Improving nurses’ level of reflection

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Conflict of interest
None declared

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Abstract
Reflecting on practice is an important aspect of nursing. There is widespread acknowledgement of the value of reflective practice and it has a significant role in coursework assessment and revalidation requirements. However, less attention has been given to the various levels of reflection and what constitutes a higher or lower level of reflection. This article aims to assist nurses to understand how identifying the various levels of reflection can improve their practice. A case study example is used to demonstrate how mentors might support nurses in incorporating reflection into their practice.

Keywords
critical thinking, mentoring, professional issues, reflection, reflective practice, revalidation

Aims and intended learning outcomes
The aim of this article is to assist nurses in understanding the lower and higher levels of reflection and how to adopt a stepped approach to improving the process of reflection. Nurses are encouraged to clarify the purpose of reflection (step one); understand the levels of reflection (step two); and consult with a mentor to prepare their written reflections for evaluation (step three). After reading this article and completing the time out activities you should be able to:

» Define the important terms relating to reflection.
» Describe why an understanding of the purpose of reflection is important in nursing.
» Distinguish between the various levels of reflection.
» Evaluate your reflective practice with a mentor.

Relevance to The Code
Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

» It outlines that trust is promoted by nurses who demonstrate that they understand and respect patients’ concerns. The Code states that nurses should promote professionalism and trust.
» The Code states that nurses should act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it. The article states that nursing care should be empathetic and consider the needs and expectations of patients.
» It states that nurses should be able to use reflection to apply concepts such as person-centred care. The Code states that nurses should put the interests of people using or needing nursing services first, making their care and safety the nurse’s main concern.
» The Code states that nurses must reflect and act on any feedback they receive to improve their practice. The article
states that reflection should be used constructively to augment, enhance or adjust nurses’ practice.

Introduction
Reflective practice is at the centre of nursing. Nurses’ understanding of their experience of delivering patient care can guide them when attempting to make service improvements. Similarly, learning about which clinical techniques are effective in practice, and eliciting patients’ views on care delivery, are important if nurses are to improve the quality of their care (Tsianakas et al 2012).

Healthcare is a dynamic area where change is normal. If nurses do not have the ability to reflect on and influence change, they will be less able to lead on initiatives (Heckemann et al 2015). Nurses are also required to reflect on any issues associated with the application of evidence to practice.

Delivering care can place significant emotional demands on nurses, particularly when working with patients who have a suboptimal prognosis. If nurses are to manage the psychological demands of care delivery, which may involve ethics, resource provision, and competing healthcare priorities and values, it is important that they can reflect on events around them and how these events make them feel (Wallbank and Wonnacott 2015).

Reflection
Reflection forms part of the curricula of nursing degree courses, and registered nurses are expected to demonstrate an ability to reflect on their practice as part of the NMC’s (2017) revalidation requirements. Gibbs (1998) described a simple reflective cycle, in which:

» The nurse attends a clinical episode, which appears remarkable or problematic in some way.

» The nurse explores perceptions associated with this episode, clarifying what it represents, for example a success, risk, failure or challenge.

» The nurse evaluates the experience in terms of its merits, limits and potential for learning, before reaching a conclusion and determining future actions.

Following on from Gibbs’ (1998) work, Johns (2010) and Jasper et al (2013) developed models of reflection. However, the fact that so many models exist indicates that reflection is a complex concept that can be applied in a variety of ways (Koole et al 2011). Price and Harrington (2016) defined reflection as a process: ‘...where experience is examined in ways that give meaning to interaction... While reflection is most closely associated with human interactions and especially clinical events, it is not limited to these. We may, for instance, reflect on the written accounts of experiences, such as those shared by dying patients. Reflection may be used in the service of different nursing goals – those that are designed to tell us something about how we think, what we value, and with regard to ways in which practice could be improved.’

Reflection relates to experiences and feelings. While reflection is often used to drive clinical improvements, it is also cathartic, enabling nurses to explore how a clinical episode felt and what it signified to them. Reflection acknowledges that nurses are required to act, sometimes urgently, upon their perceptions of a clinical event where the evidence is not necessarily complete or available to them. Nurses must examine their perceptions of a clinical episode and speculate about what is taking place and what the evidence might represent. This kind of decision-making can appear daunting to the nursing student or newly qualified nurse, particularly since speculating on a clinical event may involve conceding that they are not the expert, which can expose their reasoning to criticism from others (Gambrill 2012).

