Rapid review
Reflective Practice in crisis situations

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This is a rapid review of the evidence on reflective practice in crisis situations undertaken by the Health Psychology Exchange in light of the COVID-19 pandemic. This work has not been through a formal consultation process.

Rapid peer review was obtained for each paper, it should not replace individual practice judgements and the sources cited should be checked.

This review does not form a directive and should be used by individuals to frame an informed discussion with their colleagues about whether or not to implement reflective practice.

The views expressed represent the views of the author(s) and are not a substitute for professional advice.

Key messages

Reflective practice is what we do when we take some time to think critically about an experience or an event we have been involved in. This means that we look carefully at what happened, what we did, what we might have done differently, what we could have controlled, what was beyond our control and also we explore how other people experienced the same event.

In-depth reflection may enable the practitioner to gain useful insights into their expectations about how patients should behave, the nature of illness and the roles and responses of health professionals. Little is known about the impact and effectiveness of reflective practice in crisis situations. We reviewed the published literature and present two recommendations that are of relevance to the current Covid-19 crisis.

1) **There are things we can do now:** The importance right now of ensuring that staff have both time and a safe space in which they can reflect on their experiences either with fellow staff or via peer- facilitated reflections. That way those staff who wish to, could be supported to reflect on and process their after a difficult shift.

2) **There are things we can think about in the mid to longer term:** the importance of organisations learning from the pandemic. Post pandemic, perhaps developing simulations, but also formally engaging in structured reflective practice to ensure practical skills are honed and lessons learned and b) paying attention to the organisational culture and ensuring that reflective practice is embedded as 'business as usual'

Executive summary

This report presents a rapid review of the evidence on reflective practice in crisis situations. In the light of the current Covid-19 pandemic we asked the question "What lessons can we learn about the value of reflective practice that may be of service to our health professionals on the front line".

A search of Scopus (with no date restrictions was made. A total of 56 papers were identified. After review of titles and abstract 34 papers were rejected as not being relevant. The remaining 22 papers were reviewed and their findings synthesised.

Most of the papers (n=9) were reflections on relevant experiences. Five were commentaries, six reported the findings from qualitative studies and two reported findings from cross sectional surveys.

The findings and recommendations can be presented in terms of strategies that can be employed when preparing for a crisis, when in the midst of a crisis and following conclusion of a crisis.

There are two key recommendations identified from the review:

1. **There are things we can do now:** The importance right now of ensuring that staff have both time and a safe space in which they can reflect on their experiences either with fellow staff or via peer- facilitated reflections. That way those staff who wish to, could be supported to reflect on and process their after a difficult shift.

2. **There are things we can think about in the mid to longer term:** the importance of organisations learning from the pandemic. Post pandemic, perhaps developing simulations, but also formally engaging in structured reflective practice to ensure practical skills are honed and lessons learned and b) paying attention to the organisational culture and ensuring that reflective practice is embedded as 'business as usual'

Underpinning these two points are a range of issues organisations should bear in mind. These include:

- Supportive and encouraging organisational culture that recognises the importance of embedding reflective practice in everyday work
- Leaders should themselves be involved in the process of reflection as participants
- Staff need time and space to reflect on their experiences

The brief

I am interested in reflective practice in crisis situations. The literature appears to be sparse, although there is a lot on reflective practice in healthcare generally (with which I am reasonable familiar and don't particularly need right now).

I wondered if anyone in HPX would be able to help out, either by doing a very quick lit review and summarising (bullet points) the main findings. Or, if no one has the time for this, there a four articles in particular I would like to read (list below).

If anyone can do the lit review I'm looking specifically for peer reviewed articles on reflective practice in crises, and/or in specific areas of practice: palliative care, emergency medicine, intensive care, or field hospitals being the main ones, and also moral distress (again in the context of reflective practice rather an as a stand-alone topic). Might be useful for a publication in due course if anyone is interested. I would need the brief review quite quickly though.

If not, then if anyone is willing to access and share the following, I would be most grateful:

Lawrence, L. (2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. Nursing Forum, 46(4), 256-268.

Kinsella, EA. (2010). The art of reflective practice in health and social care: reflections on the legacy of Donald Schon. J Reflective Practice, 11(4), 565-575.

And two from psychiatric medicine:

Menon A. et al. (2015). Burnout-or heartburn? A psychoanalytic view on staff burnout in the context of service transformation in a crisis service in Leeds. J Psychoanalytic Psychotherapy, 29(4), 330-342.

Johnston J, Paley G. (2013). Mirror, mirror on the wall: who is the unfairest of all? Reflections on reflective practice groups in acute psychoanalytic settings. J Psychoanalytic Psychotherapy, 27(2), 170-186.

In addition to the usual sample characteristics, study type and research questions, I'm particularly interested in:

- The setting (e.g. hospital, community etc)
- The specialty (e.g. palliative nursing)
- Group or individual
- The reflective practice model(s) used
- The facilitator (e.g. team lead, internal or external etc)
- Experiences/issues/topics reflected on
- What worked well and what didn't (facilitators/barriers)
- Outcomes e.g. changes in practice
- Recommendations

Current knowledge

What is reflective practice?
Reflective practice is variously defined as:

> "The capacity to engage in reflection in and on practice, and to make changes in one's actions in the midst of the constantly changing contexts of practice" (Kinsella, 2010: 566)

> "Being mindful of self within or after professional practice situations, i.e., *processing* the cognitive, behavioral, moral (ethical), socio-political, and affective components of professional practice situations, so as to continually grow, learn, and develop, personally, professionally, and politically." (Lawrence, 2011:258)

Reflective practice is increasingly embedded in the teaching of health professionals, who are expected to be reflective practitioners once qualified. Engaging in reflective practice itself, takes practice and is an effortful process.

> "*Reflection is the process of engaging the self in attentive, critical, exploratory, and iterative interactions with one's thoughts and actions, and their underlying conceptual frame, with a view to changing them and with a view on the change itself [Nguyen et al., 2014].*

Wilson (2020) notes that there is a strong theoretical foundation for reflection in medical training and although there is ongoing debate about how best to 'operationalise' such theory (e.g. de la Croix & Veen, 2018), medical students are now required to demonstrate their capacity for reflection through reflective essays, critical incident reports and portfolios (Sanders, 2009).

What is the purpose of Reflective Practice
In-depth reflection may enable the practitioner to gain useful insights into their expectations about how patients should behave, the nature of illness and the roles and responses of health professionals. Through critical reflection, health professionals may also identify gaps between their expectations and the observed reality of clinical practice (Wilson, 2020). Further, Musto et al., (2015) suggest reflective practice may reduce moral distress.

When should reflective practice be conducted?
Reflective practice is commonly divided into reflection-in-action and reflection-on-action. Reflecting-on-practice takes place after the event at a time when there is the space to think over what has happened. Finding time to engage in reflection, especially reflection-in-practice is a commonly cited barrier. For example, Brown et al (2005) quote a participant who says: "'I think with the volume of work we have we don't have a great deal of time to sit here and think"

In the light of the current Covid-19 pandemic what lessons can we learn about the value of reflective practice that may be of service to our health professionals on the front line.

The rapid review question

What lessons can we learn about the value of reflective practice that may be of service to our health professionals on the Covid-19 front line.

Overview of the studies

The fifteen papers identified in the ***reflective practice search*** and the eight papers identified in the ***moral distress search*** combined can be categorised in four ways. Please note Lawrence (2011) was identified in both searches, so a total of 22 papers are included in this rapid review.

