include the use of action learning sets, reflective journals, portfolios of teaching practice and illuminative expression. They have been actively researching and evaluating the processes experienced by the students to develop this aspect of the course. The Nursing and Midwifery Council (NMC) recently commended their work.

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CHAPTER 13

Reflection and Assessment

Introduction

In this chapter I will seek to address two issues:

1. The assessment of reflective skills.
2. The use of reflective strategies to facilitate the assessment of healthcare students.

The assessment of reflective skills

Reflective skills are considered important for safe and effective practice at the point of registration across a range of healthcare professions (Dietitians' Board 2000). It has been argued that it might be inappropriate to expect students to reflect because they are novices and reflection is a higher order cognitive skill (Benner 1984, Melia 1987). However. current UK benchmark standards for healthcare professionals (Quality Assurance Agency for Higher Education 2001) all seem to indicate that complex decision making and reflective skills are needed at the point of registration.

If reflection is considered important then I would argue that it should be assessed. Hyland (1992) asserts that assessment often focuses on simple, technical skills because they are easy to observe and measure whilst ignoring more complex aspects of practice such as critical reflection. Consequently the more straightforward aspects of practice are made to seem more important with potentially disastrous consequences for the development of competent professionals.

Research suggests that if we want something to be the focus of students' attention in relation to learning then we need to make it a focus of assessment (Newble and Jaeger 1983, Scouller and Prosser 1994).

Clearly this presents us with a significant challenge. If we agree that we need to assess it, then we need to be clear about what effective reflective practice is. There are numerous definitions and conceptualisations of reflection in the literature (eg Dewey 1933, Van Manen 1977, Boyd and Fales 1983, Schon 1983, 1991, Boud, Keogh and Walker 1985, Fish, Twinn and Purr 1991, Mezirow 1991a, Johns 1993, Durgahee 1996, Donaghy and Morss 2000) and each profession is likely to have its own emphasis. For example Donaghy and Morss (2000) writing for physiotherapists present a cogent argument for moving away from models that encourage reflecting on beliefs, values and attitudes to an approach that is rooted in systematic critical enquiry, problem solving and clinical reasoning. By contrast other definitions place self at the centre of the process. For example Boyd and Fales (1983) suggest that "Reflective learning is the process of internally examining an issue of concern, triggered by an experience, which centres and clarifies meaning in terms of self and which results in a changed conceptual perspective."

The definition used in our own LTSN Newsletter (LTSN 2002) stresses the importance of the self and theory "It (reflection) is a formal method of thinking and writing which requires you to identify your actions, thoughts and feelings, either specifically or generally, and then subject these to objective analysis. The first stage of the analysis is undertaken through the act of writing narratives. You then subject your narratives to an analysis that is supported with appropriate theory…..it requires self awareness and a willingness to be self critical in order to challenge the appropriateness of personal beliefs and values. The ultimate outcomes can be personal transformation."

For assessment to be reliable students need some guidelines about what is expected of them. Stewart and Richardson (2000) explored the experiences of physiotherapists and occupational therapists who underwent several assessments of their reflective work. Data from student focus groups and faculty interviews showed that both groups had concerns about the fairness of the assessment in relation to the consistency of the assessment criteria used and the impact of the student/tutor relationship including tutors' interest in and skills in relation to reflection.

It has been argued that all reflection should be coached or guided by another person (Schon 1991, Johns 1995, Rich 1995). If we adopt this model then we need to take steps to ensure that those who attempt to facilitate and support reflection have achieved a certain level of competence themselves and that they are suitably qualified to handle the emotional aspects of the reflective process. This may be challenging for professions that have only recently introduced reflective practice to the curriculum, as experienced practitioners will not be experienced with regard to reflection. Inter-professional collaboration may offer an interim solution. Where this is not possible reflection could be guided by models and prompt questions as discussed previously (see pages ??….). What is important in terms of fair assessment is that students all have access to the same resources.

Whilst it is clearly important for students to understand what is expected of them I would argue against the development of excessively detailed assessment criteria. Ramsden (1992) showed that excessive material in the curriculum forced students to adopt surface learning approaches. In a recent qualitative study exploring the assessment experiences of student dietitians and their supervisors during pre-registration practice placements (Fade 2003), I found that although students needed a contextual understanding of the learning outcomes, when presented with detailed performance criteria they simply acted to meet the criteria in order to get a tick in the box. Clearly this is the antithesis of what we hope to achieve through reflective practice. Broader assessment criteria that encourage discussion and explication of rationale would seem to be more appropriate. This will vary from profession to profession depending on the chosen definition and emphasis of reflective practice. However the criteria developed by dietitians in the London area for the assessment of reflection on action during pre-registration practice placements are shown in table 14.1 below as a starting point for discussion.

Is able to identify critical incidents.
Is able to identify key themes from those incidents
Is able to identify the practical, theoretical and emotional factors that influenced their actions.
Recognises the need for guidance and advice where appropriate and uses appropriate sources to obtain this help.
Uses this information to plan future practice demonstrating an awareness of his/her limitations and competence.

Table 14.1 Criteria for assessment of reflection on action

Kember and Leung (2000) have developed and tested a questionnaire to identify levels of reflective thinking. This work was carried out with student physiotherapists, occupational therapists, radiographers and nurses. The questionnaire covers four scales representing Mezirow's (1991a) levels of reflective thinking. Initial versions of the tool covered all of Mezirow's levels but these were found to be unreliable and the final version focused on:

- Habitual Action – activity carried out with little conscious thought as a result of frequent repetition.
- Understanding – thoughtful action.
- Reflection – the critique of assumptions about the content or process of problem solving.
- Critical Reflection - becoming aware of why we perceive, think, feel or act as we do, leading to the redefinition of a problem and redirected action.

The pyschometric properties were established using confirmatory factor analysis and each scale was shown to be reliable using Cronbach's Alpha. Validity was assumed on the basis that the scales were derived from the literature, although only Mezirow's work was used. All testing was based on reflective thinking in the context of a university course rather than practical experience. Modification and further testing in the practice setting may offer a useful tool for assessment in the future.

Having clarified a working definition of reflection, defined broad assessment criteria, standardised the supportive resources available to students and checked the competence of those charged with facilitating reflection we need to consider how we will capture reflective practice in order to assess it.

Reflective writing is often suggested as a suitable work product for assessment, but I would like to flag up a number of potential pitfalls associated with this approach.

Students may have excellent reflective skills but poor writing skills. Deep reflection is likely to include consideration of complex cognitive and affective issues that may be difficult to express in the written form. What is more we often encourage students to document their reflections in a manner that has meaning and usefulness for them whether this be words, diagrams or sketches. These may have deep meaning for the student but may not be intelligible to an assessor.

In addition it has been argued (Rich 1995) that students may be reticent to document details of their mistakes in writing particularly if they relate to work in the practice setting where patients may have been compromised by their actions. This could lead to superficial even fictitious accounts being offered for assessment. Furthermore if students do submit honest reflections detailing practice errors that were not corrected where does this leave the assessor in terms of their professional and moral duties?

In practice I would suggest that adequate supervision should prevent these problems. In dietetics student entries on dietetic record cards and in the medical notes are counter-signed by a registered practitioner and students are required to discuss these entries and the rationale for their actions. Thus even if an error is made it should be picked up and corrected swiftly. Students are then safe to reflect on their mistakes knowing that ultimately no significant damage was done.

If we accept that some students will struggle to demonstrate their reflective skills in writing what other options are open to us?

One advantage of written reflection is that it is retrospective and allows the student time to collect and organise their thoughts using models, prompt questions and other resources as required. However students could also be given time to consider critical incidents before discussing them verbally with a supervisor. Where professions have chosen to use a conceptualisation of reflection that focuses strongly on the self, consideration would need to be given to the role of the supervisor and to who should actually make a judgement about the usefulness of the reflective session.

Reflection is likely to bring difficult feelings into the student's consciousness and it would be impossible and inappropriate for the supervisor to maintain a passive stance. Consequently it may also be difficult for the supervisor to make a fair judgement about the quality of the reflection. Taping reflective sessions for assessment by a third party may offer a way forward but students may not feel comfortable with this.

There is no easy solution to the challenges I have outlined here but I would like to propose a two-stage process for the assessment of reflection. Clearly it is important in terms of student development that they should be supported to reflect freely in a form that has meaning and usefulness for them using a full range of resources including facilitation as required. Having done this, students may be in a position to recount the process and explain the product of their reflections either verbally or in writing for the purpose of assessment.

Some healthcare students including dietitians are required to demonstrate that they can reflect in action as well as on action. Assessment of reflective activity in the midst of practice necessitates a process of thinking out loud and this is particularly awkward in professions where practice is cognitive and discursive rather than hands on. In these cases simulated assessment may be preferable and actors or video clips of practice may be useful resources. The assessor can then stop the video or role-play and discuss practice reflectively with the student at critical points. However assessment in the "live" setting may also be possible and two potential approaches were discussed in chapter 10

The use of reflective strategies to facilitate assessment of healthcare students

Competence based assessment (CBA) has achieved popularity with healthcare managers and governing bodies as a means of exposing practice to public scrutiny and much assessment of healthcare students has competence at its core. CBA systems rely heavily on observing practice and work products and comparing them with competence statements and lists of performance criteria that set out the minimum standards of safety and efficiency.

In relation to the assessment of professional practice there has been much debate about whether CBA can effectively cover the dynamic nature of practice (Bordieu 1977, Ashworth and Saxton 1990, Black and Wolf 1990, McGahie 1991, Chaiklin and Lave 1993, Nagelsmith 1995, Prideaux 2000) and the complexities of professional reasoning and action (Short 1984, Dunn et al 1985, Curl and Koerner 1991, Hager and Gonczi 1996, Worth-Butler et al 1996, Milligan 1998, Chapman 1999, Watson 2002).

Much of professional practice is difficult to assess by observation or by reviewing work products. Pearson and Smith (1985) assert that where knowledge is problematic ie where there is no clear right or wrong action we need to share our meaning and understandings through language and reflective activity in order to facilitate effective assessment. Several authors writing for the healthcare professions (Clark 1986 – nursing, Procter and Reed 1993 – nursing, Dall'Alba and Sandberg 1996 - medicine, and Haddock and Bassett 1997- nursing) have suggested discursive, reflective assessment as a tool for promoting an improved contextual understanding of competence in the practice setting.

Clearly there is a tension between reliability and validity with such systems. Those who view competence as ontologically objective would seek to develop and validate reductionist assessment tools. However the danger here is that we may sacrifice validity for the sake of reliability as such a system fits best with the assessment of simple, easily observable tasks. This ignores the vast majority of professional practice, which is "messy" and subjective. Clearly a system that is totally

devoid of assessment criteria would be equally unacceptable for professions seeking to make themselves accountable to the public and each other. A middle way may be to develop broad assessment criteria that encourage the student and assessor to engage in reflective discussion about practice embracing consideration of the full range of theoretical and contextual issues that may have influenced the student's behaviour. Assessment judgements could then be internally and externally moderated to ensure an element of reliability testing though not in the pure mathematical sense.

Perhaps the most important assessment tools are the assessors themselves and not the performance criteria they use. Fair and transparent assessment is more than simple box ticking and those who take on this responsibility will need access to suitable learning opportunities themselves if they are to develop the skills they will need. Clearly courses and distance learning materials need to address the role of reflection in assessment.

In my own role as Education and Training Facilitator for London Dietitians I have recently developed a self-guided learning pack to support student dietitians and their supervisors with regard to the development of their reflective skills (see pages x-y). Section four of the pack deals exclusively with using reflective strategies to demonstrate competence. Students find demonstrating competence particularly difficult in relation to personal, aesthetic and ethical aspects of practice. Consequently they are encouraged to reflect regularly with the aim of identifying critical incidents that may be relevant to these aspects of practice and to record them in their reflective diaries. These reflections do not have to be shared with anyone at this stage. Towards the end of the practice placement it is suggested that they review their diaries and use different colour highlighter pens to pull out potential evidence in relation to the learning outcomes that cover the more difficult personal, aesthetic and ethical aspects of practice. A summary of the student's experiences and what they have learnt in relation to specific learning outcomes could then be presented to a supervisor or group of supervisors. For example they might do a presentation on the challenges of anti-discriminatory practice or the responsibilities of a professional. This allows them to present evidence that links their behaviour with a contextual understanding of competence.

Conclusion

Assessing reflection and using reflective strategies for facilitating assessment presents the healthcare professions with a range of dilemmas. Research and inter-professional collaboration are needed to support those who have responsibility for assessment to ensure that the process is fair and transparent.

Biography:

I have been a practising dietitian for the past 13 years and I am currently employed as Pan London Education and Training Facilitator for Dietitians. My work role involves supporting reflective practice in the context of student groups and facilitated CPD groups for dietitians. I have recently developed a self-guided learning pack to support a more reflective approach to learning and the assessment of competence in dietetics. I am registered as a PhD student at the University of East London and I am carrying out a qualitative exploration of dietitians' and student dietitians' experiences of assessment in the context of the pre-registration practice placement.

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CHAPTER 14

CONCLUDING OVERVIEW

Key Points and Future Developments in Reflective Practice within the Education of Health Professionals

In this final chapter I shall attempt to distil key points from the preceding chapters and to create a general picture of the ways in which reflective practice currently impacts on the education of health professionals within the United Kingdom. I feel sure that as a reader with an interest in reflective practice you will agree that the range of contributions is fascinating. Because, as several contributors point out, reflection is a rather nebulous concept that is challenging in terms of knowing how it can be facilitated and assessing whether or not our strategies have been successful, it is encouraging and reassuring that so many contributors have been prepared to share their innovations so candidly.

I have approached analysis of the contributions much as I would approach any analysis of qualitative data. First, by paradigmatic analysis (Polkinghorne, 1995), looking across accounts it is possible to recognise similarities and differences. However, although this approach is commonly utilised it risks decontextualising data and providing a partial impression. This problem is overcome by combining an approach that focuses on 'holistic content' with one that focuses on 'categorical content' (Lieblich et al, 1998). Here, the potential contribution of each individual chapter has been considered in terms of its contribution to our overall understanding, and specific characteristics are used to illustrate points of good practice from which we may all learn.

Several themes have become apparent that form the subsections of this chapter. Particular attention is paid to facilitating and assessing reflection. As Sylvina Tate stressed in the introduction to the paper, we are not suggesting that the experiences shared represent 'best practice', only that they might help to advance our general understanding of what works and what is less successful in enhancing the reflective capabilities of our students.

Sylvina Tate opens Chapter 1 with a quotation from Peter Jarvis (1992) that highlights reflective practice as 'something more than thoughtful practice'. She goes on to consider 'critical reflection' and the necessity to engage in critical thinking that involves identifying and challenging assumptions, challenging the importance of context and imagining and exploring alternatives (Brookfield, 1987). Emphasis is placed on the notion that teachers and writers should engage in critical reflection if they are to avoid contradicting their own messages in the eyes of colleagues and students. However, it appears that the extent to which contributors to this paper are critically reflexive about their innovations forms a continuum from 'thoughtful practice' to highly reflexive. Several authors' contributions have probably been reflective opportunities in themselves and certainly this applies to myself. Contributing to a publication is a legitimate use of time in institutional terms and to be recommended as a strategy for creating space to reflect!

Rationale for Incorporating Reflection into Curricula

Political, economic and social arguments for using critical reflection as a teaching tool at undergraduate and postgraduate levels with the intention of enhancing the capabilities of newly qualified practitioners within the health professions, have been well rehearsed. That some

professions, such as certain branches of nursing and occupational therapy, have a long established association with reflection while others such as paramedics and pharmacy are only just beginning to recognise its importance to practice, is potentially energising in that it creates a dynamic for challenging established practice and for innovation. In addition, the move towards inter-professional education presents further opportunities and challenges. Several contributors, such as the occupational therapist Rebecca Khanna, considered the potential from a range of perspectives. However, the underpinning rationale for incorporation appeared to vary considerably between the different professions.

Aspiring to enhance holistic client care was acknowledged as an important reason for incorporating reflection within the curriculum for complementary therapists, nurses, mental health nurses, occupational therapists and paramedics. Less prevalent was acknowledgement of potential benefits for individual practitioners, notably in respect of utilising reflective practice as a tool for continuing professional development (CPD) needs of pharmacists and midwives. However, contributors from dietetics, midwifery, pharmacy, physiotherapy and podiatry have focused on the impact of reflective practice on their respective professions.

Emphasis on professionalisation issues might be explained if we consider that most of the professions represented fall into the category of 'new' professions or what have been termed 'semi-professions'. These professions are characterised by their progressive moving away from medical dominance and striving to achieve autonomy that necessitate a critically reflexive approach to practice. Relatively newer professions such as paramedics seeking to consolidate professional status are following suit in recognising the potential for escaping protocol-driven care.

Reflective practice has become synonymous with 'professional practice' and hence part of the discourse of professionalisation such that it is almost considered a panacea for dealing with the constant challenges inherent in the evolving health and social care setting. For example, discussions of the interface of reflective practice with evidence-based practice that was recognised by several contributors can be considered within the discourse of professionalisation.

Embeddeness within Professional Programmes

In Chapter 1 Sylvina Tate posed the question '[I]s critical reflection an add on concept or is it embedded into the wider curriculum?' On the basis of the range of contributions, it has to be acknowledged that in some cases it does appear to be bolted on rather than embedded within the wider curriculum. However, it seems fair to say that, for instance, within pharmacy, reflection is being adopted tentatively initially. There is a strong message, that comes from most of the professions represented in favour of the need to address reflection from early in a programme of study and hence forth to thread reflection throughout both university and practice based modules at all levels. As such, critical reflection provides the ideal vehicle for linking theory with practice. In principle this sounds fairly straightforward but is evidently more problematic for some professions than others.

Where qualified colleagues and peers are sceptical about the potential of reflection this seems to stem from paradigmatic assumptions, which underpin beliefs about the profession. Dietetics, pharmacy and physiotherapy all acknowledge their positivistic and techno-rational roots, giving rise to assumptions that seem to inhibit acceptance of the more 'artistic', 'craft' or subjective aspects of practice to various extents. Conversely, complementary therapists and occupational therapists at the opposite end of the continuum appear to embrace the concept of critical reflection wholeheartedly.

Nevertheless, Indra Jones and Patricia White are optimistic about the gradual incorporation of less scientific perspectives of practice. They illustrate, in the context of paramedic and physiotherapy education respectively, how practitioners are beginning to recognise the contribution that critical reflection can make to professional knowledge and concentrate less on the medical scientific explanations to the exclusion of all other perspectives.

Facilitating Reflection

Several issues are addressed under the general theme of facilitating reflection. These include the use of models and frameworks, strategies that encourage reflection, implications for teachers and the educational environment, practice based reflection and 'space' for reflection.

The Use of Models and Frameworks

In the context of midwifery education, Annie Powell-James relates the comments of one student who laments that there are 'no guidelines on how to use it or do it properly'. Some students appear to need close guidance while others do not, highlighting apparent tensions evident in several chapters between guidance and being too prescriptive.

Indra Jones suggests that to adopt a specific focus is sensible because it helps students know where to begin. However, she promotes the view that cyclical models promote a non-reflective approach to written reflection. Despite acknowledging that reflection can take place without the use of any model, Sylvina Tate advocates that students are exposed to a range of models from which they can find a model with which they most connect. In fact, an eclectic use of a range of models and frameworks characterise many of the programmes discussed in preceding chapters. For example, Kolb (1984), Boud et al (1985), Gibbs (1988), Johns (1995), Mezirow (1991a), Moon (2001) and Schon (1983) all have a part to play.

Sibyl Coldham representing the complementary therapies and Alison Clark from nursing opt instead for simple frameworks for structuring reflection. Indra Jones favours pragmatic guides that structure reflective thinking, although she suggests that use of the same framework throughout three years of study can lead to a ritualistic, superficial approach to reflective learning. The key point to emerge from the overview that has been developed seems to support simple practical guidance for students together with exposure to a range of models with flexibility within choice of models and being open to students who choose to create their own framework for reflection.

Strategies Encouraging Reflection

Maria Young and Annie Powell-James infer that reflection may be particularly difficult for younger students and students for whom reflection is new. In addition, Indra Jones' suggestion that, in the light of different learning preferences, we should adopt a variety of strategies to encourage reflection in our students, encapsulates the message that evolves from the various contributors. Teaching and learning strategies include action learning, enquiry based learning, problem based learning, critical incident analysis, profiling, portfolio development, essay writing, seminar presentations, tutorials, simulations, role-play, use of practice scenarios and Web-based discussion forums. The complementary therapy programme at the University of Westminster adopts an entirely experiential educational approach in which self-directed learning is central and strategies such as small group work, discussion and role-play are employed.

Whereas some programmes focus primarily on utilising one strategy, such as the development of a portfolio, others utilise a range of strategies that might promote both 'monological' and 'dialogical' reflection (Habermas, 1972). For instance, in the context of teacher preparation, students keep a

reflective diary but Helen Stanley favours the addition of group reflection for its potential to prevent 'navel gazing' and capacity for widening perspectives. Figure 1.3 highlights the relative advantages and disadvantages of individual and dialogical reflection with and without facilitation. A variety of strategies that promote both appear to have the potential to maximise critical reflection.

Special mention must be made of written reflection since it generated considerable debate. A general concern that students are frequently hampered by poor writing ability, confused about what constitutes proper writing and are reluctant to commit their thoughts to paper, create reservations about the potential of written reflection. Further concerns about capacity for transparency, candour and fictitious accounts indicate the need for close attention to clear guidance, example accounts and incorporation of other reflective strategies such as verbal presentation of ideas. Much reliance has been placed, and continues to be placed, on a variety of written accounts as a means of capturing retrospective reflection and perhaps too little recognition of the skill involved that needs to develop over time.

