StChristopher's

REFLECTIVE DEBRIEFING

Adapted from Gibbs Model of reflection (1988)

Reflection no:……….. Date:……..…………

Reflective debriefing is the process whereby clinical practice can be re-examined to foster the development of critical thinking and learning for improved practice. The process is on-going with each debriefing and should be viewed as an aid to lifelong learning rather than single processes.

1. Describe the person/event.
Encourage all in the group to recall their memory about the person/event – such as:
Person: What were they like, what did they like to do? Did they have family? Who was important to them? What did they like/dislike? Were they humorous/serious/sad/angry? What was their perspective on what was happening? Were their fears/anxieties?
Event: What was the event? Who was involved?

2. What happened leading up to the death/event?
Describe what happened for individuals on the various shifts that led up to the death or event

3. How do staff feel things went?
What went well? What didn't go so well? How did people feel about this?
Both positive and negative feelings should be described and owned. Feelings can be a very useful guide to how learning is progressing so whilst it is important to be honest it is also important to respect others feelings.
Look in detail at the decisions that were made – this will help you to understand what else could/couldn't be done. Opinions of others will help in this process. Remember to reflect on what was hoped and planned for, the original aims and objectives i.e. in the event of death was and end of life care plan used, anticipatory drugs in place, symptoms controlled, family supported and informed, spirituality addressed - were they in the place of their choice, was the DNaCPR and ACP completed.

4. What could have been done differently?
Existing knowledge can be built on or restructured by theorising about what could have been done differently. In order for this to be effective critical thinking in a safe learning environment is essential with a 'no blame' attitude.

5. What do we need to change as a result of this reflection?
Key learning points can be listed and any action plans needed to enhance learning/more appropriate care. This might be a change in or re-writing of a policy, further chats with GP/CNS in order that in the future the problem being discussed does not occur again, or it may highlight a need for training. It is essential that these learning points are not just logged but acted on.

Each reflection can inform practice and should be used not only as a building block to learning but as a celebration of good practice. Reflection is not a passive contemplation but an active, deliberate process that requires commitment, energy and a willingness to learn as a team.

1. Pen portrait of the person or event

2. What happened leading up to the death/event?

3. What did you feel went well about the death/event?

What do you feel didn't go well?

4. What else could you have done and what might the outcome have been?

5. What can you learn from this and what will you do differently next time?