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Theory of Reflective Practice in Nursing

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Abstract This article explicates the author's Theory of Reflective Practice in Nursing and its philosophical underpinnings. The Theory of Reflective Practice in Nursing is a middle-range theory. It mainly proposes that nurses must practice reflection-before-action, reflection-in-action, reflection-on-action, and reflection-beyond-action to advance nursing practice. Reflective practice can impact positive outcomes such as personal and professional development, improved quality of care, and improved care outcomes. Moreover, the theory posits that the environment provides the context of the concepts of reflective practice. The environment can nurture or inhibit effective reflective practice. The theory has strong interpretive and phenomenological roots thus it exemplifies a postmodernist perspective. Reflection is a way of knowing in nursing that typifies the subjective, explicatory, and contextual form of knowledge that emerges from nurses' practice experiences.

Keywords Reflective practice, Reflection, Nursing theory

1. Introduction

Reflection has been considered as a significant concept of nursing for many years. Based on the growing evidence found in the nursing literature, reflection remains to be an interesting concept because of its influence on education and practice worldwide. Nursing education has welcomed the idea of reflection as a valuable tool to assist nursing students in learning from practice (Jootun & McGarry, 2014). Likewise, reflection is considered instrumental in helping nurses provide optimum care to patients (Caldwell & Grobbel, 2013).

Dewey introduced the concept of reflection in 1933 (Ruth-Sahd, 2003) and it broadened over time. Based on Dewey's (1933) work, Schon (1991) identified two types of reflection: reflection-in-action and reflection-on-action (as cited in Armstrong & Asselin, 2017). Expanding the two types of reflection identified by Schon (1991), Edwards (2017) advanced two additional dimensions: reflection-before-action and reflection-beyond-action. Putting the four types together, Edwards (2017) proposed a modified chronology of reflection: reflection-before-action, reflection-in-action, reflection-on-action, and reflection-beyond-action.

Reflective practice is considered as a crucial part of professional practice (Asselin, Schwartz-Barcott, & Osterman, 2012) because it promotes continuous development (Gustafsson & Fagerberg, 2004). Reflection as a process of discovering alternative types of nursing knowledge, including empirical, aesthetic, personal, and ethical forms (Berman, Snyder, Kozier, & Erb, 2008) leads to change in practice (Asselin et al., 2012). Indeed, reflection helped uplift the status of nursing as a profession (Edwards, 2017). The value attached to reflection served as an impetus for the development of the theory of reflective practice. This paper aims to explicate the author's Theory of Reflective Practice in Nursing including its philosophical underpinnings.

2. Philosophical Underpinnings of the Theory

The theory was developed based on the author's philosophy that life situations and experiences provide a significant means for persons to learn. Persons are privileged to learn from and find meaning in their lived experiences throughout life. One way for persons to learn is through the reflection of their life situations and experiences. Persons subsequently grow and develop to become better individuals who can make a difference in their lives and of others'.

The author's philosophy attunes to the interpretive phenomenological perspective. Phenomenology focuses on lived experiences and personal perceptions (Finlay, 2008; Munhall, 2012). Based on Heidegger's (1962, as cited in Alligood & Tomey, 2010) phenomenological description, persons as self-interpreting beings are defined by concerns, practices, and life experiences. Persons' cognitive reflective abilities depend on embodied knowing (Benner & Wrubel, 1989 as cited in Alligood & Tomey, 2010), that is, persons learn things by being in situations (Alligood & Tomey, 2010). Persons who are continually situated engage

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meaningfully in the context of their situations (Alligood & Tomey, 2010) and find meaning in their transaction with the situations (Munhall, 2012). The persons' interpretation of experiences from their unique perceptions is critical and the reality to be concerned with (Munhall, 2012).

Furthermore, the author's philosophy conforms to a constructivist perspective which is also grounded on the philosophy of phenomenology. According to a constructivist perspective, persons actively create knowledge and meaning through an interaction between their ideas and their experiences. Persons construct their overall interpretations from their perceptions, opinions, and experiences of situations and consequently build their knowledge base (Hutton, 2009). Persons discover practical knowledge through their involvement in situations (Heidegger 1962, as cited in Alligood & Tomey, 2010).