Few contributors make explicit attempts to relate strategy to the type of reflection that they endeavour to encourage although both Rebecca Khanna and Patricia White from occupational therapy and physiotherapy respectively mention both reflection on action and reflection in action. Strategies seem largely aimed at promoting retrospective reflection and, as Sylvina Tate suggests this process is probably more appropriate at the level of student health care professionals. Personally, I would argue that even for the novice practitioner, learning to think during an experience is essential to practice and a capability that should at least begin to be addressed through facilitatory strategies adopted at undergraduate level.

Implications for teachers and the educational environment

There is consensus that embedding critical reflection within a programme necessitates a shift in philosophy from teaching in a didactic sense to facilitating learning. Patricia White sees the educator role as pivotal to the intellectual development of the novice reflector. However, facilitation represents a new role for educators within both higher education and practice contexts. Further adjustments must be made in terms of a commitment to reflection that in Stephanie Fade's experience in dietetics can be problematic. Such problems can arise often through lack of awareness highlighting the need for ample provision of workshops and short courses for educators unfamiliar with the concept. As Stephanie Fade suggests we must ensure the competence of those people who attempt to support and facilitate reflection so that they too can learn to understand and value reflection and so successfully promote it. Again this is possibly less straightforward than we might assume. Having identified potential problems with a 'supervisory' style of practice educators, Stephanie has uncovered hegemonic assumptions in practice that will need to be worked through hopefully culminating in positive action for educators and future students.

The importance of a safe environment in which to reflect is emphasised by several contributors. In particular, Helen Stanley refers to a safe place to go to be 'human', and the need for an atmosphere of trust that relates closely to the approach adopted by educators and their competence in facilitating reflection. The importance of constructive feedback cannot be overemphasised. Aside from the central role of the facilitator or mentor, Stephanie Fade calls for the need to standardise supportive resources available to students. This might prove challenging within some institutions and workplace settings. For instance, where Web-based discussion forums are utilised as a specific strategy for encouraging reflection, ensuring access may be problematic. Again this points to the need to use a range of reflective strategies as a means of creating parity.

Practice-based Reflection
Practice-based reflection deserves specific mention due to its recognised importance in particular within the complementary therapies, nursing, occupational therapy and physiotherapy, for exposing students to the realities of practice and facilitating reflection. Within pharmacy and podiatry reflective strategies currently feature more specifically in university-based modules although this may change as reflection becomes more deeply embedded within programme philosophies. Alison Clark argues that reflection should be more than a theoretical tool. She suggests that nurses may be good at discussing their ideas but not so good at performing them, highlighting the importance of exposure to practice in unpredictable environments as a means of translating critical thinking into practice.

The value of the contribution of practice to student learning is evident through the recognition of the importance of partnership and collaboration with service colleagues. Such collaboration is particularly emphasised by Indra Jones in the context of paramedic education who stresses the increased opportunities for unifying theory with practice and vice versa.

Creating 'Space' for Reflection
Embedding critical reflection within the curriculum means making space for it. A crammed curriculum is not conducive to facilitating reflection. Contributors refer to 'creating space to reflect', 'building in time' and the importance of 'dedicated time'.

Once again this premise creates challenges for programme teams. For instance, Rebecca Khanna describes how students have regular individual meetings with their personal academic tutors, which are undoubtedly invaluable but clearly make considerable demands on staff time.

Time is at a premium especially in the practice setting where, as Stephanie Fade found, educators place greater value on maximising patient contact and therefore squeezing out time for reflection. However, Stephanie shares one idea developed from Schon's (1987) 'joint experimentation model' that creates some space for students to discuss their ideas with their educator within a patient encounter. The support for time as critical to the reflective process highlights a need for creativity in providing space no matter how packed the curriculum or how busy the department or ward.

Assessment
Sylvina Tate identifies two ways in which assessment can be used: to assess students' reflective ability and to assess specific competencies using critical reflection as a format. The general overview of programmes included in this paper, suggests that the majority relate reflection to specific competencies, some more explicitly than others. For example, within nursing we are told that 'reflective tutorials …enable students to build a body of substantive evidence that illustrates they are achieving their practice competencies to the required level'. The explanation for a competency interpretation is surely closely related to the prescribed educational outcomes approach stemming from competence-based education and resultant competency frameworks that place importance on the acquisition of 'skills'. However, within the context of the occupational therapy programme Rebecca Khanna describes a programme philosophy, structure and assessment process that appears to address both specific competencies and reflective ability through which process is valued.

There is some debate as to whether or not reflection should be assessed. Indra Jones argues that it should be assessed if it is to be accepted as a valid subject, relating how formative assessments were abandoned because they did not enhance student development. Likewise, Stephanie Fade argues that if we consider reflection to be important it should be assessed. Drawing on recent research she

goes on to suggest that, if we want something to be the focus of student attention, we need to make it the focus of assessment. Where reflection is fundamentally embedded, for instance, within paramedic education, it does appear that students accept and value the potential of reflection.

Whereas critical reflection is assessed through formal summative assessment in a number of programmes, in others assessment is purely formative. Those using formative assessment are usually doing so because they are at a pilot stage of developing assessment strategies. Patricia White highlights the challenge of assessing reflection because it is not easily measurable. However, detailed marking guidelines and assessment criteria that she provides (see appendix 3.3) demonstrate that assessment is feasible when there is commitment to developing appropriate assessment protocols.

There appears to be a prevalence of written reflection within the health professional programmes included in this paper in the form of reflective diaries, portfolios, essays and reflective reports. As acknowledged previously, written reflection can prove challenging for students but neither are educators immune to its challenges. Provision of constructive feedback completes the assessment process cycle and, as the experiences of Sylvina Tate illustrate, it can be difficult to avoid appearing judgemental. Judith Rees highlights ethical uncertainties for educators faced with dealing with personal insights of their students. Sybyl Coldham's advice seems to be to provide guidelines that are fairly prescriptive as to process and ask students to focus on their learning in relation to module or syllabus content. She suggests this should dissuade students from relating sensitive personal issues and facilitators having to deal not only with the assessment process but the aftermath of revealing them. Some may feel reassured, others uncomfortable with this suggestion, which seems to put boundaries around what students are and are not allowed to relate within their written reflections. Perhaps potential for catharsis as well as challenging the comfort zone of lecturers should be debated more freely within programme teams. Nevertheless, Stephanie Fade supports the view that students need good guidelines and argues that they are essential if assessment is to be reliable.

Detail of assessment strategies is patchy. Stephanie Fade supports the ideal of having broad assessment criteria that are not too prescriptive, although where competencies are being assessed this might be difficult to achieve. Assessment tools have been developed but achieving reliability and validity of an assessment tool might not be a short-term proposition. There seems to be an imperative to bring likeminded people interested in assessing critical reflection together to further explore how both outcomes and depth of reflection might be assessed.

Evaluation

Part of the initial brief for contributors to this paper was to include how reflection had been evaluated within each programme. As a result we have been provided with a range of insight from a detailed audit tool (see appendix 3.8) to quotations from students. What seems clear is that evaluation is perceived to be a very important aspect of curriculum innovation and that many of the contributors are actively engaged in embedding critical reflection within their programmes and using an action research approach to improving practice. The development of evaluative strategies is therefore an on going and organic process that similar to assessment strategies might provide a dynamic to encourage further collaborative work.

Key Points and Ideas for Future Development

The following points emerge from insights across the range of contributions:

- Reflexivity on the part of designers and teachers is essential if critical reflection is to become embedded within programmes of study. This should extend to a consideration of the epistemological and ontological assumptions, which influence rationale

- Embedding reflective practice into curricula is a dynamic and developmental process that is a longer rather than short-term project

- Reflection should be introduced early in the programme and underpin university and practice-based learning

- Exposure to a range of models and/or frameworks is helpful for some students

- Students benefit from the use of a variety of reflection promoting strategies that make allowance for different learning preferences

- A range of strategies that encourage both individual and dialogical reflection are most likely to develop depth and breadth of critical reflection

- There is a need to be reflexive about the type of reflection we aim to promote and whether or not students would benefit from strategies aimed at promoting reflection during an experience should be considered

- It is essential to build into the programme dedicated time for reflection

- Written reflection is a skill in itself and should be recognised as such, especially in the context of summative assessment where it should be complemented by other forms of assessment

- Educators have a facilitatory role in promoting reflection including the creation of an atmosphere of trust

- Where reflection is assessed, criteria should be as broad as possible and not too prescriptive

- Dissemination of systematic evaluations are necessary to enhance development and application of critical reflection in educational programmes

- Rigorously conducted research is needed to explore links between reflection, more effective practice and improved patient care

- Inter-professional collaboration such as occurred at the Festival of Learning and Teaching in 2002 is needed to advance thinking on specific aspects of critical reflection such as assessment and evaluation.

- One of the significant contributions of this Occasional Paper is to demonstrate differences in the way that reflection in teaching and learning is developing in the different health professions. Despite consensus on aspects of incorporating reflection into the curriculum it appears that there is wide variation in conception of reflective practice in different professions. These varied conceptions influence the nature of reflection, particularly with respect to the extent of attention to affective concerns. Our ultimate aim has been to capture some sense of current practice that

provides a basis for evaluating further progress, to promote critical reflection, and further research amongst advocates of reflective and reflexive practice.

Biography

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I am a Principal Lecturer in the Physiotherapy and Dietetics Subject Group in the School of Health and Social Sciences at Coventry University. My primary role within the subject group is to co-ordinate clinical education for the undergraduate physiotherapy course. My doctoral thesis explored the social construction of identity within the process of professional socialisation of occupational therapy students and I have an on-going interest in how professional socialisation continues after qualification. Since 1996 I have been involved in embedding reflection into the undergraduate physiotherapy programme and have developing a reflective practice module that continues to evolve in response to evaluative strategies. I am currently evaluating the impact of Web CT discussion forums on the reflective capabilities of undergraduate physiotherapy students.

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APPENDICES

Appendix 2.1

Case One: Year 1, Level 1(4)
In the following case study the process by which the students' skills of reflection at level 1 are fostered and assessed, will be demonstrated. Using the different *fonts* the reader is able to map from the aims of the module, through the marking criteria, to examples of the student's work.

Title	**Clinical Podiatry 2 (single module)**
Level	1 (4)
Credit Rating	10 CAT points
Semester offered	Year 1 Semester 2
Pre-requisites	The students will have successfully completed the clinical podiatry module 1.

AIMS

to enable students to develop problem solving skills in the clinical assessment of patients;
to enable students to develop clinical skills in the treatment of common foot conditions;
to enable students to develop reflective skills.

Learning Outcomes/Objectives
The student will be able to:

demonstrate developing practical skills in the treatment of common foot conditions;
demonstrate basic vascular assessment;
demonstrate basic neurological assessment;
demonstrate a basic musculoskeletal assessment;
demonstrate a basic understanding and the ability to reflect on the principles of the treatment of common foot disorders.

Content

basic vascular assessment; basic neurological assessment; basic musculoskeletal assessment; history taking; clinical practice; topical medicaments, padding and strapping and dressings.

Teaching and Learning Strategies
Patient demonstrations, group work, tutorials, ward rounds and clinical practice with an emphasis on integration with practice.

Learning Support
Personal tutor and module team support. Use of libraries and learning resources.

Assessment

1. *Clinical Learning Journal.*
2. Statements of Competence 2.

Brief Description of Module
This module will enable the student to develop their clinical skills in the assessment and treatment of simple foot conditions. The development of problem solving skills will be encouraged to enable the student *to reflect on their assessment and treatment strategies.*

Marking Guidelines for the Clinical Learning Journal
Clinical Podiatry 2 (PP107)
ASSESSMENT
At the end of the semester you will be expected to provide written and practical evidence of your having attained the required learning outcomes. It is essential that this evidence is collected as you progress through the module to demonstrate gradual development through the course. Remember that this is at level 1 (4).

There are two pieces of assessment for this module; you are required to pass both components:
- *Clinical Learning Journal* (60%)
- Clinical Statements of Competence 2 (40%).

Clinical Learning Journal
You will be expected to write a *reflective journal* where the skills learned in the pre-clinical programme are utilised, evaluated and reviewed with each patient that you see. This aspect of the journal should show *self-evaluation and reflection appropriate at level 1 (4)*. Incorporated into the journal will be the following aspects:

1. Basic vascular assessment

There will be a clinical tutorial on how to carry out a basic vascular assessment of a patient. Following participation in this tutorial the entry in your journal must:
a) demonstrate that you have understood the meaning behind the information given
b) show an appreciation of the purpose of this assessment for effective patient treatment
c) indicate that you know what the "normal' outcomes of the assessment are
d) *reflect on what you have learned*.

On subsequent entries you should demonstrate that you have applied this assessment technique to your own treatment of the patients by detailing the process of assessment and discussing the outcomes. In this way you will be providing evidence that you are attaining the skills required of you at level 1.

2. The manufacture of orthoses

You will have a session covering the manufacture of orthoses once per fortnight. In your journal you are expected to write and justify what information you will need from a patient to be able to produce an effective orthotic. This will be approximately 300 words in length.

3. Clinical tutorials

You will be expected to write a 300 word report after each clinical tutorial you attend. Do not include any handouts you are given in these sessions, but devise your own method of *demonstrating what you learned and why.*

4. Self- and tutor-evaluation

You must be able to demonstrate developing practical skills and demonstrate a basic understanding of the principles of treatment of common foot conditions. The theory behind these aspects should be reflected in your daily journal, however evidence for them will be recorded by the completion of a clinical self-evaluation form.
Self-evaluation is an opportunity for you to identify your own strengths, weaknesses and clinical needs.

Summary
The assessment is a *reflective document* called a clinical learning journal. It will include the following:
- a session-by-session account of your learning and *reflective practice*
- a detailed *and reflective entry* about vascular assessment following the tutorial, plus demonstration within subsequent journal entries that you have applied this basic assessment technique to your patient treatment
- a written, justified explanation of what information is required of patients for the manufacture of an effective orthotic
- 300 word reports about each clinical tutorial

- both evaluation forms (pale and dark green) with *reflection on the outcomes of the 'evaluation' discussion*
- a reference section.

The journal will be marked out of 100 with the weighting as follows:

Overall clinical learning journal	*30 marks*
Vascular assessment	20 marks
Orthotics section	20 marks
Tutorial reports	20 marks
Self- and tutor- evaluation	10 marks

The inclusion of additional information and evidence of reading will be awarded marks appropriately.

Extracts from student submissions

"Having read up about chilblains and chilling it makes me realise how painful the condition can be…… it may have been appropriate today to have advised the patient to buy a mild chilblain cream…. (but) I think we chose the best course of action by giving her some warm insulating insoles."

Comment in journal by student: *"In the afternoon we leant about carrying out a vascular assessment. I found this interesting, but when doing the tutorial worksheet at home I discovered a lot of new information and learned a great deal more."*
Feedback from marking tutor: *"Your entries on the tutorials were all very good, but don't forget to demonstrate your application of them in clinical practice."*

Comment in journal by student*: "Having read the short article on toe nail growth I decided this would be a good opportunity to do some further reading…. The article I found…. was very informative and I learnt a lot of useful facts…. such as the rate and amount of water loss per unit surface area from a nail is greater than that of any epidermal surface except the palm and sole (Dykyj 1989)."*
Feedback from marking tutor: *"A pleasure to read, and some interesting extra research."*

Comment in journal by student: *"Having seen the patient who was breathless and listening to the advice given to her by the tutor it made me conscious of the fact that I hadn't taken much notice of her symptoms. I was so caught up in seeing to her feet…. This was a situation when the possibility to act more as a holistic practitioner arose, and I missed it!"*

Tutor evaluation form: *"Nail care of a very high standard, updated medical history/medications and is aware of implications of medication such as anticoagulants."*
Student evaluation form*: " I have cut a lot of nails so feel happy doing this, I always read over the patient's history and update it where necessary, since working through the vascular and neurological assessment worksheets I feel more knowledgeable when carrying out these assessments on patients."*

Summary by student: *"Surprisingly to me, I have found that by actually putting effort into my Clinical Learning Journal, rather than just looking upon it as a nuisance, I have learnt a great deal and enjoyed doing it. I still think I have put in too much 'descriptive' work, but have tried to balance it with 'reflection' and learning."*
Feedback from marking tutor: *"Your session-by-session account of your learning and reflective practice was excellent. You comment that it was possibly too descriptive and I agree, but you raise some interesting points eg. posture, cost of care, Patients' Charter."*

Appendix 2.2

Case Two: Year 2, Level 2 (5)

In the following case study the process by which the students' skills of reflection at level 2 are fostered and assessed, will be demonstrated. Using the different FONT the reader is able to map from the learning outcome of the module, through the marking criteria, to examples of the student's work

Title	Clinical Podiatry 4 (double module)
Level	2 (5)
Credit Rating	20 CAT points
Semester offered	Year 2 Semester 4
Prerequisities	Completion of clinical podiatry 3.

Aims

to develop further the students' assessment, diagnostic and treatment skills of podiatric conditions;
to develop management skills of relevance to clinical podiatric practice;
to develop professional practice by the rehearsal of communication skills identified at level 1(4);
to further develop professional practice by the demonstration of an awareness and understanding of the psycho-social considerations of podiatric medicine.

Learning outcomes/objectives

On successful completion of the module the student will be able to:

demonstrate knowledge of podiatric conditions both at micro and macro levels;
demonstrate assessment and diagnostic skills; demonstrate management skills;
DEMONSTRATE REFLECTIVE PRACTICE IN PODIATRIC CLINICS;
demonstrate an appreciation of the effects of disorders on skin and joint tissue;
demonstrate an awareness of the nature and severity of bacterial, fungal and viral infections of the foot;
demonstrate an understanding of the role of accomodative and functional orthoses;
demonstrate the ability to manufacture orthoses.

Content

physical therapies; biomechanics; orthotic management; clinical practice; professional practice.

Teaching and learning strategies

Ward rounds, patient demonstrations, workshops, problem - based learning, practical clinical and orthotic sessions.

Learning Support

Personal tutor and module team support. Use of libraries and other learning resources.

Assessment

CLINICAL LEARNING FILE and Clinical Examination.

Brief description of module content

This double module will enable the student to apply learning outcomes from other modules in a clinical environment and further develop their professional practice with particular emphasis on the psycho-social aspects of care.

Marking Guidelines for the Clinical Learning File
Clinical Podiatry 4 (PP206)

Assessment schedule
The assessment for this double module is in two parts;
i) A CLINICAL LEARNING JOURNAL (50%)
ii) A clinical examination
Clinical Learning Journal
Introduction
The clinical learning journal in the semester four of the second year should contain evidence of your learning in the clinical setting and demonstrate how you have integrated theoretical learning into clinical practice. The journal will account for 50% of your mark in the clinical podiatry module, the remaining 50% will come from your clinical examination. Your journal should be structured in such a way that you are able to demonstrate that you have achieved the learning outcomes for the module detailed below, it is therefore, not a day to day diary. In addition your journal should allow others to be able to map its contents to the learning outcomes, i.e. which mini case history or case report relates to which learning outcome, as each section of your journal may pertain to more than one learning outcome.

Learning Outcomes to be addressed in the journal
- DEMONSTRATE REFLECTIVE PRACTICE IN PODIATRIC CLINICS
- demonstrate an appreciation of the effects of foot pathologies on skin, soft tissue and joints
- demonstrate an awareness of the nature and complications of bacterial, fungal and viral infections of the foot
- demonstrate an understanding of the role of accommodative & functional orthoses and the ability to prescribe orthoses

Specific Guidelines
You are recommended to include <u>four</u> sections to your journal.

TO DEMONSTRATE REFLECTIVE PRACTICE FIRSTLY DEFINE WHAT THIS TERM MEANS IN 50 - 70 WORDS. ONCE YOU HAVE AN APPROPRIATE DEFINITION, WE EXPECT THIS UNDERSTANDING OF REFLECTIVE PRACTICE IS MADE EXPLICIT IN THE THREE REMAINING SECTIONS. YOU CAN ACHIEVE THIS BY ENSURING YOU INCLUDE A CRITICAL EVALUATION OF YOUR PRACTICE (AND YOUR LEARNING) IN EACH SECTION

To demonstrate an appreciation of the effects of foot pathologies on skin, soft tissue and joints; a critical review of a case (750 words) is required. This section will concentrate on a specific foot disorder for example;
- soft tissue pathology e.g. inflammatory disorders (i.e. plantar fasciitis)
- bone & joint pathologies e.g. Hallux Valgus

To demonstrate an awareness of the nature and complications of bacterial, fungal and viral infections of the foot; a critical review of a case (750 words) is required. This section may concentrate on asepcts such as;
- differential diagnosis of skin & nail infections for specific patient or condition,
- rationale for the choice of appropriate anti-microbial agents for specific patient(s) or conditions.

In order to demonstrate an understanding of the role of accommodative & functional orthoses and the ability to prescribe orthoses; select two orthoses (one accomodative, one functional) you have prescribed and comment on the role of thses devices in the patient's overall management (750 words)

Gerneral Guidelines
Overall your journal must contain the following sections;
- A DEFINITION OF REFLECTIVE PRACTICE
- two critical case reviews

- a section commenting on the role of two types of orthoses

Remember you must not breach patient & peer confidentiality and that information/sources used must be appropriately referenced according to University guidelines. At the end of the semester the module team will formally assess your learning journal. Overall, there should be clear evidence that the learning outcomes detailed have been achieved.

