Collaborative Team Reflective Practice in Trauma Service to Improve Healthcare

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Reflective practice in trauma care

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Abstract

The importance of reflection and reflective practice are repeatedly reported in trauma literature with the process of reflective practice being noted as invaluable for clinicians working within trauma settings. Whilst the literature on medical primary response trauma teams has reported clinicians' management of clinical roles and additional stressors, the practical applications and benefits of reflective practice insofar have not been identified in relation to complex trauma within multidisciplinary mental health services. This study aimed to identify the issues influencing the capacity for collaborative team reflective practice in a multidisciplinary child trauma mental health service within a UK National Health Service Trust. Semi-structured interviews were used to investigate the issues influencing the capacity for collaborative team reflective practice. The data were fully transcribed verbatim and analysed using Thematic Analysis. The results suggest that clinicians working in a multidisciplinary child trauma service experience a positive benefit from collaborative team reflective practice but that barriers exist which influence the capacity to reflect. These include the management of reflective practice within the service, and department and service demands including the nature of the work/cases. Recommendations for the service and for future research are suggested in order to improve the capacity for collaborative team reflective practice.

Keywords: Reflective practice, learning, personal development

1. Introduction

Reflection is an important human activity in which individuals recapture their experience, think about this experience and evaluate it (Boud, Keogh, & Walker, 2013). Reflection can occur at both a conscious and unconscious level. Conscious reflection allows decisions to be evaluated and choices to be made regarding future actions, yet unconscious processes do not allow for active learning (Boud et al., 2013).

Using a collection of prior examples and actions to critically assess behaviour to develop professional practice is termed reflective practice (Osterman, 1990). The activity of reflective practice is increasingly popular within healthcare settings and the benefits of being a reflective practitioner (termed clinician in healthcare) are well evidenced in several healthcare fields including pharmacy (Owen & Stupans, 2009), medicine (Walker, 1996; Mamede, Schmidt, & Penaforte, 2008) and most prominently, nursing (Atkins & Murphy, 1993; Walker, 1996; Wilkinson, 1999; Esterhuizen & Freshwater, 2008).

Increasing mutual support can also be facilitated by the clinical supervisory relationship, which is especially important in cases that involve processing of emotional material (Spence et al., 2001). Within group or individual supervision, time is devoted to processing and discussing cases; this is particularly crucial for trainees and clinicians working in trauma settings (Osofsky, 2009). The importance of devoted time to case discussion is supported by compelling evidence of the psychological effects of working with trauma victims; trauma nurses may experience burnout, compassion fatigue and secondary traumatic stress (Hinderer et al., 2014).

Reflective supervision allows the clinician to learn that recognising their own emotional responses (with appropriate boundaries) helps to recognise and understand the emotional responses of their cases (Eggbeer, Mann, & Siebel, 2007). Additionally, when working with

traumatised children, preparation is crucial; clinicians able to anticipate and prepare for their cases may be better able to handle the strong emotional responses (Eggbeer et al., 2007). This clinical role is challenged further when clinicians are required to cope with additional stressors (Steadman & Dallos, 2009); issues which may influence the capacity for reflective practice.

Clinicians' negotiation of their clinical role and additional stressors have been studied in the trauma literature in relation to reflective practice and is primarily focused on accident and emergency settings; primary response teams. The practical applications of reflective practice insofar have not been studied in relation to complex trauma within multidisciplinary mental health services.

The aims of this study therefore were to identify the issues influencing the capacity for collaborative team reflective practice in a multidisciplinary child trauma mental health service. The specific objectives were:

1. To investigate the perceived benefits of collaborative team reflective practice for individual clinicians in relation to trauma work
2. To investigate and identify the barriers and facilitators to collaborative team reflective practice

2. Method

2.1 Research Context

The National Health Service (NHS) in England is a publicly funded healthcare system providing free healthcare for all residents. The NHS provides healthcare services which individuals can access including specialised trauma care for adults and children across England.

This research was conducted within a child trauma service in England; a multidisciplinary outpatient mental health service comprised of two teams of clinicians with specialised expertise in the assessment and treatment of children, and their families, with a history of abuse, neglect or trauma. This corresponds with a physically injured paediatric population as children and adolescent people treated by the service typically suffer severe and enduring physical injuries, including head injuries, multiple fractures and severe wounds.