Fittingly, reflection is an epistemology of practice (Fragkos, 2016) attuned to postmodernism which stresses that knowledge or truth is multifaceted (Holloway & Galvin, 2017) and multiple voices are valuable (Munhall, 2012). Reflective practice privileges knowledge arising from interpretations of experiences in practice situations (Mantzoukas & Watkinson, 2008). Experience in nursing practice is a reliable source for knowledge claims (Avis & Freshwater, 2006). Categorically, reflection exemplifies the subjective, explicatory, and contextual form of knowledge (Mantzoukas & Watkinson, 2008) derived by nurses from their practice experiences. Reflective practice also privileges knowledge that is systematically created by conscious analytical methods similar in various ways to those of science and research (Mantzoukas & Watkinson, 2008). Reflective practice allows practitioners to develop nursing theories and generate nursing knowledge thereby influence practice (Emden, 1991; Reid, 1993 as cited in Greenwood, 1998; Peterson, Davies, Rashotte, Salvador, & Trepanier, 2012 as cited in Goulet, Larue, & Alderson, 2016).

3. Description of the Theory

The Theory of Reflective Practice in Nursing is a middle-range theory. This level of theory has limited scope and number of variables but testable (Walker & Avant, 2005). The theory posits that reflective practice must entail reflection-before-action, reflection-in-action, reflection-on-action, and reflection-beyond-action to optimize the potential of reflection in advancing nursing practice. The assumptions, key concepts, propositions, conceptual framework, and metaparadigm concepts are presented to provide a comprehensive description of the theory.

Assumptions of the Theory

The author's assumptions shaped her theory. The assumptions include:

1. Persons consist of multiple dimensions which include physical, cognitive, emotional, social, and spiritual.
2. Persons are integrated holistic beings.
3. The environment affects persons, processes, and results.
4. Persons incessantly encounter events that affect their multiple dimensions.
5. Persons can learn from and find meaning in their lived experiences.
6. Learning is a lifelong process.
7. Reflection is one of the ways by which persons learn.

Key Concepts of the Theory

Key concepts comprise the Theory of Reflective Practice in Nursing. The key concepts are reflection, clinical situation or experience, promoting factors, hindering factors, and outcomes.

Reflection involves a detailed exploration of a clinical situation or experience which includes an analysis of personal feelings, thoughts, and actions or behaviors. It entails cognitive activities such as description, critical analysis, evaluation, and planning. Reflection is also a way of learning from a clinical situation or experience. It is a means by which feelings, perspectives and/or behaviors change. Moreover, reflection is an active and dynamic process. It involves *reflection-before-action*, *reflection-in-action*, *reflection-on-action*, and *reflection-beyond-action*. Lastly, reflection is a cyclic process. New understanding, thought or perspective about a clinical situation or experience is considered in planning for future learning or in taking future actions.

Clinical situation or experience refers to an incident which involves the individual client, family, group, or community and the nurse. It presents to the nurse a chance to learn and/ or demands a solution to a problem in clinical practice. In a clinical situation, both the client and the nurse demonstrate certain actions or behaviors that evoke thoughts and/or feelings of the nurse that serve as triggers. *Triggers* refer to the nurses' negative or positive thoughts and/or feelings associated with the clinical situation or experience that give rise to reflection.

Promoting factors refer to the elements which encourage nurses' reflection. These include *developed cognitive skills*, *sufficient theoretical knowledge*, *positive attitudes*, *time commitment*, and *supportive workplace culture*.

Hindering factors refer to the elements that impede nurses' reflection. These include *underdeveloped cognitive skills*, *deficient theoretical knowledge*, *negative attitudes*, *lack of time commitment*, and *unsupportive workplace culture*.

Outcomes refer to the favorable results of reflection. These include personal development, professional development, improved quality of care, and improved care outcomes.