Extracts from student submissions

The student's definition of reflective practice: "REFLECTIVE PRACTICE IS A PROCESS INITIATED BY THE PRACTITIONER WHICH INVOLVES LOOKING AT ONE'S OWN PROFESSIONAL BEHAVIOUR WITH THE INTENTION OF IMPROVING AND DEVELOPING IT (CLARKE AND CROFT 1998). BY EXAMINING AND EXPLORING AN AREA OF CONCERN, THE PRACTITIONER CAN CLARIFY THE MEANING OF THE EXPERIENCE, LEARN FROM IT AND THUS BE ABLE TO DEVELOP A CHANGED PERCEPTUAL CONCEPT TO ACHIEVE MORE DESIRABLE, EFFECTIVE AND SATISFYING WORK (BOYD AND FALES 1985, JOHNS 1995B)."

Demonstrating reflective practice in the podiatic clinics: "THE DRESSINGS USED WERE INTRASITE DIRECTLY ONTO THE WOUND, WITH A PROTECTIVE COVER OF ALLEVYN. THESE DRESSINGS BOTH SEEM TO HAVE BEEN AN APPROPRIATE CHOICE, BUT AN ALTERNATIVE COULD HAVE BEEN TO USE A DRESSING WITH ANTI-BACTERIAL PROPERTIES, SUCH AS INADINE. THE IODINE IN THIS PROVIDES A WIDE-SPECTRUM ANTI-MICROBIAL ACTIVITY EVEN THOUGH IT IS RAPIDLY DEACTIVATED BY WOUND EXUDATE (BNF 2000)."

Demonstrating reflective practice in the orthotics laboratory: "ONE OF THE MAIN FACTORS THIS CASE DEMONSTRATED WAS THE IMPORTANCE OF CARRYING OUT A FULL EXAMINATION AND MAKING A REASONED, JUSTIFIED DIAGNOSIS. THIS WAS VERY GRATIFYING AND WAS AN EXAMPLE OF HOW THE OBSERVATION AND INTERPRETATION OF THE CLINICAL SIGNS CAN LEAD TO A DIAGNOSIS FROM WHICH A NEW, AND HOPEFULLY MORE SUCCESSFUL MANAGEMENT PLAN CAN BE FORMULATED."

Marking tutor's feedback: "A GOOD ATTEMPT HAS BEEN MADE TO APPLY THEORY INTO PRACTICE. REFLECTION IS PRESENT THROUGHOUT, ALTHOUGH A MORE CRITICAL EVALUATION AND DISCUSSION OF DIAGNOSES AND MANAGEMENT WOULD HAVE ENHANCED THE JOURNAL."

Appendix 2.3

Case Three: Year 3, Level 3 (6)

In the following case study the process by which the students' skills of reflection at level 3 (6) are fostered and assessed, will be demonstrated. Using the appropriate FONT the reader is able to map from the aim of the module, through the marking criteria, to examples of the student's work.

Title	Clinical Podiatry 6 (double module)
Level	3 (6)
Credit Rating	20 CAT points
Semester offered	Year 3 Semester 6
Pre-requisites	Students will have completed the clinical podiatry 5 double module at level 3 (6).

Aims

TO CONTINUE THE DEVELOPMENT OF THE STUDENT INTO AN AUTONOMOUS REFLECTIVE PRACTITIONER WITH DEMONSTRABLE SKILLS THAT ARE REQUIRED FOR THE EVER CHANGING HEALTHCARE PRACTICE IN THE U.K.

Learning Outcomes/Objectives

The student will be able to:

demonstrate the assessment of the patient in a holistic fashion;
demonstrate analytical skills to evaluate treatment effectiveness;
demonstrate confidence when dealing with clinical problems;
demonstrate advanced psychomotor skills in the management of patients;
communicate effectively with other members of the multidisciplinary team;
demonstrate the ability to progress or modify treatment through enhanced evaluation of treatment.

Content

effective communication skills; assessment skills and diagnostic techniques; interpretation of information gained from patient assessment and diagnostic techniques; clinical decision making and problem solving; treatment planning including setting treatment aims and outcomes; evaluation and audit of clinical practice; safe and competent delivery of specific treatment skills (this includes the administration of local analgesia and the use of non-invasive and invasive surgical skills).

Teaching and Learning Strategies

patient demonstrations, ward rounds, placement clinics, tutorials, clinical practice and case conferences, inter- disciplinary and inter-cohort learning.

Learning Support

Personal tutor, module team support. Use of libraries and other learning resources.

Assessment

Clinical Examination and CLINICAL EVIDENCE FILE (CEF 2).

Brief description of module content

This double module is intended to focus on the holistic approach to patient care and to enable the student to critically appraise podiatric management in a comprehensive knowledgeable manner.

Marking Guidelines for the Clinical Evidence File (CEF 2)
Clinical Podiatry 6 (PP306)

70% and above
This journal will have met all of the objectives and will have demonstrated the enhanced application of theory into practice in a most comprehensive fashion, including EVIDENCE THAT REFLECTIVE PRACTICE, PROBLEM SOLVING AND A HOLISTIC APPROACH HAS BEEN ADOPTED in all sections. There will be additional evidence that the student has shown initiative in all aspects of their clinical practice and placement experiences. Links between theory and practice will be supported by a wide range of appropriate references and cited in the standard University of Brighton format.

60 – 70%
This journal will have met all of the objectives and will have demonstrated the application of theory into practice in a clear and concise manner. It will contain all specified sections with relevant and complete information. It will be clearly presented WITH GOOD EVIDENCE THAT REFLECTIVE PRACTICE AND PROBLEM SOLVING HAS TAKEN PLACE. There will be additional evidence that the student has shown initiative in most aspects of their clinical practice and placement experience. Links between theory and practice will be supported by a range of appropriate references and cited in the standard University of Brighton format.

50 – 60 %
This journal will have met all of the objectives and will have demonstrated the application of theory into practice. All specified sections will be documented with appropriate information. It will be clearly presented with EVIDENCE THAT REFLECTIVE PRACTICE AND PROBLEM SOLVING HAS TAKEN PLACE. There will be additional evidence that the student has shown initiative in some aspects of their clinical practice There will be additional evidence that the student has shown initiative in some aspects of their clinical practice and placement experience. Links between theory and practice will be supported by appropriate references and cited in the standard University of Brighton format.

40 – 50%
This journal will have met all of the objectives although the emphasis on applied theory may be limited. It may contain MORE FACTUAL EVIDENCE THAN REFLECTIVE PRACTICE. There will be little additional evidence and scant demonstration of problem solving in clinical practice. There will be limited additional evidence that the student has shown any initiative in aspects of their clinical practice and placement experience. Links between theory and practice will be minimally supported by references but cited in the standard University of Brighton format.

Fail
This journal will be incomplete. There will be limited evidence that the objectives have been met. There will be no clear evidence of the links between theory and practice. It is poorly presented, WITHOUT ANY REAL EVIDENCE THAT REFLECTIVE PRACTICE HAS TAKEN PLACE. There will be limited additional evidence that the student has shown any initiative in their clinical practice and placement experience. References will be minimal and cited inappropriately.

Extracts from student submissions

"THIS CONFIRMED MY FEELINGS FROM LAST WEEK THAT IT IS NOT NECESSARILY POSSIBLE TO EMULATE THE SKILLS FROM ONE WEEK TO THE NEXT AND CONSTANT EVALUATION OF THE TREATMENT IS NECESSARY TO BE ABLE TO PROGRESS SAFELY AND WITH THE PATIENT'S BEST INTEREST IN MIND."

"ALL SHE WANTED WAS TO COME IN ON A REGULAR BASIS AND HAVE HER NAILS CUT AND CALLUS DEBRIDED. AS HEALTH PROFESSIONALS WE SHOULD BE LISTENING TO OUR PATIENTS AND HEARING THEIR AGENDA; THEY DO NOT ALWAYS MATCH OUR OWN."

"IN THE FIRST DRAFT OF THIS LETTER TO THE GP I WAS ASKING PERMISSION TO CARRY OUT THE PROCEDURE. HOWEVER I NOW REALISE THAT, AS A PODIATRIST, I AM QUITE CAPABLE OF DECIDING THE BEST COURSE OF TREATMENT FOR THE PATIENT WITHIN MY OWN SCOPE OF PRACTICE. WHAT I REQUIRED FROM THE GP WAS CONFIRMATION THAT THE INFORMATION THE PATIENT HAD GIVEN TO ME WAS COMPREHENSIVE AND CORRECT."

"OVERALL I ENJOYED THE DIABETIC CLINIC AND FOUND IT A USEFUL EXPERIENCE TO SEE HOW THE MULTI-DISCIPLINARY TEAM WORKS. HOWEVER, I DO FEEL THAT EVEN THOUGH THE SPECIALISTS ARE CONSIDERED TO BE ALL WORKING TOGETHER, IN MANY RESPECTS THEY ARE STILL QUITE SEPARATE IN THEIR APPROACH TO THE PATIENT. I WOULD LIKE TO SEE EACH UNDERSTANDING MORE ABOUT THE OTHERS' ROLES SO THEY COULD COMPLEMENT ONE ANOTHER MORE EFFECTIVELY."

"WHAT THIS TAUGHT ME WAS THAT THE LENGTH OF TIME SINCE QUALIFICATION DOES NOT NECESSARILY MAKE YOU BETTER OR MORE COMPETENT AT SOMETHING. YOU NEED TO SEEK UPDATE COURSES TO IMPROVE YOUR SKILLS IN AREAS YOU DO NOT PRACTICE VERY OFTEN, AND YOU NEED TO CONTINUE YOUR EDUCATION THROUGHOUT YOUR PROFESSIONAL LIFE."

APPENDIX 3 1
From section 3 of Professional Portfolio - an example of a completed documentation with the students work presented in italics and teacher comments in uppercase.

Learning Outcomes
By the end of the module you will be able to:

- Complete a basic and appropriate assessment
- Demonstrate safe and effective use of basic physiotherapeutic skills, clinical reasoning and problem solving
- Demonstrate an awareness of psychological issues impacting on the care of individuals
- Present a professional approach and show an awareness of fundamental ethical and legal issues of professional practice
- Engage in basic reflective practice and experiental learning
- Demonstrate a developing awareness of the roles of the multidisciplinary team

Date Achieved 22.7.200X **Clinical educator's signature:** ..M. Smith MCSP

Placement Unit
Write a brief description of the unit you are working in and include the client group you are dealing with.

A busy outpatient unit in a large inner city teaching hospital. The client group comes from GP and Consultant referrals. There is a large proportion of asylum seekers and quite a few Asian and Afro Caribbean patients and so interpreters are used quite a lot. All my patients have mostly musculoskeletal and spinal problems but because there is a specialised hand unit and Hydrotherapy pool in the department. Have worked with two postoperative hand surgery patients and treated some rheumatology patients in the pool e.g Knee and hip replacements + the Ankylosing Spondylitis mobility and fitness class. My time is equally split between outpatients and hydrotherapy and I have helped to treat a post trauma patient who came down from the ward to the pool - he had multiple injuries and has problems mobilising on his fractured legs, fractured pelvis and a fractured humerus.

Personal Goals

- *To be able to complete a subjective/objective assessment & write up my notes well*
- *Develop a problem list and be able to justify my treatment from it*
- *To be able to cope better with anxious patients and patients in pain*
- *Practice Bad Ragaz techniques in pool and be able to 'handle' patients confidently*

+ after visiting clinical lecturers feedback and suggestions

- *Develop a more self-directed approach to my personal professional development i.e. read around more & prepare a presentation*
- *Improve my interpersonal communication skills - especially listening skills*
- *Try to understand different cultures better i.e. things like eye contact etc*
- *Read around Clinical Governance so that I will be able to understand it and its implications (It seems to be very important because it is mentioned all the time)*

Comments from visiting lecturer:
YOU NEED TO REVIEW AND REFINE OBJECTIVES AND MAKE THEM MORE SPECIFIC SO THAT THEY DO NOT MIRROR THE LEARNING OUTCOMES FOR THIS FIRST PLACEMENT. ADD IN PERSONAL DEVELOPMENT GOALS AND BEGIN TO MAKE YOUR OBJECTIVES SMART - NAMELY SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC AND TIMED. YOU ARE VERY THOROUGH AND ENTHUSIASTIC AND IT IS GOOD TO SEE THAT YOU ARE DEVELOPING YOUR CLINICAL REASONING SKILLS AND BECOMING MORE REFLECTIVE IN THE PROCESS. WELL DONE.

Visiting Lecturer: …M. Bloggs (M BLOGGS) **Date:** …22.5.0X…….

Personal Learning Achieved
Evaluate your achievements in relation to the learning outcomes and your personal goals. You may find it useful to review and summarise your final self-assessment.

My learning outcomes and personal goals changed as soon as I arrived on placement because I found that I was able to assess patients with simple problems quite well but struggled with treatment decisions and keeping my notes brief.
I had assumed that the placement would be about assessment and implementing treatment and didn't appreciate the importance of communication and time management. This placement has boosted my confidence as I have proved to myself that I can use what skills I have very well and develop and improve new ones. I think that I have become more reflective and have been challenged into thinking more deeply and expressing my thoughts - but in a nice way.
My communication skills have improved but was shocked to find out how unprepared I was to work with patients who couldn't speak English. We had an Interprofessional scenario on asylum seekers in the university yet I hadn't an inkling of how carefully words have to be selected so that they can be translated effectively. I now feel more aware of what 'culture' means to me and my patients and understand how being unaware of my patients' culture can 'block' rehabilitation.

Learning Opportunities Undertaken
e.g. Inservice Training, Domicilary visit, Theatre, Presentation etc
Acupuncture and McKenzie presentations from staff
A half day electrotherapy update including TENS, PEME and Interferential
Gave a presentation to my supervisor and three other members of staff
Listened to my Clinical Educator's feedback to staff on what was covered in a Clinical Educators Development Day - multiple models of supervision & facilitating student reflection/thinking.

Outstanding Personal Goals
To Improve clinical reasoning and become more reflective
To develop my ability to assess and treat spines
To understand social policy and what it means to me

Proposed Action
Go back to my course handbooks over the summer and improve my clinical reasoning
Read around different treatment philosophies for spines
Write up several SLER's on incidents that I would benefit from reflecting on
Surf the Internet re Clinical Governance and Social Policy

Results

No results yet !

APPENDIX 3 2
From Section 4 of Professional, Portfolio - an example of a completed diary sheet with the students work presented in italics and teacher comments in uppercase.

Reflective Diary / Sheet
Placement details Year **1**[✓] **2** [ ] **3** [ ] Week **1** [✓] **2** [ ] **3** [ ] **4** [ ] **5** [ ]

What went well this week?

This has been a brilliant first week that almost went wrong before I arrived! I checked out how long it would take me to get to work on Sunday evening but didn't make enough allowance for the rush hour traffic on Monday morning. I was almost late and arrived very flustered. My heart sank when the secretary took me to the staff room, which was filled with physios, but my Clinical Educator saw me and quickly put me at my ease.
I Was nervous about treating patients, was given a diary with three patients booked in after lunch - but my educator let me observe her in the morning. I think this was better than being expected to treat a patient at once and much better than putting it off for days! The patient didn't seem to mind being treated by a student and this was a big relief. My Educator stayed with me throughout and only stepped in when the patient asked how long it would be before he could go back to squash. Apart from that I did it on my own and felt a surge of achievement! The rest of the week has gone well but I am SO tired.
It is good to listen to how other physios communicate with their patients and I feel I am getting better at being able to 'put things in my own words' rather than physiobabble. I have seen how important this is because it helps the patients' understanding and improves their motivation.
Brilliant to see the MDT working well as one patient on Tuesday had to be referred straight back to their GP. The patient's wife phoned us today to say that he had been given an emergency appointment in Oncology today (Frid). This particular patient made me very aware of the importance of asking 'special' questions and getting advice from colleagues if sinister signs and symptoms are found.
Have seen a wide range of patients, a few didn't arrive (DNA) but went to the library and also used the department's computer to surf the net.
Have felt very welcomed by all the staff. We had an American leaving lunch on Thursday and we all brought something and shared it. Ymm!

What did not go as well this week?

I got a parking ticket on day 1!

I feel so tired that it is hard to read around things in the evenings. I am in B&B and do not have cooking facilities so it has either been a cup-a-soup or the expense of eating out in the evenings.

My confidence is growing but I have become more aware of how little I know. My assessment skills and just getting the information down on paper, is difficult. I can't do it all and talk to the patient at the same time - is frustrating. Had a lovely asylum seeker patient but was completely thrown by time management because I had to speak through an interpreter (it took forever!) & so was late for my next two appointments.

Another patient came with a sprained ankle. It turned out that he has cancer of his spine. He had

hurt his ankle because his muscles were weak because a growth was beginning to compress his spinal cord. He and his wife were lovely. I felt OK with treating the swollen ankle but I felt totally useless when talking to them about 'it'. Hope he will be OK.

Have found it difficult to explain how I reach my clinical decisions but my theoretical knowledge is OK.

My clinical educator thinks that I have been a 'pragmatic activist' in the past and therefore have not developed my reflective side. I felt bad about this at first but its OK now I have talked it through with her.

My Clinical educator seems to be strong in all these aspects and so I feel rather inadequate when I compare myself with her. Will try harder to explain myself better next week.

APPENDIX 3.3

From section 4 of Professional Portfolio - examples of the marking guidelines and criteria for assessment

0 –19% Incompetent. Majority of criteria (including safety and effectiveness) are consistently unacceptable. This is a referral.

20 – 39% Competence consistently lacking in significant areas. Some elements may show acceptable performance. This is a referral.

40 – 49% An acceptable performance of competence in most sections. Nothing significant is unacceptable (i.e. safety & effectiveness). There are weaknesses to be addressed.

5**0- 55%** A consistently good performance with some criteria meeting a high standard and the majority being good or acceptable

60 – 69% A consistently very good performance with most criteria meeting a high standard and the remainder being acceptable or good.

70 – 79% An excellent performance. The majority of criteria consistently meeting an excellent standard.

80 – 89% All criteria consistently demonstrated to an excellent standard. Excels equally in all aspects.

90 – 100% A thoroughly exceptional performance with all aspects demonstrated at the highest level.

I. INTERPERSONAL SKILLS AND PROFESSIONAL BEHAVIOUR

Positive extreme	Negative extreme
Communication skills are highly effective. Is eloquent and coherent in verbal language and able to adapt to all levels e.g. children, adults of 'limited code', professional colleagues, etc. Effective and appropriate use of non-verbal communication. Excellent, professional written communication.	Powers of verbal expression are limited. Is ineffective in communication. Cannot adapt language code to different levels. Poor or inappropriate non-verbal communication. Poor, unprofessional or ineffective written communication.
Listening skills are highly developed. Responds appropriately. Reflects.	Unable to listen. No response to teaching or advice. Does not reflect.
Gains rapport with individuals. Shows respect and consideration. Is tactful and co-operative. Values the opinion of others without being obsequious or servile. Shows a professional loyalty to colleagues. Gains confidence of the patients/clients and adjusts to different personalities automatically. Able to demonstrate empathy, sympathy & sensitivity. There is no over familiarity.	Fails to gain rapport. Appears 'off-hand' or rude and shows lack of consideration for others. Is arrogant and self-opinionated. Disloyal. Patients/clients lack confidence in the student. Is unable to adjust to different personalities. Tendency to a degree of over-familiarity.
Gains the respect of others and is respectful. Establishes and maintains good relationships.	Is not respected. Poor relationships.
Appearance is clean, neat, tidy & well groomed. Clothing is pressed: shoes clean and appropriate. Make-up is discreet, etc. Uniform appropriate to the nature of the work	Is dirty, unkempt. Clothing is crumpled/unclean. Make-up is extreme and beyond the bounds of social acceptability for a professional individual. Inappropriate uniform.
Has a co-operative, positive attitude to the clinical experiences offered. Shows understanding of the 'big picture' and is tolerant and constructive when faced with obstructions. Is realistic.	Has uncooperative and negative attitudes. Is self-focused and intolerant of any interference or obstructions to own perceived needs. Is unrealistic.
Displays a well developed sense of responsibility for self and others	Is irresponsible.

II. ORGANISATIONAL AND MANAGEMENT SKILLS

Positive Extreme	Negative Extreme
Is consistently punctual in all aspects of professional life, showing respect for others	Is not punctual and is unaffected by the repercussions and the consequences for others. Repeatedly keeps others waiting.
Is consistently reliable and can be trusted to carry out responsibilities. Always asks for clarification if doubt exists. Does not require prompting unnecessarily.	Is unreliable. Frequently fails to carry out tasks or report back on difficulties. Requires prompting. Is inclined 'muddle through' rather than ask for help. Cannot be trusted.
Abel to prioritise workload and manages time effectively. Uses time to maximum effectiveness and makes most of opportunities.	Unable to prioritise workload and does not manage time effectively. Wastes time and opportunities.
Displays an acute awareness of relevant legislation, policy and procedures concerning quality issues affecting the service within the clinical setting, manages work day accordingly	Is unaware of relevant legislation, policy and procedures concerning quality issues affecting service. Does not take these into account.
Is able to identify and manage resources effectively, e.g. other sources of assistance, supporting services, professional time. Is aware of cost implications.	Is unable to identify or effectively manage resources. Is unnecessarily wasteful and unaware of or fails to consider cost implications.