Within this child trauma service, the individual teams met once a week specifically for group reflection.

2.2 Research Design

The study used both a briefing session and semi-structured individual interviews to gain insight and knowledge of the research topic. The nature of semi-structured interviews allowed flexibility to follow up interesting responses and investigation of additional influential issues.

An interview schedule was prepared at the beginning of the study, informed through engagement with the literature. This was piloted with a member of the trauma service. A final version was produced but due to the nature of semi-structured interviewing, the interview schedule was modified slightly during the course of the interviews as new information was obtained and incorporated into the schedule in an iterative manner. The pilot data was not included in the final analysis. Broad and open-ended questions were used with additional

questions to clarify responses or probe interesting issues. This allowed participants to comment on issues from their own perspective.

2.3 Sampling

Purposive sampling was used to recruit participants most likely to provide useful insights into working within a child trauma service (Smith et al., 2009). The study utilised one of the only services undertaking this type of trauma work in England comprised of two separate teams, within a NHS Trust. The researcher conducted the research within a population of which they had shared experiences and as such was an insider researcher (Corbin Dwyer & Buckle, 2009).

The participants in this study were recruited using emails sent to their work accounts; this was considered the most appropriate forum during busy clinical hours. The email briefly outlined the different stages of the study and participants were invited to contact the researcher if interested. No incentives were offered.

The primary criterion for inclusion in this study was experience working within a child trauma service. The sample composition intentionally covered a range of disciplines and reflected potential differing perspectives from those professions. The final sample consisted of 7 participants in the briefing session and 8 for individual interviews.

2.4 Procedure

The study was subject to and in accordance with the requirements of Loughborough University Ethical Advisory Committee for research involving human participants. Approval was also gained from the Head of Service of the participating organization.

Having agreed to participate, the participants were invited to attend a group briefing session where they were informed of the nature of the study. The briefing session was conducted 7 weeks prior to individual interviews and was facilitated by one of the lead researchers. Prior to both the briefing session and interviews participants were provided with

written information on the nature of the study, their rights to withdraw from the study, confidentiality and anonymity. Written informed consent was obtained from all participants.

Of the 8 interviews, 7 were conducted face-to-face and 1 was conducted via telephone due to unforeseen circumstances prohibiting a face-to-face interview. Telephone interviews are considered an acceptable form of interviewing, as they are as productive as face-to-face interviews for qualitative interviewing (Sturges & Hanrahan, 2004).

The briefing session and interviews were recorded with the knowledge and consent of the interviewees. The same researcher conducted the briefing session and each interview, both lasting approximately 25 minutes and an hour respectively.

2.5 Analysis

The recorded briefing session and interviews were fully transcribed verbatim. The analysis of the interview data was conducted using Thematic Analysis (Braun & Clarke, 2006). The process of thematic analysis involves the identification of themes important to the description of the data; a form of pattern recognition within the data where identifying themes becomes categories for analysis (Fereday & Muir-Cochrane, 2006). The method of analysis for this study was deductive in nature but became progressively more inductive as the coding process progressed. Throughout the course of analysis, the codes were reviewed and revised as key categories emerged from the data. The same researcher, who transcribed the interviews, coded the sample data.

3. Results

3.1 Participant details

Participants were qualified clinicians (N=7) and a trainee clinician (N=1) who were all members of a child trauma service from one NHS Trust in the UK (see Table 1).

[Table 1 here]

3.2 Perceived benefits of collaborative team reflective practice for individual clinicians in relation to trauma work

Participants reported a number of perceived benefits from collaborative team reflective practice. Participants viewed collaborative team reflective practice as being constructive as they learnt from others' experiences. They also identified further advantages such as self-clarification through verbalising a case and receiving guidance from different disciplines:

'Just talking about it to a group sometimes clarifies things in your mind, just that process. And then also they can see things, as outsiders that you can't necessarily see. You know we all have blind spots and they can see that in a way'
(Junior clinician)

Participants described the collaborative benefits as advantageous for the entire team, those directly or indirectly reflecting. This was described by a senior member of the team:

'Everybody doing the collaborative work gets something from it so yeah the effects are kind of multiplied. And it changes- it just makes- it just makes for- it just gives- creates an atmosphere of more thoughtful, careful work. Erm and people looking after themselves, looking after each other and providing thoughtful care to patients'

Discussing the complexity of the trauma cases stimulated conversations that considered all plausible explanations for overcoming difficulties within a particular case. This included understanding the history in relation to the difficulties. Reviewing the complexities of the cases collaboratively ensured different explanations could be explored:

'Reflection kind of allows you to kind of question some of those strong beliefs that we might have which I think particularly important in this population where things can be a bit unclear sometimes as to what exactly is going on. And so there's complex histories to try and formulate and understand and try and work out what's the best thing but having time to kind of think about "could it be this formulation or this formulation that would work best" and I think that's important especially in this population'.