Reflections on relevant experiences (n=9)

The ten reflection papers included reflections on novel treatment techniques in the intensive care unit during H1N1 influenza virus (Berryman, 2010), reflections on the establishment of a grief team (Brosche, 2007), delivering emergency preparedness training (Greci, 2013), working with mental health patients in crisis on acute mental health in-patient wards (Johnston, 2010; Johnston & Paley, 2013), the post SARS pandemic reflections of a nurse manager (Lau & Chan, 2004), employing leadership methodologies; including reflective practice (Potter 2015), the monthly ethical meeting in a surgical care unit (Santiago & Abdool, 2011), exploring the use of reflective practice in the NICU (Vittner, 2009)

Commentary (n=5)

Four papers were commentaries or literature reviews. One explored the relationship of organisational culture, leadership and crisis management (Bhaduri, 2019). The second paper explored how burnout develops in nurses and what can be done to prevent it (Epp, 2010). The third and fourth papers reflected on Schön's theory of reflective practice (Kinsella, 2007; 2010). And the fifth on family caregiving problems in the context of paediatric crisis care (Tomlinson et al., 2002).

Qualitative study (n=6)

Six papers reported on qualitative studies. The first explored survivors' feelings, interactions, and interpretations of the crisis, as well as their roles in post-earthquake relief following the Taiwan earthquake in 1999 (Chiang et al., 2005). The second set out to discover whether moral distress was something experienced by military nurses (Fry et al., 2002). The third interviewed clinicians with experience of humanitarian work (Hunt et al., 2013). The fourth focused on identifying factors influencing gatekeeping decisions by crisis resolution and home treatment teams (Lombardo et al., 2019). The fifth interviewed staff about ethically challenging situations in oncology practice (Pavlish et al., 2014). The sixth interviewed nurses two years after they had graduated (Kelly, 1997).

Quantitative study (n=2)

Two papers reported on cross-sectional survey data. One survey focused on staff in intensive care units to explore how *inter alia* reflective practice impacted on work engagement (Lawrence, 2011). The other surveyed clinicians and administrators working in a crisis team (Menon et al., 2015).

Synthesis of findings

The findings of the studies can be summarised in terms of four strategies undertaken when preparing for a crisis, when in the midst of a crisis and following the conclusion of a crisis.

Preparing for a crisis: Simulations of crisis situations stimulate reflective practice and enable staff to keep their skills 'sharp' between crises (e.g. Berryman, 2010; Greci et al., 2013).

During a crisis: Recognition that staff who have been involved in past pandemics (e.g. SARS) may benefit from reflective practice – their past experiences may be really helpful for the current pandemic, but they may also be prompts for difficult emotions and memories. Processing their experiences through reflective practice could be beneficial (e.g. Lau & Chan, 2004).

Having a counsellor or grief team on-hand so that staff can debrief with them after a particularly difficult shift is important (e.g. Epp, 2012). Staff also need space and time to reflect on their experiences (Brosche, 2007).

In addition, it is important to encourage staff to reflect on the patient-professional relationship, particularly when they may feel difficult emotions towards patients (e.g. in this context: some perceived culpability for being in intensive care due to lifestyle illness, or when their desire to cure the person is thwarted) so they can retain empathy and compassion over time rather than over-compensating in their efforts out of guilt for 'bad feelings' or succumbing to compassion fatigue and become cold and distant in providing care (e.g. Johnston, 2010; Johnston & Paley, 2013). This is particularly so in an emotionally demanding context.

During and after a crisis: Running reflective practice groups was seen as positive. For example, Menon et al., (2015) note that such groups provide an important opportunity to discuss difficult cases, for staff to take a break, and to realise that colleagues share similar experiences. As a consequence greater recognition that one is part of a team working together is engendered.

For such groups to work well:

- The facilitator of the groups should be experienced and person-centred (e.g. Chiang et al., 2005; Johnston & Paley, 2013)
- The focus of the group should be on the issues the group members bring to the session (e.g. Chiang et al., 2005).
- The timings of the sessions are important – should they be flexible to enable all staff to attend (including night staff)? When should they be held – how practical is it for staff to attend during a shift? Would staff want to stay after their shift, or come before their shift starts? (e.g. Chiang et al., 2005).
- Is the culture of the organisation one where talking about emotions and reflecting on practice is recognised as valuable? (e.g. Johnston, 2010)

After a crisis: It is important to reflect on practice after a crisis. Bhaduri (2019) emphasizes the importance of organisations documenting the procedures and actions taken during the life cycle of the crisis. The notes taken will facilitate reflection and enhance the likelihood that learning from past practice will take place, thereby making it more likely that any mistakes made will not be repeated in the future.

Hunt et al., (2013) suggested two frameworks that could be used to structure discussions that are themselves effectively reflective practice. Such a framework could be useful after such a complex and emotive experience as Coivd-19 pandemic.

Implications for the Organisation

For reflective practice to work well:

- Organisational culture needs to be one which supports and encourages reflective practice (e.g. Brosche, 2007; Epp, 2012; Johnston, 2010; Johnston & Paley, 2013; Lau & Chan, 2004, Lawrence,2011; Vittner, 2009)

- Leaders who are involved in the practice of their service are trusted by staff to understand what it is like on the front line (e.g. Lawrence, 2011)

- There needs to be recognition that high pressure and the difficulty of situations will have an influence on the decision-making process (e.g. Lombardo et al., 2019)

- Role modelling is important (e.g. Epp, 2007; Tomlinson et al., 2002).

- Staff need time and space to reflect on their experiences (Brosche, 2007)

- Structured questions can help encourage reflection in a focused manner (e.g. Hunt et al., 2013).

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Include all references quoted in the final report in your reference list.

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Appendices

Searches

Scopus searched 18th April 2020 – no date restriction placed on the searches.

5 searches were conducted. Searches 4 (reflective practice) and 5 (moral distress) form the basis for this report.

The searches were sent to the reviewing team for comment and selected papers shared between the team for reviewing.

Reflective Practice (Searches 1-4)

Search 1: produced 6 papers.

(TITLE-ABS-KEY ("health professional" OR doctor OR gp OR nurse OR psychologist) AND TITLE-ABS-KEY (crisis OR "corona virus" OR "Covid-19" OR "severe acute respiratory syndrome" OR sars OR mers OR influenza OR flu OR pandemic) AND TITLE-ABS-KEY ("palliative care" OR "end of life" OR hospice OR "emergency medicine" OR hospital OR er OR "A&E" OR "accident and emergency" OR "general practice" OR "field hospital") AND TITLE-ABS-KEY ("reflective practice"))

Chiang, H.-H., Chen, M.-B., Sue, I.-L. (2007). Self-state of nurses in caring for SARS survivors, *Nursing Ethics*, 14 (1), pp. 18-26.

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Vittner, D. (2009). Reflective strategies in the neonatal clinical area, A*dvances in Neonatal Care*, 9 (1), pp. 43-45

Search 2: removing the terms for setting produced 12 papers

(TITLE-ABS-KEY ("health professional" OR doctor OR gp OR nurse OR psychologist) AND TITLE-ABS-KEY (crisis OR "corona virus" OR "Covid-19" OR "severe acute respiratory syndrome" OR sars OR mers OR influenza OR flu OR pandemic) AND TITLE-ABS-KEY ("reflective practice"))

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Greci, L.S., Ramloll, R., Hurst, S.et al (2013). VTrain: A novel curriculum for patient surge training in a multi-user virtual environment (MUVE), *Prehospital and Disaster Medicine,* 28 (3), pp. 215-222. ***[FOUND IN SEARCH 1]***

Jenkinson, T.P. (1997). Adolescents as reflective practitioners: Implications for nurse education, *Nurse Education Today*, 17 (1), pp. 58-61.