III. PATIENT/CLIENT EXAMINATION AND ASSESSMENT

Positive Extreme	Negative Extreme
Is able to select and implement appropriate examination procedures demonstrating knowledge gained prior to this placement	Is unable to select and implement appropriate examination procedures or requires excessive prompting. Does not apply knowledge gained prior to this placement.
Is able to adapt to various clinical situations and respond to change. Is able to analyse and interpret findings and synthesis an action plan. Shows sound clinical reasoning.	Unable to adapt procedures appropriately. Does not respond to change Is unable to analyse or interpret findings. Unable to find any meaning from the examination results.
Is able to make sound basic decisions with rationale and a deep knowledge for level of assessment.	Is unable to make basic decisions or requires excessive guidance. Actions unsupported by basic knowledge base.
Is consistently safe in examining patients & is considerate of their needs	Is unsafe. Is negligent.
Records findings appropriately, using a format relevant to the nature of the examination. Written records succinct, well organised and legible, meeting legal requirements. Consistently signs records.	Does not record examination findings or records are muddled, contain irrelevant material, are long-winded and illegible. Fails to follow any format & does not consistently sign records. Follows inappropriate format. Does not meet legal requirements.

IV. IMPLEMENTATION OF PHYSIOTHERAPY PRACTICE

Positive Extreme	Negative Extreme
Is consistently able to implement competent and appropriate physiotherapy treatment, advice or other appropriate strategy	Is unable to implement competent physiotherapy practice or implements inappropriate procedures.
Makes on-going evaluation of effectiveness with sound analysis. Is able to modify procedures/plans and respond to change. Can work with guidelines as opposed to rules. Shows application of principles. Is autonomous in the majority of core clinical skills appropriate to the placement.	Does not evaluate effectiveness or is incompetent at evaluation. Is unable to modify procedures/plans or does not respond to change - works with rules and unable to apply principles as guidelines. Remains at the fixation level in core skills where there has been an opportunity to practice.
Has the ability to cope with and manage many clinical contingencies appropriate to this level.	Unable to cope with a variety of clinical contingencies.
Is safe.	Is unsafe or repeatedly show lack of awareness to safety issues. Negligent.
Shows evidence of a high level of knowledge base for this stage. Perceives and responds to whole situations. Recognises the abnormal. Contributes ideas from the literature. Abel to justify.	Lacks basic relevant knowledge base. Unable to perceive whole situations. Is blinkered. Unable to recognise the abnormal. Unable to contribute ideas from the literature. Little or no evidence of theoretical understanding. Unable to justify.

V. LEARNING BEHAVIOUR

Positive Extreme	Negative Extreme
Student owns responsibility for own learning and exploits the opportunities for experiential learning in the clinical setting.	Student tends to see others as responsible for his/her learning and is not proactive in maximising opportunities for experiential learning. Has a disposition to drift along.
Is able to analyse own strengths and weaknesses. Invites and values appraisal and guidance, balanced with an appropriate degree of independence.	Is unable to analyse own strengths and weaknesses and does not give value or invite appraisal or guidance. Given appraisal / guidance, does not respond. Excessively requests appraisal & guidance with little/no independence.
Is able to reflect on clinical practice and related issues with minimum prompting.	Unable to reflect on clinical practice and related issues. Requires excessive prompting to reflect and any response is shallow.
Positive and constructive use of feedback. Persistent and positive concern to improve. Practices when possible, maximises opportunities to work with feedback issues.	Negative reaction to feedback. Shoes no concern about personal development. Does not ask for feedback. Does not seek opportunities to practice in response to feedback.
Open and honest about own learning and any difficulties encountered.	Afraid of exposing 'inadequacies' and is defensive.

APPENDIX 3.4

From section 3 of Professional Portfolio - example of a completed half-way student's Continuous Practice Self Assessment (CPSA) form. Students' work presented in italics.

Title of the Module, Student name, Placement Location, Clinical area/specialism, Clinical Educator Name(s), Number of clinical hours for module [x], actual hours achieved [x], Absence due to: sickness, other reasons (please specify) or unauthorised absence [x].

Marking summary	
I Interpersonal and professional behaviour	68/100
II Organisational and management skills	66/100
III Patient/client examination and assessment	66/100
IV Implementation of physiotherapy practice	68/100
V Learning behaviour	69/100
TOTAL = 337 /500 67.4 % *(got 77% at the end!)*	

I believe I am a	
Delete as appropriate	PASS [✓] FAIL [ ]

See notes for guidance for completing all five sections:

I.**INTERPERSONAL SKILLS AND PROFESSIONAL BEHAVIOUR**

e.g. Communication and listening skills. Rapport, relationships & respect for others. Appearance. Attitude. Responsibility.

1/2 way -*I communicate (verbally and non-verbally) well and this helps my patients trust me. I do waste time when I let the patients talk about sometimes irrelevant stuff. Good rapport with staff. Professional appearance -neat and tidy.*
Have a positive attitude & sense of responsibility for others despite sometimes being unsure exactly what tasks are my responsibility

End/ - *My listening skills are vastly improved can now guide patients away from their life stories but don't stop the flow if I think it is relevant but longwinded. Communication via interpreters still improving but time consuming.*
Have gained greater respect and trust from staff and have maintained this with my patients.
Attitude to work is now more confident so that I appear more relaxed but still professional

[68%]

II.ORGANISATION AND MANAGEMENT SKILLS

e.g. Punctuality. Reliability. Prioritisation & time management. Awareness of legislation, policy and quality issues. Resource management.

1/2 way - *Always punctual and reliable and will always ask for clarification if unsure. Tend to waste time waiting for clinical educator to come to me - need to be more pro active but at the moment I am unsure of how much I can do on my own and this has affected my time management badly. Have spent some time with receptionist who has shown me the relevant legislation and policy documents used here. I am maintaining the expected standards. Using resources well i.e. library, Internet, anatomical models and charts in dept.*

End/ *Consistently punctual and reliable.*
Can manage time more effectively especially by taking the initiative and booking patients in by myself and getting their hospital notes and Xrays etc.
Heightened awareness of safety especially falls procedure after a patient fell in the department (not one of mine thank heavens) + + paperwork required. [66%]

III PATIENT/CLIENT EXAMINATION & ASSESSMENT

e.g. Selection & implementation of procedures. Adaptation & interpretation. Decision-making. Safety. Recording

1/2 way - *Am feeling more and more competent to assess peripheral joints as assessment skills are now slick (this has been helped by a crib sheet I have written out for guidance). Problems with clinical reasoning out loud - I can think it through better now but find I can't explain how I got to make the decision.*

End/ - *I can't believe how much easier it is to link my findings to treatment options. Notes are less wordy and I can happily write it all down as I do the assessment and talk to the patient! Am so relieved to find that I can assess shoulders and need to have more confidence in my own abilities. Have become much more adaptable and the patients have benefited from this - can think on my feet better. I am becoming more aware of safely issues and especially the need to screen patients and ask them the special questions.* **[66%]**

IV IMPLEMENTATION OF PHYSIOTHERAPY PRACTICE

e.g. Ability to implement treatment, advice or management strategy. Evaluation & modification. Copes with variety. Evidence of supporting knowledge-base

1/2 way - *Skills are improving with practice. Am able to explain in laypersons terms what I am doing and why I am doing it. It is still hard not to give a complicated answer to some patient questions but is getting better every day.*
I am not yet progressing my patients without advice from my clinical educator yet. Have done lots of background reading etc. Need to practice manual techniques and do a lit search for my presentation on the management of shoulder problems.

End/ - *Can't believe how competent I have become even with simple spinal problems. I can take the lead in suggesting treatment and can justify my choice well. Time management versus the sheer variety of patients' problems have challenged me. Lots to remember but find I can do it when not tired! Have begun to feel much safer and capable of treating patients in hydro. Was able to do my presentation on shoulders and included a literature search that I did on line. Positive feedback has boosted my confidence even more.* **[68%]**

V LEARNING BEHAVIOUR

e.g. Ownership of experiental learning. Self analysis using guidelines given. Reflective practice. Ability to negotiate learning contract/opportunities. Response to feedback.

1/2 way -*I look up or ask the appropriate person about anything that I feel will benefit my placement - find it difficult to discuss what I have learnt.*
I openly accept constructive comments, whether positive or negative, and am using the feedback constructively. I notice that I am more able to analyse my weaknesses rather than my strengths.
I feel I do reflect on my experiences but need to be more open about my thoughts.

End/ - *I feel I have become more open regarding my reflective practice but I still need to be more open. I have begun to feel more comfortable with suggesting and negotiating things with my educator. I wrote my SLER on feeling unprepared and abandoned by my educator - the experience showed me how easy it is to become dependent on a person with lots of skills rather than 'having a go' and doing it myself. Surprised how my insecurity over shoulder assessment affected me and my ability to communicate with the poor patient.* **[69%]**

MID-WAY APPRAISAL

This should entail reflection guided by sections 1 – V (see notes for guidance) and the informal comments of your Clinical educator(s).

Your comments:
I was very pleased with the half way feedback because it boosted my confidence and confirmed that my skills have improved a great deal in the last week. I am going to try to think things through a bit more. I have a mental blank about examining shoulders and am pleased that we will go through assessment of it before I have my first shoulder patient. Found it very difficult trying to write comments about my self and especially giving myself a fair mark. My marks for myself were a lot lower than the provisional ones given to me by my clinical educator, hers were a nice surprise!

Comments on completion of the Professional Practice Portfolio:

COMPLETION OF PLACEMENT

Your comments:
I have learnt so much and have enjoyed the placement - time has gone so quickly and all the staff have been so friendly and approachable. I made sure that I was as well prepared as poss. My clinical educator proved to me that I knew more about shoulders than I gave myself credit for! Can't wait for my next placement.

Comments on completion of the Professional Practice Portfolio:

APPENDIX 3.5

From section 3 of Professional Portfolio - example of a completed Clinical Educator's Continuous Practice Assessment (CPA) form. Educator's comments in UPPERCASE and students in *italics*.

I.INTERPERSONAL SKILLS AND PROFESSIONAL BEHAVIOUR

e.g. Communication and listening skills. Rapport, relationships & respect for others. Appearance. Attitude. Responsibility.

YOU HAVE DEVELOPED VERY GOOD COMMUNICATION AND LISTENING SKILLS. YOU HAVE AN EXCELLENT ATTITUDE TOWARDS YOUR WORK AND ARE WELL PRESENTED AT ALL TIMES. AS YOUR CONFIDENCE HAS GROWN YOU HAVE BEEN ABLE TO ENTER INTO DISCUSSION WITH OTHER MEMBERS OF STAFF.
YOU HAVE A FRIENDLY AND OUTGOING NATURE WHICH HAS MADE YOU A POPULAR MEMBER OF THE DEPARTMENT. YOU HAVE BUILT A GOOD RAPPORT WITH PATIENTS - SEVERAL HAVE COMMENTED ON YOUR PROFESSIONAL AND COMPETENT MANNER AND ABILITY TO EXPLAIN THINGS CLEARLY AND SIMPLY.
YOU ACTED VERY PROMPTLY WHEN YOUR PATIENT PRESENTED WITH SINISTER SIGNS AND SYMPTOMS AND WERE PROFESSIONAL IN THE WAY YOU HANDLED DIFFICULT QUESTIONS.
YOU HAVE AN EXCELLENT ATTITUDE TOWARDS YOUR WORK - YOU ARE ALWAYS ENTHUSIASTIC, WELL PREPARED AND EAGER TO DEVELOP YOUR HANDLING SKILLS AND CLINICAL REASONING.

[86/100%]

II.ORGANISATIONAL AND MANAGEMENT SKILLS

e.g. Punctuality. Prioritisation & time management. Awareness of legislation, policy and quality issues. Resource management.

EXCELLENT PUNCTUALITY. HAVE SHOWN SKILL IN JUGGLING TIME BETWEEN PATIENTS WHO HAVE BEEN LATE OR WHO HAVE ARRIVED EARLY AND SO ARE EFFICIENT IN KEEPING TO PATIENT APPOINTMENT TIMES. ANY SPARE TIME HAS BEEN SPENT READING AROUND TOPICS ETC.
LITTLE TIME HAS BEEN WASTED, AS YOU HAVE BEEN A REGULAR VISITOR TO THE LIBRARY AND INTERNET. YOU HAVE MANAGED YOUR DIARY WELL AND HAVE SELECTED AND BOOKED PATIENTS IN ON YOUR OWN. YOU ARE AWARE OF HEALTH AND SAFETY GUIDELINES AND HAVE DEMONSTRATED AN UNDERSTANDING OF PATIENT CONFIDENTIALITY AND ETHICAL ISSUES AROUND TRUTH TELLING.

[81/100%]

1.1.1.1

III. PATIENT/CLIENT EXAMINATION & ASSESSMENT

e.g. Selection & implementation of procedures. Adaptation & interpretation. Decision-making. Safety. Recording

PATIENT ASSESSMENT SKILLS HAVE DEVELOPED AND IMPROVED WITH PRACTICE. RECORDING IS METHODICAL, THOROUGH, ACCURATE AND WELL PRESENTED. THERE HAVE BEEN NO SAFETY ISSUES THAT HAVE ARISEN. YOU HAVE SHOWN AN ABILITY TO PROGRESS YOUR ASSESSMENT SKILLS SIGNIFICANTLY AND HAVE BEEN HAPPY TO ASSESS YOUR PATIENTS EITHER SUPERVISED OR UNSUPERVISED BY ME.
MOST FOLLOW UP APPOINTMENTS HAVE BEEN LEAD BY YOU AND YOUR PROGRESSION OF EXERCISE HAS IMPROVED WITH PRACTICE.
YOU APPEAR TO ENJOY PROBLEM-SOLVING AND HAVE SHOW GOOD EARLY CLINICAL REASONING SKILLS DESPITE STRUGGLING IN THIS AREA DURING THE FIRST PART OF THIS PLACEMENT.

[69/100]

IV. IMPLEMENTATION OF PHYSIOTHERAPY PRACTICE

e.g. Ability to implement treatment, advice or management strategy. Evaluation & modification. Ability to cope with variety. Evidence of supporting knowledge-base

INITIAL LACK OF CONFIDENCE IN YOUR KNOWLEDGE-BASE ESPECIALLY IN TREATMENT PROCEDURES. YOU HAVE WORKED HARD TO IMPROVE YOUR THEORY AND LINK KNOWLEDGE WITH PRACTICE. YOU HAVE HAD A VARIED PATIENT LIST AND ARE ABLE TO ASSESS ANY PERIPHERAL JOINT WELL. YOU HAVE SHOWN A KEEN INTEREST IN PATIENTS' WITH SPINAL PROBLEMS AND, AS A RESULT, HAVE NOW PROGRESSED TO DO EARLY SPINAL ASSESSMENT UNDER SUPERVISION. TREATMENT PROCEDURES HAVE CONTINUED TO IMPROVE THROUGHOUT THE PLACEMENT - YOU HAVE SUCCESSFULLY ADAPTED YOUR APPROACH TO INDIVIDUAL PATIENTS AND HAVE DEMONSTRATED AN ABILITY TO THINK IN AND ON ACTION. YOU HAVE MANAGED YOUR TIME WELL AND HAVE TAKEN EVERY OPPORTUNITY TO READ AROUND AND READ ARTICLES WHICH GIVE EVIDENCE TO SUPPORT YOUR PRACTICE - THIS WAS DEMONSTRATED WELL IN YOUR CASE STUDY PRESENTATION ON ROTATOR CUFF INJURIES AND THEIR MANAGEMENT. [69/100]

V LEARNING BEHAVIOUR

e.g. Ownership of experiental learning. Self analysis using guidelines given. Reflective practice. Ability to negotiate learning contract/opportunities. Response to feedback.

I BELIEVE THAT YOU HAVE ACHIEVED YOUR PLACEMENT GOALS AND ARE A VERY GOOD AT NEGOTIATING LEARNING OPPORTUNITIES - UNFORTUNATELY ONLY A SHORT PERIOD OF TIME WAS AVAILABLE FOR YOU TO SPEND IN THEATRE. YOU HAVE CONSISTENTLY USED GOOD QUESTIONING TECHNIQUES TO TRY AND HAVE WORKED HARD TO IMPROVE SKILLS AND PRACTICE. GOOD REFLECTIVE PRACTICE, YOU ARE OPEN TO POSITIVE AND CONSTRUCTIVE FEEDBACK. YOU ARE VERY GOOD AT DISCUSSING ANY ISSUES WHERE YOUR KNOWLEDGE-BASE IS LACKING AND HAVE BEEN ABLE TO ACT ON ADVICE GIVEN. YOU APPEAR TO BE VERY MUCH AN ACTIVIST AND SO IT WILL BENEFIT YOU TO DEVELOP YOUR MORE THEORETICAL AND REFLECTIVE NATURE.

[80/100]

MID-WAY APPRAISAL

This should entail feedback guided by sections 1 – V (see notes for guidance)

Clinical educator's comments:
A VERY POSITIVE APPROACH TAKEN TO THIS PLACEMENT. YOU ARE BEGINNING TO QUESTION YOUR PATIENTS IN THE SUBJECTIVE ASSESSMENT WITH MORE CONTROL AND FLUENCY. SUBJECTIVE INFORMATION, COMBINED WITH THE OBJECTIVE ASSESSMENT FINDINGS WILL HELP WITH YOUR CLINICAL REASONING AND CLINICAL DECISION MAKING. I REALISE THAT THERE ARE CONCERNS ABOUT COMPETENCY ON TREATMENT BUT THIS WILL IMPROVE WITH PRACTICE AND WITH CONTINUED READING AND RESEARCH. YOU HAVE BEGUN TO MAKE GOOD PROGRESS IN ALL FIVE AREAS AND I FEEL THAT YOUR STRONGEST AREAS RELATE TO YOUR INTERPERSONAL SKILLS/PROFESSIONAL BEHAVIOUR AND YOUR LEARNING BEHAVIOUR.
YOUR WEAKEST AREA IS IMPLEMENTATION OF PHYSIOTHERAPY PRACTICE BUT ,AS SAID ABOVE, THIS HAS ALREADY BEGUN TO IMPROVE AND WILL CONTINUE TO DO SO WITH MORE PRACTICE.
YOU HAVE STRUGGLED WITH THE THEORY PRACTICE GAP AND SO I FEEL THAT THE OPPORTUNITY FOR YOU TO DO A SMALL INFORMAL CLINICAL PRESENTATION (ON A PATIENT OF YOUR CHOICE) WILL BE A VALUABLE LEARNING EXPERIENCE WHICH WILL BOOST YOUR CONFIDENCE. YOU NOW HAVE CONTROL OF BOOKING YOUR PATIENTS INTO YOUR DIARY AND HAVE SHOWN THAT YOU ARE FLEXIBLE AND WELL ORGANISED. WELL DONE.

Student's comments:
I agree very much that I have limited knowledge in treatment areas, and although I am trying to research these areas more, (and have tutorials from you) I feel that lack of experience affects my clinical practice at the moment. I am enjoying my practice very much and am feeling more confidant when carrying out subjective and objective examinations. I am pleased that we have been able to arrange extra teaching on shoulder assessment as I feel it is one of my weakest areas.

Clinical Educator's signature: M. Smith(M. SMITH) **Date**…22.7.200X
Student's signature: ……J.Brown (J.BROWN) **Date**…22.7.200X

FINAL APPRAISAL: Clinical Educator's comments and advice:

CONGRATULATIONS ON YOUR FIRST PLACEMENT. YOU HAVE USED EVERY OPPORTUNITY TO LEARN AND TO DEVELOP/PROGRESS YOUR HANDLING SKILLS. YOU HAVE ENTERED INTO DISCUSSION ENTHUSIASTICALLY & WITH A VERY POSITIVE MANNER - BE AWARE THAT YOU NEED TO REFLECT AND REASON A LITTLE MORE BEFORE MAKING CLINICAL DECISIONS. YOUR CLINICAL REASONING HAS BEEN GOOD & SUPPORTED BY A SOUND KNOWLEDGE BASE - WITH MORE PRACTICE AT ASSESSMENT YOU WILL BE ABLE TO DEVELOP THE SKILL OF BEING ABLE TO JUSTIFY CLINICAL DECISIONS BY BASING THEM ON YOUR SUBJECTIVE & OBJECTIVE FINDINGS. YOUR ASSESSMENT SKILLS ARE STRONG & YOUR ABILITY TO PROGRESS TREATMENT AND 'THINK ON YOUR FEET' IS GOOD - YOU NEED TO WORK ON RETROSPECTIVE DECISION-MAKING AND BE MORE ABLE TO JUSTIFY YOUR CHOSEN MODES OF TREATMENT. I HOPE THAT YOU HAVE FOUND THE WORKLOAD INTERESTING AND GAINED AN INSIGHT INTO AN INNER CITY OUTPATIENT DEPARTMENT. IT HAS BEEN A PLEASURE WORKING WITH YOU AND TO SEE YOUR CONFIDENCE GROW.

Completion of relevant section of the Professional practice Portfolio for module
Delete as appropriate [yes/no]

Clinical Educator's signature: …M. Smith (M. SMITH) Date…22.7.200X
Students signature:…J Brown (J.BROWN) Date …22.7.200X

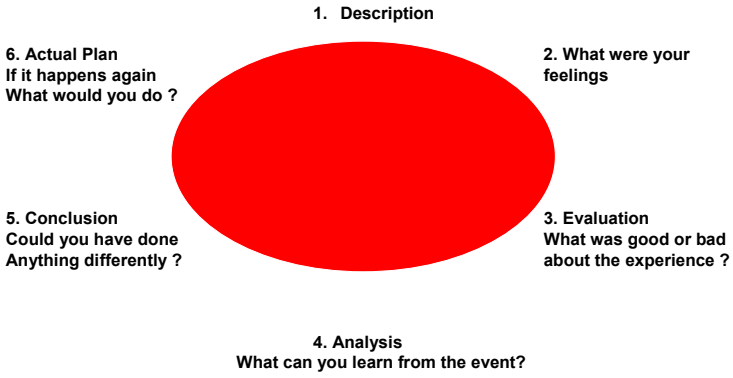
COMPLETION OF PLACEMENT: **Student's comments:**

I have really enjoyed my first placement, it has given me a good insight into the musculo-skeletal aspect of physiotherapy and also all the other areas I was introduced to. It was good to learn how the computerised appointment system operates and how GP referrals are acted upon. I was surprise at how much effective communication there was with the GP's and how this helped in managing one of my patients who had cord compression signs and symptoms. We referred him back to the GP who made him an urgent neurology appointment and his wife phoned us this week to tell us that he had begun a course of six radiotherapy treatments this week.