(Junior clinician)

3.3. Identified barriers to collaborative team reflective practice

3.3.1 Management of collaborative team reflective practice

Participants reported that a lack of time was a major barrier to collaborative team reflective practice; there was limited time to meet as a team and limited time within team meetings for reflection:

'The thing is we are very busy, I think of all us and also, I think the team is divided into different teams- you know [name of team] and [name of team]. And I think this is why they don't have time [to meet].'

(Junior Clinician)

Participants reported that it was accepted and expected within the departmental culture that additional service demands would be prioritised, leaving less time for reflection. This was highlighted by one participant:

'When people become very busy that's the thing that gets dropped [reflection] because it is seen as a luxury. So, and I suppose that's because sadly you're not going to get in trouble if you don't go you know to reflective practice whereas you need to make sure you're doing your reports, you need to make sure you're fulfilling all your job criteria whereas maybe I don't know, maybe it's not seen as an essential kind of part of the day'.

(Junior Clinician)

Feeling overburdened can result in clinicians being preoccupied with these additional demands, leaving less capacity to participate in discussions as summarised by a senior clinician:

'I think sometimes when you're so stressed that the capacity to engage in reflection is affected and I definitely sometimes feel so tired and so preoccupied by something, that I find it quite hard to really engage in whatever the case discussion is'.

Where meetings did take place, there was a lack of time set aside for reflection:

'One of the meetings is admin, heavily admin, managing cases and assigning people and stuff. And then I think case discussion which I think is just kind of bouncing things back, checking things out with the team you know kind of giving us updates on what's going on, thinking- And then I guess there is some reflection in these instances where thinking about what decisions maybe should be made or what we should do going forward. Erm but it's not like, it doesn't feel like massively reflective'

(Junior Clinician)

An absence of a shared focus was also described which led to participants to have different expectations for team meetings. In some cases, participants expressed feeling

unsafe and invalidated by colleague's responses, which dissuaded them from reflecting in subsequent team meetings:

'There were previously team meetings where I have taken cases and particularly in [name of team] and felt that it just became a critique of my work and where it just became "why don't you do this, why didn't you do that" sort of like case management rather than helping me to reflect, and I [...] felt like I was bombarded and not particularly helpful.'

(Senior Clinician)

3.3.2 Culture

The amount and emphasis of reflection experienced in training differed from that of clinical practice. A senior clinician described the consequence of having less reflection in clinical practice than in years of training:

'I mean reflective practice should happen all the time to some extent but perhaps to engender it within the team. I mean it's really difficult because I do think it happens at times it's just I don't know what it is. If you've done a training and you've had all that space to reflect, maybe there's always then going to be a sense that you're not having the same amount you once did and that's just the reality; you're not. Erm maybe that always leaves one feeling that they want more'.

Previous discipline-specific training experiences may act as a marker at which future amounts of reflection are judged. Therefore, the amount of reflection experienced in training may influence individual perceptions of an acceptable and sufficient amount of reflection in clinical practice.

Participants viewed departmental culture as not valuing reflection. Participants reported the culture was focused on efficient case progression rather than reflection. One participant, a junior clinician, summarised this:

'People might be wary to open up too much reflection because the culture we're in now within this kind of setting with [name of department] is very much to kind of- there's lots of kind of external pressures in terms of making sure that you've got treatment sorted, that you're moving forward and that you've got your outcomes sorted rather than there being more of an emphasis on thinking about things. There's more of a kind of hurry to get things on.'

Participants also reported accepting the departmental culture of not prioritising reflection. This was reportedly due to an unwillingness to engage in something (reflection) not encouraged within the department because of concerns with how their mistakes may influence other's opinions of their professional competence. This was described by a junior clinician:

'I suppose I'm not really encouraged to like talk about what you've done wrong, it might make you feel a bit concerned if you're sort of saying all the things that didn't go well because you're- you want to be a good clinician and want people to think you're a good clinician and immediately you'd worry that that might taint their view'.

