# Reflection: Reflective Writing at Level 7

Reflective writing is an essential component of demonstrating your level of critical thinking and reasoning commensurate with advanced practice. It allows the RCEM ACP Credentialing Panel to see your approach to analysing your experience, learning from events and adapting your practice to provide better patient outcomes. It is different from other academic pieces of work and, used appropriately, it should show how you have developed over time as a clinician.

Reflection is expected for:

- **Workplace-based assessments (WBA),** where you will need to explain what happened within the 'case to be discussed' section, and then, in the 'reflection of event' section, outline how you felt about it, what you learned, whether you could have handled things differently, and what you need to learn or do differently in the future.
- **Curriculum and Syllabus Comments (CSC) for each KC**, where it is really important to think about what the Key Capability is – how your evidence demonstrates your competence in this area and, importantly, how you have developed and what else you might do to optimise this capability.
- **Reflective practice logs,** which will be more detailed and require more thought, and are recommended for complex patients where there is not a WBA associated but you feel your involvement with the case has led you to learn something. The form has its own headings which take you through one framework for reflection.
- **Action points identified in WBA**, either as some kind of self-reflection with evidence that shows how the actions were achieved, or included within the CSC.
- **Other activity,** with reflection used to illustrate learning and application to practice. Activity may include (but is not limited to):
    - Study days
    - eLearning/podcasts
    - Teaching delivered or attended
    - Meetings attended

    This could be written as a separate reflection, such as comments attached to the uploaded evidence or, again, included within the CSC. Such reflection should be short but should comment on the structure and delivery of the activity and how you have changed as a result.

There are several reflective models that you may use as a basis for your reflection, and you should choose a pattern or model that works for you. You do not need to use any sub-headings but, when you re-read the reflection, consider whether it demonstrates to the Panel your development as a clinician and any learning that has occurred.

### A note on triangulation

Reflection is an important part of the picture you are building of your capability. The Panel will read the reflection alongside other evidence presented for the KC or procedural skill and so reflection should complement other evidence – this is called triangulation. Triangulation uses multiple sources of information to best inform an assessment of that competence. Reflection can therefore mitigate against a less successful WBA by showing what you learnt or how you recognise what would have made a difference. Reflection in healthcare is an important part of the personal development journey but is also a skill that underpins a culture of lifelong learning and continuous improvement.

# Examples of Reflection

The examples below are illustrative only but should give you a sense of the kind of detail and depth that would be expected. Not every reflection needs to be this long – these are probably the longest you'd reasonably need to write.

## 1. Workplace-based Assessments (WBAs) and Reflective Practice Logs

The examples provided below are for reflection on a skill.

Naturally, reflection is more effective when considered for an actual case, even if that case is not as successful or smooth as you would like. Consequently, a Case-based Discussion (CbD) should always be based on a real, rather than "imaginary", patient. You can, of course, discuss what *might* have happened in your reflection, but the main patient details and circumstances should be real. So, the case itself might be very straightforward, but your reflection will consider what you would have done, and how you would have escalated or taken a different course if it had been more complex or the patient had not responded.

### Example A: CBD on Colles fracture (for a developing tACP)

***Case discussed***

*Reducing a Colles fracture under haematoma block in an 80-year-old with a trip and fall. Having ensured there were no medical problems that had led to the fall (careful history and physical exam, ECG, urine dip) and excluded other injuries, I determined the Colles needed reduction. I performed a haematoma block, having gained informed consent, and allowed a short time for it to work. I had a student nurse with me to assist in the reduction and plaster. The procedure went well, and the patient was comfortable. A check X-ray was performed which showed a good reduction and I arranged follow-up.*

***Reflection on case***

*This was the first reduction I had undertaken, I have watched two previously. It felt particularly challenging as the relative wanted to stay with their mother during the procedure. I was worried that I would not get a good enough reduction. I was pleased to have the ED consultant present for this assessment.*

*I gained consent for the procedure and was careful to explain the risks and benefits clearly. It was useful to have the patient's daughter present as the patient was hard of hearing and the daughter was able to help me ensure the patient understood. She was also able to support the patient during the procedure, which was especially valuable in the last section when moulding the cast.*