Reflection can be practised at various levels. However, determining what represents a higher level of reflection that will assist nurses in examining their care and improving practice remains challenging, partly because a plethora of models describe the process of reflection as well as suggesting what might constitute a higher level of reflection (Koole et al 2011).

In general terms, the lower levels of reflection are governed by rules and are...
Inflexible and unresponsive to change. In lower-level reflection, the individual re-examines events with reference to what is believed to be self-evident (Price and Harrington 2016), for example the nurse might assume that all patients experience pain in the same way as they do. Conversely, higher-level reflection is a nuanced and complex examination of events, involving greater scrutiny or examination of the nurse’s actions and the purpose of the clinical activity. It also explores the perspectives that others might have of a clinical event.

Nursing students may find it challenging to achieve the highest levels of reflection, which can affect their clinical decision-making (Padden 2013). This is, in part, associated with their limited experience of providing care, but may also be linked to fears about how others might judge them (Padden 2013). The NMC (2017) requires nurses to include five written reflective accounts within their revalidation submissions, but standards for the required level of reflection have not been detailed. Therefore, there is a risk that nurses’ reflection records may vary in quality and be judged inconsistently by revalidation confirmers.

This article outlines the various levels of reflection. It also examines the steps that nurses can take to connect experience, ideas, theory and evidence to achieve a higher level of reflection on clinical events (Korthagen and Vasolas 2005).

TIME OUT 1
Reflect on whether the amount of practice experience gained by a nurse determines their ability to reflect effectively on clinical events. Consider whether your reflections are based on an instinctive review of what you have experienced, or whether they are underpinned by theory.

Step 1: clarifying the purpose of reflection
The first step in improving the nurse’s level of reflection is for them to understand why they are reflecting. If reflection is not clearly defined, with specific terms of reference and expectations, it will be challenging for nurses to engage with the process appropriately. Clarifying the purpose of reflection, for example for an episode of care, practice audit, assignment or revalidation submission, enables the nurse to reflect and subsequently record their reflection with increased clarity and confidence. Price and Harrington (2016) described six purposes of reflection as shown in Table 1.

Nurse educators and regulators have not always been clear about what constitutes appropriate reflection (Padden 2013). Husebø et al (2013) examined the effectiveness of reflective practice questions set by facilitators as part of a simulated resuscitation package for nursing students. A total of 23 out of 117 (20%) questions posed by the facilitators were sufficiently clear for the students to understand what was being asked of them. When asked to reflect on their experience of the simulation, 45 of 130 (35%) students’ responses were described as ‘analytical’, but the focus of their analysis was not always what the facilitators expected. The researchers found that it was important for facilitators to guide nursing students on exactly what was required in their reflections (Husebø et al 2013).

Reflective practice questions that are too broad, for example ‘Choose a care episode and reflect on what you discovered’, can result in a lack of clarity for students about what is required. Writing about the use of reflective practice exercises with university students in Hong Kong, Leung (2016) discussed the importance of clarifying the expectations of tutors and students. Leung (2016) observed that some students assumed that the role of education was to provide skills that would improve their future employability. Tutors had to encourage the students to question their own thinking and investigate the purpose of reflection, and the students were cautious about exploring their own attitudes and values, preferring to learn about facts, policies and expert judgements. It is important that tutors do not assume that students understand the purpose of reflection.
TIME OUT 2
Reflect on your revalidation process. Are you confident that you understand what aspects of your practice you are being asked to reflect upon? If not, consider clarifying the purpose of your reflective activity with your revalidation confirmer.

Step 2: understanding the levels of reflection
While there are some established principles that identify higher or lower levels of reflection – for example a lower level of reflection may require the individual to notice their surroundings during an event, while a higher level of reflection would require them to make judgements about the event (Mezirow 1981) – the focus of the reflection is usually related to its stated purpose. For example, for the nurse conducting a review of risk on their ward, the focus of reflection might be on interpreting the latest research on risk and developing a plan that incorporates current policies. In clinical practice, there may be increased emphasis on interpersonal understanding, for example the focus of reflection may be on the nurse’s ability to interpret and respond to patients’ needs (Devenny and Duffy 2014).

