Reflective Practice And The National Continuing Competency Framework

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Abstract

It is proposed that the recommendations of the Australian Nursing and Midwifery Council (ANMC) for a National Continuing Competence (NCC) Framework (currently in its third draft) be introduced from 2010. One of the more interesting requirements of the Framework is the need for self-assessment through the practice of reflection. This article will discuss the recommendations of the ANMC regarding the NCC Framework and briefly outline the components of the NCC Framework with a specific emphasis on self-assessment. Further, this article will discuss what reflective practice is, why it is important to nurses, and techniques that can be used to develop the skills for reflective practice. Anecdotal evidence suggests that as a concept essential to professional development, reflection is poorly understood, unexplored or a foreign concept for some nurses and midwives. For those who are familiar with the concept, reflection is commonly not part of routine practice. The purpose of this article is to begin their journey into reflective practice, thereby enabling a smoother transition towards 2009.

Key Words: Reflection; Reflective Practice; Reflective Thinking; Critical Thinking; Critical Incident Analysis.

BACKGROUND

Over two thousand years ago, Socrates, a Greek philosopher, accused by the Athenian court of ‘failing to acknowledge the city’s gods, introducing new divinities and corrupting youth’ (Plato, 1977, p. 31) refused to offer counter proposals to a death sentence such as imprisonment or exile (West, 1979, pp. 213 – 214) and died of poisoning by drinking hemlock (Barrow, 1977, p.1). In his second speech to the court Socrates claimed ‘the unexamined life is not worth living’ (West, 1979, p. 217). According to Barrow (1977, p.16), ‘Socrates died for philosophy, the pursuit of truth and the exercise of critical thought unhampered by tradition, authority or prejudice’. From this time, the notion of the ‘unexamined’ life has been the source of philosophical debate and continues to be relevant in the twenty-first century along with dialectical reasoning defined by Burchfield (2000, p. 210) as ‘logical disputation’. Reflection, essential to an ‘examined life’ is a key concept in nursing theory and education and a central theme of this article.

The Australian Nursing and Midwifery Council Incorporated (ANMC) is ‘a peak national nursing and midwifery organisation established in 1992 with the purpose of developing a national approach to nursing and midwifery regulation’ (ANMC National Competency Standards for the Registered Nurse, 2008). As stated on the ANMC website, ‘working in conjunction with state and territory nursing and midwifery regulatory authorities (NMRAs), the ANMC works to produce national standards as an integral component of the regulatory framework to assist nurses and midwives to deliver safe and competent care’ (ANMC National Competency Standards for the Registered Nurse, 2008).

INTRODUCTION TO NATIONAL CONTINUING COMPETENCY FRAMEWORK

On March 26, 2008, the Council of Australian Governments signed the Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the Health Professions (http://www.coag.gov.au). As a consequence, both the ANMC and the NMRAs have completed a substantial amount of work on how the national scheme might best be implemented for nursing and midwifery (Australian Nursing and Midwifery Council, home page http://www.anmc.org.au, accessed 5 September, 2008). However as outlined in the July 2008 edition of NMB update, the scheme has been deferred for two years and, on current information, the New South Wales Nurses and Midwives Board will continue to function until mid 2010 (NMB Update, 11, July, 2008, p.2).

The purpose behind the development of the NCC Framework by the ANMC was to provide consistency, at a national level, for the Australian regulating bodies, employers and nurses/midwives in relation to the clinical abilities of nurses/midwives. The impetus for the development included ‘increased consumer expectations, demographic and social changes, changing relationships between health workers, new technology and a greater focus on research and evidence-based practice’ (ANMC Continuing Competence Framework, (Draft II) 2007, p. 1).

Competency is to be evaluated by an assessment process. It is proposed that from 2009, it will be mandatory to complete the requirements for the NCC Framework in order to renew registration to practice in all Australian states and territories. New South Wales is the only state/territory that has yet to introduce similar requirements to those drafted by the NCC Framework. The components of the NCC Framework are a Professional Portfolio; Assessment (self-assessment and performance appraisal); Proof of Continuing Professional Development (CPD); Hours of Practice and a Declaration of Continuing Competence (ANMC Continuing Competence Framework (Draft III) 2008, p. 5).

The main requirement of the Professional Portfolio is that it provides sufficient evidence to demonstrate Competence in the other components of the NCC Framework. The Portfolio should include proof of self-assessment and professional feedback, proof of practice hours, evidence of CPD and a declaration of self-competence (ANMC Continuing...
Competence Framework (Draft III) 2008, p. 5). The nurse/midwife does not need to submit the Portfolio to ensure continuing registration, however it may be requested as part of an auditing process. It is expected that 5% of nurses/midwives across Australia will be randomly selected and requested to submit evidence to prove compliance with the NCC Framework in any given year (ANMC Continuing Competence Framework (Draft III) 2008, p.13).