The in-service training at lunch times has been fantastic and I learnt about Acupuncture and McKenzie technique from two staff who had been on courses. It has been a bonus to treat patients in the hydrotherapy department. I was able to watch my patient with post operative shoulder pain being mobilised gently in warm water before coming to me for strengthening exercises. What was even more fantastic was that I had gone to theatre and saw the surgery performed (also saw a knee replacement). My educator has been fantastic and all the other physios, physio assistants and secretaries have been really supportive.

APPENDIX 3.6
From Section 3 of Professional Portfolio - an example of a completed Significant Learning Experience Report (SLER). Student's work in *italics.*

The Significant Learning Experience



The Reflective cycle (based on Gibbs 1988)

Choose an incident that has made some form of an impression on you – things may have gone particularly well or not as well as expected. Write your report on the following sheet(s) of paper, or word process the report and insert it here.

Description
My selected SLER is my first shoulder assessment because it was the one occasion when I was ill prepared and felt poorly managed and supported. I had missed both the practical classes at the university and had only attended the basic foundation lecture on shoulder disorders. I had practised with my friends but felt that I lacked knowledge and ability. I spoke to my Clinical Educator and she agreed to put time aside to work together. Unfortunately much of the allocated time was used up in other ways and I only covered the very basics with her. On the day of my first shoulder assessment my educator left the cubicle just as I was beginning my examination.

What were my feelings
I felt flustered when my educator disappeared as I felt I needed to be supervised. I could wanted to be corrected/shown how to do it if I was doing it wrong - in my first knee assessment she had watched me and had been at hand when I needed her help. I felt a bit cross about this as shoulder examination as after all it is more complicated than a knee. All this resulted my verbal and non-verbal communication with the patient going to pot. I was eventually able to 'get it together' and ploughed on. I got through everything OK but didn't feel not confident enough to treat the patient without discussion so when I left the cubicle to speak to my educator I found her, to my surprise, sitting quietly outside the curtain listening to me.
After a quick discussion about my findings and proposed treatment I returned to my patient and explained what I was about to do. To my amazement I made a big difference to the pain and range of movement (just did a simple mobilising technique) and it felt great to know that I had been effective. When I gave the patient some exercises to do at home she was so grateful that I felt embarrassed and I also felt a bit ashamed at doubting my educator's support when she got up and left the cubicle. On reflection I see why she did it and it is good to know that she felt that I was competent to do it without help. It was a fantastic way to end my third week.

Evaluation

On the positive side I can say that I was put on the spot and was able to muddle through and 'do it'. On the negative side I felt frustrated that we had not had more time to go over the shoulder assessment. On reflection I see that we had done enough and that it just hadn't taken very long to go over the assessment! I felt let down and angry at being left alone with the patient and I upset myself even more when I began to go to pieces.

On the positive side it has shown me that I can pull myself together when things don't go a I had planned them. It has certainly shown me how not to act if this ever happened again. It has reinforced that I need to have confidence in myself and that, despite feeling unprepared, that my educator felt I was and proved it to me by leaving me to assess the shoulder alone.

Analysis

I have learnt that I need to be more assertive in 'discussing' and explaining my feelings e.g. lack of skills and my self doubt. I also need to take responsibility for self-directed learning and not become too reliant on expert guidance because it is OK to make mistakes - provided that I learn from them.

Conclusion

I have found that when self doubt was present I had the capacity to overcome it by acting confidently and that it stopped me from falling into a downward spiral of incoherence and incompetence. I have learnt that I am not as confident as I thought I was especially when meeting things for the first time but I also have proved to myself that I am always thoroughly prepared (from a theoretical perspective).

Throughout the placement my clinical supervision was excellent. I have been very lucky that my Clinical Educator was such a well organised person with such excellent skills and ability to teach. I am aware that I became a bit reliant on her support and that I tried to achieve a level of competence that was far above my ability - I wanted to do everything perfectly, just like her, right from day one of the placement. When she abandoned me with may shoulder patient she made me aware of how comfortable I had felt with her supervisory style and how unsettled I was when she changed it! In future placements I hope that I will be less likely to be 'thrown' by variations in clinical educators styles, so that, despite my lack of experience, I will be able to use my theoretical knowledge to help me examine and treat patients with confidence.

Action plan/lessons to remember

Be more assertive in stating needs
Be more realistic in setting my own standards - it is OK to make mistakes provided that I learn from them and don't repeat them
Be confident and calm even when feeling uncertain
Act appropriate when feeling out of depth - get help!
Take responsibility for filling in gaps in my knowledge base (and understand that the more I know the more I realise how little I know)
Expect and adapt to the variations in styles of supervisors
Be prepared to make mistakes and to learn from them

APPENDIX 3.7
The following are general description of reflectors in professional practice

1. Features of a non-reflector

- Descriptive and makes assertions without real supportive evidence
- Makes assumptions without testing the validity of knowledge or reality of experiences
- Things are seen as being straightforward; unaware of contextual factors. Uses 'allness' – prefixes statements with general axioms ie Everyone knows that..; 'You would be a complete idiot if you don't see that….'
- Language used to assert self rather than beliefs
- Is entrenched in existing knowledge and will not consider new ways of thinking
- May have fear of moving forward or changing view. Cannot accept challenge.
- Sees failure as personal rather than organisational. Does not use failure a positive stepping stone.

Reflector

- Does not exhibit the above non - reflective characteristics
- Attends to feelings of self & others. Can perceive effects of dynamics & process(s) of groups
- Can demonstrate empathy.
- Association demonstrated; links prior knowledge with new.
- Integration seen; accepts and uses new knowledge to gain more insights.
- Is prepared to revisit experiences in the light of new knowledge

1.2 Critical reflectors

- Iterative; returns to the trigger or experience in the discussion
- Ability to frame the problem in context
- Adventurous in method of presentation
- Amenable to change
- Can see the contextual limits of knowledge, concepts and theory. Ie is able to see when a concept would apply and in what situations it would be best to apply.
- Moves away from inductive reasoning where limited knowledge is applied to all experiences
- Is aware of meta cognition
- Can assess self and performance in a positive way
- Is able to accept multiple realities when required

Mezirow et al (1990)

APPENDIX 3.8

Professional Practice Portfolio (Gordon & White 2003)

Feedback for student from audit relating to achieving the aims of the PPP

- To enable you to record, evaluate and influence your clinical education
- To ensure competence in core areas is achieved
- To begin to develop the ability to critically reflect on your practice and practice of others
- To develop ability to be self directed in/responsible for personal professional development
- To enable you to link your practice modules and develop a continuum of experience with which to maximise learning opportunities
- To provide you with a personal and detailed log of your clinical experience which will help to prepare you for your post-registration career.

Aims achieved are indicated by a ✓ in a white box. Please discuss any unachieved aims with your personal tutor

	Yes	No	Recorded clinical experience	Evaluated	Influenced	Competent	Ability to critically reflect	Self directed	Link practice	Log experience
Description of placement	✓		✓	✓		✓				✓
Learning outcomes signed	✓									
Personal goals documented			✓	✓						
Goals signed	✓		✓	✓						
SMART goals achieved	✓									
None										
A few										
Some										
Most										
Vast majority	✓									
Personal learning achieved	✓		✓				✓			✓
Outstanding personal goals	✓			✓			✓		✓	✓
Proposed action	✓								✓	
SLER documented	✓		Level achieved: Non Reflector				Reflector	✓	Critical Reflector	
SLER signed	✓									
Skills and competencies signed		✓								
CPSA completed										
Section 1			✓	✓		✓				
Section 2			✓	✓		✓				
Section 3			✓	✓		✓				
Section 4			✓	✓	✓	✓			✓	✓
Section 5			✓	✓		✓		✓		
Midway			✓	✓	✓	✓		✓	✓	✓
Completion of placement	✓									
Reflective diary	✓		Level of reflection:: Non reflector				Reflector	✓	Critical reflector	

APPENDIX 3.9

The following are suggestions and are not intended to be prescriptive.

Try and assist the student to develop the following strands of reflection (Fish and Twinn 1997) in their SLER: i) The Factual Strand, ii) The Retrospective Strand, iii) The Substratum Strand and iv) The Connective Strand

The factual strand is a description of events and processes of what occurred in practice (a thumbnail sketch). This is accurate factual detail that needs to be 're-lived'. Therefore try to recognise what actually happened and clear the ground to avoid points of potential disagreement over the events that occurred.

The retrospective strand is concerned with looking back over all the events of the practice situation so that theories can be drawn out from clinical practice. Begin to question how others may have viewed what happened and focus on sensitivity, imagination, and alternative ranges of perspectives. Try to evaluate the success of what happened and stimulate further critical reflection. Consider what patterns emerge and what emotions, failures, limitations, constrains and coercions may have ensued.

The sub-stratum strand is concerned with discovering and exploring assumptions, beliefs and value judgements which relate to a and b. Try to avoid superficial criticism and seek to broaden considerations beyond mere technicalities of the event. Question the validity of the reasoning and deliberate over intended goals whilst developing a tolerance towards a range of views. Essentially dig around under the surface of what has happened.

The connective strand is concerned with the overarching theoretical and practical elements of a, b and c and how they might be modified in the future. It is necessary to consider the wider perspective and face the real world and its wider perspective. At this juncture consider further reading to illuminate the issues and press the student to define a clear plan of action for the next phase of practice and/or make contact with the patient/client – with the benefit of hindsight and experience.

APPENDIX 3.10

Interprofessional Working

Interprofessional – 'Occasions when two or more professionals learn together with the object of cultivating collaborative practice CAIPE (Center for the Advancement of Interprofessional Education)

Multiprofessional education – 'Occasions when two or more professionas learn together for whatever reason'CAIPE.

Enquiry based learning – 'A learning approach based on the principle of using scenarios as a starting point for the acquisition and integration of new knowledge' The DARE(Disability and Rehabilitation Education) Foundation.

Level 1 IP – One of the learning outcomes 'Reflect on own health and well-being, professional role and contribution to collaborative enquiry based learning'.
One of the key skills – ' Critically reflect on own performance'.

The assessment – a 3.000 word assignment discussing the potential benefits and difficulties associated with collaborative working. Examples should be given relating to your own experience of IP group work (including reflection on your own contribution to the collaborative learning process)

Level 2 IP - One of the learning outcomes – 'Explore and analyze the concept of power in the process of professionalisation within different groups of health and social care professionals.
One of the key skills – 'Show an awareness of the contribution of researcher based evidence to professional accountability and life-long learning.

Part 1 of the assessment – Present evidence of your participation in the two day UWE Interprofessional Student Conference.
Part 2 – A 3,000 word assignment, including 4 self assessment topics and a 1,500 word essay to demonstrate your understanding of the learning outcomes of the module, a reflection on your participation and role that you played to help your group meet the goals it set.

Level 3 IP – Outcomes – ''Critically evaluate your own and others contribution in Interprofessional practice & …….. Explore own professional development within the context of collaborative education and practice.

Part of the assignment is a 2,000 reflective essay to reflect on your learning using evidence from your participation in the UWE on-line discussion boards and, in particular, a consideration of your own professional development within the context of collaborative education and practice

Appendix 4.1

Self assessment form

My Reflections on interview number 5

Thinking about the **interview** you have just conducted, how would you rate your own performance. Please complete the following:-

	I think my performance was excellent	I think my performance was good	I think my performance was okay	I was not happy with my performance
The way I introduced myself	❒	❒	❒	❒
The way I asked the questions (Were they appropriate and logical?)	❒	❒	❒	❒
The way I structured the interview	❒	❒	❒	❒
The quality of the information I obtained	❒	❒	❒	❒
My use of appropriate body language	❒	❒	❒	❒
The way I finished the interview	❒	❒	❒	❒

Thinking about your completion of the **interview evaluation form**, how would you rate your knowledge about:

	My Knowledge is excellent	My knowledge is good	My knowledge is okay	I am not happy with my knowledge
Symptoms and diseases	❒	❒	❒	❒
Suitability of actions by the patient	❒	❒	❒	❒
Appropriate use of medicines	❒	❒	❒	❒

Please add any other areas in which you feel particularly strong or particularly weak in skills or knowledge

At the end of the interview.....

I realize that I:-

had forgotten to ask some important questions

a lot	1	2	3	4	not at all

had forgotten some of the information given to me

a lot	1	2	3	4	not at all

enjoyed the interview experience

a lot	1	2	3	4	not at all

found the interview

difficult	1	2	3	4	not at all difficult

Appendix 5.1

ENB (1996) Ten Key Characteristics

1. Accountability
2. Clinical Skills
3. Use of Research
4. Team Work
5. Innovation
6. Health promotion
7. Staff Development
8. Resource Management
9. Quality of care
10. Management of Change

Appendix 5.2

Extract Example of Reflective Writing.

Significant proportion of ambulance emergency calls involve patients with breathing difficulties (Greaves *et al* 1997). Many of these patients have pre-existing respiratory illnesses, which often have a cardiovascular component. Successful management of these cases relies heavily upon accurate assessment of the presenting complaint, in order that appropriate treatment may be initiated quickly. The following case study highlights some of the issues associated with paramedic assessment of patients suffering with LVF and the introduction of Frusemide.

It is generally accepted that well developed assessment skills are a vital component of pre-hospital care (Greaves *et al* 1997). The NHS Paramedic Training Manual states that "Assessment is a key process that has to be done before you can decide how to manage the patient" (IHCD 2001). Despite the obvious importance of respiratory assessment in paramedic practice, little attention is given to extending or developing assessment skills in post registration training. Santy (1997) asserts that it is no longer appropriate for health care practitioners to acquire standard qualifications and expect to be able to practice unchallenged for the remainder of their careers. In response to this, Driscoll and Teh (2001) propose the use of reflective practice as a viable method for health care providers to maintain their professional development in practice. Therefore reflective practice may provide a useful framework for examining assessment skills amongst paramedics. Although the value of informal reflection has been acknowledged, certain commentators have called for the introduction of more formalised reflection as part of the paramedic curriculum (Jones & Cookson 2000). Boyd & Fales (1983) define reflection as "The process of internally examining and exploring an issue of concern, triggered by an experience which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective." This is a useful definition in the context of pre-hospital care, as paramedics generally practice in a reactive manner in circumstances that are often chaotic and preclude advanced planning. As a result, existing informal reflection amongst paramedics is often triggered by isolated events which raise concerns and stimulate group discussion. However, Boyd & Fales (1983) assert that the end product of reflection should be clarification of meaning in terms of self and a change in conceptual perspective. Without engaging in the reflective process, paramedics are unlikely to achieve this clarification of meaning, and conceptual perspectives will remain unchanged.

In order to facilitate reflection on action, several commentators have developed academic frameworks for reflective practice. Gibb's (1988) conceptualises the reflective process as a cycle, which begins with a description of an event and culminates in the development of an action plan for future practice. The cycle is based on an educational framework, which relates to a theory of experiential learning described by Kolb (1984). Rolfe *et al* (2001) note that the cues which comprise Gibbs Cycle (1988) are relatively general and unspecific. As a result, the focus of the cycle is learning from experience, rather than attempting to change the experience.

.On the basis of the assessment made by Rolfe *et al* (2001), models such as Gibbs Cycle (1988) are unlikely to promote reflective activity beyond stage 1. As reflection on action develops within the paramedic profession, the need for more complex reflection at a higher level becomes increasingly apparent. Rolfe *et al* (2001) assert that the advanced practitioner requires a reflexive framework that addresses both the micro and macro levels of reflection.

Sanders (2001 p878) states that "a complete, but focused, patient history and examination" is essential in ensuring adequate assessment and management of LVF by paramedics

There is also evidence to suggest that a mismatch exists between the areas in which training is provided and the actual caseload routinely seen by paramedics (Lendrum *et al* 2000). Training in assessment techniques is generally based upon the primary and secondary survey approach, which aims to identify and correct life-threatening conditions in order of priority. Although this approach is recognised to be of benefit in treating patients with multiple injuries, paramedics are often constrained by the limitations of what is essential a protocol based assessment system. In addition, the frequency of cases where adherence to the primary survey is essential is limited in comparison to the number of patients who would benefit from a more comprehensive systems based assessment approach.

There has been some debate over the type and level of training required to enhance and expand the role of the ambulance service, but it is clear that future developments will need to concentrate more on in depth patient assessment, and less on skills usage (Cooke 2000, Audit Commission 1998). Mentoring for novice practitioners is also an important aspect of developing sound assessment techniques. The experienced unconsciously competent practitioner may not always be ideally placed to support newly qualified paramedics, and may experience difficulties in passing on well honed assessment skills (Rolfe *et al* 2001). Paramedics have traditionally relied on protocols to guide the assessment and treatment of patients. Although there is now a move towards guidelines (JRCALC 2000), the use of protocols is an almost inevitable consequence of the relatively limited training provided for ambulance staff. This is further compounded by a lack of continuing professional development to support the introduction of new assessment and treatment techniques (Hassan 1998).

Appendix 5.3

Extract Example of Reflective Writing

The aim of this reflective essay is to critically discuss the skills involved when carrying out the successful patient assessment of an elderly person.

There are a number of reasons for choosing this area of patient assessment for reflection. The population is becoming older and elderly people are the largest single group using the National Health Service (NHS) (NHS Plan, 2000). This inevitably means that the number of ambulance calls to elderly people will increase. The consequence of the above will ultimately require that the standard of care offered by paramedics, including patient assessment, will have to be improved.

Reflection is becoming a widely accepted form of learning in many professions. In defining reflection Jones and Cookson (2000:75) suggest that it is " A flexible, action-centred approach to learning from experience through deliberate conscious examination, structured analysis and integration of thought and action." The idea of consciously and deliberately looking back at previous actions can have many benefits. Burns and Bulman (2000) suggest that it can lead to understanding the meaning of experiences, can highlight the value of practical experience, can encourage research and allows knowledge to be learned and used in new and exciting ways. It is important to emphasise that reflection, in this sense, is a conscious, structured process. It is the feeling of many paramedics that they already practice informal reflection by thinking about situations and past experiences. Although there can be benefits to this Driscoll (2000) argues that this is mainly a static process that can be unresponsive to changing situations. He suggests that reflective learning is much more than just thinking about something. It requires commitment and motivation to purposefully return to events with a willingness to learn (Driscoll, 2000).

There have been a number of models created to aid the reflective practitioner. Models simply act as guides, assisting the practitioner to access the whole experience in a structured manner (Johns, 2002). Driscoll's What? model is an example of this and encourages the practitioner to reflect by answering a number of trigger questions. The advantage of this model is that the practitioner can choose which questions are relevant to the experience in question and can therefore control how involved the process becomes (Driscoll, 2000).

An extended patient assessment needs to reflect the changing nature of the emergency calls being received.

It should be highlighted that experience is not simply acquired through the passage of time. Gaining experience involves encountering numerous differing practical situations that deviate, to some degree, from accepted theory (Benner1984)

Real situations rarely match what can be taught in a classroom and it is only through experience that the practitioner can gain the ability to manage these situations. As previously discussed, one of the key benefits of reflective practice is being able to learn from experience..

Ageism and stereotyping are also important issues that need to be considered when providing care to elderly patients. The rationale for this essay highlighted that this has become a serious problem. Chaisty (1996) suggests that there is a widely viewed misconception that old age brings with it deterioration in both mental and physical health. In addition to this Bradbury (1995) believes that many professionals involved with care of the elderly have been socialised into a society where stereotyping is more or less accepted. This would suggest that many professionals involved with elderly care are being ageist without even realising it on scene. In an attempt to deal

with this issue Bradbury (1995) argues that health professionals should be encouraged to review their own attitudes towards elderly patients. Accomplish these measures and incorporate the improved training into an extended patient assessment.

There is no doubt that the numbers of elderly people using the NHS are increasing. Using an example from practice, this reflective essay has critically discussed how carrying out a patient assessment on an elderly person can be a difficult, complex process. The increasing numbers of social or non-physical problems being attended to by paramedics has highlighted the limitations of the current patient assessment training. An extended patient assessment incorporating improved communication skills, psychosocial skills and a better general understanding of special patient groups could equip paramedics with the reflective, problem solving abilities increasingly required in today's ambulance service. More importantly than this, these skills could make a major impact on the care provided to elderly patients.

Appendix 6.1

Indicative Content for the Reflective Essay within Critical Reflections on Professional Practice Module (311 O.T)

- Brief descriptive narrative identifying the critical issue
- Exploration and analysis of personal assumptions within the event
- Selection and reference to theoretical literature on reflective practice
- Examination of this critical issue with reference to a reflective framework or model and rationale for its use
- Discussion and evaluation of internal and external contextual issues* and their impact on the event currently or within future similar events
- Evaluation of own performance through discussion of a changed personal perspective and implications for professional practice

*Internal and external issues may refer to, national directives, local policy and procedures, government policies within the NHS/LASS, legislation, professional codes of conduct, social and economic factors

Appendix 7.1:

Abstract from Assessment Strategy for diploma in nursing students

Portfolio Activity - first semester - level 1 (4)

Reflecting is a fundamental and vital component of your learning. Recording this reflection is a vital part of your portfolio.