Johnston, J., Paley, G. (2013). Mirror mirror on the ward: Who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings, *Psychoanalytic Psychotherapy*, 27 (2), pp. 170-186.

Lau, P.Y., Chan, C.W.H.(2005). SARS (Severe Acute Respiratory Syndrome): Reflective practice of a nurse manager, J*ournal of Clinical Nursing,* 14 (1), pp. 28-34. ***[FOUND IN SEARCH 1]***

Lawrence, L.A. (2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing Forum*, 46 (4), pp. 256-268. ***[FOUND IN SEARCH 1]***

McMullan, E., Gupta, A., Collins, S.C. (2018). Experiences of mental health nursing staff working with voice hearers in an acute setting: An interpretive phenomenological approach*, Journal of Psychiatric and Mental Health Nursing*, 25 (3), pp. 157-166. ***[FOUND IN SEARCH 1]***

Tomlinson, P.S., Thomlinson, E., Peden-McAlpine, C., Kirschbaum, M. (2002). Clinical innovation for promoting family care in paediatric intensive care: Demonstration, role modelling and reflective practice, *Journal of Advanced Nursing*, 38 (2), pp. 161-170.

Vittner, D. (2009). Reflective strategies in the neonatal clinical area, (2009) *Advances in Neonatal Care*, 9 (1), pp. 43-45. ***[FOUND IN SEARCH 1]***

Search 3: Search 1 with “disease outbreak” and “crisis intervention” added in produced the same 6 papers for search 1

(TITLE-ABS-KEY ("health professional" OR doctor OR gp OR nurse OR psychologist) AND TITLE-ABS-KEY (crisis OR "corona virus" OR "Covid-19" OR "severe acute respiratory syndrome" OR "disease outbreak" OR "crisis intervention" OR sars OR mers OR influenza OR flu OR pandemic) AND TITLE-ABS-KEY ("palliative care" OR "end of life" OR hospice OR "emergency medicine" OR hospital OR er OR "A&E" OR "accident and emergency" OR "general practice" OR "field hospital") AND TITLE-ABS-KEY ("reflective practice"))

Search 4: A more general search produced 39 papers (These included the 12 papers produced by searches 1, 2, 3 as well as 3 of the 4 papers mentioned in the brief)

(TITLE-ABS-KEY (crisis OR "disease outbreak" OR pandemic) AND TITLE-ABS-KEY ("reflective practice"))

Adams, R. (2011). Exploring dual professional identities, the role of the nurse tutor in higher education in the UK: Role complexity and tensions, *Journal of Advanced Nursing*, 67 (4), pp. 884-892. ***[ALSO FOUND IN SEARCH 2]***

Bacon, H. (2007). Special section: Learning from experience, *Clinical Child Psychology and Psychiatry*, 12 (3), pp. 369-373 ***[ALSO FOUND IN SEARCH 2]***

Berryman, S. (2010). Extracorporeal membrane oxygenation in a Scottish intensive care unit. *Nursing in critical care,* 15 (5), pp. 262-268. ***[ALSO FOUND IN SEARCH 2]***

Bhaduri, R.M. (2019). Leveraging culture and leadership in crisis management, *European Journal of Training and Development,* 43 (5-6), pp. 554-569.

Brown, K., Fenge, L.-A., Young, N. (2005). Researching reflective practice: An example from post-qualifying social work education*, Research in Post-Compulsory Education*, 10 (3), pp. 389-402.

Channa, L.A. (2017). Letter writing as a reflective practice: understanding the shuffling, shifting, and shaping of a researcher identity, *Reflective Practice*, 18 (3), pp. 358-368.

Chiang, H.-H., Lu, Z.-Y., Wear, S.E. (2005). To have or to be: Ways of caregiving identified during recovery from the earthquake disaster in Taiwan, *Journal of Medical Ethics*, 31 (3), pp. 154-158. ***[ALSO FOUND IN SEARCH 1,2,3]***

Childs-Fegredo, J., Fellin, L. (2018). 'Everyone should do it': Client experience of a 12-week dialectical behaviour therapy group programme – An interpretative phenomenological analysis, *Counselling and Psychotherapy Research,* 18 (3), pp. 319-331.

Dong, L., Marshall, J., Wang, J. (2009). A Web-based collaboration environment for K-12 math and science teachers, *Proceedings - Frontiers in Education Conference,* FIE, art. no. 5350659,

Fuchs, S. (2020). Seeing More Clearly, (2020) *Nineteenth-Century Music Review*

Greci, L.S., Ramloll, R., Hurst, S., et al (2013). VTrain: A novel curriculum for patient surge training in a multi-user virtual environment (MUVE), (2013) P*rehospital and Disaster Medicine,* 28 (3), pp. 215-222. ***[ALSO FOUND IN SEARCH 1,2,3]***

Jenkinson, T.P. (1997). Adolescents as reflective practitioners: Implications for nurse education, (1997) *Nurse Education Today,* 17 (1), pp. 58-61. **[ALSO FOUND IN SEARCH 2]**

Johnston, J. (2010). Being disturbed: Integration and disintegration in the patient and professional relationship, *Psychoanalytic Psychotherapy*, 24 (3), pp. 231-251.

Johnston, J., Paley, G. (2013). Mirror mirror on the ward: Who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings, *Psychoanalytic Psychotherapy*, 27 (2), pp. 170-186. ***[ALSO FOUND IN SEARCH 2 ALSO IDENTIFIED IN THE BRIEF]***

Kinsella, E.A. (2007). Technical rationality in Schön's reflective practice: dichotomous or non-dualistic epistemological position., *Nursing philosophy : an international journal for healthcare professionals*, 8 (2), pp. 102-113

Keogh, J., Garrick, B. (2011). Creating Catch 22: Zooming in and zooming out on the discursive constructions of teachers in a news article, *International Journal of Qualitative Studies in Education*, 24 (4), pp. 419-434

Koljonen, K., Raittila, P., Väliverronen, J. (2011). Crisis journalism at a crossroads?: Finnish journalists' reflections on their profession after two school shooting cases, *Journalism Practice,* 5 (6), pp. 719-734

Lau, P.Y., Chan, C.W.H. (2005). SARS (Severe Acute Respiratory Syndrome): Reflective practice of a nurse manager, *Journal of Clinical Nursing*, 14 (1), pp. 28-34. **[ALSO FOUND IN SEARCH 1,2,3]**

Lawrence, L.A.(2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing forum*, 46 (4), pp. 256-268. ***[ALSO FOUND IN SEARCH 1,2,3 ALSO IDENTIFIED IN THE BRIEF]***

Liddle, J., Diamond, J. (2012). Business and management schools in times of crisis and austerity: Choices and dilemmas, *Critical Perspectives on International Public Sector Management,* 1, pp. 25-45.

Livingston, L.L., West, C.A., Livingston, J.L., et al (2016). Simulated disaster day: Benefit from lessons learned through years of transformation from silos to interprofessional education, *Simulation in Healthcare*, 11 (4), pp. 293-298.

Lombardo, C., Santos, M., Van Bortel, T., Croos, R., Arensman, E., Kar Ray, M. (2019). Decision-making in crisis resolution and home treatment teams: The AWARE framework, *BJPsych Bulletin*, 43 (2), pp. 61-66

Lowe, H.I. (2015). Dwelling in possibility: Revisiting narrative in the historic house museum, *Public Historian*, 37 (2), pp. 42-60.

McKendree, A.G. (2011). Synthesizing and integrating the crisis literature: A reflective practice, *Review of Communication*, 11 (3), pp. 177-192.