Mezirow (1981) was one of the first authors to describe several levels of reflection, including:

» Most basic level – involves being aware of issues, noticing surroundings and acknowledging that a situation is ‘of note’.

» Second level – involves understanding how an experience makes the individual feel.

» Third level – involves demonstrating discrimination, for example distinguishing between fact and perception, belief and value, and what is relevant and irrelevant in a given context.

» Fourth level – involves providing a judgement on a situation and explaining how the individual arrived at it.

» Fifth level – involves applying concepts, for example person-centred care, rehabilitation and palliation. The individual can draw on theories to enrich their analysis of a situation.

» Sixth level – described as psychic and involves understanding how reflection can relate to personal identity, and what the individual believes is right in any situation.

» Seventh and highest level of reflection – involves modelling ideas for the future, for example where a series of reflections encourage the nurse to adopt a particular attitude towards care.

Mezirow’s (1981) levels of reflection emphasised both personal insights and the practical application of reflection. It acknowledged that the higher levels of reflection combine an understanding of theory, evidence and experience, and centre on future actions. Many university’s reflective practice assignments draw directly on Mezirow’s (1981) levels of reflection, with tutors assessing students’ ability to progress through the levels of reflection.

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<tr>
<th>Purpose</th>
<th>Rationale</th>
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<tr>
<td>Challenging assumptions</td>
<td>Reflection can be used to challenge a nurse’s assumptions about clinical practice as well as those of their colleagues. However, since it may be difficult for an individual to change their attitudes and values, it is important for the nurse to identify a rationale for revisiting a task or procedure. Reflection should be used constructively to augment, enhance or adjust practice</td>
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<tr>
<td>Celebrating practice</td>
<td>Nurses can learn from successes as well as setbacks. Understanding why and how a task or procedure was successful is vital if best practice is to be replicated</td>
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<td>Correcting practice</td>
<td>Reflective practice is linked to problem-solving and the analysis of decisions that have produced suboptimal results</td>
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<td>Understanding the concept of self</td>
<td>Nurses often draw upon their personal values, beliefs and life experience to provide care for others. Developing a rapport with patients relies upon nurses sharing their own experiences. Therefore, it is important for nurses to understand their values and attitudes if they are to provide a rationale for the care they provide</td>
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<td>Understanding others</td>
<td>Nursing care should be empathetic and consider the needs and expectations of others. Reflecting on how the care provided by the nurse meets the expectations of patients, relatives and colleagues, is essential to ensure person-centred care</td>
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<td>Understanding the profession and its standards</td>
<td>The Code (Nursing and Midwifery Council 2005) is the basis for any care provided. Reflecting on the themes of The Code can assist nurses in providing appropriate care as well as understanding how their practice can contribute to the reputation of the nursing profession as a whole</td>
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Korthagen and Vasolas (2005) have emphasised the connection between the practitioner and the wider team or institution. In Korthagen and Vasolas’s (2005) analysis, the effective learner considers practice in relation to their mission, identity, beliefs, competencies and behaviour, and the wider environment.

Moon (1999) has written extensively about reflection and refers to stages, or levels, of learning, including:

- Stage 1 – the individual notices events and experiences.
- Stage 2 – the individual begins to make sense of the experiences; they are catalogued as good or bad, progressive or regressive, challenging or familiar.
- Stage 3 – the individual begins to explore the meanings attributed to events, re-examining what might be considered true, authentic or representative.
- Stage 4 – the individual’s thinking is transformed, for example their attitudes and values have changed, they are able to reprioritise care, or work in different ways with colleagues.

