The potential of reflective practice to develop individual orthopaedic nurse practitioners and their practice

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LEARNING OUTCOMES

On completion of the article, the reader should be able to:

- **Describe the importance of reflective practice in everyday orthopaedic nursing practice**
- **Begin to identify and challenge the various types of knowledge used in everyday orthopaedic nursing practice**
- **Use a simple model of structured reflection to begin to validate ones' own practice and of the potential for engaging in more formalized reflective practice.**

UKCC CATEGORIES

This article will enable the reader to address PREP categories:

- **Patient, client and colleague support**
- **Care enhancement**
- **Practice development**
- **Education development.**

Examples of how this may be achieved and possible evidence for the reader's professional profile are given throughout the article. Other ways to demonstrate your continuing professional development may be to:

- **Use this article as a discussion item in a ward meeting**
- **From the available literature, select a reflective framework to assist in your on-going compilation of a reflective section in your Professional Portfolio**
- **Approach a colleague or other significant person outside your clinical area to regularly reflect on practice with, ensuring that you also brief your manager to legitimise your intentions to begin to formally reflect on your practice.**

Keep a copy of this article together with the notes you make as evidence of completing the reflection items in the text.

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INTRODUCTION

Santy (1997) has described previously the concept of reflection as a viable method for orthopaedic nurses to maintain their professional development in practice. She rightly warned that it is no longer sufficient for an orthopaedic nurse to undertake the standard post-registration specialist qualifications and expect to be able to practice unchallenged for the rest of his or her career in nursing.

Since that article, further expectations for UK practitioners are being realized with the

Box 1 Reflection item 1

In your own personal experience and based on what you have read so far, can you think of an example that illustrates when YOU (not somebody else), might have been on an `auto-pilot' routine in practice? What were you doing at the time?

Draw up lists indicating some of the advantages and disadvantages of being in this mode of practice for:

- yourself as a practitioner
- your clinical area
- the person(s) you were caring for

Compare what you have found and the implications for your practice by reading the article by Jones (1995) or browsing the book by Ford and Walsh (1994). What may now need to happen?

80 min

implementation of National Health Service reforms (DOH 1998a, 1998b, 1999a, 1999b, 2000) and the setting of a Continuing Professional Development (CPD) standard by the regulating body for nurses, midwives and health visitors (UKCC 1999, 2000). Undoubtedly, this has given practitioners added impetus to consider reflection as a practice-based learning activity for re-registration, as well as a legitimate method for questioning their personal effectiveness and responsibilities in the delivery of that health care.

This article looks at how to get going with reflective practice as a practice-based learning activity and how engaging in reflection can contribute to meeting, or even highlighting, your CPD needs as an individual practitioner. It serves not as a prescription for practice, but invites the practitioner into a reflective mode and to question the need to legitimise and lobby support for reflection as a relevant practice based activity.

A second article will give you some ideas about constructing a Professional Development Portfolio/Profile and how documenting significant formal and informal learning can contribute as evidence towards meeting regulation requirements and validating, as well as developing, your own practice based learning.

REFLECTION AS MORE THAN JUST THINKING ABOUT PRACTICE

Reflective practice is often seen as representing a choice for practitioners to be reflective or not about their clinical practice, but in reality, all practitioners engage in reflection about their professional work (Bright 1995). If I was to probe more deeply into your belief that you were already reflective in clinical practice, what I would probably find is that in your daily work you constantly have to think about what you are doing. However, reflecting on an experience is an intentional and skilled activity requiring an ability to analyse practice actions and make judgements regarding their effectiveness. What passes for reflection is often not reflection. Contemplating an experience or event is not always purposeful and does not necessarily lead to new ways of thinking or behaving in practice which is the crux of effective reflective activity (Andrews et al. 1998). So why is there so much emphasis on change through reflection?

Jarvis (1992) advocates the need for reflective practice since nurses are dealing with people who because of their individual nature require us to be responsive and reflective instead of simply carrying out the routine tasks or rituals of everyday nursing practice. Cox et al. (1994) suggest nurses, like other people in all aspects of living, do not think through in detail their every action. Such actions can sometimes be likened to 'working on autopilot', in which set patterns are followed that governs and direct nursing actions. Such complacency in everyday nursing practice has been documented (Jones 1995, Ford & Walsh 1994). Far from engaging in individualised care, what the literature reveals is a tendency for nurses to want to keep care the same.