McMullan, E., Gupta, A., Collins, S.C. (2018). Experiences of mental health nursing staff working with voice hearers in an acute setting: An interpretive phenomenological approach, *Journal of Psychiatric and Mental Health Nursing,* 25 (3), pp. 157-166. ***[ALSO FOUND IN SEARCHES 1,2,3]***

Menon, A., Flannigan, C., Tacchi, M.-J., Johnston, J. (2015). Burnout-or heartburn? A psychoanalytic view on staff Burnout in the context of service transformation in a crisis service in Leeds, *Psychoanalytic Psychotherapy*, 29 (4), pp. 330-342. ***[ALSO IDENTIFIED IN THE BRIEF]***

O'Hare, V. (2020). The plight of the well sibling: A psychoanalytic reflection on a counselling relationship with the 'healthy child' in crisis, in a family living with chronic disease, *Psychodynamic Practice*, 26 (1), pp. 34-46

Post, K.M. (2019). Reflective Practices in Sustainability Education, *Sustainability* (United States), 12 (5), pp. 248-251.

Potter, C. (2015). Leadership development: An applied comparison of Gibbs' Reflective Cycle and Scharmer's Theory U, *Industrial and Commercial Training*, 47 (6), pp. 336-342.

Rae, D. (2010). Universities and enterprise education: Responding to the challenges of the new era, *Journal of Small Business and Enterprise Development*, 17 (4), pp. 591-606.

Raven, R.P.J.M., Jolivet, E., Mourik, R.M., Feenstra, Y.C.F.J. (2009). ESTEEM: Managing societal acceptance in new energy projects. A toolbox method for

project managers, *Technological Forecasting and Social Change,* 76 (7), pp. 963-977.

Ranglund, O.J., Vold, T., Kiønig, L., Bjurström, E., Holen, S. (2016). Using games to detect positive deviance in crisis training, *Proceedings of the European Conference on Games-based Learning,* 2016-January, pp. 547-551.

Sasser, J.R. (2014). Transforming trauma through reflection and praxis: Embracing the principles of critical educational gerontology life-wide, *SAGE Open*, 4 (2), pp. 1-10.

Schindler, J. (2019). Confronting the role of my identity as a mother in my social work practice, *Learning Critical Reflection: Experiences of the Transformative Learning Process*, pp. 79-89.

Tomlinson, P.S., Thomlinson, E., Peden-McAlpine, C., Kirschbaum, M**.** (2002). Clinical innovation for promoting family care in paediatric intensive care: Demonstration, role modelling and reflective practice, (2002) Journal of Advanced Nursing, 38 (2), pp. 161-170. ***[ALSO FOUND IN SEARCH 2]***

Uhlig, P.N., Berry, W.R., Raboin, E.W., et al (2009). Preventing Complications: New Frontiers of Safety Science in Cardiothoracic Surgery, *Complications in Cardiothoracic Surgery: Avoidance and Treatment:* Second Edition, pp. 1-21.

Vittner, D. (2009). Reflective strategies in the neonatal clinical area, (2009) Advances in Neonatal Care, 9 (1), pp. 43-45. ***[ALSO FOUND IN SEARCHES 1,2,3]***

Waddock, S., Lozano, J.M. (2013). Developing more holistic management education: Lessons learned from two programs, *Academy of Management Learning and Education,* 12 (2), pp. 265-284

Wong, A.C.K. (2016). Considering Reflection From the Student Perspective in Higher Education, *SAGE Open*, 6 (1)

The 4th paper in the brief that was not identified in the search was added: Kinsella, EA. (2010). The art of reflective practice in health and social care: reflections on the legacy of Donald Schon. *J Reflective Practice,* 11(4), 565-575.

Making 40 papers in total.

Search 5: Replaced “reflective practice” with “moral distress” produced 16 papers

(TITLE-ABS-KEY (crisis OR "disease outbreak" OR pandemic) AND TITLE-ABS-KEY ("moral distress"))

Barlam, E.L.D., et al., (2013). Moral distress: challenges for an autonomous nursing practice. *Revista da Escola de Enfermagem*, 47(2), 506-510.

Brosche, T.A. (2007). A grief team within a healthcare system. *Dimensions of Critical Care Nursing*, 26(1),. 21-28.

Doobay-Persaud, A. et al (2019). Extent, nature and consequences pf performing outside scope of training in global health. *Globalization and Health*, 15(1), 60.

Epp, K. (2012). Burnout in critical care nurses: A literature review. *Dynamics (Pembroke, Ont.)*, 23(4), 25-31.

Fry, S.T. et al., (2002). Development of a model of moral distress in military nursing. *Nursing Ethics*, 9(4), 373-387.

Helmers, A. et al (2020). Moral distress: Developing strategies from experience. *Nursing Ethics*,

Hunt, M.R. et al., (2013). How are do you how and where are the issues surrounding that?” Dilemmas at the boundaries of clinical competency in humanitarian health work. *Prehospital and Disaster Medicine*, 28(5), 502-508.

Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing*, 28(5), 1134-1145.

Lawrence, L.A. (2011). Work, engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nursing Forum*, 46(4), 256-268.

Leider, J.P. et al (2017). Ethical guidance for disaster response, specifically around crisis standards of care: A systematic review. *American Journal of Public Health*, 107 (9), e1-e9.

Pavlish, C. et al (2015). A culture of avoidance: voices from inside ethically clinical situations. *Clinical Journal of Oncology Nursing,*19(2), 159-165.

Rivard, A.M. & Brown, C.A. (2019). Moral distress and resilience in the occupational therapy workplace, *Safety*, 5(1), 10

Santiago, C & Abdool, S. (2011). Conversations about challenging end of life cases: ethics debriefing in the medical surgical intensive care unit. *Dynamics (Pembroke, Ont.)*, 22(4), 26-30.

Schröder Håkansson, A. et al (2019). Balancing values and obligations when obtaining informed consent: Healthcare professionals' experiences in Swedish paediatric oncology. *Acta Paediatrica.*

Steger, J.A. (2013) Potrč's early prose in a social, moral and political context. *Studie Historica Slovenica* (2-3) 817-828. [LISTED TWICE IN THE SEARCH]

Relevance assessment criteria

Reflective Practice Papers

After reading the abstracts, 18 papers were rejected.

1. Adams et al (2011) – focus on professional identity and its impact on practice
2. Channa et al (2017) – focus was on the author's researcher identity crisis
3. Childs-Fegredo et al (2018) – focus was on clients experience of therapy
4. Dong et al (2009) – focus is on school pupils performance
5. Fuchs (2020) – focus: autoethnography on digital humanities
6. Jenkinson (1997) – focus on impact of adolescence on ability to care for others
7. Keogh et al (2011) – focus on teacher quality and school standards
8. Liddle & Diamond (2012) – focus on the impact of banking crisis on business schools
9. Lowe (2015) – focus on historic house museums
10. McMullan et al (2018) – focus on impact of encouraging service users to talk about the content of voices they hear
11. O'Hare (2020) – focus on a child in crisis after loss of brother
12. Post (2019) – focus on reflective practice in education
13. Rae (2010) – focus on entrepreneurship education & learning
14. Raven et al (2009) – focus on public participation in new projects
15. Sasser (2014) – focus is memoir on personal crisis
16. Schindler (2019) – focus on a crisis in confidence in social work
17. Uhlig et al (2009) – This was a book chapter – we could not access it.
18. Waddock et al (2013) – focus on assessment crisis in education
19. Wong (2016) – focus on students response to crisis, in this case a major change to curriculum