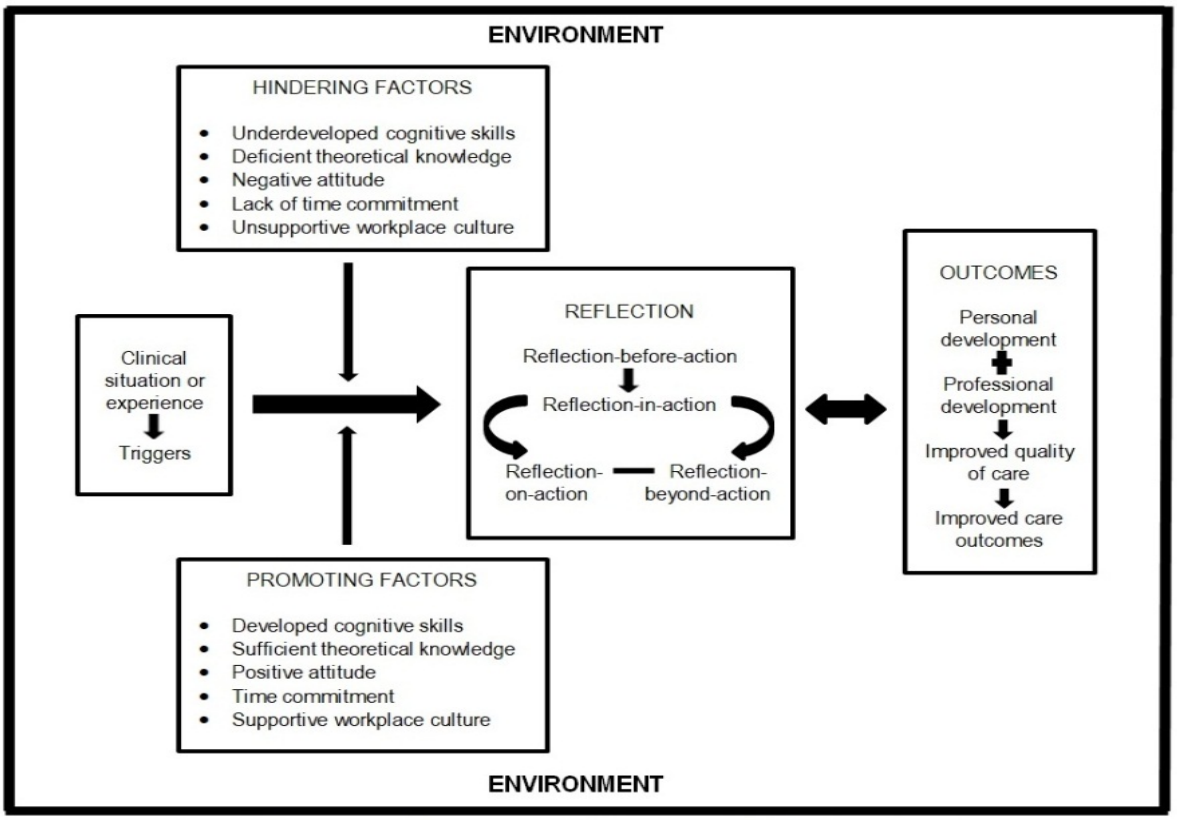

Figure 1. Conceptual Framework of the Theory of Reflective Practice in Nursing

Propositions of the Theory

The propositions explain the relationships that exist among the concepts of the theory. The propositions include:

1. A clinical situation or experience evokes nurses' thoughts and/or feelings that serve as triggers of reflection.
2. Nurses' developed cognitive skills, sufficient theoretical knowledge, positive attitudes, time commitment, and supportive workplace culture promote reflection.
3. Nurses' underdeveloped cognitive skills, deficient theoretical knowledge, negative attitudes, lack of time commitment and unsupportive workplace culture hinder reflection.
4. Reflection occurs before, during, and after a clinical situation or experience.
5. Reflection brings about nurses' personal and professional development.
6. Nurses' personal and professional development through reflection results to improved quality of care provided to clients.
7. Reflection leads to improved care outcomes through nurses' provision of better quality of care to clients.
8. The attainment of positive outcomes encourages nurses to integrate reflection into their day-to-day clinical practice.
9. The environment provides the context of the concepts of reflective practice.