Kember et al (2008) discussed four levels of reflection, with the first and lowest level being habitual where the individual acts according to custom or formula. At this level, practice is regarded as self-evident, for example: ‘This is what we always do’; ‘This is just how it is.’ The second level is described as ‘understanding’, where concepts, theories and principles are considered relevant to practice even though the individual may still find it challenging to relate these to personal experiences; for example, the concept of informed consent might be understood, but its application to a patient with attention deficit issues may not be fully appreciated. It is only at the third level that Kember et al (2008) reasoned that the individual begins to combine ideas, theories and experiences, and use these to explain their experience. The fourth and highest level, critical reflection, involves the individual developing new perspectives and examining why care episodes might be viewed as challenging or successful.

Carroll (2010) outlined six levels of interpersonal reflection accompanied by methods that could assist the nurse in progressing through each level. Table 2 shows the six levels of reflection relating to understanding the patient’s experience.

**TIME OUT 3**
Examine the models of reflection outlined in this article and identify what they have in common, for example are there characteristics that they all list as important to higher levels of reflection? Do you think that considering reflection in terms of different levels might be helpful when considering your own reflective accounts?

Irrelevant of how convenient it might be to have universally agreed levels of reflection, these do not exist. For example, the ascending levels of reflection in Mezirow’s (1981) model prioritise personal insight and the ability to make connections between theory and practice, while both Moon (1999) and Kember et al (2008) place greater emphasis on the individual’s ability to adjust their attitude, contrasting previous knowledge with new methods of critical thinking.

The highest level of reflection has been described as ‘Gestalt’, that is, viewing the ‘whole picture’ (Wertheimer 2014). In a healthcare setting, this could refer to the nurse as a change agent who functions in a way that complements the institutional setting. Korthagen and Vasolas (2005) have emphasised the connection between the practitioner and the wider team or institution. In Korthagen and Vasolas’s (2005) analysis, the effective learner considers practice in relation to their mission, identity, beliefs, competencies and behaviour, and the wider environment; in this case, the healthcare institution and its values.

**TIME OUT 4**
Consider the model you use when reflecting. If you are a student, ask your tutor to describe the criteria against which levels of reflection are to be judged within an assignment, for example are you expected to focus on how your personal insights have developed, or on the integration of theories and ideas? If you are a registered nurse, identify the purpose of your reflection and select the most appropriate model of reflection. The NMC does not provide training in the assessment of reflective practice records and your revalidation confirmer might not be an expert in reflection themselves. However, agreeing the purpose of your reflection and which model of reflective practice to use can be a constructive exercise in itself.

**Step 3: consult with a mentor to prepare written reflections for evaluation**
Reflective writing is often considered as a ‘one-off’ act where the nurse records their
Reflections on a single event or incident. However, completing a series of reflections, only the last of which is presented as the final work, has been recommended (Brockbank and McGill 2012). To assist in this process, the nurse will benefit from a critical dialogue with a trusted mentor (Brockbank and McGill 2012). Where the nurse is able to explore their insights and theories with a mentor, the conclusions reached are likely to be increasingly nuanced. A revalidation portfolio developed in this way will demonstrate that the nurse’s reflections have evolved, from lower-level observations to sophisticated higher-level reflections. In the author’s clinical experience, the ideal mentor for this type of reflective analysis is characterised by the following:

1. They have an interest in assisting the nurse to develop their critical thinking.
2. They understand how reflection can identify the nurse’s anxieties, for example concerning the accuracy or adequacy of their reasoning.
3. They understand the level of reflection that best applies to the stated purpose of the nurse’s reflective activity (Table 2); only then can they provide feedback to the nurse on their progress.
4. They are honest and candid, prompting the nurse to reconsider what they have observed alongside any conclusions.

Irrespective of how tempting it might be for the mentor to instruct the nurse on what represents a more appropriate reflection, the emphasis should be on assisting the nurse to explore their own ideas and conclusions.

A variety of nurses can act as a mentor, including those who have completed clinical teaching or mentorship courses and those who are comfortable raising questions concerning best practice, for example nurse consultants and researchers. Nurses who have completed specialist courses where reflective practice is widely used for assessment purposes might also be prepared to act as a mentor. What is most important is that the chosen individual has a genuine interest in assisting the nurse to develop through reflection.

It may be tempting for the nurse to select a mentor who can assure them that their reflections are valid. However, the mentor’s role should be to encourage the nurse to...