The remaining 21 papers were then read in full. 6 were rejected

1. Bacon (2007) – personal reflective piece on psychology practice
2. Brown (2005) – study of social work students and their view of the post qualification year.
3. Koljonen (2011)- reflective practices amongst individual journalist and journalistic organisations following two school shootings.
4. Livingstone (2016) – evaluation of a simulation disaster day – not focused on individual reflective practice
5. McKendree (2011) – an essay about the reflective practice of synthesising literature
6. Ranglund (2016) – conceptual paper on videogames and reflection

The remaining 15 papers were included in the review

1. Berryman 2010
2. Bhaduri (2019)
3. Chiang (2005)
4. Greci (2013)
5. Johnston (2010)
6. Johnston & Paley (2013)
7. Kinsella (2007)

8. Kinsella (2010)
9. Lau (2005)
10. Lawrence (2011)
11. Lombardo (2019)
12. Menon (2015)
13. Potter (2015)
14. Tomlinson (2002)
15. Vittner (2009)

Moral Distress

After reading the abstracts 2 papers were rejected (1 paper was represented twice) so a total of 3 were rejected:

1. Schröder Håkansson, A. et al (2019).
2. Steger, J.A. (2013). [LISTED TWICE IN THE SEARCH]

The remaining 13 papers were read. A further 5 were rejected

1. Helmers, A. et al (2020) – unable to access
2. Barlam, E.L.D., et al., (2013) – paper translated, v poor English. A descriptive overview of moral distress not a study.
3. Doobay-Persaud, A. et al (2019) – interesting study, focus was on performing outside the scope of your training when working in low income countries
4. Leider, J.P. et al (2017)- focus on ethical guidance for rationing of scare resources during crisis (moral distress hardly touched on).
5. Rivard, A.M. & Brown, C.A. (2019). – review of moral distress, but not on crisis.

The remaining 8 were reviewed:

1. Brosche, T.A. (2007).
2. Epp, K. (2012).
3. Fry, S.T. et al., (2002).
4. Hunt, M.R. et al., (2013).
5. Kelly, B. (1998).
6. Lawrence, L.A. (2011).
7. Pavlish, C. et al (2015).
8. Santiago, C & Abdool, S. (2011).

Description of Reflective Practice Papers

Author	Aim and methods	Summary of findings	Recommendations
Berryman 2010	Reflection on training in use of Extracorporeal Membrane Oxygenation (ECMO) and its successful application in ICU with a young person who had experienced respiratory failure as result of H1N1 virus Context: Part of strategic development, funded by endowment (grateful patients and relatives), training attended by keen senior nurses and two consultants so inter-professional. Also did not have expected surge in hospital admissions due to H1N1	Close teamwork necessary Adapted national protocol to own and used template for deciding when to apply ECMO. Had consultant cover available at all times Significant extra support from critical care team despite not having additional resources: long term sustainability uncertain Unfamiliarity with circuitry Medical designation of responsibilities had not been formalised due to lack of time – inconsistency in who made decisions. Distress of relatives when admitted to ICU and took time to get consent as they adjusted to this Cost may be prohibitive May not have another client who needs ECMO for a long time as specialised skill set, resulting in 'skills fade'	Template/guidance on physiological parameters for individualised patient management important to facilitate monitoring and timely intervention Protocols for streamlining access to equipment Formalising delegation of medical responsibilities Having sufficient numbers of skilled staff to deliver specialised treatment so those who have the skillset do not have to take extra shifts to provide effective support Simulations to practise skills when have significant gaps between opportunities to apply skills and keep these 'sharp' amongst clinical staff (if very few cases or have months between cases)

Bhaduri (2019)	The purpose of this paper is to explore the relationship of organizational culture, leadership and crisis management through exploration of these three constructs with respect to crisis management. Commentary paper based on literature review.	Five research propositions proposed based on stages of crisis management: Signal detection Preparation Damage containment Recovery Learning (this phase is focused on critical reflection of the crisis experience).	Proposes research based on the 5 stage model. Notes that most organisations tend to neglect the learning phase of the crisis life cycle. Essential for organisations to document procedures and actions taken at each stage of the crisis management life cycle so that they can reflect and learn from their past practices and avoid making the same mistakes in the future.
Chiang (2005)	Aim: To report and evaluate the types of reflective practice/therapy offered to survivors of the Taiwan earthquake in 1999. This qualitative study involved interpretive analysis of group dialogues and participant observations to illuminate caring experiences in the groups. 4 schools recruited. A therapy session took place in each school. Each group had 7–14 members, including school administrators and teachers who had the potential to empower other survivors, such as students and their families The topics discussed were derived from the dialogue facilitated by two group	They looked at 3 types of reflections delivered in group sessions – encumbered reflection (where the facilitator is too egocentric – this can cause harm to the recipients if their needs are not met), connected caring and reflective caring Issues: 1.The effects of the earthquake and the trauma encountered and 2.A reflection on how the reflective practice is working, Barrier – school children were distracted and did not always want to engage in the practice Facilitator – the facilitators of the session shared best practice so each group was able to learn from the others.	Train the facilitators to be self-aware, so that they are not letting their own experiences/traumas cause extra stress for the recipients Adequate time is needed to process emotions/engage in reflective practice the technique needs to be adapted based on the situation and the group Note that other work highlights timing of debriefing is important staying at the end of the shift to reflect may not be what individuals want. For some, being asked to engage in self-reflection increased stress – is implemented, it needs to be implemented in the correct manner so

	therapists, who moderated the sharing of feelings and perceptions in the aftermath of the earthquake	Key learning point was that this is not a one size fits all model, and that quick adaptations need to be made based on how the session is working on the day	that it doesn't lead to unnecessary extra stress
Greci (2013)	Reflection on delivering an emergency-preparedness training programme after a disaster or pandemic using an online virtual (MUVE) environment (i.e. role play game using avatars to simulate real-life interaction in a virtual environment. Health Services Research study team encompassing emergency preparedness, emergency medicine, public health subject matter experts (inc medical anthropologist) and IT programmers and engineers. Students expected to triage + tag patients and transport to appropriate treatment areas and also in accordance with appropriate infection control procedures. Command staff given info on resources and communication info for dissemination	Communication helped by familiarity of team members with each other, enabled setting up of response team rapidly Focus on individual role designation and established chain within command structure when resource management and communication became problematic Command post participants being able to see what was happening in main operations area (ED triage) which often is not the case in real life, potentially helpful for planning Enabling independent problem-solving without facilitator help Cross-training in command post duties in case someone is unexpectedly unavailable Virtual training helped with understanding real issues Training in unfamiliar environment helped quick skill and relationship development in	Simulation of emergencies helpful for preparedness when combined with face to face learning (blended learning, Cross-training in command post roles helpful Early communication and determination of threshold numbers during shift to trigger re-evaluation of use of temporary individual triage/treatment areas during patient surges Resource tracking for equipment needed in high supply during emergency Good knowledge of command post role and chain of command established for real emergencies Planning for temporary treatment areas by command post staff improved for real life contexts

		context of rapid decision making and incomplete info Initial cost of and expertise needed to set up environment and use of gaming computers as they have the required graphics card – recoup over time as takes less time to code new scenarios and can reuse IT equipment Ability to attend a 6 session programme due to clinic schedules and time taken to familiarise with a virtual environment	Time to establish new communication methods and ask for help to navigate (especially in novel environments) in the early stages of a disaster when protocols have not been established
Johnston (2010)	Reflection on working with patients with personality disorder versus psychotic disorder diagnoses Conceptual paper – discussion of dynamics in long term professional-patient relationships in mental health ward context – NOT crisis situation	Patients with psychosis may be easier for psychological professionals to manage. Psychiatry is occupied by safety – person who is sane but unsafe is more of a threat than the person who is insane but safe. Crisis team – more cut and thrust oriented, more overt conflicts with other services, may echo the nature of their work where dealing quickly and actively with people is paramount. Clear focus on patient-professional relationship in reflection was important Terror of patient disintegration can make it enormously difficult for professionals to	A 'palliative care' culture where could think about patient quality of life and could talk about emotional responses to them rather than a 'firefighting' orientation focussed on keeping people safe and alive despite themselves. Reflective practice, key elements to consider that are relevant to this rapid review: Expecting resistance to reflection and for this to take time, persevering in the face of obstacles to creating a boundaried space for staff Recognising the importance of limited achievements