Reflection is a process that allows practitioners to uncover and expose thoughts, feelings and behaviours that are present in a period of time. Hull and Redfern (1996) assert that by understanding more about nursing practice through reflection and examining why certain interventions are used, and in what situations, practitioners can extend their personal and professional knowledge making the process of reflection more than just simply thinking about practice (Box 1: Reflection item 1).

REFLECTION AS CHALLENGING KNOWLEDGE FOR CLINICAL PRACTICE

Donald Schon (1983, 1987) considered two kinds of knowledge that professionals use in practice

– technical rationality and 'tacit knowledge'. 'Technical rationality' is the most dominant view of professional knowledge for practice associated with empirical and scientific knowledge developed in university or research environments. In this technical–rational mode of thinking, it is anticipated that the health professional applies the 'theoretical' knowledge from the university in order to solve their practical problems. Whilst useful to explain practice as it should be, it often fails to address practice as it really is.

Schon (1983) describes this as the 'swampy lowland' of professional practice where situations can become confusing 'messes' incapable of technical solution. He goes on to suggest that whilst a good practitioner does require a sound theoretical and scientific basis on which to operate practice, this in itself does not always produce effective practice. It is within this quagmire of uncertainty and personal conflict in clinical practice, that the more 'tacit' or intuitive knowledge of practice can become realised.

Exploring alternative forms of nursing knowledge through reflection is suggested by some authors in nursing as lessening the 'theory–practice gap' (Conway 1994, Ousey 2000, Rolfe 1996) and helps a practitioner make more sense of, learn and even discover new types of knowledge that is already embedded in practice. More specifically, Carper (1978) identified four fundamental patterns of knowing in nursing that formed an integral part of John's model for structured reflection (1995, 1998, 2000).

(A) Empirical: technical, factual or scientific knowledge often developed through research
(B) Aesthetic: subjective knowledge gained through unique and particular situations
(C) Personal: knowledge that an individual brings to the situation often based on prior personal experience
(D) Ethical: knowledge based on one's own values and understandings about what is right or wrong or ought to be done in particular situations.

Carper (1978) extends the knowledge possibilities beyond the more traditional empirical or 'technical-rational' approach and begins to legitimize other forms of knowing as relevant to nursing practice. Reflection, therefore, encourages the orthopaedic nurse practitioner to challenge the existing knowledge put forward by those often 'outside practice' and evaluate this in relation to other forms of knowledge from within, the 'real' world of everyday orthopaedic nursing practice.

The 'swampy lowlands of practice' that Schon spoke of, as often presenting as confusing and muddling, might instead offer the practitioner, when systematically exposed through reflection, an opportunity to begin to develop practice-generated theory (Wilkinson 1999) and help make more sense of those complex and ambiguous practice situations. In other words the development of orthopaedic nursing knowledge from 'inside-out' rather than simply trying to apply knowledge from 'outside-in'.

Questioning one's knowing and understanding in practice is an integral aspect of reflection. For instance, what do you tend to base your orthopaedic nursing practice on? Is it good enough to 'borrow' knowledge for practice, or is there a need for orthopaedic nurses to develop a more 'specialist' knowledge base as Davis (1997) suggests?

The former, I would argue resigns orthopaedic nurses as being passive 'care-takers' of other health professionals knowledge. Perhaps current 'evidence-based practice' is still reliant on someone else's 'evidence' for the way that you practice. Alternatively, identifying, questioning and evaluating the more intuitive and 'taken for granted' knowledge in everyday orthopaedic nursing through reflection, might help realise those therapeutic activities which really make a difference in caring and contribute to McMahon & Pearson's (1998) aspirations for nursing becoming a therapy in its own right.

Chris Johns (2000) in his definition of reflection, invites us to enter and embrace the contradictions of Schon's 'swampy lowlands of practice' (previously described) rather than step around or avoid it.

> Reflection is 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 desireable and actual practice. Through the conflict of contradiction, the commitment to realise desireable work and understanding why things are as they are, the practitioner is empowered to take more appropriate action in future situations.

By doing so reflection offers a focus for caring and to become more self aware of the contradictions that exist between how we would like to practice, and how we actually do.

All practitioners reading this article will have personal knowledge of what 'desirable practice' means to them individually, and would, if they had the opportunity or the resources, want to work in that particular way. So rather than just passively read about reflection, why not use this article to test your commitment to the process of reflection and more importantly begin to validate the use of reflection in your own practice? (Box 2: Reflection item 2).

