Development of a Critical Incident Reflective Practice Framework for Paediatric Emergency Nurses

Sharon Bluett MN, GCert Clin.Ed, BN, DipApp.Sci (Nursing)
Education Coordinator, Mater Children's Hospital, Mater Health Services Brisbane

Introduction

In practice staff ruminate over a critical incident with or without guidance. A reflective framework can provide structure and purpose to enable a deeper analysis of a situation and encourage critical thinking. Reflection is more than simply mulling over a situation or pausing for thought. It is more than a description of an event. It is more than a description of an event, it is a process by which we find meaning of a situation by making sense of the complexities involved in challenging situations encountered in practice.[1]

There is global evidence of reflective practice being mandated by professional registration bodies as an essential attribute for demonstrating professional competence and development.[2] Reflective thinking "contributes to better contextual understandings and as such may influence behaviour" allowing an individual to make sense of an experience and learn from it.[3] Practitioners who learn to scrutinise their practice are able to improve their professional skills. In contrast those without this ability to self-scrutinise maintain ineffective habits.[4]

Background

Our Paediatric Emergency Department (PED) staff care for approximately 47000 children and their families annually. The nursing cohort is comprised of seventy registered nurses with experience ranging from new graduates to those with greater than twenty-five years of experience. Staff are employed full-time or in a part-time capacity to work a combination of eight and twelve hour shifts across a twenty-four hour period.

Debriefing provides the most familiar opportunity for reflection. In a chaotic and fluid environment such as the PED, carpe momentum or seize the moment determines the opportunity to debrief which is highly dependent on the clinical workload and the bringing together of stakeholders in a shift-work environment.

Debriefing is more than a conversation about an experience. A debrief is purposeful, requires a facilitator and benefits from an underlying structure.[5] Whilst there is limited evidence to stringently support the benefits and improved outcomes of debrief, it is generally considered valuable and to contribute to patient safety.[6]

The consequence of an undesirable outcome of resuscitation such as the death of a child can lead to staff experiencing lowered self-esteem, disbelief and grief. Following a period of increased episodes of unsuccessful resuscitations, staff reported that the opportunity for formal debrief was not available. They expressed their feelings and concerns elaborating that some individuals were experiencing flashbacks, insomnia and unpleasant dreams. This identified an area of need. No framework existed to support staff and guide reflection following critical incidents.

Staff Experiences of Critical Incidents

"I didn't know what to do or say, I didn't know how to feel, I had never been involved in a paediatric death before, so it was an absolute shock"

"During this time I felt quite numb, I felt as though I was going through a very clinical process, there were moments when I realised exactly what was happening from an emotional perspective and I felt sincere concern for the family and what they were experiencing"

"My initial reaction was shock. I couldn't believe that this beautiful little girl was sitting up and talking, and then 2 minutes later was having CPR"

"Sometimes, we don't save all lives but any parent who comes to the department should know that we all try our hardest"

Aims

The overarching purpose of this project was to develop a tool to provide support and encourage professional development of the (PED) nursing staff following critical incidents or resuscitations.

The aim was to develop staff knowledge, competence and life-long learning skills to enable them to deliver high quality care that is evidence-based.

In addition project objectives included the development of written reflective practice skills, improved patient outcomes, improved knowledge, skills and attitude to manage future critical incidents, and an element of protection for staff from burnout and post-traumatic stress.

Methods

1. Discussion with Emergency Nursing staff
   Discussions with staff and an in-depth knowledge of the current state of the PED informed the need for an intervention of support
2. Literature Review
   A review of literature was conducted to develop an understanding of the importance of debrief and reflection following a critical incident and to identify reflective practice models
3. Reflective models selected to develop the aide memoir
   Published reflective practice models were reviewed and the work of Borton, Driscoll, Johns, & Gibbs appraised for suitability.[7] A figure to aptly define why reflection is so important in nursing was identified.[8] This representation considers reflection according to inquiry from the perspective of the individual, with consideration of colleagues, patient and family, the successful practice, the problems, the challenging of assumptions and including the aspect of understanding this unique profession.[8]
4. Development of the framework
   Borton's model selected as a base for it's simplicity, questions under three stems – What? So what? and Now what?[7]
   - "What?" directs staff to describe the situation or incident.
   - "So what?" guides the analysis of the situation within the context of their knowledge to identify feelings and assumptions.
   - "Now what or what now?" guides the follow-up to help staff determine future actions, how to explore and establish an understanding of self-knowledge.

Clinical education is predominantly targeted at preparing staff for experiences. In contrast, this educational initiative aims to facilitate learning from experience.

A pragmatic solution was to develop an outreach platform or tool that would engage the principles of adult learning, be flexible, allow staff autonomy and provide essential support.