		stay realistic and curious, and thus maintain their own psychological integration Difficulties getting senior management to listen and create a space for reflection by staff at times Resenting manager for lack of protection from patient 'onslaughts' due to perception of incompetence	Using resonance (of concepts) with everyday experience to foster ordinary links Placing central importance in honest as possible communication between staff Resisting trying to answer the question 'but what should I do' (from staff)
Johnston & Paley (2013)	Reflection on reflective practice groups within acute mental health in-patient wards, crisis teams and community mental health teams from psychologists in different therapy orientations	Groups focused on: Difficulties in treatment responsibility and resentments around this. Cultural differences between therapists and ward staff Less explicit focus on theory and more on task completion Past experience of therapists and whether they are in their 'ivory tower' or have experienced challenging (mental health) situations The group was Insufficient alone to deal with mental health job strain and reduce stress/burnout	Meet team and manager to better understand their culture and context. Gain agreement on practicalities (day, time, frequency, location; whether people can come in late or leave early, confidentiality and on who can attend). Maintaining trust and rapport with all members (may be up to 30 members) over time and as relationship changes; having high self-awareness is key to ensure that this is equal and not inadvertently getting drawn into splitting off or supporting particular sub-groups Active listening skills and containing the unconscious desire to cure,

		Deeply emotionally challenging and can be difficult to keep the spirit of enquiry, empathy and humanity as central emotional focus, suicidal despair can be common Humour and affirmation (light relief) Greater attendance in groups, unclear whether reduces stress or burnout though was experienced as rewarding for facilitators and attendees	Rarely challenging practice to avoid moving from naive and interested outsider to insider embroiled in difficult team dynamics – emphasis on the team finding solutions. Being prepared to hear about the 'dark side' of providing care and that this can evoke strong emotions for facilitators, so need supervision from skilled colleagues experienced in running reflective groups to help containment and development of reflective practice work.
Kinsella (2007)	To outline the epistemological perspective (critique) underlying Schon's theory of reflective practice.	Experience that scientific discourse is insufficient to guide practice in applied settings and removes understanding, knowledge and perspectives gained through the minutiae of everyday practice experience. Reflective practice may provide opportunity to bridge gap between theoretical learning and application in the 'messy, lowland, swampy' embodied practice where straightforward application of theory may not be possible. Technical problems may be relatively easy to address, but the problems encountered in practice may be 'messy' and difficult to	Avoid dichotomy of technical/scientific theoretical knowledge versus learning through practical competencies gained from experience - practice is not either/or (it involves both) Understand that 'problem-setting' may be caused by 'tacit' (implicit) reflection and learning from past experience when applied to 'problematic' situations and this enables practitioners to operate with uncertain, unique and indeterminate situations. Enable, 'artful, reflective, contextualised' use of knowledge and skills in experimental ways that enables

		work with but are often more pressing to humanity. 'Problem-setting' is as important as problem-solving, by paying attention to salient facts/data. This is done by spontaneous, intuitive 'reflection in action' and 'reflection on action' to frame/construct the problem in a narrative that allows for its resolution. This may deepen and change over time. Experiencing a 'surprise' or failure to achieve desired outcomes may stimulate reflective processes	pragmatic feedback for practitioners using their interpretation.
Kinsella (2010)	Aim: This paper reflects on Donald Schön work on reflective practice, and why it might be seen as a means of moving toward phronesis, or practical wisdom, in health and social care. Conceptual paper. Paper begins with a consideration of why we might need reflection and particularly why it might be crucial at this point in history. Second, it considers the legacy of some of Donald Schön's work on reflective practice. A case study is presented to show how Schön's ideas go some way toward a re-invigoration of a notion of phronesis (wise action) as a complement to	N/A	1) that we are living in times where the need for reflective learning in health and social care is growing at the same time that the structures that might support it appear to be contracting. 2) Importance of re-conceptualizing professional practice knowledge in ways that attend to reflection. 3) Schön's reflective practice has practical importance in education and practice in health and social care

	episteme (scientific knowledge) and techne (pragmatic knowledge) in professional life.		4) Attention to the art of reflective practice in the health and social care professions has the potential to move practitioners and policy makers toward what Aristotle referred to as phronesis, practical wisdom.
Lau (2004)	Aim: To encourage reflective practices amongst nurses in Hong Kong during the SARS outbreak (lead by the lead nurse). This paper describes the reflective practice of a nurse manager in Hong Kong in supporting frontline nurses to overcome the crisis of SARS.	Issues raised: Death of colleagues, shared experiences of being a nurse in ICU, infection control and adequate provisions needed. Facilitators / Barriers: Facilitator – the lead nurse sharing his thoughts/feelings on the situation lead to the creation of an environment where the other nurses felt more comfortable to express their thoughts and feelings Giving the nurses clear visions/goals lead to nurses attitudes appearing to be more positive and hopeful Barriers – suggestions that were approved often took time/were inadequate e.g. bathing facilities were inconveniently placed, waterproof gowns took time to arrive etc	States that a lack of protective equipment and death of nurses triggered negative emotions in nurses – as we are facing a similar situation during COVID, this could make our nurses/health care professionals vulnerable – hence emphasising the need for reflective practices. Empowerment – include all healthcare professionals (regardless of seniority) in decision makings/encourage them to give feedback Uncertainty e.g. constantly changing or unclear policies/advice lead to confusion and frustration – need for clear information and to have proper sessions e.g. how to use PPE correctly

		Outcomes: Team spirit, empathy and mutual respect in the team Lead nurse realised the importance of team spirit and empowerment in nursing management – and pledged to continue such qualities in future learnings	
Lawrence (2011)	Aim: To examine how nurses' moral distress, education level and critical reflective practice related to their work engagement. Motivated by the need to gain a better understanding of the factors that may enhance registered nurse work engagement Intensive care nurses – registered nurses in 3 separate ICUs (medical intensive care, paediatric intensive care, neonatal intensive care) completed individual questionnaires. Nurses encouraged to engage in critical reflective practice – defined as thinking about personal visions of nursing practice and the current realities of nursing practice – identifying contradictions between these, develop a vision for practice, and encourage nurses to take action to make changes to the reality of practice to make the	Issues raised: Contradictions between the reality of nursing practice and their personal visions of what nursing practice should be like Facilitator – provision of space for nurses to come together ad discuss clinical encounters/experiences AND group activities in safe environments, so that the nurses can discuss the cognitive and affective components of their practice Adequate time to discuss matters Personal reflective diaries and regular meetings as a group to discuss the contents Multidisciplinary meetings to discuss all aspects of patients care (and raise any contradictions/changes that they thought needed to be made) + regular meetings with managers to discuss this.	Increased nurse education on reflective practice to ultimately increase critical reflective practice in the workplace Provide an environment in which critical reflective practice is encouraged and supported Weaknesses: correlational study (not an experimental study looking at reflective practice techniques) – looked at the relationship between four different factors – moral distress, education level, critical reflective practice and work engagement CRPQ (critical reflective practice questionnaire), an unstandardized measure, was developed by the investigator (also used a standardised reflection measure as well) Techniques for critical reflective practice deemed appropriate were