I wonder how many of you actually stopped reading the article to attempt the exercise! Many of you, I am sure have already replayed this troubling aspect of practice in your mind for some time. Some of you may have already spoken to colleagues, peers, even members of your family about it in an attempt to resolve such contradictions that existed in your practice, but have you just been thoughtful or reflective?

SOME CONDITIONS AND CONSEQUENCES OF BECOMING A REFLECTIVE PRACTITIONER

Bulman (2000) suggests that reflection forces practitioners to face incongruity and uncomfortable facts about their nursing, the organizations they work in and themselves. I would argue that there is always a choice for practitioners to engage or not in reflection and that the process whilst encouraged, cannot be forced on anyone.

If you completed the previous activity, you will realise that reflective practice is an intentional event and takes both time and commitment. What made you complete the activity? The answers to this question will form part of the conditions necessary for regular clinical supervision to happen in practice. Alternatively, if you chose not to do the activity, what were your reasons? This may also form part of the reasons for reflection as a practice based learning activity not happening in practice.

Some of the intended benefits of becoming reflective in practice are:

- Enhances rather than competes with, traditional forms of knowledge for nursing practice
- Can generate practice-based knowledge, as it is based on real practice
- Values what practitioners do and why they do it
- Can help practitioners to make more sense of difficult and complex practice
- Can support practitioners by offering a formal opportunity to talk to peers about practice
- Has improvements to patient care delivery at the centre of the reflective conversation
- Focuses the practitioner on ways of becoming more effective in practice as the reflective conversation is action based
- Reminds qualified practitioners there is no end point to learning about their everyday practice
- Offers a practice based learning activity that can contribute to the Continuing Professional Development of qualified practitioners
- Offers an inquiring and evidence based approach to clinical practice.

Some of the burdens of becoming a reflective practitioner in clinical practice are:

- Finding the time to engage in the process
- Standing out from the crowd
- Challenging conformity in practice
- Often being a lone voice
- Being less satisfied with the way practice is carried out
- Wanting to find out more about why things are done a particular way
- Being labelled a troublemaker
- Suggesting alternative ways of working
- Often faced with making difficult choices
- Not having a knowledge of how to proceed with an idea
- Having more questions than answers
- Finding that others may not have answers to practice concerns
- Peer pressure to keep things as they are
- Fear of rocking the boat in relation to future promotion or ambitions.

In our experience of facilitating formalized reflective practice in the UK, practitioners will benefit from considering some of the positive and negative aspects before embarking on a reflective journey through practice. While perhaps liberating to learn from and challenge the way we act in practice, unlearning what we have been routinely doing requires practical support as well as the courage to do so. As Fish & Twinn (1997) rightly point out:

> .... any systematic approach to reflection can be used to investigate and theorise about practice ... but reflection does presuppose a seeking, rather than a knowing attitude to practice and requires a practitioner to be open to criticism and to the possible need to change ... what it does not do, is to provide a clear set of detailed instructions for carrying out new practice.

Instead, it is likely that further support will be required to cope with the new challenges presented by re-viewing clinical practice through reflection. In summary, becoming a reflective practitioner is an intentional activity with the focus on improving and changing practice. Some of the skills and attributes required for reflection are equally important for those facilitating the process as well as those engaging in reflection. They are summarized below and are based on the use of adopting a reflective approach to clinical supervision (Driscoll 2000) in UK nursing practice:

Box 2 Reflection item 2

In your own personal experience and based on what you have read so far, can you think of a significant experience that illustrates when you (not somebody else), got stuck in the 'swampy lowlands' of orthopaedic practice? Write brief notes about the significant experience that best describe and highlight for you some of the contradictions between what you practised at the time and what you considered 'desirable' practice. It is important to describe in your own words what actually happened to you, rather than concentrating what you thought was happening at the time.

30 min

- A willingness to learn from what happens in practice
- Being open enough to share elements of practice with other people
- Being motivated enough to 'replay' aspects of clinical practice
- Knowledge for clinical practice can emerge from within, as well outside clinical practice
- Being aware of the conditions necessary for reflection to occur
- A belief that it is possible to change as a practitioner
- The ability to describe in detail before analysing practice problems
- Recognizing the consequences of reflection
- The ability to articulate what happens in practice
- A belief that there is no end point in learning about practice
- Not being defensive about what other people notice about ones' practice
- Being courageous enough to act on reflection
- Working out schemes to personally action what has been learned
- Being honest in describing clinical practice to others.