Figure 1 shows the existing relationships between the concepts of the theory. The ***clinical situation or experience*** encountered by the nurse evokes negative or positive thoughts and/or feelings that serve as triggers. The negative feelings that often trigger reflection include guilt, anger, sadness, frustration, resentment, and hatred (Boyd & Fales, 1983 as cited in Johns, 2013). Moreover, nurses tend to reflect when they think that they have delivered poor care (Gustafsson & Fagerberg, 2004). Nurses may also reflect when they feel satisfied with their clinical performance and/or think that they have provided excellent client care.

Promoting factors are essential to encourage nurses' reflection. The nurses' *developed cognitive skills* that enable them to perform the cognitive activities of reflection include description, critical analysis, synthesis, and evaluation (Bulman & Schutz, 2013). Nurses also need to have *sufficient theoretical knowledge* regarding caring, nursing, ethics, pharmacology, sociology, and medicine which they use implicitly in their reflection (Gustafsson & Fagerberg, 2004). Moreover, the *positive attitudes* that nurses must possess include openness, flexibility, and sincere intent to reflect (De Swardt, Du Toit, & Botha, 2012). Willingness to learn from practice (Mayville, 2011 as cited in Goulet et al., 2016) and honesty (Price, 2011) to account for the clinical situation or experience are also important. Additionally, the persons with whom nurses share reflection must be trustworthy and approachable (De Swardt et al., 2012). *Time commitment* is also essential since nurses need to

spend adequate time for reflection before, during, and after the clinical situation or experience. Lastly, a *supportive workplace culture* (Kofoed, 2011 as cited in Goulet et al., 2016) allows opportunities for reflection, recognizes its consequences and facilitates changes in clinical practice which are impacted by reflection.

Conversely, ***hindering factors*** impede nurses' reflection. *Underdeveloped cognitive skills* prevent satisfactory performance of the cognitive activities that reflection entails. *Deficient theoretical knowledge* on caring, nursing, ethics, pharmacology, sociology, and medicine also inhibits reflection. The nurses' *negative attitudes* such as unwillingness to learn from practice and to share about a clinical situation or experience with other people, reluctance to accept the possibility of change and to act out change in clinical practice, lack of sincerity with the intention to reflect, and lack of honesty to account for the clinical situation or experience hamper reflection. Besides, nurses tend to avoid reflection when the persons with whom they share reflection are not trustworthy and approachable. Moreover, *lack of time commitment* makes reflection impossible since nurses need to invest time in the activity. Lastly, *unsupportive workplace culture* does not provide opportunities for reflection and devalues its consequences.

Reflection ensues with the interplay of triggers and promoting factors. This theory proposes that nurses should practice reflection-before action, reflection-in-action, reflection-on-action, and reflection-beyond-action to optimize the potential of reflection in advancing professional practice.

Reflection-before-action entails reflecting in advance of the learning event or before entering into clinical practice work or situation. It allows nurses to analyze a clinical situation and become mindful of their future actions. It also provides an opportunity for nurses to consider any concerns and the particular skills needed to face a clinical situation (Edwards, 2017). Through reflection-before-action, nurses become better prepared for the actual clinical situation.

Reflection-in-action involves reflective thinking while still immersed in the clinical situation (Schon, 1991 as cited in Armstrong & Asselin, 2017). It serves to reshape what nurses are doing while doing it (Bulman and Schutz, 2013). Reflection-in-action also makes explicit moment-to-moment decision making done by nurses while providing care at the bedside (Edwards, 2017). Through reflection-in-action, nurses are better able to cope with the demands of current clinical situations thus they provide relevant and best care to clients.