<table>
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<th>TABLE 2. Levels of reflection relating to understanding the patient’s experience</th>
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<td><strong>Level (1 = lowest, 6 = highest)</strong></td>
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<tr>
<td>1. Zero reflection</td>
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<td>2. Empathetic reflection</td>
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<td>3. Relational reflection</td>
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<td>4. Systematic reflection</td>
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<td>5. Internal shift reflection</td>
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<td>6. Transcendent reflection</td>
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Care episodes will vary in their capacity to prompt reflection at the highest levels. For example, a single care episode might not be significant enough to transform the nurse’s wider values and attitudes (level 6). A series of care episodes might be necessary before the nurse is able to re-examine their values. The approach adopted by the nurse might not be so aberrant that it requires level 5 reflection. Similar adjustments may be enough, such as gathering additional information from the patient. It is for this reason that reflection is enhanced by working with a mentor. The maximum level of reflection achievable may be determined, in large, by the significance of the care episode.

(Adapted from Carroll 2000)
KEY POINT
The primary role of a mentor is to assist the nurse in identifying the useful elements of their reflection. This will support the nurse in undertaking a detailed exploration of any care episode (Price 2006).

analyse their conclusions, remembering that there is no correct method for managing complex care situations. Working with a mentor is an exploratory process that aims to identify best practice in any clinical situation.

TIME OUT 5
Considering your own practice, reflect on how you chose your mentor. Did you select a person who you thought would validate your reflections or did you attempt to identify a mentor who would challenge your conclusions?

Working with a mentor on reflection has several benefits for the nurse and can be divided into several stages as follows:

» Stage 1 – the mentor attempts to motivate the nurse by acknowledging the value of any work they have already undertaken. Reflection is about developing the nurse’s initial work, even if this is modest.
» Stage 2 – the mentor encourages the nurse to question themselves and their practice. Care is not always perfect or individualised and the mentor can assist the nurse in exploring the limits of their practice, even if this is uncomfortable.
» Stage 3 – the mentor encourages critical thinking, confronting the nurse’s assumptions about their care.
» Stage 4 – the mentor assists the nurse in considering their future practice. The nurse may have identified a particular treatment approach with a patient, whereas the mentor may suggest an alternative strategy.

Stage 1
The primary role of a mentor is to assist the nurse in identifying the useful elements of their reflection. This will support the nurse in undertaking a detailed exploration of any care episode (Price 2006). Practice reflections are often incomplete, with the nurse recalling some elements, while forgetting others. There can be an extensive focus on the activities and outcomes involved in a care episode, when insights into why an intervention worked and how the patient felt about it may be more useful. Similarly, nurses often list the interventions undertaken during a care episode, but provide less information about their rationale. In such instances, the reflection may be relatively low level.

This stage is illustrated by the case study example in Box 1, where a nurse reflects upon an episode of interpersonal care, involving the needs of a patient with anxiety. This case study example can be read in conjunction with Carroll’s (2010) levels of reflection outlined in Table 2, as both focus on interpersonal care.

The care episode outlined in Box 1 demonstrates a clear concern for the patient’s feelings, with the nurse acknowledging the patient’s anxieties. The nurse is attempting to communicate a message to the patient that says, ‘You have nothing to fear.’ However, the nurse’s approach centres on the rehabilitation process and the competence of the team and its methods. The nurse seeks to reassure the patient without fully exploring why he was anxious.

The case study example in Box 1 demonstrates the nurse operating at level one or two of Carroll’s (2010) model (Table 2). The engagement with the patient is not individualised and centres on the healthcare services offered. The expression of concern for the patient appears genuine but is not developed as part of a therapeutic relationship.

Stage 2
The role of the mentor is to clarify and develop any elements that are missing from the nurse’s initial reflection. Kennison (2012) identified the importance of feedback, which is designed to assist nurses in identifying where their reasoning may be incomplete or not sufficiently coherent. In the reflection detailed in Box 1, which outlines the nurse’s failure to explore the patient’s anxieties about cardiac rehabilitation, the mentor might suggest that the nurse could have consulted the rehabilitation team’s cardiac measurements so she could explain to the patient why he was considered well enough to commence the exercise programme.