The trouble with lists of skills and attributes of becoming reflective is that readers can become at best bored with reading them, or at worst, develop an overwhelming sense of not being able to achieve such things for practice. Often the best thing is to have a go! As one of the fore fathers of reflective practice, John Dewey (1929) succinctly stated: 'We do not learn by doing ... we learn by doing and realising what came of what we did ...'

Prior to reflecting on your practice, you may find it useful to look at some of the other literature contained in the references to check out the validity of this article. More detailed reviews of reflection and reflective practice in nursing can be found in Atkins and Murphy (1994), Clarke et al. (1996), Ghaye and Lillyman (2000), Goff (1995a, 1995b), Johns (2000), Palmer et al. (1994), Burns and Bulman (2000).

Get into the habit of writing

Writing is a powerful medium for facilitating reflection on practice (Health 1998, Holly 1989, Kottkamp 1990, Walker 1985), whether in the form of reflective diaries or journals, and it assists the reflective process, by acting as a reminder and a more in depth analysis of what went on in practice (Fisher 1996). Apart from being a useful aide-memoire about clinical practice, recorded documentation is essential about what goes on in the reflective session. Reflective writing as a preparation for the session or, as a post session activity, allows the facilitator and the individual practitioner to also follow up on any intentions for practice and is a useful tool for monitoring the effectiveness of reflective practice.

Find someone you feel comfortable with to disclose and share your practice with

A respected colleague, preceptor, mentor or clinical supervisor can all provide you with the potential space to intentionally reflect on practice. Bulman (2000) suggests that it is helpful to find someone who already has experience of using reflection and you feel safe with to disclose practice experiences. It is important to note that you are already a qualified and accountable practitioner in your own right and reflective practice is not an assessment, or managerial tool to beat you with. The whole point of reflective practice is to improve your practice by becoming more consciously aware of it.

Use a reflective framework to get you started

When you look at the nursing literature, there are a number of reflective models to choose from (Atkins & Murphy 1993, Benner 1984, Ghaye & Ghaye & Lillyman (1997), Holm & Stephenson (1994), Johns (1996). All reflective models are based on the premise that intentionally reflecting, or learning about clinical practice, will lead to a better understanding and awareness, thereby enhancing clinical practice.

THE WHAT? MODEL OF STRUCTURED REFLECTION

The model (Driscoll 1994, 2000), contains three elements of reflection:

1. WHAT? A description of the event
2. SO WHAT? An analysis of the event
3. NOW WHAT? Proposed actions following the event.

Each of the three elements interacts within the different stages of an experiential learning cycle (Fig. 1). The associated trigger questions are designed to help in completing a learning cycle (Box 3). The What? model of structured reflection is not intended as a 'right way to reflect', but offers a framework for entering into a more meaningful exploration of events in clinical practice, either alone such as while reading this article, or preferably with others.

While simplistic to suggest that considering a checklist of questions about clinical practice can make a significant difference to orthopaedic nursing practice, the questions are intended to emphasise practitioner learning and the subsequent actions that arise from them (if any). Many individuals may find that after using the What? model of structured reflection that they then wish to adapt, or adopt more complex models of reflection as they become more familiar with the process of reflection. The emphasis in being a reflective practitioner is to convert thinking about practice, into some workable form of action in practice (Box 4: Reflection item 3).

Box 3 Associated trigger questions (Driscoll 2000)

1. A description of the event

WHAT? Trigger questions:
- is the purpose of returning to this situation?
- happened?
- did I see/do?
- was my reaction to it?
- did other people do that were involved in this?

2. An analysis of the event

SO WHAT? Trigger questions:
- How did I feel at the time of the event?
- Were those feelings I had any different from other people who were also involved at the time?
- Are my feelings now, after the event, any different from what I experienced at the time?
- Do I still feel troubled, if so, in what way?
- What were the effects of what I did (or did not do)?
- What positive aspects now emerge for me from the event that happened in practice?
- What have I noticed about my behaviour in practice by taking a more measured look at it?
- What observations does any person helping me to reflect on my practice make of the way I acted at the time?