3.3.3 Service Demands

A further barrier identified was the nature and severity of the trauma cases assessed and treated within the service. Participants reported that involvement with traumatic cases results in undeniable assimilation/ingestion of the trauma, which is difficult to express/talk about. One participant, a senior clinician, described the emotional duress of engagement with direct trauma experiences of most cases:

'It just is really, really devastating- You know just hearing stuff that shouldn't ever happen to anybody and you're hearing it from a tiny child and it's incongruent with how you want the world- I'm upset thinking about it. It's incongruent to how the world should be or really hearing the worst things about people really and what people are capable of. Erm yeah and it's just- so there is secondary trauma you know, secondary trauma from that.'

Despite participants' acknowledgment that collaborative team reflective discussions about the impact of the trauma were imperative in these instances, some participants described managing strategies of avoidance, one example was provided by a senior clinician:

'You avoid it [reflection] it's not just how busy you are, it's the nature of, it's an avoidance, it's acting out other people's coping strategies with their own trauma that we all avoid stopping and thinking about the trauma.'

3.4 Identified facilitators to collaborative team reflective practice

3.4.1 Support

3.4.1.1 Group size and Informality

Whilst a number of barriers were identified by participants during this study, one facilitator was also recognised which was derived from two different sources: group size and informality. Support within small groups or in pairs, such as co-working cases and supervision, permitted participants to readily display vulnerability about their cases. This was described by one senior clinician:

'I think in those individual relationships or in smaller groups within the team I think that it's much easier then to be open and very honest about how you feel, particularly if you feel that you haven't handled something well for whatever reason.'

A further senior clinician added that a smaller forum allows her to reflect with a dependable colleague:

'I think to be honest it's a bit like the smaller the number, the easier it is to really open yourself up which is why one-to-one supervision or one-to-one discussions with a trusted colleague is probably where you're most helped to reflect on.'

Co-working was also reported as supportive as participants felt able to share or express any emotions with a colleague who mutually understood the case. A senior clinician explained:

'We don't always work in pairs, but we quite often share a case and so there's someone who knows the case as well as you do and I think that's an excellent way of balancing, whatever you're feeling, off someone else'.

The casual nature of informal conversations facilitated reflection because participants had the ability to choose whom they felt comfortable to confide in. Consequently, these moments of reflection were described as more effective due to the relaxed nature of the conversation, compared to the official nature of a team meeting. One junior clinician summarised this:

'The best moments of reflection are definitely the informal ones in the office. I think it's just, it's more of a relaxed environment maybe; that's probably why there's a difference [...] also people are more aligned with some people, some people are closer than other people, so I think that it's just like chatting to your friends really.'

4. Discussion

The findings from this study have identified several perceived benefits of collaborative reflection. The findings have also identified a number of barriers and facilitators influencing the capacity for trauma clinicians to collaboratively reflect.

The benefits identified by participants reflect what is already known about the process of reflection. Participants were aware that conscious reflection allowed complex cases to be discussed and decisions to be evaluated (Boud et al., 2013). This was reported as being constructive and beneficial to the entire service as they learned from other's experiences.

Collaborative team reflective practice was reported as an integral part of working in a trauma setting, however, the nature of the service's work and associated feelings of emotional distress from engagement with trauma experiences led to avoidance behaviours from participants. Such behaviours are consistent with secondary post-traumatic stress (SPTS) and vicarious traumatisation; both implications reported by Tosone et al., (2012). The effects of working directly with trauma survivors were reported as most pronounced in highly empathic and newer clinicians and clinicians with a previous trauma history (Tosone et al, 2012). Participants acknowledged that despite previous direct or indirect trauma experiences, clinician's employed avoidance strategies because revisiting/discussing the trauma was perceived as being too difficult, limiting the opportunity to reflect collaboratively in a team setting. Future research is required to understand/identify methods of improvement for individual and collective coping strategies for the service.