	environment better for them – this was referred to as 'double loop learning'	The devised critical reflective practice was found to have a positive relationship with work engagement – so ultimately having adequate provisions in place for critical reflective practice to occur would lead to greater work engagement (defined as 'the positive, fulfilling, work- related state of mind that is characterized by vigour, dedication and absorption')	suggested in the discussion section, but were not tested in this study
Lombardo (2019)	Aim: To improve patient safety by identifying factors that contribute to decision making regarding gatekeeping by CRHTTs A theoretical sampling method was used to identify qualified multidisciplinary team members in a CRHTT of working-age adults in East Anglia. Eighteen interviews were carried out across 12 multidisciplinary team staff (10 nurses, 2 social workers; post-qualification experience: 10–25 years; 6 men, 6 women), who were primary assessors. Six participants were interviewed once and six participants were interviewed twice.	AWARE (anxiety, weighting, agenda, resource and experience) – bringing factors that can influence decision making but often unconsciously e.g. lack of beds consciously to people's minds – so that they can be processed properly and then brought into the decision making process. Issues: How external/uncontrollable factors such as resources could influence decision making, the use of heuristics to make decisions, how this can relate to patient safety Facilitator – the acronym was easy to remember – and thus easy to bring to mind (especially in the context where heuristics are often used to guide decision making) AWARE made more mindful when making clinical decisions. Better recording of the decision making process e.g. in the	Talked about a bed crisis in mental health inpatient beds, and how having this lack of resources subconsciously influenced decision making – this paper would suggest that making people mindful of this, in addition to any other uncontrollable factors and heuristics used consciously would help to improve decision making and thus patient safety (and handovers e.g. letting other healthcare professionals know what to look out for or why a certain decision has been made) 'It would be unrealistic to expect the high pressure and difficulty of the situations not to have an impact on the decision making process' Interesting as it brings the issue of limited resources and the impact that it

		handover notes so that if the individual is treated again, more attention can be paid to developing appropriate safety plans and systematically attend to warning signs	has (both subconsciously and consciously) on decision making The study notes that these techniques may only serve to reduce practitioners anxiety with relation to patients risk etc – so may not be applicable in all healthcare settings
Menon (2015)	To examine stress reported by staff in a Crisis team in Leeds over two years and quantify burnout. The study population in 2011/2012 (N = 49) and in 2012/2013 (N = 50) included all the clinicians and administrative staff in the service. We designed a semi-structured survey questionnaire1 to explore generic and specific issues around stress in the workplace. This is as yet unvalidated in the study population,	Issues: Stressful experiences; clinicians mostly affected by patient suicide and violence. Such situations bring self-doubt. The service transformation led to clinicians feeling unsupported, experience inter-professional conflict and feel scrutinised. Group meetings perceived as helpful, providing a chance to: - discuss difficult cases - take a break from work - feel like the problems are shared - feel part of a team - feel supported Sense of grievance emerged – loss of something dear (home treatment); loss of	Recommendations not discussed in the paper Contact with colleagues and work with patients seen as rewarding. Talking to colleagues, friends/family, time management techniques and stress reducing activities as used ways of coping with stress. Additionally, some mentioned formal supervision. Participants perceived specific training as inadequate for a complex work environment. The change in service transformation didn't change burnout significantly, but a clinically relevant increase was noted. Drop in use of formal and peer supervision after service transformation.

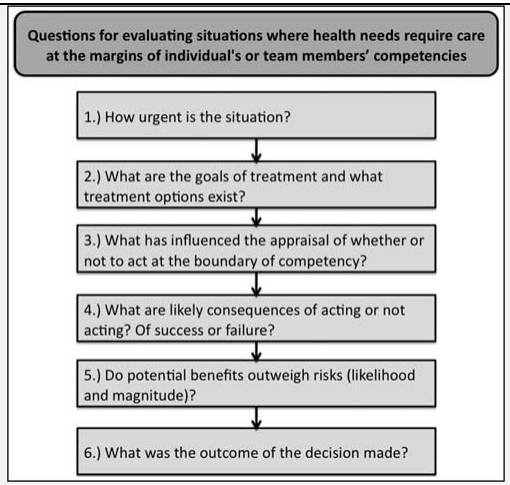
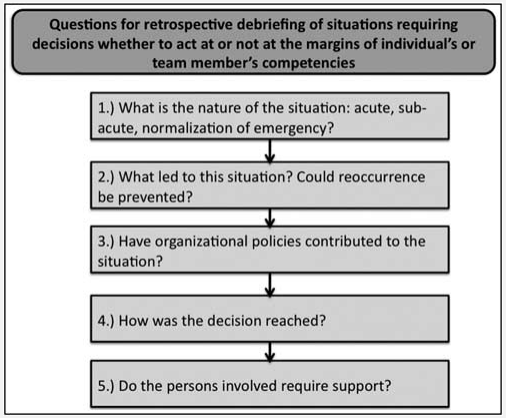
		felt impact of the therapeutic intervention on mitigating trauma The group stopped discussing patients and focused on discussing their dissatisfaction with the service change and its impact on the team.	This study was not an intervention, it was observation of the effects of service change through group discussions and burnout questionnaire.
Potter (2015)	To examine two contracting leadership methodologies – Reflective Practice and Scharmer's Theory U. The author applied the two models on himself in order to reflect on a leadership incident – challenging negative culture within a group meeting	Both approaches seemed to have strengths and weaknesses. Reflective Practice provided helpful insights through focusing on one's thoughts, feelings and motives during the event, as well as the actions of others and the author's responses to them. The author found that using Scharmer's Reflecting Deeply exercise enabled a deeper understanding of the incident to emerge, which also provided new and distinct insights.	To develop rounded leadership skills, leaders can benefit from tapping into all of their resources; these two approaches allow different aspects of one's intelligence to be accessed, which ought to facilitate greater development. Theory U requires suspending thinking which in fast-pace environments might not be possible.
Tomlinson (2002)	To explore family caregiving problems in paediatric crisis care (PICU) and methods that could be applied to move the abstraction of family care to development of specific family interventions. Think piece offering an overview of guided reflection; general reflective practice – discussing role modelling; reflection in action, reflection on action;	N/A	Specific techniques of role modelling and reflective practice are suggested as effective approaches to teach family sensitive care in clinical settings where families are part of the care environment. However, more complex interventions might offer the most benefits to intensive care and family sensitivity. The complex models needed for family sensitive nursing require a mixed educational approach to transfer

	structured reflective practice (incl. coaching and dialogue)		expert knowledge and skills into practice. Demonstration of specific techniques and communication skills in working with families, through role modelling and reflective practice by practitioners skilled in family sensitive care, is suggested as one effective approach to integrate family care within the practices of PICU nurses. However, this needs to be tested empirically.
Vittner (2009)	To describe the use of reflective practice to prepare for a major change (implementing an individualized developmentally supportive care program) in NICU With help of a 'reflective process consultant' the leadership team in the NICU developed bi-weekly 1.5hour sessions with a social worker. Later this changed to a PhD level psychologist who led the group. Reflective techniques such as guided dialogue, role-playing, journaling, and guided imagery were utilised.	The context of challenges that arose because of the change process; enhancing change integration; dealing with emotional tension due to change; discussion of challenges, communication between staff and management, mindfulness, etc. Also, discussion of critical incidents. Staff found meetings productive and useful; the thoughtful venue choice was appreciated by the staff. The fact that the facilitator was external helped, as then everyone from the staff side was a participant. Also having clear rules about discussions was seen as a positive. The meetings helped with initiation of conferences where staff discussed difficult cases and reflected on them together. This was suggested to help with the new system in place – individualised care.	Utilising a variety of reflective process strategies is essential to make changes in a structured setting such as the NICU. Enhancing care for newborns was more effective due to enhancing support strategies for healthcare staff. The support and engagement of leadership is crucial as well.