3. Proposed actions following the event

NOW WHAT? Trigger questions:
- What are the implications for others and me in clinical practice based on what I have described and analysed?
- What difference does it make if I choose to do nothing?
- Where can I get more information to face a similar situation again?
- How can I modify my practice if a similar situation was to happen again?
- What help do I need to help me 'action' the results of my reflections?
- Which aspect should be tackled first?
- How will I notice that I am any different in clinical practice?
- What is the main learning that I take from reflecting on my practice in this way?

Box 4 Reflection item 3

Either:
Go back to your earlier description of a significant experience from practice outlined in the previous exercise (Reflection item 2). This illustrated some of the contradictions between what you practised at the time and what you considered 'desirable' practice?

Or

Describe a new scenario.
Using the What? model of structured reflection to help you (Box 1), describe on a sheet of paper in as much detail as you can remember, the situation or event (What?). You might just want to put in brief reminders, or phrases that were significant at the time rather than write the whole story. Next, take a fresh sheet or page of paper and again using the trigger questions to help you, analyse in more detail why for you such an experience happened in your practice (So What?). Now compare your findings with a practice colleague you feel comfortable to disclose and share your practice with. Concentrate particularly on your Proposed Actions (Now What?).

60 min

Johns described previously reflection in terms of working towards desirable practice. I suspect that achieving desirable practice through reflection in the exercise was likely to be about what hinders you as a practitioner in delivering your desirable practice. The actions resulting from your reflection illustrate what it is you may need to work towards in your orthopaedic practice. It may have also illustrated that it is not always the organization, or lack of resources that are to blame. It may well be the way