Results

A framework to address the professional development needs of staff following critical incidents. The framework is designed to be both complementary and synergistic with established programs (debriefs) within the clinical environment.

Critical Incident Reflective Practice Framework

What? - A description of the event
- What happened?
- What did I do? What was my role? What did I see?
- What were the roles of the team members?
- What was my reaction to the situation?

So what? - An analysis of the event
- What were the effects of my actions?
- What were the effects of actions of others? Focus on the nursing and multidisciplinary contribution
- Did the team demonstrate crisis resource management principles?
- What went well? Celebrate and acknowledge the accomplishments
- How were other's feeling (staff, family)? What do you think made them feel like that?
- How did I feel at the time of the event? How do I feel now?
- Do I feel troubled? If so, in what way?
- Do I have any "gaps" or unanswered questions regarding the situation?

What now? – Proposed actions following the event
- Where can I get more information?
- Have I identified any knowledge deficits (practical or theoretical)?
- How could I modify my practice if I was in a similar situation?
- What help do I need (education, equipment, facilitated support, counselling, graded assertiveness training etc.)?
- What value and assistance can I offer to my work colleagues?
- What is the main learning I take from reflecting on my practice?
- How do I now feel about this experience or event?

Discussion

Caring for families and children following trauma or life-threatening illness has a profound effect on health care professionals. Grief and distress is experienced following the death of a child. A reflective practice model can assist individuals to view alternative perspectives of a situation rather than focussing on the initial reaction to it.

Guided reflection following a critical incident can ensure that emotions and feelings are explored in relation to the experience. This process can help to establish meaning and clarity to the situation. Emotions are closely related to values. Knowledge of our own values and the values that guide our practice help to identify and evaluate conflicts of interest following a challenging practice situation.

The Framework as an aide-memoir is intended to assist staff to 'frame' the incident and guide reflection in the pursuit of understanding and meaning. Framing, is the "cognitive activity of building mental constructions that enable the person to further analyse a particular situation for increased understanding".[3]

Conclusion

Reflective practice is inextricably linked with nursing and other health professions. PED employees are exposed to confronting and challenging critical incidents in a chaotic work environment. A resuscitation of a child requires a multidisciplinary team with expertise in clinical knowledge, skills, attitudes and behaviours that are modelled on crisis resource management (CRM) principles. Staff invariably reflect and mull over the resuscitation of a child which may be accompanied by grief. The opportunity for face-to-face debrief sessions is variable and inconsistent.

The Critical Incident Reflective Practice Framework is anticipated to enable staff to review a clinical situation with purpose and to develop reflective writing skills. The framework is designed to provide structure and guidance to support staff. In addition it is created to acknowledge both individual and team professional practice, to celebrate success, to honour the uniqueness of the profession and the children and families in their care, to identify areas for improvement, to manage grief, and to plan and action professional development.

Recommendations for Practice

This framework is designed to be used in conjunction with already established debrief sessions, or to guide individual reflective practice when a face to face debrief is not possible.

Future Directions

Following ethics approval the framework will be implemented as a trial in the PED. Pre-post implementation focus groups will be arranged for staff and a questionnaire designed to identify the contribution of the framework on staff following a critical incident.

This framework is potentially suitable for multidisciplinary health professional use in a variety of critical care areas.

Acknowledgements

The staff of the Mater Children's Emergency Department and CarlyMarie Dudley, Project Heal - http://carlymarieprojectheal.com

References

1 Thompson, N., & Pascal, J. (2011). Reflective Practice: an existentialist perspective. Reflective Practice: International and Multidisciplinary Perspectives, 12(1), 15-26.
2 Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. Advances in Health Sciences Education, 14, 595-621.
3 Teekman, B. (2000). Exploring reflective thinking in nursing practice. Journal of Advanced Nursing, 31(5), 1125-1135.
4 Rudolph, J.W., Simon, R., Dufresne, R.L., & Raemer, D.B. (2006). There's no such thing as "nonjudgmental" debriefing: a theory and method for debriefing with good judgement. Simulation in Healthcare, 1(1), 49-55.
5 Cantrell M.A. (2008). The importance of debriefing in clinical simulations. Clinical Simulation in Nursing, 4(2), 19-23.
6 Corbett, N., Hurko, P., & Valee, T. (2012). Debriefing as a strategic tool for performance improvement. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 41, 572-579.
7 Bulman, C., & Schutz S. (2008) Reflective Practice in Nursing (4th Ed.) Oxford: Blackwell publishing.
8 Price, B., & Harrington, A. (2010). Critical thinking and writing for nursing students, Exeter: Learning Matters Ltd.

Mater
Exceptional People. Exceptional Care.

Poster produced by: MULTIMEDIA SERVICES, Mater Health Services Brisbane (VLA 09.13) 25040