The aims of this assignment are to:

- Help you develop the skills of learning from practice by providing opportunities for you to reflect on your experiences
- Assist you to reflect on some of the professional, legal and ethical issues that you encounter
- Enable you to relate the theoretical components of the module to your nursing practice

Assignment Guidelines

The topic chosen for reflection should be an interaction / incident / experience from one of your practice placements. It should focus on a specific patient / client and the care you gave her / him during this interaction.
Reflect upon the interaction, paying particular attention to professional, legal and ethical issues involved. ….

The emphasis should be on *critical reflection* and things you have learned from the incident and your reflections.

You should use a framework to guide and present your reflections.

Nottingham School of Nursing 2003

My comment - can you expect students to do "critical reflection" at level 1(4)? Needs criteria for the level of, breadth and depth to distinguish between levels 2 and 3, and level M. i.e. more descriptive and discursive, rather than analytical?

Appendix 7.2

Patient and Public Involvement Information: Adult Branch Themed Placement
Introduction: Application to Practice Outcomes and Module Outcomes.

Practice
Focus: care delivery domain: Improving "patient"/public information and support skills through enabling people to:

- access to services, understand services, utilise services
- knowledge and understanding of investigations, procedures, illness, treatment, support available
- provide service feedback through patient /public forums/participation

By:- effective communication

- greeting users/carers, assessment of need for information, level of information appropriate, methods of providing information, information delivery,
- working with interpreters
- accessing health informatics, data analysis and accreditation; accessing resources
- enhanced listening skills, summation skills
- verbal information skills, written information skills, telephone information skills; documentation skills
- negotiation skills; conflict and anger management skills (insight only)

Link to: professional/ethical domain: professional behaviour in dealing with wide range of clients

- from diverse cultural backgrounds; with communication difficulties
- with concerns/complaints about services/care (insight only possible)

Link to: management domain:

- maintaining confidentiality, documentation, use of databases
- working to standards, guidelines recommended for good practice
- handling complaints (insight only)
- quality of services - audit (insight only)
- organisational working - interdepartmental as well as intradepartmental (insight only), multi-agency work/collaboration (partnerships)
- change management (insight only), wider health service/social service/voluntary sector collaboration

Link to:Personal domain:

- development of key skills

Links to: Modules 9,10,11:

- philosophy - of partnerships; equality and equity in provision of health care - …….right to , availability and access to information;… advocacy - patient voices/ voices for patients; … - seamless joined up services etc
- current health policy - … continuity of service to users/carers …. ; informal care sector; private care sector; and voluntary care sector;.informed choice and informed consent; co-ordination of patients journey; expert patient initiative /training; treatment concordance (compliance); identifying information gaps in service provision and how action is taken

Appendix 7.3. Learning Summaries One and Two.

Student 1. "… the basic task of taking a patient's blood pressure goes much deeper than the technical skill Once trained, anyone can take a blood pressure, … as responsible health care professionals, we need to look at the wider picture. As nurses we should act as an educator, advocate, listener, counsellor, communicator and supporter. … we must first consider why we are taking blood pressure. a routine part of all health screenings. .. Occupational Health nurses, … responsibility that (a) they are fit to work in their specific job and (b) that they are healthy in themselves as part of the general community. If a patient had a high blood pressure reading … we would assess whether this would put them at risk of carrying out their daily job; … in instances where blood pressure does not directly affect their job e.g. a pregnant nurse, then they should be considered healthy to work at the same time assessing possible risks to them where adjustments to their role could be. A low blood pressure, … make them prone to postural hypertension whereby if they stood up quickly they may be liable to fall. Advice can be given to them … Blood pressure checks … are also a useful way of picking up irregularities which may otherwise go unnoticed due to the asymptomatic nature of blood pressure problems… referrals can then be made i.e. to a GP if necessary. The biological effects of blood pressure - the heart and blood vessels, cardiac output, peripheral resistance, blood viscosity, hormones (rennin and angiotensin), blood volume regulated by the kidney and spleen. Factors which may cause high blood pressure are also important as a knowledge base when taking blood pressure such as obesity, smoking, during exercise, high cholesterol, sedentary lifestyle, diabetes, genetics, age, sex and stress. The patient's history … in establishing what is normal for them e.g. family history, medication, pregnancy; an athlete may have lower than normal blood pressure readings and stress/anxiety. A normal blood pressure reading would be 120mmHg systolic and 80mmHg but everyone is different and this may vary. However, blood pressure readings above 140mmHg systolic and 90mmHg diastolic may be considered as high blood pressure or hypertension. … Occupational Health nurse … a health promoter .. regarding obesity (if this is the cause of the hypertension) regarding healthy eating and exercise. However evidence suggests that compliance may be low especially regarding blood pressure advice as the patient may feel perfectly well in themselves whereby making such major life changes will have an impact on their happiness. … the patient remains autonomous in their decision to combat the problem. .. we should supply the material! advice covering all options to the patient who must make an informed decision themselves. …… The work process impinges on the health of the worker and so it is important that certain measures are in place to maintain this. … whenever they can.

Or Student 2.…taking a patient's blood pressure goes much deeper than the technical skill in use. .. we need to look at the wider picture…. To do this we must first consider why we are taking blood pressure…. It is important to first gain the consent of the patient to take their blood pressure; this is most likely to be given verbally. The environment should then be assessed before the reading is taken, i.e. is the patient relaxed and comfortable? Has a sufficient rapport been established between yourself and the patient? How is the temperature of the room? Under what circumstances are they visiting? If this is of a stressful nature the reading may be affected.…etc (*this student starts with a different perspective*)

ACTION PLAN: 'Health Assessment and Health Screening' To fully understand the reasoning behind questions asked during a health screening by seeking advice from a qualified nurse; To put into action everything learnt and discussed on blood pressure during a health screening.; To be able to undertake an aspect of health promotion confidently and empathetically e.g. healthy eating and exercise for overweight individuals; Read up on Government strategy for Health at Work. Guidelines or legislation? Who pays? of a stressful nature the reading may be affected.

Appendix 7.4.: Stages of "IT" - recognising shades of competence: rule of thumb measure for students to reflect on

- I can tell you about …….. but not do "it"
- I know how to do "it", but I am not sure why
- I was shown how to do "it", and just did it the way I was told to do "it"
- I know when to say I am not happy to do "It"

- I asked why "it" was done in this way, I understand if I "do it" this way it will be better
- I can do this much of "it" , but need help …..
- My mentor is happy for me to "go off and do it"
- I can do "it" , and my mentor just watches me for legal reasons …
- I know when to say I am not happy to do "It"

- I am aware of other ways of doing "it"
- I have done "it" other ways and know which is the best way , when…
- I know when to say I am not happy to do "It"

- I do it well; and
- made an appropriate choice from the options I had for action;
- I have a strong basis for the decisions; and that
- my actions were appropriate, and
- I can and will accept responsibility ; and
- be deemed, and held, accountable

- I can teach someone else to do "it"

- I know when and to whom I can delegate "it"

Doing " It" is a complex activity.

Alison Clark 2003

Appendix 8 1.

Reference to U.K.C.C. Rule 33 (3) (c) (i)-(xi)	Reference to Care Components	MID 221: LABOUR AND BIRTH PRACTICE OUTCOMES
(i) (ii) (iii) (iv) (vii) (viii)	**1,10**	**221:A1.** Define and diagnose the onset of normal labour, collecting and utilising relevant information.
(i) (ii) (iii) (iv) (vii) (viii)	**1,10**	**221:A2.** Define and diagnose the onset of the second and third stages of labour, collecting and utilising relevant information.
(i) (ii) (iii) (iv) (vi) (vii)	**1,10**	**221:A3.** Use observation and questioning skills to monitor progress during normal labour.
(i) (ii) (iii) (vii) (ix) (x)	**2,10**	**221:A4.** Assist with planning intranatal care with the woman and her partner.
(iii) (iv) (v) (viii) (ix) (x)	**3,10**	**221:A5.** Carry out care planned for women in normal labour and participate in the care of women who develop complications during labour.
(iii) (viii)	**4,10**	**221:A6.** Contribute to evaluations of care given.
(i) (ii) (iii) (iv) (v) (vii) (ix) (x)	**5,10**	**221:A7.** Use midwifery skills in the assessment of care needs and delivery of care, in real or simulated environments (eg. abdominal and vaginal examination, fetal monitoring, delivery techniques, active birth, mobility and positions, home birth, water birth, examination of the newborn, safe administration of drugs).
(vi) (viii) (x)	**6,10**	**221:A8.** Demonstrate appropriate interpersonal skills during interactions with mothers, the family and with other members of the care team.
(iii) (vi) (ix)	**6,10**	**221:A9.** Record care given in accordance with legal requirements.
(vii) (ix) (x)	**8,10**	**221:A10.** Demonstrate independent learning skills through structured reflection on practice, identification of learning needs from practice, location and utilisation of relevant learning resources.

Reference to Care Components	MID 221: LABOUR AND BIRTH INTEGRATED OUTCOMES
1,10	**221:B1.** Describe in detail the anatomical and physiological changes which occur during normal labour in the mother, fetus and newborn.
1,10	**221:B2.** Apply knowledge of the anatomy of the fetal skull and female pelvis to the assessment of progress during normal labour.
All	**221:B3.** Reflect on factors contributing to effective support of the woman in normal labour.
All	**221:B4.** Compare, contrast and use different methods for the relief of pain during labour.
2,10	**221:B5.** Reflect upon ethical and legal requirements, informed consent and evidence used in care planning and goal setting.
All	**221:B6.** Reflect on principles and techniques of effective tissue alignment and perineal repair.
4,10	**221:B7.** Reflect on the contribution of intranatal care to the long term health of the woman, family, community and society.
7,10	**221:B8.** Reflect on different ways of organising intranatal care and on factors which influence this.
9,10	**221:B9.** Reflect on factors which influence whether a woman feels in control and an equal partner in her care during labour.
9,10	**221:B10.** Reflect on practice in order to consider and demonstrate effective use of self in the spheres of sexuality, privacy and intimacy, in accordance with the woman's wishes.
All	**221:B11.** Reflect on the relationship between intranatal care experienced and the midwifery practice guidance documents published by the U.K.C.C.

Appendix 8.2.

Module Assessment Table (contributory components)

The assessment strategy is based on 15 level 2 (5) ***or*** *3 (*6) credits awarded for the successful completion of a 3,000-4,000 word equivalent assignment. It incorporates a 2 stage dissertation of 8000 words.

Module	Weight %	Week	Assessment Detail	
Mid 220 Foundations for Midwifery Practice	25	9	**Written**: One and a half hour anatomy and physiology MCQ exam. Related to normal midwifery and fertility.	
	25	12	Evaluation of published research. (2000 words)	
30 level 2 (5) credits	50	12	**Portfolio:** outcome-based seminar.	
Mid 221 Labour and Birth	25	25	**Written**: critical analysis of an aspect of intranatal care. (2000 words)	
	25	22	**Practice**:	
30 level 2 (5) credits	50	25	**Portfolio**: outcome based seminar	
Mid 320 Health Promotion in Midwifery Practice	25	38	**Written**: teaching presentation to peers with supporting written rationale. (2000 words)	
	25	35	**Practice**:	
30 level 3 (6) credits	50	38	**Portfolio:** outcome based seminar	
Mid 321 Health Risk and the Role of the Midwife (Antenatal and Postnatal)	25	51	**Written**: case presentation analysing an encountered obstetric complication with supporting written analysis. (2000 words)	
	25	46	**Practice**:	
30 level 3 (6) credits	50	51	**Portfolio**: outcome based seminar	
Mid 322 Health Risk and the Role of the Midwife (Labour)	50	64	**Written**: critical literature review of an aspect of practice. (5000 words: **stage 1 dissertation**)	
	25	60	**Practice**:	
30 level 3 (6) credits	25	63	**Portfolio**: outcome based seminar	
Mid 323 The Midwife Practitioner	50	71	**Written**: situational analysis or research proposal based on previous module assignment. (3000 words: **stage 2 dissertation**)	
	25	75	**Practice**:	
30 level 3 (6) credits	25	72	**Portfolio**: outcome based seminar	

Appendix 8.3.

Grades for module seminar assessment, BSc (Hons) Midwifery

MODULE.....

FOCUS OUTCOMES.....

STUDENT.....

ASSESSORS.....

DATE.....

INSTRUCTIONS TO ASSESSORS

The criteria are in two sections, relating to **A. PRESENTATION SKILLS AND B. THEORY PRACTICE INTEGRATION.** Both sections must be passed.

Rate the presentation A2 - F2 for each criterion.

Score as follows for each rating:-

- F2=15, F1=25, E=35, D=45, C=55, B=65, A1=75, A2=85.

Calculate the average score for each section: if the average for either section is below 35, the student has failed the seminar presentation. If the average for either section is 29 or below, offer of re-presentation will be at the discretion of the Board of Examiners.

If the student has passed the seminar presentation, calculate the average score for the 2 sections: this is the final mark for the seminar.

EXPERIENCES SELECTED

AVERAGE SECTION A.....AVERAGE SECTION B.....

PASS OR FAIL (circle accordingly) AVERAGE BOTH SECTIONS.....

FINAL MARK.....

SECTION A PRESENTATION SKILLS

STRUCTURE AND ORGANISATION

		A2	A1	B	C	D	E	F1	F2	
Introduction	Clear and appropriate									Ineffective
Sequence	Logical, flowed well									Rambling and muddled
Focus	Clear and relevant									Confused
Sources of evidence	Clearly identified									Absent
Summary	Effective									Ineffective

INTERACTION WITH GROUP

		A2	A1	B	C	D	E	F1	F2	
Speech	Clear and audible									Unclear, difficult to hear
Professional language	Used appropriately									Not used appropriately
Verbal interaction	Invited and managed effectively									Not invited
Eye contact	Used effectively									Poor
Questionning	Used effectively									Not used effectively
Listening	Demonstrated									Not demonstrated
Posture	Appropriate									Inappropriate
Use of visual aids &supporting material	Lively, good use of aids									Dull, only reading paper

SECTION B: THEORY PRACTICE INTEGRATION

SELECTION AND TREATMENT OF EVIDENCE

		A2	A1	B	C	D	E	F1	F2	
Examples from portfolio	Relevant and explicit links made to focus									Relevance to focus not clear
Range of sources of evidence	Comprehensive									Narrow - omissions
Range of issues raised	Comprehensive									Narrow - omissions
Accuracy	Accurate									Inaccuracies
Level of analysis	Critical evaluation									Descriptive - assertive

CONCLUSIONS DRAWN FOR PERSONAL AND PROFESSIONAL DEVELOPMENT

		A2	A1	B	C	D	E	F1	F2	
Implications of learning for personal development: knowledge	Identified and comprehensive, innovative, insightful									Not identified
Implications of learning for personal development: skills	Identified and comprehensive, innovative, insightful									Not identified
Implications of learning for personal development: attitudes	Identified and comprehensive, innovative, insightful									Not identified
Implications of learning for development of the midwifery profession: knowledge	Identified and comprehensive, innovative, insightful									Not identified
Implications of learning for development of the midwifery profession: skills	Identified and comprehensive, innovative, insightful									Not identified

Implications of learning for development of the midwifery profession: attitudes	Identified and comprehensive, innovative, insightful									Not identified

Appendix 9.1

Assessment - Portfolio Activity

Reflecting on your experiences in school and in practice is a fundamental and vital component of your learning. Recording this reflection is equally fundamental and will be a vital part of your portfolio.

The aims of this assignment are to:

- Help you develop the skills of learning from practice by providing opportunities for you to reflect on your experiences
- Assist you to reflect on some of the professional, legal and ethical issues that you encounter during your nursing practice experience
- Enable you to relate the theoretical components of the module to your nursing practice

Assignment Guidelines

The topic chosen for reflection should be an interaction / incident / experience from one of your practice placements. It should focus on a specific patient / client and the care you gave her / him during this interaction.

Reflect upon the interaction, care, observations and experience, paying particular attention to professional, legal and ethical issues involved. Examples of these issues could be consent, confidentiality, privacy, dignity and autonomy.

You are advised to discuss the topic you have chosen with either your Enquiry Based Learning Group Facilitator or the module leader.

The emphasis should be on critical reflection and things you have learned from the incident and your reflections.

You should use a framework to guide and present your reflections. The following is an example of a reflective framework. You will find several others in the literature on reflection.

Describe the activity - write down a concise account of what you did.
How did you feel at the time?
Did the activity raise any professional, legal or ethical issues?
What have you learned from the activity?
What sources of evidence have you drawn on to support your learning?
Are there any areas you can identify for further learning?
What sources of information / support could you access to support this learning?
When undertaking the same activity again would you do anything differently?

It is acceptable to write in the first person. For example: I gave him a drink. I cleaned his teeth. NOT 'the author…' or 'the student…'

The patient/client and placement must not be able to be identified in your work.

The completed assignment should be 3000 words in length and a word count should be given on the front page of the assignment.

You should include a full and accurate referencing system.

Appendix 9.2 - Extracts from Student's assignment

…My first practice placement as a student nurse involved working in a nursing home that provides care for long stay residential patients and shorter term nursing patients; all are diagnosed with mental illnesses. The home has approximately 30 beds, the age range is very broad, and the needs of the patients very diverse. The interaction that I shall describe happened on my first day, in fact in the first few minutes of entering the building. I was naturally quite nervous at the prospect of starting this placement, although I have been a Nursing Assistant before, I wasn't sure what to expect. I have previously worked in the Learning Disabilities field and have very little experience of working in a Mental Health setting.

As I entered the building I was greeted by a health care assistant who showed me where to put my coat etc, then asked if I would help to attend to the personal hygiene needs of one of the residents. Mr. James has a diagnosis of Dementia, a disease that affects 5% of people over the age of 65, and rises to 20% in people 80 years old (Bartlett and Martin 2000). It would be useful at this point to give a brief description of what dementia actually is. Smith, P (2002) states that dementia is a condition that affects the function of the brain. A variety of symptoms result from these changes. Smith goes on to suggest that these changes typically result in difficulties in communication, cognitive ability and perception. Although dementia is a degenerative disease, the rate at which this happens varies widely between individuals….

It is important to assess the persons' ability to give consent, not presuming or making decisions based on your own beliefs or point of view. The Department of Health booklet on Seeking Consent when Working with Older People (www.doh.co.uk/consent/guidance/htm) gives guidance on how this consent is gained. The individual must be competent, i.e. capable of making the decision. They must be acting independently and must have been given sufficient information to be able to make the decision. The document also states that people in the early stages of dementia may be able to make decisions about certain areas of care, such as bathing, but less able to comprehend more complex issues relating to their care, which is an interesting point. We should never presume that a person is unable to make any decisions at all, but must assess their level of ability and function carefully. Certain questions must be considered in order to decide whether certain decisions could be made, such as is the patient able to paraphrase, or differentiate between several options. (www.doh.co.uk/consent/guidance/htm). Considering these questions will give some indication as to the patients' capabilities, allowing them as much control as possible in their lives.

In the case of Mr. James, where consent cannot be obtained verbally, is it still possible to lawfully provide care or treatment? Can Mr. James' personal hygiene be completed legally despite his inability to make his opinions and preferences known? In short, the answer is yes, but you must be seen to be acting in the 'best interests' of that person. It is important to uphold an appropriate level of personal hygiene in patients; this is particularly true for Mr. James who is incontinent of urine and faeces and wears incontinence aids 24 hours a day. A good hygiene routine is crucial for the prevention of pressure sores and also to prevent infection, which could be harmful to himself, members of staff or other patients. I can understand the need for Mr. James to be showered, despite his inability to give consent for this to be completed, but on reflection I wonder if it was necessary for all four of us to be involved in this activity. This raises questions about privacy and dignity, and with this in mind I wonder if I was acting in the 'best interests' of Mr. James by remaining in the shower room for the duration of the activity, when my gut instinct was that I should not be there, wondering if my skills could have been better utilised elsewhere…..

The experience made me realise that there are very wide issues involved in what may appear, at first glance to be a relatively simple exercise. It is not simply a case of completing a task such as

personal hygiene because we have to. It is important to be sensitive to individual needs and to try to empathise. If I were in Mr. James' situation in later life, I would like to think that my privacy and dignity would be upheld, even if my mental capacity had diminished because of dementia. As I mentioned earlier, it is still important to continue to respect the values and beliefs of a patient in the later stages of the disease, even when those views cannot be aired independently by the individual. As a result of completing this assignment I have been prompted to find out more about dementia and the surrounding issues. I have found this to be of interest and a tool for further learning and understanding of the disease and it's implications. Relevant information has been added to my portfolio for future reference.

Appendix 9.3 - Assessment guidelines –

Special Care in Mental Health Nursing Practice

Level 2 (5)

Care Delivery and Management Assignment = 30 Credits

Topic - Reflective Study = 5,000 words

Introduction
This assignment is designed to enable the student to reflect upon their professional and personal development. The Reflective Study and resultant Action Plan provides an in-depth analysis of the student's own performance when involved with planned care for people with special care needs. The assignment consists of two parts:

Reflective Practice Paper - 4,000 words [50%].
This paper is the student's reflection on their own performance including the quality of their caring, a focus on skills and evidence of advancement in their practice. Students should consider their performance in relation to service users, carers and staff.
A reflective model may be included.

Action Plan - 1,000 words [50%]
This plan is to be developed from the above paper and will contribute to the student's portfolio. It is essential that recognition of potential professional and personal development is included. Students are expected to identify factors that may help or hinder these developments. It is important that the student charts the following: why chosen these as issues, what are the goals, how to reach the goals.
Confidentiality must be maintained throughout the work.

Aims of the assignment
To provide the students with an opportunity to:
- relate theory to nursing practice:
- review own personal and professional development:
- examine and explore issues related to continuing professional development:
- participate in the care for clients experiencing special care needs:
- support the assignment with reference to appropriate research.