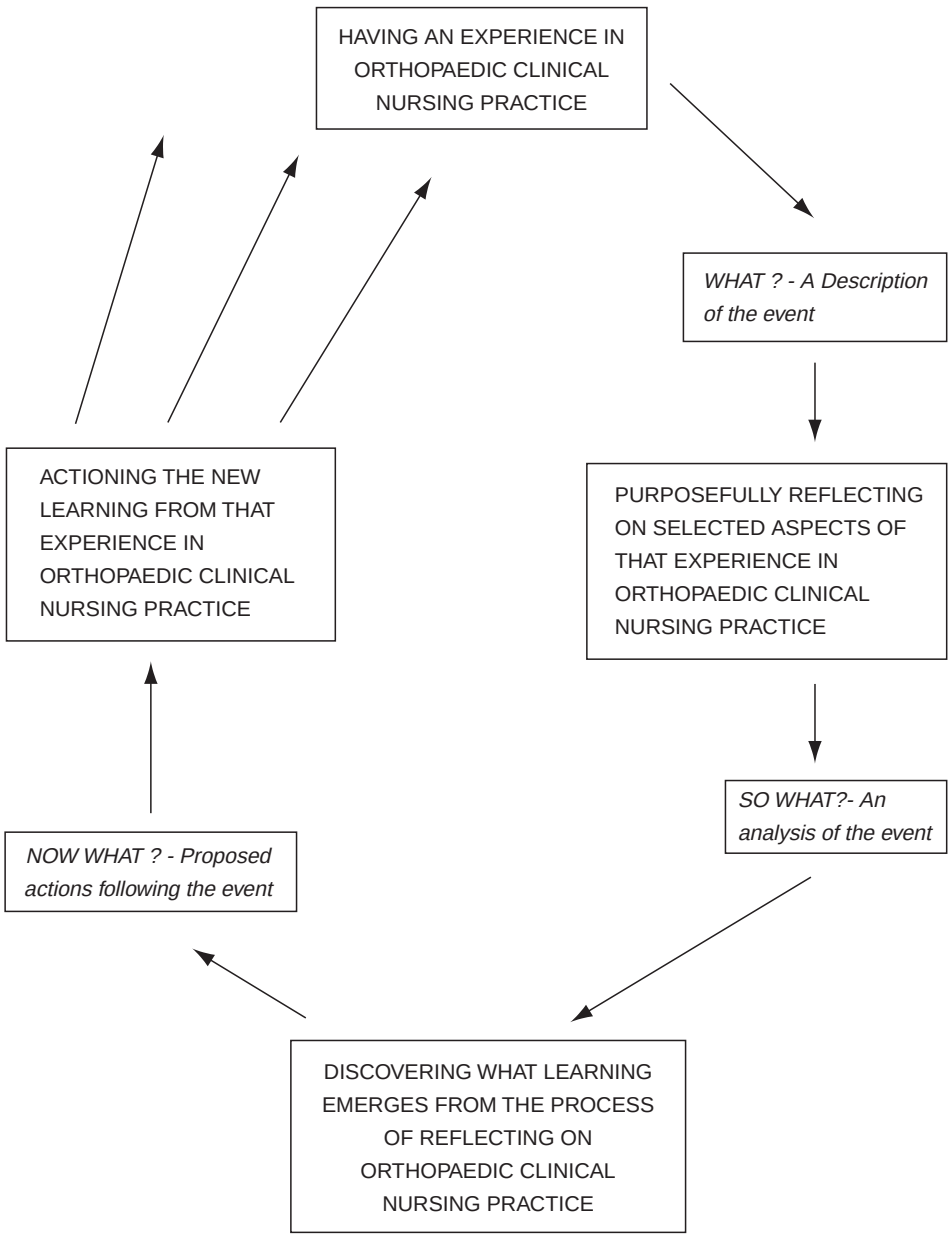

Fig. 1 The What? Model of structured reflection (Driscoll 2000) and its relationship to an experimental learning cycle.

in which practitioners organize and go about their work in orthopaedic nursing.

Many of the opportunities for reflecting about clinical practice are probably not too focused, the chances being that while there may be an intention to learn, there is little follow up on what actions arose from spending the time reflecting on practice. Talking, listening and reading can be helpful mediums for reflection, but are more powerful if shared with others rather than keeping things to yourself.

THE NEED TO LEGITIMISE REFLECTION

Examining some of the contradictions that exist in practice, with someone else who understands that practice through reflection, coupled with a commitment to action, offers an opportunity for the individual and organization to transform nursing through reflective practice (Johns & Freshwater 1998).

However, increasing commitments of time are compounded in some cases by inappropriate staffing levels, poor skill mix and decreasing resources. It may therefore not be surprising that orthopaedic nurses initially find it difficult to find the time and energy to engage in organized reflection as opposed to superficially just thinking about practice.

Despite reflective practice being a practice learning activity to maintain registration and fulfil CPD requirements it is unlikely to be acknowledged in any serious way unless managers also accept that reflective activities can be part of routine clinical practice and allocate appropriate resources.

Wanting to realize desirable practice and believing that learning has no end point in clinical practice is just as important at the top as it is at the lower end of healthcare organizations. The actions of the senior staff in supporting practitioners who wish to

be more reflective in practice is paramount, but they will need to be convinced that the time is well spent and really does contribute to more effective practice. The notion of a learning culture in clinical practice, one in which there is practitioner freedom to learn through reflection, as well as do the work, must be a longer term goal for an organization if reflective practice is to be fully realised in clinical practice.

I wonder how many readers would agree with formalising reflection as a planned event. Other formalised activities such as student assessment and regular meetings with the ward or unit manager, are less likely, or more difficult, to just quietly forget about. Some informal, as well as formalized, opportunities for orthopaedic nurses to reflect on practice are listed below, you can probably think of others:

- hand-over times
- telephone conversations
- teaching sessions
- reading a journal article or attending a journal club
- networking meetings or conferences
- clinical case notes
- case conferences
- attending doctors rounds
- clinical supervision sessions
- mentoring and preceptorship discussions
- working with other more experienced staff
- working with nurses who are new to the ward environment
- letters of complaint
- critical or significant happenings on the ward
- maintaining a professional portfolio
- accident and near misses forms
- clinical risk assessments
- clinical audits
- ward meetings
- the annual appraisal
- the staff restaurant or rest room.

Reflection should be regarded as an important and intentional activity, otherwise when things get busy, it will be the first thing to be dropped in practice. How many other good ideas in practice can you think of that 'wither on the vine' because they only happened in an ad-hoc way, or were only seen as informal?

Gail Parsons an orthopaedic liaison practitioner (2000) describes her personal reflections on setting up formalised reflective practice in the form of clinical supervision in the UK. She describes it as:

> A support system which allows practitioners to form a professional trusting relationship that enables them to reflect on their practice, to challenge the process, and then to move forward with improved knowledge and skills always aware of the impact of this from one's own professional values ... When discussing the process in some detail, we came to understand that our learning had to be made as visible as possible. The tacit and unconscious knowing had to be made more conscious and therefore more open to inspection and critique ... as a group we came to an understanding that the reflective conversation lay at the heart of the clinical supervision process.