For level three relational reflection to be achieved as in Carroll’s (2010) model (Table 2), there needs to be increased exploration of the patient’s perceptions of his health status. This might involve the use of selected questions about why
the patient experiences anxiety and what he believes might happen when he commences the exercises. The nurse should shift from a focus on systems, providing information about standard care, to an emphasis on the patient’s perceptions and needs (Pattison 2015). Simply reassuring the patient may not be sufficient, and using language that demonstrates to the patient that the nurse is taking their anxiety seriously, for example ‘I think you will be fine, but let’s help you examine why,’ is preferable to, ‘You will be fine, because others were fine before you.’ It is also important to diagnose before prescribing; for example, with reference to the case study example in Box 1, it is important for the nurse to correctly diagnose that the patient is experiencing anxiety before attempting to ameliorate that anxiety.

TIME OUT 6
Reflect on the case study example in Box 1 and consider a patient that you have treated who was experiencing anxiety. What questions might you have asked to develop a rapport with them? Do you always explain the details of a procedure to your patients so that they have the necessary information when making a decision? Reflect upon whether you are providing individualised care, or simply offering patients generic information.

Relational reflection (Table 2) is concerned with the nurse and the patient having a mutual understanding of the patient’s needs, as well as the purpose and nature of any planned care (Carroll 2010). It involves working to the mutual benefit of the nurse and patient as well as incorporating the patient’s perceptions (Carroll 2010).

Once the mentor has determined with the nurse which level their reflection has reached and how this represents an improvement, subsequent reflective discussion is designed to progress the nurse’s reflection onto the next level. For example, in the case study example in Box 1, John will only gain maximum benefit from the rehabilitation programme when he trusts the nurses involved.

Trust is promoted by nurses demonstrating that they understand and respect patients’ concerns. Asking the following questions may have assisted the nurse in improving rapport and establishing trust with John:

» ‘Tell me about the chest pain that you felt. What did it feel like and when does it appear?’
» ‘The clinical tests are designed to assess whether you are ready to undertake the rehabilitation programme. What have my colleagues told you about the clinical tests so far?’
» ‘What do you think might help you feel a little more in control when you perform the exercises with the remedial therapist?’
» ‘What issues would you like the rehabilitation team to understand before you join the exercise classes?’

Stage 3
Another role of the mentor is to promote critical thinking. Reflection involves debate rather than instruction (Brockbank and McGill 2012), with the mentor and nurse able to discuss the benefits of various interventions. It is also important to move the patient’s care forward; however, progressing without an understanding of the patient’s perceptions of their condition and treatment can result in complications.
later in the care pathway. For example, in the case study example in Box 1, without the nurse explaining the rationale behind the patient’s treatment, John may have abandoned his rehabilitation altogether or possibly complained to the healthcare trust about his care.

Using traditional theories and methods to address clinical challenges can mean that the nurse risks operating within comfortable parameters; instead, critical thinking and reflection can identify innovative care strategies. Applying a systematic level of reflection (Table 2) (Carroll 2010) to the case study example in Box 1 might involve the nurse and John examining the anxieties that commonly recur for patients undertaking the cardiac rehabilitation programme. Instead of focusing on generic information that is provided to all patients, care could more accurately reflect the individual needs of patients on the programme. A reflection that began with a specific episode of care that focused on John’s concerns about the cardiac rehabilitation programme could become a wider exploration of how the team has habitually managed patients’ anxiety.

**Stage 4**
The mentor has a role in investigating what form the nurse’s idealised vision of care would take. Whether the nurse featured in the case study example in Box 1 achieves reflection levels five or six (Table 2) (Carroll 2010) depends on the extent to which they are able to re-examine the complicated issues involved in John’s cardiac rehabilitation, as well as addressing their own values. For example, the nurse may raise questions about their therapeutic relationship with John and whether they are acting as an advocate, a teacher or a clinician. Similarly, the nurse might investigate what represents a successful outcome and whether John undertakes the rehabilitation programme because he has been instructed to do so, or because, after considering the available information, he feels ready to continue.

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**References**


Leung H (2016) Levels of reflection on teaching a leadership and positive youth
TIME OUT 7
Considering the levels of reflection outlined in Table 2, reflect on your practice and consider which level of reflection you have achieved, for example are you operating at a low level that does not sufficiently examine your practice, or at a higher level of empathetic reflection?