Guidelines
The assignment should be of 5,000 words.
The assignment must be referenced in accordance with School policy.
The assignment must reflect the modular content and themes and should be discussed with tutorial and placement staff.
The background of the assignment should be the student's practice placement.
Research findings and/or appropriate literature must support the assignment.
The assignment should reflect the student's learning in practice related to the Competencies.
The student's writings should provide a direct linkage between the reflective practice paper and the action plan.

Expectations
The following should be included:
A word count must be written on the front page of the assignment.
An effective model of reflection where appropriate.
Relevant literature and research regarding evidence-based care.
The student's contribution to the implemented care for clients with special care needs.
The critique of the effectiveness of the care delivered by the student.
Confirmation of clinical supervision throughout.
A discussion of the student's personal learning and implications for own future practice.
Both parts of the assignment are to be submitted in the same folder.
The action plan format provided is to be used.

Appendix 9.4 – Extracts from Student Assignment

Introduction.
This reflective study comprises of a detailed consideration of a seemingly innocuous topic that I had decided to add to the end of a supervision session. During a recent special care practice placement on a ****** ward, I attended a regular clinical supervision session with my mentor. I had prepared some issues that were dealt with successfully and rather quickly so having a little time left I mentioned that it annoyed me a little bit that nurses always made the tea / coffee for the multi-disciplinary team meetings.

At first glance this looks like an uninspiring subject on which to base an assignment but I believe (and hope to show) that it relates to the special care module objectives and addresses some of the key skills as listed in the Diploma In Nursing DN16 module handbook (University of Nottingham 2002), particularly those looking at working with others and improving own performance. The handbook states that the assignment should enable me to reflect on my professional and personal development, I believe this to be the case. As this essay is born out of the supervision and reflection process it worth taking a moment to review what these terms mean and how they have guided this essay……

Reflective Study.

Description.
…As part of my duties on the ward I was asked to participate in the ward round, something that I have done many times before, not only on this placement but on previous placements also. On this occasion the ward round consisted of a meeting of the multi-disciplinary team including the consultant Psychiatrist, the ward medical doctor, a social worker, two psychologists, an occupational therapist, the ward manager, a staff nurse and myself as a student nurse. The team was assembled (routinely twice weekly) to discuss, review and keep up to date on the treatment and care of the patients who were scheduled for a review that day (in this case four patients)…. During the meeting whilst finishing off the discussions for the second patient, the consultant asked me directly if I would go and organise a tray of tea for the team. I said yes of course and went to make the tea... Once back I found that the discussions had moved on to the next patient and I was asked to serve the tea which involved me asking in turn each person whether they wanted tea or coffee, if so did they want milk and sugar, then pouring and passing the drink to the person before moving on to the next one. On several occasions I had to wait for conversations to finish (stood there with teaspoon poised) before I could ask the person what drink they wanted. Finally I poured my tea and sat down. During the ward round it was also necessary for someone to fetch each patient from the sitting area, sometimes that was me and the staff nurse took notes and for other patients the staff nurse went and I took notes.

As the ward rounds were set weeks in advance I had had time to prepare and had made myself familiar with the current issues concerning each of the patients as well as reading the nursing day reports for each patient for the past couple of weeks. This was beneficial as I was able to participate in most of the discussions and was aware of the major problems likely to be raised……..

Feelings.
Feelings, also known as emotions can be difficult to define, Westen (1996) says that an emotion is the evaluative response (either a positive or negative feeling) of a subjective experience and typically includes a degree of physiological arousal and an expression of that emotion in ones behaviour. Although Westen (1996) argues that these four basic components are common to all

emotions. The theories of emotion are complex and include biological, behaviourist and cognitive approaches (amongst others) but he suggests that an integrated perspective gives a comprehensive and rounded view that feelings are mechanisms which enable us to select behavioural and mental responses, these responses are viewed as emotional feedback which in turn impel us to instigate action. This emotional homeostatic process is relatively easy to see in the intense emotions such as fear or anger (Atkinson, Atkinson, Smith, Bem, Nolen-Hoeksema 1996). I like this idea of emotional homeostasis and feel that it provides a logical reasoning for me mentioning the negative feelings expressed in my supervision session. To follow the idea through this seems to be saying that I experienced a negative feeling (evaluative response) as a consequence of being given small tasks at a ward round, this negativity emerges from my subjective way of thinking about and dealing with the event (subjective experience) and as a result this caused my body to respond (physiological arousal, sometimes described as a gut reaction), leading me to act in a certain way and lessen the negative feelings (behavioural expression). This seems a relatively simple process but many other factors complicate it, for example we may be motivated to act in a certain way and we all hold values and beliefs about how we should behave in different situations. This socialisation makes us express ourselves (or not) in culturally defined acceptable ways, sometimes we are allowed to be angry, at other times we have to control our emotions (Westen 1996). As the process of reflection is to facilitate change I will concentrate on the negative thoughts and feelings I have of the situation but acknowledge that any experience has both it's good and bad points.

Personally I felt that being asked to make tea or fetch a client from the day room was always aimed at the nursing staff, but on this occasion, me in particular, being the student. I felt de-motivated and undervalued. Having to stand and wait whilst someone finished speaking (especially as I felt that they knew I was waiting) was an overly aggressive way of letting me know my place in the team. I felt annoyed that I had spent a considerable amount of time preparing for the ward round and was left out of parts of the discussion when out of the room. I felt that my presence as a student nurse (at that moment in time) was tolerated but not really encouraged.

From a professional point of view I thought that the team was not working very well, the strict hierarchical structure made sure that some points of view were more important than others. I felt that fulfilling these simple tasks gave the members of the team, including patients, the view that nurses were there as dogs-body's, fetching and carrying and providing only a supporting and monitoring function to the treatments provided by the other disciplines. I feel that this undermines nursing and does not recognise the importance of the therapeutic relationship between mental health nurses and clients.

I also feel that this seems petty and that someone has to make the tea and fetch clients and that it is not such a big deal, I make very good tea anyway.

Evaluation.

….During my clinical placement I was given opportunities to experience and participate in a large number of direct care activities, communication activities and management activities, participating in the ward round was one activity that encompasses aspects of all of these (Stuart & Laraia 2001). As I was able to complete and present at the ward round a risk assessment for a patients rehabilitation outing, and also was asked at the end of the ward round to prepare a brief teaching session for the ward staff, on a drug that hadn't been used previously and that one patient had been prescribed (the teaching session is included in my learning outcomes for this semester), I was being given responsibilities and gaining experiences commensurate with my role as a student nurse.
On the other hand being sent to make tea and then serve the other team members was very de-motivating for me. I completely entered into the historical role differences as described by McCallin

(2001) in her literature review of interdisciplinary practice. Which describes nurses as being passive, helpers and seen as an adjunct to medicine. Blue & Fitzgerald (2002), whilst discussing working relationships in rural Australia, further reinforce this conflict and reiterate the historical domination of medicine over nursing….

Analysis.
As previously stated, reflection looks at historical, cultural, social and personal experiences (amongst others) to explain and improve nursing. To this end I will try to use these concepts to look at the setting in which my placement took place and multi-disciplinary teamwork in general, however, I will start by acknowledging the fact that had I not been present another student nurse or nurse would have been assigned the tea making role and so what makes the experience unique is my personal view of it, with this in mind I will look at the self and self awareness to try to make sense of the situation…….

Self-awareness is described as a process of narrowing the divide between how we see ourselves and how others see us (Rowe 1999). Bearing this in mind and on the advice of my mentor, I organised two sessions of peer supervision. I invited the placement co-ordinator (a registered nurse) who agreed to take notes and act as chairman, and five student colleagues who were also on placement at the hospital but on different wards. I asked each participant to come to the meeting prepared to discuss a topic, which had presented itself in practice. We had some good discussions but it is interesting to note that the placement co-ordinator couldn't attend the second meeting and it became clear in our discussions that as an outsider to the student group he was viewed with suspicion and that the discussion wasn't as open as it could have been (a point alluded to in the article by Cottrell 2002)…..

Conclusion.
….The conclusion part of this model is seeking to ask what can I change if the situation were to happen again? In answer I would have to say that the reflective process has been an effective tool to aid in my understanding of a situation and as such I would use the process again. it has encouraged me to examine my beliefs and whilst not change them at least be aware of why I felt a particular way, if I was asked to make tea again as a student nurse I would do so but with greater understanding. I may want to look at assertiveness, delegation and other leadership tools in a non confrontational way to try and address some of the issues such as a firm suggestion that we stop and help ourselves to tea then carry on when everyone is ready. As previously mentioned the essay is not about making tea, but about the way mental health nursing is viewed by others.

Action Plan.
What
1. What I have identified from the reflective study that I have undertaken is the value of reflection and the importance to practice of the reflective process. To this end I intend to regularly reflect on areas of practice that are both challenging but also on the mundane. In this essay I have used a model of reflection that I am familiar with but there are other models which may be more suited to different situations.
2. Clinical supervision was the catalyst that provided a topic for reflection. I will continue to access supervision from my mentor but I will also try to engage in other forms of supervision where it is offered or provided, such as peer supervision and managerial supervision.
3. I will continue my nursing education. Looking at my professional and personal learning needs should enable me to identify knowledge deficits and address them.

4. The personal deficits that I feel need addressing as a result of this essay are to do with organisational abilities such as time management, delegating tasks to others and looking at ways to be more professionally assertive.

Why

1. I have discussed the benefits of reflection in the essay but the work of Burns & Bulman (2000), Johns & Freshwater (1998) and Walton (1995) all describe how reflection is transforming nursing into an insightful, humanistic and meaningful profession. As nursing is a practice based essentially hands on skill it requires effective and appropriate ways of knowing, reflection provides us with unique practice based ways of knowing.
2. Clinical supervision is heralded as being the support and guidance so long lacking but so much needed in mental health nursing as a combat for the increasing levels of stress evident in a profession coping with change (Bond & Holland 1998). Clinical supervision has been an important aspect of my practice placements, formative support through the mentor route has both informed and supported my practice and the care decisions that I have made. I have also found the peer support useful in the restorative function, evident in this essay by validating, to some extent at least, my personal feelings. Butterworth, Faugier & Burnard (1998) however say that the concept of any supervisor can supervise any supervisee is fundamentally flawed, for this reason they assert that well trained supervisors are needed to improve nursing practice.
3. This seems an easy thing to do as I am a nursing student, but I believe we get out what we put in to our education and anecdotally, many of the students in my group feel that they lack a sound knowledge base, a common feeling alluded to in much of the literature used in this essay when looking at the role of the nurse in the multi-disciplinary setting (Cowman et al 2001) (Long, et al 2002) (Barker et al, 2000). An obligation under clause six of the code of professional conduct (2002) states that we must maintain our professional knowledge and competence. The commitment to lifelong learning is a pre-requisite for nursing and health care in general.
4. The identification of some personal deficits that I need to address only highlights the benefit of reflective practice and the need for reflection. I have chosen time management because on the day of the ward round I did not effectively prioritise my time, I left an important piece of work (writing up the nursing notes) whilst I did other less important ones (washing the cups up and putting them away) although I could not leave the cups out for safety and security reasons.
Delegation, because I could have delegated the tea making to the ward domestic staff or to one of the nursing assistants, similarly I could have delegated the washing of pots. On the day it seemed easier to do it myself, although that did cause the comment to my mentor, hence this assignment. Again, a worthy reason to reflect on the mundane as well as the challenging incidents in practice.
Assertiveness skills have been chosen because I could have altered the way I served the tea at the very least, confrontation is not an option in those circumstances but I could have lessened the negative affect on myself and I feel that I owe it to my nursing colleagues to challenge the out dated systems.

How

1. My next practice placement is fifteen weeks long split into two parts with three weeks in school in the middle. An ideal opportunity to learn about and use a reflective model in each of the two parts. The WHAT formula (Driscoll 1994) and the Johns model (Johns 1992) will be used to aid the reflective process.
2. Clinical Supervision will be sought on my next placement as on my previous placements. I will endeavour to seek not only mentor supervision but if the placement has a trained supervisor I will avail myself of that resource. I will organise peer supervision as I did on my previous placement as this proved to be beneficial. Once a structure is provided and a referee sought the meetings are productive and supportive.

3. As previously stated this seems to be an easy point to fulfil. I will attend all taught sessions by the tutors and teaching staff at the school of nursing. I will seek out learning opportunities in the placement arena and complete the practice based learning record. Specifically I will learn about neuroanatomy and neurofunction in an attempt to better understand the action of drugs used in mental health, using as a starting point the book by Rinomhota and Marshall (2000). This is to increase my nursing knowledge base to be able to contribute in a positive way with the medical staff.
4. As the last semester of the course approaches and I look forward to qualifying and practising as a nurse, it seems quite fitting that I should concentrate on the leadership and management skills of nursing. I will look specifically for the areas that I have identified, I will access the key skills online web site provided by the university as a starting point.

Appendix 9.5 - Assessment guidelines

Management within Mental Health Provision - Level 1 (4)

Care Delivery and Management Module, Semester 6
30 credits = 5,000 words

Format
Critical Incident Analysis - Written Assignment of 4,000 words [50%]
Individual Presentation - 20 minutes (equivalent to 1,000 words) [50%]

Introduction
The assignment format is designed to enable the student to demonstrate their ability to critically analyse an incident experienced whilst in practice, allowing an opportunity to explore professional responsibilities, concepts of care management and the impact of health policy/legislation on care provision. The presentation aspect will provide students with the opportunity to demonstrate their communication skills and ability to disseminate information to others in an appropriate manner. Confidentiality must be maintained throughout the work.

Guidelines for written assignment
The assignment should be:
- 4,000 words in length.
- supported with appropriate literature/research and referenced in accordance with the School of Nursing policy.
- discussed with both clinical placement and tutorial staff to ensure it reflects modular content and practice competencies.
- based on clinical practice experienced during Semester 6 of the Diploma in Nursing Course.

Expectations
The following are to be included:
- A brief description of the incident to be analysed (e.g. a person's admission or discharge; CPA meeting; multidisciplinary case review; crisis in recovery; mental health tribunal).
- An analysis of the care provided and the professional responsibilities of the nurse in relation to the delivery and management of care.
- The management issues to be addressed both in relation to personal care and the care environment.
- The impact and implications of health policy and legislation on and for the delivery of care
- A summary of the student's learning in relation to the incident chosen and implications of this for future practice as a qualified mental health nurse.

Guidelines for individual presentation
The presentation will be to peers (in small groups) and the module teacher(s). It is intended that the presentation will be:
- 20 minutes in length
- based on the critical incident essay

The students are to use the resources (examples - overhead projector transparencies, flipchart, handouts) they feel are most appropriate for the presentation of their topic and which will facilitate a clear understanding of the key aspects of their work.

Appendix 10.1

Suggestions for using a film clip of an outpatient consultation to learn by using reflection in action.

What should you look out for/think about/do?	*Skills and knowledge you will need to use.*	*Relevant learning outcomes.*
Before starting to watch the clip make sure you are organised to take notes. Think about the questioning style used by the dietician and how she helps the patient overcome barriers to change.	Interviewing skills. Ability to identify and tackle patients' barriers to change. Medical, nutritional, biochemical, pharmacological social and psychological knowledge.	C1 P5 K1
Watch the film clip and stop it at: 09.37 minutes. Using the information you have so far think about the advice you would give to the patient. You may want to role-play giving this advice before continuing to watch the film.	Ability to evaluate information qualitatively and quantitatively. Ability to formulate an appropriate care plan.	P2 P3
What approach does the dietician take? Discuss this critically with a supervisor. Would you have had the necessary knowledge to tackle all aspects of this case competently? If not what areas do you need to work on?		

Appendix 10.2

Prompt questions

1. Are there any differences in the styles of the 2 dieticians on the film clips? How might this affect your placement experience?
2. How long was the out-patient consultation? How many of these do you think you will have to do in one clinic? How do you feel about this?
3. When you feel ill do you want to talk to other people? How do you feel about talking to people in hospital who are feeling unwell?
4. What areas of knowledge did the dietician in the outpatient clinic demonstrate? How does this link with what you have covered at university?
5. What do you think patients will expect from you? How do you feel about this?
6. What will your responsibilities be on placement?
7. How much time do you think you will have to ask questions?

Appendix 10.3

Reflective questions to consider after an activity (Selected from a broader range of questions included in the pack. Letters and numbers in brackets link the questions with the practice placement learning outcomes.)

1. What were you aiming to achieve when you started out? (C1 - communication, P3 – care planning, P4 – if the patient was a follow up.)

2. Did your aims change? Why? (P2 – evaluating information qualitatively and quantitatively, P5 – dealing with barriers to change, P4 – if the patient was a follow up.)

3. What questions did the patient ask? When did they ask them? How did you tackle this? (C1 - communication, P1 – record keeping.)

4. Do you think that you managed to collect all the information you needed to help the patient? If yes, what strategies helped you in this case? (Was it that the case was straightforward? Did you use a particular type of questioning ie open, closed, probing, rhetorical, hypothetical? Did you prepare in a particular way? If you didn't get the information you needed, what got in your way?) (C1 - communication, P1 – record keeping.)

5. What if any were the patient's barriers to change? How do you know this? How did you tackle them? Was your strategy successful? How do you know this? (P5 – dealing with barriers to change.)

6. Did you give any advice? Do you think this helped the patient? How do you know this? Did you help the patient in other ways? How do you know this? (P2 – evaluating information qualitatively and quantitatively, P3 – care planning.)

7. Do you think your knowledge was adequate in this case? Do you have evidence (this could be from books or journals or from your experience of practice) to back your advice up? What was your rationale for each action you took? Was there anything you were unsure about? (K1 – knowledge.) If yes, what could you do about this? (P11 – b block, P12 – c block - demonstrating an enquiring attitude.)

8. Have you seen a patient with similar problems before? How did this consultation differ? Were you prepared for this? Using a model of reasoning try to work out why this was and comment on whether you feel confident that you acted appropriately. (P3 – care planning, P10 – reflection in and on action, P12 – b block, P13 – c block – taking responsibility for personal and professional development.)

9. How did your communication with the patient differ from that with the nurse/doctor/consultant, dietician etc Do you feel that you used an appropriate communication style? What sort of terminology did you use? How would you describe your manner ie formal, informal, chatty, or serious? Was this appropriate? How do you know? (C1 - communication, P6 – team working.)

APPENDIX 11.1

Level 4 Learning Outcomes - Personal and Professional Development

On successful completion of the module students will be able:

1 To use critical incidents to identify areas for personal development and learning.
2 To explore incidents reflectively from relevant perspectives without judging yourself or others.
3 To relate reading on the topics of the syllabus to these perspectives to develop personal understanding.
4 To formulate and follow a personal learning contract that has goals and criteria for learning, and to evaluate personal learning in relation to those goals and criteria.
5 To explore theories of learning and personal learning styles within the context of developing the skills of self-directed learning.

Level 5 Learning Outcomes – Patient-Centred Care

On successful completion of the module you will be able to:

1. Identify your level of skill in structuring a consultation, and your attitudes, beliefs and values in respect of patient-centred care, as shown through group work and peer feedback;
2. Use critical incident-based reflection to identify and integrate constructive feedback from peers and tutors into a personal plan for learning and periodic appraisal of progress;
3. Analyse and interpret your own behaviour and development in the light of relevant literature, and of continuing practise and observation in a range of settings including these classes;
4. Demonstrate attitudes and values appropriate for ethical working, with both patients and colleagues, in a clinical setting where the aims is to involve the patient or interview partner in a mutually acceptable care-plan
5. Re-focus learning plans in the light of reflective and periodic appraisal of your own learning over a period of time

Level 6 Learning outcomes– Dynamics of Clinical Practice

On successful completion of the module you should be able to:

1. Support colleagues in understanding complex issues of interpersonal communication and in evaluating how to proceed in ethical dilemmas;
2. Critically and reflectively evaluate your own developing strengths in application of a range of theories of communication to your work with patients and colleagues, building on the evidence of critical incidents;
3. Demonstrate ethical attitudes, values and understanding appropriate for both a clinical relationship with vulnerable individuals and working in a collaborative environment;
4. Work within an interprofessional group-supervision framework.

APPENDIX 11.2

SCHOOL OF INTEGRATED HEALTH

GENERIC FRAMEWORK FOR CRITICAL REFLECTION

The staged development listed below presents the approach to the development of critical reflection and reflexivity used in the School. The indicators for each level describe pass requirements. There are two strands:

(a) the self and other(s)
(b) self-directed learning, application and validation of change (often referred to as the reflective cycle or the experiential learning cycle)

Although the two strands are intertwined, in different situations one or other may take a dominant focus. For example in the Practitioner Development theme of the CT Undergraduate Scheme the aims are to develop understand of one's own make-up and how this is transferred into assumptions about others and the world. However, in clinical observation and practice this self-awareness is assumed as the starting point for identifying learning needs from observation and feedback, and so the focus of these assessments will be how input from the situation is used to critically evaluate both learning needs, and one's developing understanding of how to apply and integrate theory(ies) in keeping with the expectations and values of that community of practice.

Definitions:

Critical reflection: systematic appraisal that considers something (incident, interaction, ideas etc) from a range of view points so as to identify underlying assumptions, influences, and personal meaning. Viewpoints will include self in different moods, others involved, and the theoretical positions presented in background reading. "Critical" in this sense means keeping an open mind, as different from the every-day sense of apportioning blame.

Reflexivity: ON-going, critical reflection of the relationship between one's own development (intellectual, interpersonal, socio-cultural) and one's perception of the situation, institution, research question etc as an aspect of change within change. In this sense reflexivity is a research technique that is essential to qualitative research and researching one's own practice.

The components of reflection, as developed in the School are indicated below. Individual assessment descriptions and criteria will expand on these components.