More detailed explanation of clinical supervision as applied to reflective practice can be found in Bishop (1998), Bond and Holland (1998), Butterworth et al. (1998), Driscoll (2000), Fowler (1998) and UKCC (1996). In reality the importance attached to reflection will be not be decided by those outside of orthopaedic practice, but those inside that practice who, like Gail Parsons, after engaging in the process valued it enough to be a prominent feature of orthopaedic nursing practice.

CONCLUSION

There would appear to be a new impetus for orthopaedic nurses to become involved in reflecting on practice as a way of validating their practice. Reflection is more than just thinking, it is an intentional practice based learning activity that focuses on improving future actions in clinical practice by looking back at what has already happened or is happening.

The supported exploration and questioning of one's knowing and understanding about orthopaedic nursing is not yet an everyday activity. However reflection does give practitioners a legitimate opportunity to regularly stop and think, in the midst of practice, with the intention of enhancing what already goes on in clinical practice. If actions occur as a result of a practitioner reflecting on practice, then legitimising the process, despite the challenges it presents, may well be able to transform whole areas of orthopaedic nursing practice (Johns & Freshwater 1998). But as Lumby (1998:91) warns, unless being reflective in practice is also manifested in some form of actions or changed practice by practitioners, it is not transformation and unlikely to become legitimized in everyday practice.

The *Journal of Orthopaedic Nursing* is your journal and an opportunity to set up a dialogue or network with orthopaedic colleagues, whether by talking, writing or in cyberspace. Having a questioning and inquiring dialogue about your practice and getting some constructive feedback is the start of becoming reflective. But are you prepared to act on what you have just read, or prefer to just think about it?

REFERENCES

Andrews M, Gidman J, Humphreys A (1998) Reflection: does it enhance professional nursing practice? British Journal of Nursing 7(7): 413–417

Atkins S, Murphy K (1994) Reflective Practice. Nursing Standard 8(39): 50–56

Atkins S, & Murphy K (1993) Reflection: a review of the literature. Journal of Advanced Nursing 18: 1188–1192

Benner P (1984) From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Addison Wesley, California

Bishop V (1998) Clinical Supervision in Practice – some questions, answers and guidelines. Macmillan Nursing Times Research Publication, London

Bond M, Holland S (1998) Skills of Clinical Supervision for Nurses. Open University Press, Milton Keynes

Bright B (1995) 'What is reflective practice?'. Curriculum 6(12): 69–81

Bulman S (2000) Exemplars of reflection: A chance to Learn through the Inspiration of Others In: Bulman S, Burns C (eds.) Reflective Practice in Nursing The Growth of the Professional Practitioner. Blackwell Science, London

Bulman S, Burns C (2000) Reflective Practice in Nursing The Growth of the Professional Practitioner. Blackwell Science, London

Butterworth T, Faugier J, Burnard P (1998) Clinical Supervision and Mentorship in Nursing, 2nd edn, Stanley Thornes, Cheltenham

Carper BA (1978) Fundamental patterns of knowing in nursing. Advances in Nursing Science 1(1): 13–23

Clarke B, James C, Kelly J (1996) Reflective practice: reviewing the issues and refocusing the debate. International Journal of Nursing Studies 33(2): 171–180

Conway J (1994) Reflection, the art and science of nursing and the theory practice gap. British Journal of Nursing 3(1): 77–80

Cox H, Hickson P, Taylor B (1994) cited in: Gray G & Pratt R (eds.) (1994) Towards a Discipline of Nursing. Churchill Livingstone, Edinburgh p 378

Davis P (1997) Are we anything special? (Editorial). Journal of Orthopaedic Nursing 1(1): 1

Dewey J (1929) Experience and Nature. Grave Press, New York

Department of Health (2000) The NHS Plan A plan for investment, A plan for reform. Department of Health, London

Department of Health (1999a) Clinical Governance: Quality in the new NHS Department of Health, Leeds

Department of Health (1999b) Making a Difference Strengthening the nursing, midwifery and health visiting contribution to health and healthcare Department of Health, London

Department of Health (1998a) A First Class Service – Quality In The New NHS. Department of Health, Leeds

Department of Health (1998b) The new NHS – Working Together : Securing a Quality Workforce for the NHS. Department of Health, London

Driscoll J (2000) Practising Clinical Supervision: A Reflective Approach. Bailliere Tindall (in association with the RCN), London

Driscoll J (1994) Reflective practice for practise – a framework of structured reflection for clinical areas. Senior Nurse 14(1): 47–50