Description of Moral Distress Papers

Author	Aim and methods	Summary of findings	Recommendations
Brosche (2007)	The article describes the establishment of a grief team in an intensive care in a hospital setting.	Mourning is not part of the culture of ICU and so nurses seldom talk about their grief when a patient dies. Applied Watson's theory of Human caring for mind, body and soul. Tips were shared about the practicalities of setting up a grief team. Grief team needed to be available 24 hours a day, 7 days a week. Grief team should be contacted after every death on ICU so that they are ready should a member of staff contract them. Some of the practicalities – i.e.,. visiting the grief team during shift – would not work well in the current crisis.	How this would work in the midst of the current crisis is not clear – but the need for a space for staff to mourn their patients and their colleagues is clear.
Epp (2012)	Aim to understand how burnout develops in critical care nurses and how it can be prevented – lit review (2007-2012) conducted	Since ICU patients are in a critical condition and nurses have the closest contact with the, performance expectations of critical care nurses are high. P26: critical care nurses were particularly vulnerable to being in morally distressing situations because their ability to make decisions regarding patient care is limited,	Prevention: Supportive environment – clear communication between HCPs Nurse managers need to be visible AND play an active role in patient care – nurses then feel better supported and

			managers have a better understanding of what is happening on the unit. Moral distress workshop – (following the American Association of critical care nurse 4As model) can increase interdisciplinary collaboration Having a counsellor / grief team available for nurses to debrief with after a difficult shift is important. Nurses also need to take responsibility for self-care and live a healthy lifestyle.
Fry (2002)	To identify experience of moral distress in military nursing Reports on a systematic review and a series of interviews with military nurses who had been 'crisis-deployed'. Military deployment – likely to work in mobile or field hospitals under difficult situations, with unfamiliar colleagues and authority relationships may not be established at the start of the mission. Environment may be unstable dangerous. Also military nurses are deployed – ordered to work and as such are removed from their support systems and separated from family and loved one	Conclusion was that they DO experience moral distress.	None offered.

	13 military nurses interviewed (6 female), aged 35-62 years. All had served in war and/or humanitarian missions.		
Hunt (2013)	Aim is to help clinicians evaluate competency dilemmas. – focus is on those clinicians operating at the margins of their competency (something that happens during crises) The paper is drawing from data from studies the authors have already published. This paper draws on qualitative research interviews with expatriate clinicians who have experience in humanitarian work They present two sets of questions designed to support reflection and discussion around competency dilemmas. The last question is focused on reflective practice (What was the outcome?)	 	Discussion of these questions will not necessarily lead to resolution of the issue, avoidance of malpractice legal actions, or removal of moral distress for those involved, but the goal of this process is to support a more comprehensive analysis of the situation so that the team can enact well-considered and ethically defensible actions.

Kelly (1998)	The purpose of this follow-up study was to describe, explain and interpret how new graduate nurses perceived their adaptation to the `real world' of hospital nursing and what they perceived as major influences on their moral values and ethical roles in the 2 years following graduation	New graduate nurses experience severe job stress. 6 stages of adaptation to being a graduate nurse were discussed: 1. Vulnerability – shock of being inexperienced member of a team 2. Getting through the day 3. Coping with moral distress 4. Alienation from self 5. Coping with lost ideals 6. Integration of new professional concept	Better education needed so that graduate nurses are prepared for the reality of the world of work – questions whether too much emphasis is placed on individual performance in training, when being a team member is key on graduation. Danger point of integration with new professional concept = opportunity for patients to become dehumanised due to work culture and coping strategies of more experienced staff.
Lawrence (2011)* *also identified in the reflective practice search	Aim: To examine how nurses' moral distress, education level and critical reflective practice related to their work engagement. Motivated by the need to gain a better understanding of the factors that may enhance registered nurse work engagement Intensive care nurses – registered nurses in 3 separate ICUs (medical intensive care, paediatric intensive care, neonatal intensive care) completed individual questionnaires. Nurses encouraged to engage in critical reflective practice – defined as thinking	Issues raised: Contradictions between the reality of nursing practice and their personal visions of what nursing practice should be like Facilitator – provision of space for nurses to come together ad discuss clinical encounters/experiences AND group activities in safe environments, so that the nurses can discuss the cognitive and affective components of their practice Adequate time to discuss matters	Increased nurse education on reflective practice to ultimately increase critical reflective practice in the workplace Provide an environment in which critical reflective practice is encouraged and supported Weaknesses: correlational study (not an experimental study looking at reflective practice techniques) – looked at the relationship between four different factors – moral distress, education level, critical reflective practice and work engagement

	about personal visions of nursing practice and the current realities of nursing practice – identifying contradictions between these, develop a vision for practice, and encourage nurses to take action to make changes to the reality of practice to make the environment better for them – this was referred to as 'double loop learning'	Personal reflective diaries and regular meetings as a group to discuss the contents Multidisciplinary meetings to discuss all aspects of patients care (and raise any contradictions/changes that they thought needed to be made) + regular meetings with managers to discuss this. The devised critical reflective practice was found to have a positive relationship with work engagement – so ultimately having adequate provisions in place for critical reflective practice to occur would lead to greater work engagement (defined as 'the positive, fulfilling, work- related state of mind that is characterized by vigour, dedication and absorption')	CRPQ (critical reflective practice questionnaire), an unstandardized measure, was developed by the investigator (also used a standardised reflection measure as well) Techniques for critical reflective practice deemed appropriate were suggested in the discussion section, but were not tested in this study
Pavlish (2015)	The purpose of this ethnographic study was to examine the challenges and circumstances that surround ethically difficult situations in oncology practice. 6 focus groups, 12 interviews. Participants were asked about ethical challenges.	A culture of avoidance was identified – silence about ethical concerns, until a precipitating crisis occurs. The silence might be maintained by a fear of harming relationships or by systems that 'inadvertently and easily silence people';. (p162)	Health organisations should develop processes and practices that make ethical considerations an early and routine part of everyday clinical practice: p164: building cultures where interdependence and shared decision making ae valued, moral differences are addressed and dialogue is encouraged.
Santiago (2011)	This article describes the medical surgical intensive care unit (MSICU)	Location of meeting was import ant – needed to be near the patients so staff	Frequent education sessions

	experience with its monthly ethics initiative and explores the next steps to enhance its use through maximizing attendance and value to MSICU clinicians. To optimize attendance of staff, a small group discussion among critical care clinicians (n = 8) was conducted asking about their perceptions of the debriefing sessions and their suggestions on how to promote their use.	could duck out and look after their patients if needed, Clear advertising was needed with reminders 2 days before the group. Sessions needed to be held at flexible times so as to include night staff Open agenda – staff talked through whatever they brought to the session Resulted in increased awareness of the benefit of these sessions and there was greater consensus and teamwork.	on end-of-life care, death and dying, and the importance of reflective practice and feedback should be provided to decrease the caregivers' feelings of isolation, moral angst, and despondence, and increase his/her knowledge base and personal and professional fulfilment and satisfaction. This could only serve to enhance holistic patient care and support to the worried family. Open discussion about end of life during ethics debriefing session would inevitably lead to consistent ethical practice and a safer, healthier, more respectful and therapeutic work environment.