Level 4

- Able to identify occurrences (critical incident(s)) that have the potential for indicating personal learning needs in relation to a given topic;
- Able to explore these incidents through reflective questioning of the significance of your own thoughts and feelings in your perception of events; by attempting to put yourself into the situation of others; and/or by looking for patterns in similar events; and through this exploration to arrive at personally relevant questions and issues relevant to the given topic that can be explored through reading;
- Able to show internalisation of theory through explanation and application to the gaps in understanding identified. For personal development this will usually involve discussion of strategies for acting differently and how you might implement them.

Level 5

In addition to the above:-

- Able to draw on the tension between feedback and personal impressions to identify assumptions about yourself, others, the world, and/or your understanding in relation to the given topic;
- Able to articulate the development of strategies of changed behaviour (when relevant) that implement significant learning, and self-appraise the results;
- Able to relate the insights from several cycles of learning over a range of related topics and articulate significant change in relation to the application of that learning.
- There is an assumption at level 5 that you are implementing new learning and reflecting on the outcomes.

Level 6

In addition to the above:-

- Application in and to practice - identification of critical incidents will be informed by the accumulated and integrated learning and application from levels 4 and 5;
- Critically reflective appraisal of complex situations and demonstration of understanding, application of complex theoretical models (or integration and comparative application of models);
- Beginnings of reflexivity in relation to appraisal of own practice.

Level 7

In addition to the above:-

- Critically reflective appraisal of (your role in) complex communities of practice, which may include the learning community of the School;
- Reflexivity in exploration and comparison of different communities of practice;
- Critical appraisal of theory includes discussion of limits of applicability;
- Reflexivity in research.

APPENDIX 11.3

MARKING CRITERIA FOR CRITICAL REFLECTION Level 4

PERSONALAND PROFESSIONAL DEVELOPMENT: CRITICAL REFLECTION MARKING/FEED-BACK GRID August 2002

CRITERIA	FAIL	Taken	40 - 49%	50 - 59%	60 - 69%	70 - 79%	80 – 100%
Presentation, structure and clarity of expression	Lacks coherence, Presentation and structure which is not relevant, clear or logical, Syntax, grammar, spelling and essay construction, contains many inaccuracies.	Presentation and structure that is not relevant, clear or logical. Syntax, grammar, spelling and essay construction, contains many inaccuracies.	Presentation and structure that is mainly clear and logical. Syntax, grammar, spelling and essay construction may contain some inaccuracies.	Good presentation and structure that is clear and logical. Good syntax, grammar, spelling and essay construction.	Very good presentation and structure that is clear and logical. Very good syntax, grammar, spelling and essay construction.	Excellent presentation and structure that is always clear and logical. Excellent syntax, grammar, spelling and essay construction.	Excellent presentation and structure that is always clear and logical. Excellent syntax, grammar, spelling and essay construction.
Identification of critical incident from within the class activity	Critical incident not identified from within the class activity	Critical incident not identified from within the class activity but related to the subject area.	Critical incident loosely located within the class activity	Critical incident identified from within the class activity	Critical incident soundly identified from within the class activity.	Critical incident soundly identified from within the class activity.	Critical incident soundly identified from within the class activity
Personal exploration of meaning through reflective questioning about the incident	Personal exploration of meaning through reflective questioning about the incident not demonstrated	Limited use of reflective questioning about the incident resulting in little personal understanding	Some use of reflective questioning about the incident resulting in some personal understanding.	Good use of reflective questioning about the incident resulting in relevant personal understanding	Very good use of reflective questioning about the incident resulting in very relevant personal understanding	Excellent use of reflective questioning about the incident resulting in very relevant personal understanding	Excellent use of reflective questioning about the incident resulting in excellent understanding
Reflexive exploration of literature for developing understanding	Unsubstantiated ideas based on generalisations only with no reference to theory & literature	Exploration of literature but no analysis or personal application	Exploration of literature with limited analysis and personal application	Good exploration of literature, and an analysis that is applied personally.	Very good exploration of literature, and an analysis that is applied personally.	Excellent exploration of literature, and an analysis that is applied personally.	Excellent exploration of literature, and an analysis that is applied personally
Ability to identify and test new strategies	No evidence of identification and testing of new strategies	Limited evidence of identification of new strategies but no evidence of testing	Limited evidence of identification and testing of new strategies.	Good evidence of identification of new strategies but limited evidence of testing	Good evidence of identification and testing of new strategies.	Excellent evidence of identification and testing of new strategies.	Excellent evidence of identification and demonstration of a perspective transformation
Ability to articulate personal relevance of new learning and its relevance to the qualities of a practitioner	No evidence of the personal relevance of the new learning or its relevance to the qualities of a practitioner	Limited evidence of the personal relevance of the new learning, but relevance to the qualities of a practitioner not demonstrated	Evidence of the personal relevance of the new learning, and its relevance to the qualities of a practitioner.	Good evidence of the personal relevance of the new learning, and its relevance to the qualities of a practitioner.	Very good evidence of the personal relevance of the new learning, and its relevance to the qualities of a practitioner.	Excellent evidence of the personal relevance of the new learning, and its relevance to the qualities of a practitioner.	Excellent evidence of the personal relevance of the new learning, and its relevance to the qualities of a practitioner
Quality of referencing using the Harvard System	Referencing that is inappropriate containing many inaccuracies. No referencing	Referencing that is appropriate but may contain inaccuracies.	Good referencing that is appropriate but may contain some inaccuracies.	Good referencing which is appropriate and generally accurate.	Very good referencing which is appropriate and accurate	Excellent referencing which is appropriate and always accurate.	Excellent referencing which is appropriate and always accurate.

PATIENT CENTRED COMMUNICATION Criteria for reflective papers at Level 5 NAME:_____

Please note – it is assumed that students will show reflective working over a number of incidents and aspects of the guideline

CRITERIA	FAIL	TAKEN	40-49%	50-59%	60-69%	70-100%
Selection of incidents <u>from the PCC class activities</u> that give rise to issues relevant to the assessment topics.	No reference to class activities OR not focussed on self; OR no attention to thoughts and feelings; OR anonymity not respected →	Summarised to the extent of excluding the reader from the plot OR rambling without a sense of purpose – significance not apparent; OR tends to self-justify or blame	Beginnings of clear description focused on self, some thoughts and feelings that open the link to other experiences, which may be from clinic or life	Rich but concise description of external and internal detail; Incidents drawn from feedback and discussion	As before - enables opening for reflective analysis that follows. Incidents selected that lead to and link to significant learning of many aspects of the syllabus / semester	
Exploration of incidents using reflective questioning	No attempt to apply reflective questioning frameworks; and/or self justificatory and/or dumping on others	Very few questions applied; tending to one explanation; little or no "putting oneself into others' shoes" or linking to other situations	Some exploration of what triggered thoughts & feelings; of other's situation; linking got other situations to identify personal patterns	As before, but with a sense of direction in the exploration; evidence of exploring your assumptions & responses with an open mind.	As before, but writing creates a sense of greater depth of exploration to underlying issues, patterns relevant to the topic. Sense of cyclical development.	As before, but also reflective questioning also used to evaluate change and re-assess learning needs as understanding develops.
Identification of personal learning needs / interests in relation to the assessment brief.	Link between trigger incident and later reading is not apparent to the reader.	Personal issues / interests arising out of the reflective questioning are left implicit	Reflective questioning related to general overview of the syllabus to arrive at personal learning needs assumptions about others etc relevant to a proportion of the topic	Issues identified go beyond the trigger incident to underlying aspects of communication etc relevant to several aspects of the topic	Development over the semester shown through cyclical appraisal as learning develops	As before, but with clear evidence of input from reflection on application and observation in clinic and in life.
Reflexive exploration of relevant literature, and understanding gained	Literature presented is not L5 standard & / or relevant to topic guideline – while finding personal literature is encouraged, there is a difference between this and relying on old knowledge	Uses limited reading to affirm personal stance rather than explore the themes in the topic guideline OR reading not explained – assumes the reader knows it.	Beginning to use reading relevant to the topic guideline to and to learning needs; theory is presented but not applied.	As before – but theory is succinctly explained and applied to the issues identified to show greater understanding of aspects of the syllabus	As before – but also writing demonstrates depth of understanding of theory through application to personal style and across a number of aspects of the syllabus	As before – but additionally giving the reader a clear sense of transformation in personal understanding of broad significance.
Application of learning – development and testing of different ways of working or being with people <u>NOTE – can be in any settting</u>	No evidence of trying things out **[Continued – PTO]**	Identifies strategies but no evidence of trying them out in any setting	Strategies for change relevant to the issues identified and relevant reading; indication of how/ where practiced (This may be in class or at work. There is no priority to clinic prac.)	As before – strategies tried and outcomes reflected upon feeding into refined understanding of the issues and personal assumptions.	As before – and evidence of embedded new understanding and skill in terms of a broad aspect of the topic guideline and in terms of the complexities of communication.	Evidence of application and further reflection that shows substantial development and transformation of perspective in relation to the assessment guideline

Discussion of relevance of learning to the practitioner role	Attitudes/behaviour, unreflected upon, that would be inappropriate for clinical work **(PAPER MUST FAIL)**	No consideration of the ethical or patient/centred dimension.	Some attempt to self evaluate own interactions in terms of professional criteria	Significant development shown in understanding of the patient's perspective and how to work effectively within it	Identification of current level of development appropriate to level 5 and plans for addressing learning needs	Significant learning re the professional role from the incidents chosen integrated for sensitive working in relation to patients/clients interests and vulnerabilities
Structure, coherence, presentation and referencing	Incoherent writing and/or presentation; No referencing of ideas	Meaning not explicit – reader interprets meaning; one or two sources only referred to in the text and/or substantial errors in the management of referencing or texts used not of level 5 standard..	Meaning is beginning to be explicit, but some interpretation from the reader required; some referencing, from texts of relevant academic standard; referencing shows substantial understanding of the guidelines.	Coherently structured writing where structure enhances meaning re use of introduction and paragraphs; referencing from a range of appropriate texts, managed in terms of the guidelines	The writing is beginning to have a flow that engages the reader and anticipates and answers reader's questions; Source ideas explained in terms of the writers development. No routine ref. issues.	structure supports the economical presentation of complex development; manages complex referencing issues consistently (if applicable)

Reflective observations of the marker and constructive feedback.

Marker : _____ moderated by: _____ MARK:

DYNAMICS OF CLINICAL PRACTICE Criteria for reflective papers at Level 6 NAME:_____

Please note – it is assumed that students will show reflective working over a number of incidents and aspects of the guideline

CRITERIA	FAIL	TAKEN	40-49%	50-59%	60-69%	70-100%
Description of incidents <u>from the class/clinic activities</u> that give rise to issues relevant to understanding & application of the syllalbus.	No reference to class/ clinic activities **OR** not focussed on self; **OR** scarce attention to thoughts and feelings; **OR** anonymity not respected	Summarised to the extent of excluding the reader from the plot OR rambling without a sense of purpose – significance not apparent; OR tends to self-justify or blame	Clear description focused on self, some thoughts and feelings that open the link to other experiences, which may be from clinic or life	Concise but rich description of external and internal detail (thoughts & feelings) . Incidents showing cyclically developing understanding and application.	As before - enables opening for reflective analysis that follows. Incidents selected that lead to and link to significant learning of many aspects of the syllabus / semester	
Exploration of incidents using reflective questioning to arrive at learning needs & interests related to the syllabus	Self-justificatory and/or dumping on others. Link between trigger incident and later reading is not apparent to the reader.	Little or no "putting oneself into others' shoes" , reason for interpretation not apparent. Personal issues arising out of the reflective questioning are left implicit	Some exploration of what triggered thoughts & feelings; of other's situation; linking to previous situations to identify personal patterns and learning needs related to the syllabus.	As before, but with a sense of direction in the exploration; evidence of exploring your assumptions & responses with an open mind.	Reflective questioning succinctly reported showing a range of approaches that triangulate the issues and learning needs.	As before, but also reflective questioning also used to evaluate change and re-assess learning needs as understanding develops.
Reflective critical appraisal of relevant literature, and of its application. Developing learning	Literature presented is not L6 standard & / or relevant to topic guideline. Literature is simply recounted largely through quotes	Uses limited reading to affirm personal interpretation of the incidents rather than explore the topics in the syllabus OR reading not explained and related to the issues identified	Beginning to use reading relevant to the topic guideline and to learning needs; theory is presented but not applied.	As before – but theory is succinctly explained and applied to the issues identified to show greater understanding of aspects of the syllabus	As before – but also writing demonstrates depth of understanding of theory through application to personal style and across a number of aspects of the syllabus	As before – but additionally giving the reader a clear sense of transformation in personal understanding of broad significance.
Application of learning – evidence of reflective working over time – application of learning and continuing appraisal of different ways of working.	No evidence of trying things out OR no evidence of working over time (ie retrospective analysis of one incident) **[Continued – PTO]**	Explains the incident and Identifies strategies but no evidence of trying them out in any setting	Strategies for change relevant to the issues identified and relevant reading; indication of how models and theories are being incorporated into practice to refine and deepen understanding of interpersonal dynamics.	As before – strategies tried and outcomes reflected upon, feeding into refined understanding of the issues and personal assumptions. Able to articulate changes in understanding and approach, and what is still to be learned.	As before – and evidence of embedded new understanding and skill in terms of a broad aspect of the topic guideline and in terms of the complexities of communication.	Evidence of application and further reflection that shows substantial development and transformation of perspective in relation to the assessment guideline

Discussion of relevance of learning to the practitioner role and continuing development	Attitudes/behaviour, unreflected upon, that would be inappropriate for clinical work **(PAPER MUST FAIL)**	No consideration of the ethical or patient/centred dimension.	Some attempt to self evaluate own interactions in terms of professional criteria	Identification of current level of development appropriate to level 6 and plans for addressing learning needs	Significant development shown in understanding of the patient's perspective and how to work effectively within it	Significant learning re the professional role from the incidents chosen integrated for sensitive working in relation to patients/clients interests and vulnerabilities
Structure, coherence, presentation and referencing	Incoherent writing and/or presentation; No referencing of ideas	Meaning not explicit – reader interprets meaning; one or two sources only referred to in the text and/or substantial errors in the management of referencing or texts used not of level 6 standard..	Meaning is beginning to be explicit, but some interpretation from the reader required; some referencing, from texts of relevant academic standard; referencing shows substantial understanding of the guidelines.	Coherently structured writing where structure enhances meaning re use of introduction and paragraphs; referencing from a range of appropriate texts, managed in terms of the guidelines	The writing is beginning to have a flow that engages the reader and anticipates and answers reader's questions; Source ideas explained in terms of the writers development. No routine ref. issues.	Structure supports the economical presentation of complex development. Manages complex referencing issues consistently (if applicable).

Marker : _____ moderated by: _____ MARK:

Reflective observations of the marker and constructive feedback.

_____

APPENDIX 12.1

Postgraduate Certificate in Health and Social Care Education

Action Learning Set Feedback

Set Facilitator:

Please give a rating for the following specific aspects of your experience as a member of the set.

		Excellent	Good	Room for Improvement	Poor
1	Set adviser's role in creating cohesiveness of the set				
2	Quality of guidance on course requirements				
3	Set adviser's support for individual members' development				
4	Active listening among the set				
5	Supportive challenge by set members to each other				
6	Time management in set meetings				
7	Transfer of 'facilitator' expertise to set members				
8	Skills development for reflective practice				
9	Productivity/focus of set meetings				
10	Appropriate assertiveness on the part of the set adviser				

(i)	Positive features of your Action Learning Set experience
(ii)	Ways in which your experience of the Action Learning Set could have been improved
(iii)	What role has the set (and its individual members) played in relation to your professional development as a university teacher during the PGCHSCE Course?

Many thanks for your responses

Helen Stanley
Senior Lecturer. INAM

Appendix 12.2

Portfolio Criteria

The portfolio of teaching practice will be **formatively** assessed at the end of semester one and **summatively** assessed at the end of semester two and must meet the following criteria:

Teaching Practice

- There should be a **clear** teaching log documenting **100 hours** (semester one) and **100 hours** (semester two), a total of **200 hours** teaching practice
- There should be evidence of a **range** of educational activity that a lecturer/practice educator might experience (see NMC relevant standards)
- There should be evidence of teaching taking place in a **higher education setting**
- There should be evidence of teaching in a **variety** of topics to a **range** of academic levels
- Where appropriate (for example, for those taking the **Practice Educator** route), there should be evidence of the experience of educational activity in both the **higher education** and **clinical** setting
- There should be **two** observations of other teachers (facilitator, personal tutor, peers or any other relevant health care professional with an educational remit) **per semester**
- There should be **two** documented incidents of being observed by the facilitator, personal tutor, peers or course leader (formative teaching assessments) **per semester**
- There should be **one** summative teaching assessment at then end of semester two
- There should be a **selection** of lesson plans, handouts and audio-visual media to demonstrate the range of teaching achieved and the developing skills in using these aids to teaching
- There should be a self evaluation of **each** teaching session in the portfolio

Reflection

Students should maintain a **reflective teaching journal,** highlighting critical incidents arising from teaching practice. This should be kept private and relevant issues explored in the fortnightly Action Learning Sets with monthly reflection on progress documented.

At the end of semester two, as part of the 'Developing the Teacher's Role thought Reflective Practice' module, a **reflective account** is required which will be a synthesis of the students' journey over the year, demonstrating the integration of the knowledge, teaching skills and learning achieved. Specific details of the portfolio content will be subject to an individualised learning contract. The student will link educational theory to practice and include relevant research as appropriate. It is useful to focus on factors, which have helped to develop the students' role as a lecturer/practice educator throughout the year, awareness of difficulties/concerns that have been a challenge and ways in which these have been in part/wholly addresses. The portfolio should contain the following:

Semester One

- A critical analysis of **why** and **how** particular methods of teaching, assessment and evaluation were used
- A **critical evaluation** as to whether the methods were successful, particularly in terms of student learning, and **why**
- There should be **reflection** on future development and improvements of the methods used
- There should be **critical analysis** of what the student has learned about **learning** (from being a student on the course) and **teaching** (from the experience of teaching practice)

Semester Two

The outcomes from Semester One will be continued through Semester Two and developed to include:

- A **critical analysis** of the self and the students own abilities and weaknesses as a lecturer/practice educator in the health professions
- A **critical examination** of how the students' preferences or prejudices and awareness about how these may have affected their performance
- An ability to **explain and articulate** the process through which the role development has been achieved
- A detailed **assessment** of how well the student has achieved their goal(s)
- **Reflection** on their developing educational and professional roles

Presentation

- The portfolio should be clearly organised with a contents page
- The use of language should demonstrate a **professional standard** of spelling, punctuation and grammar
- Confidentiality should be maintained at all times of student/client/patient/colleague names, cohort, home and workplace and any information which would allow them to be identified should be removed
- The language of teaching, learning and assessment should be used appropriately
- The academic assignments and feedback comments received will form part of the portfolio

Professional Development

- A completed **Personal Development Plan** should be submitted at the end of Semester One and Two
- A completed **Learning Contract and Action Plan**, signed by the student, facilitator and personal tutor, should be submitted at the end of Semester One and Two. The Action Plan should be reviewed for Semester Two at the end of Semester One
- At the end of Semester Two, a final review and planning for future professional development should be included

ILT Areas of Learning and Teaching Activity, Core Knowledge and Professional Values

At the end of Semester One and Two:

- The student will **map** their teaching practice activity to the ILT five areas of Learning and Teaching Activity, Core Knowledge and Professional Values
- The students should provide sufficient evidence to show that the requirements of **each** area have been satisfied

NMC Standards for Lecturer/Practice Educator Route

The new standards for nurse teacher preparation issued by the UKCC in March 2000, endorsed by the Nursing and Midwifery Council (NMC) have been incorporated into the PGCHSCE and will be addressed and assessed through the modules and the assignments. In addition, the period of supervised teaching practice throughout the course will require students to map evidence of meeting these standards in their portfolios. The student's respective **Lecturer/Practice Educator** route will be identified at the outset of the course, and their appropriate teaching practice experience and supervision will be planned. For example, a Health Visitor wishing to follow the **Practice Educator** route will be allocated a facilitator who is an experienced Health Visitor Lecturer, and their teaching practice will be mainly with students in the community, with some in academic settings.

For those wishing to record their teaching qualification with the NMC, a second year of **200 hours** of supervised teaching practice and submission of a further Year Two portfolio is part of the professional requirements. This will also be mapped against the NMS standards appropriate to the route chosen (**Lecturer or Practice Educator)**

Appendix 12.3

Journal Guide

- What was the moment (or moments) when I felt most connected, engaged or affirmed as a teacher – the moment I said to myself, "This is what being a teacher is really all about"?

- What was the moment (or moments) this week that I felt most disconnected, disengaged or bored as a teacher – the moment I said to myself, "I'm just going through the motions here"?

- What was the situation I faced that caused me the greatest anxiety or distress – the kind of situation that I kept replaying in my mind as I was dropping off to sleep, or that caused me to say to myself, "I don't want to go through this again for a while"?

- What was the event that happened this week that most took me by surprise – an event where I saw or did something that shook me up, took me off guard, put me off my stride, gave me a jolt, made me unexpectedly happy?

- What were the most significant events or moments I passed through this week in my life as a teacher?

- Of everything I did this week in my teaching, what would I do differently if I had to do it again?

- What do I feel proudest about regarding my teaching activities this week? Why?

- What do I feel most dissatisfied with, regarding my teaching activities this week? Why?

- What teaching tasks gave me the greatest difficulties this week? What made them so tough?

- What teaching tasks did I respond to most enjoyably and easily this week? What made them so pleasurable?

Adapted from Schuller T. 1995 *The Changing University* Buckingham: OU Press