Fish D, Twinn S, (1997) Quality Clinical Supervision in the Health Care Professions – principled approaches to practice Butterworth-Heinemann, London

Fisher M (1996) Using reflective practice in clinical supervision. Professional Nurse 11(7): 443–444

Ford P & Walsh M (1994) New Rituals for Old: Nursing Through the Looking Glass. Butterworth-Heinemann, Oxford

Fowler J (1998) (ed.) The Handbook of Clinical Supervision – Your questions answered. Quay Books, Salisbury

Ghaye T, Lillyman S (2000) Reflection: principles and practice for healthcare professionals. Quay Books, Mark Allen, Wiltshire

Ghaye T, Lillyman (1997) Learning Journals and Critical Incidents: Reflective Practice for Health Care Professionals. Quay Books, Mark Allen, Wiltshire

Goff A (1995a) Reflection – What is it?: A Literature Review. Assignment 1(1): 7–14

Goff A (1995b) Reflection – What is it?: A Literature Review. Assignment 1(2): 24–28

Heath H (1998) Keeping a reflective practice diary: a practical guide. Nurse Education Today 18: 592–598

Holly M (1989) Writing to Grow: Keeping a Personal – Professional. Journal Heinemann, Portsmouth, New Hampshire

Holm D, Stephenson S (1994) Chapter 4 Reflection-A Student's Perspective in Palmer A, Burns S, Bulman C 1994 Reflective Practice in Nursing – The Growth of the Reflective Practitioner. Blackwell Scientific, London

Hull C, Redfern L (1996) Profiles and Portfolios: A Guide for Nurses and Midwives. MacMillan, Basingstoke, Hampshire

Jarvis P (1992) Reflective Practice and Nursing. Nurse Education Today 12: 174–181

Johns C (2000) Becoming a Reflective Practitioner A reflective and holistic approach to clinical nursing, practice development and clinical supervision. Blackwell Science, London

Johns C Freshwater D (eds) (1998) Transforming Nursing Through Reflective Practive. Blackwell Science, London.

Johns C (1998) Chapter 1 Opening the Doors of Perception in: Johns C, Freshwater D (eds) (1998) Transforming Nursing Through Reflective Practice. Blackwell Science, London

Johns C (1996) Visualising and realising caring in practice through guided reflection. Journal of Advanced Nursing 24: 1135–1143

Johns C (1995) Framing learning through reflection within Carper's fundamental ways of knowing. Journal of Advanced Nursing 22: 226–234

Jones A (1995) Reflective process in action: the uncovering of the ritual of washing in clinical nursing practice. Journal of Clinical Nursing 4: 283–288

Kotthamp R (1990) Means for facilitating reflection. Education & Urban Society 22(2): 182–203

Lumby (1998) Chapter 8: Transforming Nursing Through Reflective Practice in: Johns C, Freshwater D (eds.) Transforming Nursing Through Reflective Practice. Blackwell Science, London

McMahon R, Pearson A (1998) Nursing as Therapy. 2nd Edition Stanley Thornes, Cheltenham

Ousey K (2000) Bridging the theory-practice gap? The role of the lecturer/practitioner in supporting pre-registration students gaining clinical experience in an orthopaedic unit. Journal of Orthopaedic Nursing 4: 115–120

Palmer A, Burns S, Bulman C (1994) Reflective Practice in Nursing – The Growth of the Reflective Practitioner. Blackwell Scientific, London

Parsons G (2000) Chapter 3 Some reflections on the implementation of clinical supervision in: Ghaye T, Lillyman S (2000) Effective Clinical Supervision – The Role of Reflection. Quay Books, Mark Allen, Wiltshire

Rolfe G (1996) Closing the Theory-Practice Gap. Butterworth- Heinemann, Oxford

Santy J (1997) The role of reflection in the education and development of orthopaedic nurses. Journal of Orthopaedic Nursing 1: 183–187

Schon D (1987) Educating the Reflective Practitioner. Jossey Bass, San Francisco

Schon D (1983) The Reflective Practitioner. Avebury Publ, Aldershot

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2000) The practice standard. UKCC, London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) The continuing professional development standard. UKCC, London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) Position statement on clinical supervision for nursing and health visiting. UKCC, London

Walker D (1985) Chapter 3 Writing and reflecting in: Boud D, Keogh R, Walker D (eds.) Reflection: turning experience into learning. Kogan Page, London

Wilkinson J (1999) Implementing reflective practice. Nursing Standard 10(13): 36–39