The last two dimensions of reflection occur following a clinical situation or experience. *Reflection-on-action* involves retroactive critical analysis to create and recreate incidents (Bulman and Schutz, 2013). It is a means by which nurses can connect theory and practice (Field, 2004 as cited in Edwards, 2017). In this type of reflection, the use of a framework for organized examination and analysis of a clinical situation or experience is considered helpful (Edwards, 2017).

Finally, *reflection-beyond-action* involves critical thought of the claims integrated into the descriptions of nurses' experiences in clinical practice or how nurses consequently developed or improved. This last dimension of reflection allows nurses to look back into the past, inward at the present, and forward into the future (Edwards, 2017).

Reflection consequently brings about positive ***outcomes***. These include personal development, professional development, improved quality of care, and improved care outcomes.

Personal development involves the advancement of nurses' knowledge and skills, as well as a change in attitudes and behaviors. It entails the improvement of nurses' capabilities along cognitive, emotional, social, spiritual, and physical dimensions transforming them to become better persons.

Additionally, reflection results in *professional development* which involves the advancement of nurses' clinical knowledge and skills including a change in attitudes and behaviors. It entails the development of nurses' capabilities along the dimensions of nursing practice that enable them to deliver quality care to clients.

Furthermore, *improved quality of care* occurs as a consequence of personal and professional development. An improved quality of care involves better promotive, preventive, curative, and rehabilitative care that nurses provide to clients.

Lastly, reflection leads to *improved care outcomes* through nurses' delivery of better quality of care to clients. In general, reflection brings about better clients' health status as a result of the enhanced quality of care provided to them. In terms of goal attainment, improved care outcomes range from not achieved to partially achieved and from partially achieved to fully achieved.

Moreover, the theory proposes that when reflection yields positive outcomes nurses are encouraged to integrate reflection into their day-to-day clinical practice. Nurses tend to indulge in reflective practice when it advances personal development and professional practice.

Ultimately, the theory posits that the environment provides the context of the concepts of reflective practice. A clinical situation or experience is an integral part of the clinical practice environment. Likewise, promoting and hindering factors are components of the nurses' internal and external environment. Additionally, the environment provides the context of nurses' reflection before, during, and after the clinical situation or experience. The outcomes of reflection also take place within the internal and external environment. Finally, the environment can nurture or inhibit effective reflective practice.

Metaparadigm of Nursing

Nursing metaparadigm refers to the four basic concepts central to the discipline: nursing, person, health, and environment. ***Nursing*** is a caring practice that constantly changes. This constant change requires responsiveness of

the nurse(s) to ensure the provision of quality care to clients. The ***person*** refers to the client, the recipient of nursing care that includes individuals, families, groups, and communities (Berman et al., 2008). The person is a holistic and unique being with a personal set of values, beliefs, principles, and cultural identity (Branch, Deak, Hiner, and Holzwart, 2016). The clients are involved in clinical situations that require nurses to respond. ***Health*** is a state of balance established within self and between self and the physical and social environment (Sartorius, 2006). This state of balance is achieved by individuals, families, groups, and communities through nurses' responsiveness to their health needs. The ***environment*** refers to the internal and external surroundings that affect clients and nurses. The environment serves as the context of the conditions and events involving clients and nurses.

4. Conclusions

The theory of Reflective Practice in Nursing is a middle-range theory which has strong interpretive and phenomenological philosophical roots. The theory exemplifies a postmodernist perspective. Reflection is an epistemology of practice that represents the subjective, explicatory, and contextual form of knowledge that emerges from nurses' practice experiences. Reflective practice allows practitioners to develop nursing theories and generate nursing knowledge thereby influence practice. Reflective practice ultimately advances professional nursing practice.

Testing of this theory is imperative. Research studies using qualitative and quantitative approaches are recommended. Tools to measure the concepts particularly the outcomes of reflection must be developed to establish substantial scientific evidence regarding the relevance of this theory in nursing practice. The propositions of the theory can provide direction for research studies aimed at theoretical testing.

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