If audited, the nurse/midwife will be required to show CPD of a minimum of 90 hours over three years. That is 30 hours of in-service or ongoing education that can be proven. They will also be required to show a minimum of 420 hours of practice for every three years, equal to 10.5 weeks of full time roster and there is a pro rata equivalent for part time employees. It is proposed that the Annual Declaration will be sent out with Registration renewals. By signing the declaration the nurse/midwife is stating that they are compliant with the NCC Framework (ANMC Continuing Competence Framework (Draft III) 2008, pp. 10 - 12).

Self-assessment is expected to take the form of a declaration of competence. As stated in the NCC Framework, it is expected that the nurse/midwife will use reflection to assist in this process, including the value or impact on practice of participation in the learning activities (ANMC Continuing Competence Framework (Draft III) 2008, p.10). Therefore, it is timely to discuss the emergence of reflection and what reflection involves.


Emden (in Gray & Pratt, 1991, p. 335) argued that Reflective Practice is of “pre-eminent interest to nurses [...] and that to be a reflective practitioner suggests professional maturity and a strong commitment to improving practice, a reasonable aspiration for every registered nurse.” Reflective Practice, as defined by McGill & Brockbank (2004, p. 94), is a means by which a professional develops “the capacity to continuously engage in critical dialogue about professional activity, individually and with others” and as “a reflective process that is constant and continuing”. Given both these definitions, it is simple to accept that Reflective Practice is a continuous action that directly affects anyone who is a practitioner.

Similarly, Jasper (2006, p. 53) argued that the benefit to the profession is in the development of the nursing knowledge base and in the recognition that nurses are contributing to both patient care and improved practice surrounding that care. Further, while reflection, reflective practice and reflective learning are phrases that in the past have been used interchangeably, Jasper (2006, p. 43) explains that Reflective Practice is the foundation upon which reflection and reflective learning are based. Jasper illustrated this process graphically with the following Reflective Process equation.

Experience + reflection + learning = change in behaviour/ action.

DISCUSSION ON STRENGTHS AND LIMITATIONS OF REFLECTIVE PRACTICE

Reflective Practice is not without its critics. Detractors of reflective practice include Scanlan, Care, & Uddod (2002, p. 2 – 3) who cited recall-related discrepancies as a potential limitation of the reflective process; Hyrkas, Tarkka & Paunonen-Ilmonen (2001, p. 505) cite ineffectual practice habits and ineffective training techniques. Gustafsson, Asp & Fagerberg (2007, p.135) claim contextual bias where practitioners choose not to study negative memories and/or choose those that reflect positive outcomes. A recent Australian contribution to the debate is that offered by Cotton (2002), who, drawing on Foucauldian concepts of power-knowledge and discourse challenges what she refers to as the ‘hégemonique discours de réflexion in nursing’ and an uncritical acceptance by some authors that reflection is necessarily good for nurses.

Proponents of reflective practice include Usher & Holmes (cited in Daly, Speedy & Jackson, 2006 pp. 104 -105) who see some of the benefits of this practice as assisting the practitioner to educate their emotions, re-sensitising the practitioner to marginalised and less fortunate people within our society, and assisting in the understanding of theoretical relationship between practice and reality. The two main benefits they see are that firstly action leads to decision, and secondly that reflection ‘helps to make you a better person and not just a better nurse’.

Other supporters include Jasper (2006, pp. 47 – 49) who argued that the list of benefits of Reflective Practice is long and includes not only the practitioner but also the patient, the work environment and the profession as a whole. The following are the benefits Jasper (2006, pp. 47 – 49) sees for the individual (nurse) and the patient.

Benefits for the individual
- Ensures you are giving evidence-based care
- Avoids routine practice
- Focuses on patients as individuals rather than cases
- Maximises learning opportunities identifies shortfalls in your knowledge and skills
- Identifies learning needs
- Values your own good practice
- Continually develops your practice
- Continually develops your own knowledge base
- Creates your own ‘practice theory’

Benefits for patients
- Receiving a better quality of care
- Individualised and evidence-based care derived from their needs
- Better standards of patient safety
- Improved decision-making
- Care using recent knowledge
- A reduction in the number of adverse patient incidents (such as drug errors, operating practice errors, falls)
- Higher confidence in professional practitioners

THE REFLECTIVE PROCESS

The reflective process equation is the sum of

Experience + reflection + learning = change in behaviour/ action

(Jasper, 2006, p.43).

These elements are examined below.

Experience

Experience includes knowledge that which is learned at a tertiary level (epistemology) and that which is learned at and during the process of nursing work (experiential knowledge).

Reflection

Beginning with reflection in action, the practitioner makes every day decisions, reflects on the appropriateness of responses and continues to work. Reflection in action leads to reflection on action, the point where the nurse, as practitioner, needs to take the time to acknowledge their own memories, emotions and to really look at their own practice. This is where nurses can learn. This learning affects the working environment and brings about all of those benefits for nurses and to their patients (Brockbank & McGill, 2006, pp. 95 - 99).