Conclusion
Nurses attempting to achieve a higher level or reflection should understand the purpose of reflection, identify the levels of reflection and engage with a mentor to further develop their initial reflection. While reflection can be intuitive, its strategic use in nursing requires clarity regarding what the nurse wishes to achieve. Unconsidered and inadequately focused reflection is unlikely to result in productive results.

Nurses are likely to engage in reflection when they have a clear framework within which to operate. Where reflection is regarded as a series of one-off tests or performances, it can appear daunting. However, where reflection is understood as a process of practice examination and improvement, it is more likely to be undertaken by nurses.

While early models of reflection implied that it was a deceptively simple process involving a sequence of steps, reflection is now regarded as a complex activity where the nurse is asked to revisit their assumptions, beliefs and values. However, with the assistance of a mentor, there is no reason why nurses cannot achieve higher levels of reflection.

TIME OUT 8
Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how reflecting on your practice relates to the themes of The Code.

TIME OUT 9
Now that you have completed the article you might like to write a reflective account as part of your revalidation.
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Reflective practice

TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 909

1. Which of the following statements is true?
   a) Nurses are required to reflect on issues associated with applying evidence to practice
   b) Reflective practice involves the nurse asking the patient to keep a daily record rating their care
   c) Nurses should request feedback from a superior only
   d) Nurses do not need to engage in reflection as part of their revalidation

2. Which of the following is not an aspect of Gibbs’ (1998) reflective cycle?
   a) The nurse attends a clinical episode
   b) The nurse requests the patient’s permission to reflect on the clinical episode
   c) The nurse explores perceptions associated with the clinical episode
   d) The nurse evaluates the experience and determines future actions

3. The purpose of reflection is to:
   a) Celebrate practice
   b) Correct practice
   c) Understand others
   d) All of the above

4. A lower level of reflection involves the nurse:
   a) Modelling ideas for the future
   b) Being shadowed by a superior throughout a clinical episode
   c) Noticing their surroundings during a clinical episode
   d) Understanding how reflection can relate to personal identity

5. A higher level of reflection involves the nurse:
   a) Being aware of issues
   b) Transforming their thinking and attitude towards care
   c) Being able to grade clinical episodes as ‘good’ or ‘bad
   d) Taking notes

6. Which of the following is an aspect of transcendent reflection?
   a) The ability to translate insights from an episode of care to wider nursing values
   b) Assuming that the nurse is always correct
   c) Ignoring the patient’s perspective
   d) The nurse acting as an observer only

7. The highest level of reflection ‘Gestalt’ involves:
   a) Meditation only
   b) Avoiding challenging assumptions
   c) Viewing the whole picture
   d) Habitual practice

8. The ideal mentor to support reflective analysis will possess which of the following characteristics?
   a) A sense of humour
   b) A wide knowledge of nursing history
   c) At least 2 years’ clinical experience
   d) A genuine interest in the nurse developing their critical thinking

9. The benefits of working with a mentor include:
   a) Motivates the nurse by acknowledging the value of their work
   b) Encourages the nurse to question themselves
   c) Confronts the nurse’s assumptions about care
   d) All of the above

10. Which of the following statements accurately describes relational reflection?
    a) The nurse and the patient have a mutual understanding of the patient’s needs
    b) The nurse consults the patient’s family
    c) The nurse identifies the links between different clinical episodes
    d) The nurse relates to the patient on an unconscious level

How to complete this assessment

This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 52. There is one correct answer to each question.

- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 13 September.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically. Alternatively, you can cut out this page and add it to your professional portfolio. Don’t forget to record the amount of time taken to complete it.

You may want to write a reflective account based on what you have learned. Visit rcni.com/reflective-account

This self-assessment questionnaire was compiled by Jason Beckford-Ball

The answers to this questionnaire will be published on 13 September

Answers to SAQ 907 on transformational leadership, which appeared in the 16 August issue, are:

1, d, 2, c, 3, a, 4, d, 5, c, 6, a, 7, b, 8, d, 9, b, 10, a