Participants reported that the focus for team meetings were not always communicated clearly and this reduced the opportunity for collaborative team reflective practice. An absence of a shared focus was described which led participants to have different expectations for team meetings. A unanimous understanding/clarity for the focus of these meetings through clear

expectations via procedural guidelines may provide boundaries and containment within a team (Ruch, 2007), facilitating a safe and supportive space for reflection. A designated opportunity for the service to identify a unanimous focus for the team meetings may encourage a reflective team opportunity and reduce participants' acceptance of self-compensation for reflection. All participants proclaimed a positive change in team dynamics about reflection following reflection-focused discussions such as the briefing session and individual interviews.

Discipline-specific training experiences may also be a barrier to collaborative team reflective practice because the emphasis/amount of reflection within different training may have influenced individual perceptions of reflection in clinical practice. Despite all participants reporting the necessity of collaborative team reflective practice, achieving sufficient reflection may differ between the disciplines due to different professional training attitudes and experiences. This finding is similar to Reuben et al., (2004) who reported attitudinal traditions of different health professionals were an obstacle to creating an optimal interdisciplinary team-training experience.

Participants reported conforming to departmental culture due to an unwillingness to engage in something (reflection) not encouraged within the department because of concerns with how their mistakes may influence opinions of their professional competence. Paradoxically the ability to admit uncertainties and 'not knowing' is a crucial component in the process of reflective practice (Ruch, 2007). The lack of reflective practice identified within the department may be related to the perspectives and attitudes of the organisation (Ruch, 2007). The departmental culture could be echoing that of the wider hospital which may not prioritise reflective practice, potentially explaining the disparity between the service and departmental attitude toward reflection. Further research is warranted to determine the exact influence of the hospital/organisation on the department.

Participants reported being most helped to reflect in smaller groups or informally; in the latter, the relaxed environment compared to a formal team meeting, stimulated/initiated casual reflective conversations with team members that participants felt comfortable with. The supervisory relationship between clinicians (supervisor and supervisee or among clinicians) and smaller forum may have fostered more reassurance and support for clinicians to reflect on difficult cases, as participants sought team members whom they felt comfortable with. In co-working instances participants may have sought and received comfort from another team member simultaneously trying to understand the case difficulties. Comforting and assuring spaces may endorse a relationship-sensitive environment, which may ease the difficulty of the reflective process and permit clinicians to discuss mistakes or uncertainties (Howe, Brandon, Hinings, & Schofield, 1999). Support derived from these multi-faceted forums for reflective practice, such as one-on-one and peer supervision, smaller groups and informality, inclusive of some team members may have fulfilled a current absence from collaborative team reflective practice inclusive of the whole team (Ruch, 2007).

4.1. Conclusions

This research has identified the perceived benefits of and barriers and facilitators to collaborative team reflective practice for clinicians. The sample included a range of disciplines with different and extensive experiences of working with trauma providing greater insight into the issues influencing collaborative team reflective practice. Whilst this study focused specifically on child trauma work, understanding the specifics (barriers and facilitators) of applied reflective practice and the recommendations has wider applicability. This study provided a foundation for potential approaches that could improve the capacity for collaborative team reflective practice across service providers. The findings will be of interest to those working in other mental health and specialist teams both within the country and elsewhere worldwide, and managing bodies interested in the professional health of mental health clinicians. With an enhanced understanding of the issues influencing collaborative team reflective practice, it is possible to develop and implement appropriate strategies to improve

collaborative team reflective practice for clinicians facing the constant and challenging demands of clinical practice within trauma settings.

4.2 Limitations

Access to the service may not have been possible/feasible without one of the lead researchers shared experiences with the participants. Insider-knowledge about participants' experiences of collaborative reflective opportunities provided difficulty in separation of insider-knowledge and participants', however, it allowed important supplementary questions to be asked which has strengthened this work.

The sample of participants recruited was purposive therefore participants' views may not be representative of trauma nurses. This limits the ability to generalise these findings although, they are aligned with previous work undertaken in trauma settings for nurses and multidisciplinary medical teams (Alzghoul, 2014).

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Key Point Summary Statements

- Clinicians working in a multidisciplinary child trauma service experience a positive benefit from collaborative team reflective practice.
- This study has identified barriers which influence the capacity for collaborative team reflective practice. These include the management of reflective practice within a given service and service demands such as the nature of the work/cases.
- Recommendations are provided for clinicians working within trauma in order to improve the capacity for collaborative team reflective practice within a multidisciplinary trauma service to improve healthcare.