Learning

Another approach to learning in relation to reflection is that proposed by Jack Mezirow, whose seminal work, Transformative Dimensions of Adult Learning was published in 1991. Mezirow argued that transformative theory is based on the premise that it is not so much what happens to people but how they interpret and explain what happens to them that determines their actions, their hopes, their contentment and emotional well-being and their performance (Mezirow, 1991, p. xiii). Further, ‘the basis of constructivist transformation of adult learning is overcoming limited, disturbed and arbitrarily selected modes of perception and cognition through reflection on faulty and previously uncritically accepted assumptions’ (Mezirow, 1991, p. 5). For Mezirow, learning from reflection should lead to a redefining of the individual’s actions and practice.

REFLECTIVE TECHNIQUES

There are many useful frameworks and tools that have been devised to allow for and promote the practice of reflection. One of the simplest is that devised by Borton (1970) and described by her as the ‘What, so what and now what sequence’ of the model according to Borton ‘relies not only empirical or scientific proof but on its usefulness in real situations’ (1979, p. 9). Each of Borton’s three questions can be expanded to suit clinical situations which lead to reflection.

BORTON’S FRAMEWORK

What....
...Is the problem that I am facing?
...Role was I in during this incident?
...Am I trying to achieve?
...Appropriate actions did I/did I not take?
...Was my response to the incident and that of others?
...Were the consequences for all involved?
...Feelings did this incident evoke for all involved?

So what.....
...Does this incident tell/teach me about me, my patient and others? ...Does this mean about me, my patient and others?
...Does this mean about our working relationship? ...Does this mean about the model of care that I am using, my attitudes and those of my patients? ...Was I thinking of as I acted? ...Did I base my responses on?
...Other knowledge can I bring to this incident: experiential, personal, scientific?
...Could/should I have done to make it better?
...Is my understanding of the situation?
...Other issues arise from this incident?

Now What....
...Do I need to do in order to improve my nursing practice and patients care?
...Do I need to do to resolve the negative outcomes from this incident? ...Can I do to enhance the positive outcomes of this incident?
...Broader issues need to be considered if action on this incident is to be successful?
...Might be the potential consequences of this action, both negative and positive?

REFLECTIVE PRACTICE STRATEGIES

Following Borton’s (1970) framework, what are some strategies that can be used to make answering these questions less problematic? Strategies within Reflective Practice include journaling, critical incident analysis, clinical supervision, poetry, letter writing, story telling, photography and creative arts. The choice of expressive mode is left up to the practitioner. There is no correct or incorrect way. There are however inexperienced and experienced practitioners. A suggested strategy for the beginner is journaling. The following technique has been adapted for the purpose from Usher & Holmes (cited in Daly, Speeey & Jackson 2006, pp. 106-107).

Find an environment where you will not be disturbed and get comfortable. In a book using one side of the page write a descriptive account of the incident that is being examined. Leave the other side of the page for later reflection and comments. Be as vivid and descriptive as possible. Include your remembrances of emotion, thoughts and reactions to what happened. If you feel it needed include pictures, diagrams and drawings to help prompt your memory at a later date.

Critical incident analysis may help practitioners used to reflective practice. While the term ‘critical incident analysis’ may imply negative connotations, the practice is positive as it helps bring meaning and significance to an event. The following technique has been adapted for the purpose of this article from Usher & Holmes (cited in Daly, Speeey & Jackson, 2006, pp. 109-110). This form of reflection allows for distancing staff from the incident under examination, in turn allowing a better understanding of that incident. It works very well if used in conjunction with the questions from Borton’s (1970) framework.

Describe the incident under review. Be clear and concise. Outline the reasoning for the choice of this incident and why
you feel it in need of review. Identify any issues relating to this incident that stand out more than others. Reflect on those points and decide within your own mind your involvement, the involvement of others, any ethical or moral issues that need addressing, and the rational for any action to be taken.

Once the nurse as a practitioner of Reflective Practice develops basic proficiency and understanding of the practice of reflection there are many simple micro-cues that can be utilised. One such form of micro-cueing is the 5WH technique (Jasper, 2006, p. 69). This is a basic six question technique that asks what, why, when, where, who and how. The use is simple in that the word cue initiates the reflective process offering guidance and focus to the topic.

**5WH Technique**

‘What’ questions help with the selection of the incident to be written about or reflected upon. ‘Why’ questions focus attention onto the importance of reflecting on this incident. ‘When’ questions attempt the planning of an appropriate time for reflection. ‘Where’ questions the availability of needed equipment and space. ‘Who’ questions the need for someone else’s involvement. ‘How’ questions the learning achieved from the reflective incident (Jasper, 2006, pp. 69 - 72).

**CONCLUSION**

The Australian Nursing and Midwifery Council’s draft National Continuing Competence Framework clearly outlines the expectations that nurses and midwives become reflective practitioners and use reflection for the benefit of their professional development. Nurses need to become comfortable with reflection on and of their practice in order to use the process for their own benefit as well as the benefit of the recipients of their care, their workplace and for the advancement of the profession. This article has overviewed the importance of reflective practice within the confines of current practice and has suggested strategies for reflection.

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