*I recognise that having family in the room can help facilitate clinical encounters, although it can create some anxiety for me as a tACP when developing a new skill. Ensuring that the procedure was clearly explained and understood by both the patient and the relative allowed me to rehearse the skill in my head and to ensure they (and the student nurse) were able to assist. Giving a realistic description of the potential for pain and allowing time for the block to work helped, as well as the option for the patient to have some Entonox alongside the block.*

*I achieved a good reduction, and the patient's pain was well managed. Afterwards I had to be prompted to check sensation/CRT and document this in the notes. This detail is important for me to remember but I think it has the potential to get forgotten in the flurry and excitement.*

*I need to have further exposure to consolidate my skills in reducing fractures, including Colles fracture, to become fully independent.*

### Example B: Reflective practice log for an experienced tACP at a higher level of entrustment

Reduction of Colles fracture under haematoma block in an 80-year-old with a trip and fall - engagement with relative.

***Describe the circumstances***

*I have undertaken more than 10 such reductions. I am confident with the dosing of Lidocaine in the low weight patient. I explained the procedure to the patient and their daughter who wanted to stay. I positioned the patient's daughter looking at her mother to offer her support and encouragement. I had a tACP with me to support the procedure.*

*I gained informed consent for the procedure and explained that there would be a risk of a skin tear as the patient's skin was very thin due to long term steroid use. I was able to answer the daughter's questions about the length of time the procedure would take in a clear straightforward manner. I am happy to have family present during procedures as it can calm the anxious patient and help facilitate communication in the hard of hearing. I explained that there was a trainee observing the procedure and that I would be talking them through my technique for the block and the importance of also injecting Lignocaine if there is also a fracture of ulna styloid.*

*Pre and post procedure I documented the radial pulse and CRT/warmth, as well as sensation of radial medial and ulnar nerve. A post reduction X-ray was ordered and interpreted. There was good alignment.*

***Reflection on the case***

*This is a skill I am confident in and able to teach others. I think the case went well and both the patient and her daughter remained happy and relatively relaxed. On reflection, having explained their role, I think it would have been good to involve the trainee more as they felt a little out of the loop and afterwards commented that they would have appreciated being more involved in helping.*

*This has helped me realise that training others is not just about demonstrating but also about involving the learner and considering how best to give them the best opportunity to develop their own skills.*

### Example C: DOPS for a competent ACP

Case discussed: Non-invasive ventilation in type 2 respiratory failure.

***Case observed***

*77-year-old man in type 2 respiratory failure. Carbon monoxide level very high from arrival – tolerating oxygen at low rate as known retainer. Patient had received NIV on previous admission – understandably reluctant to use before. Has a ceiling of care defined in the notes.*

*Discussion with the patient and their relative regarding the potential benefit of trial of NIV, daughter very keen and patient persuaded. I reassured the patient that if he didn't tolerate, we would reconsider.*

*I prepared the equipment – the NIV trolley had not been restocked that day (very busy) and I had to go to the store myself, so it took me slightly longer. Together with the nursing staff I placed the mask and was able to titrate to bring up the saturations to the 88-92% range. I set the alarms according to the guidelines and back up rate at 15 bpm. There was a student nurse in with me, so I engaged them in support for the patient and took slightly longer explaining what I was doing.*

***Reflection of event***

*This was initially a tricky conversation. I was pleased I had read all the notes, including the ceiling of care, so that in the discussion I could respond to his daughter appropriately. As the patient was a bit drowsy from the CO2 retention it was more difficult to be sure we had full consent but, in the end, it felt that it was in the patient's best interest. The senior nurse and the consultant were also available to discuss in resus and fully agreed with me – but I felt confident enough to have the discussion first without involving them directly.*

*The practicalities of the procedure felt fine – I have done this enough times to feel confident, but it reminded me of the issue of restocking, and I have dropped the matron a line with a few suggestions on how we might all work to support available stock. I had some nice feedback from the student nurse at the end, which was encouraging as I had to "teach" on the hoof which is sometimes something I feel less confident in doing.*

## 2. Curriculum and Syllabus Comments (CSCs)

The length of the reflection will depend on the case being reflected on and the learning that has taken place. It will also depend on the capability being demonstrated. There will be a separate reflection for each KC in any SLO.

**Example D: CSC for SLO1 KC1:** Gather appropriate information, perform a relevant clinical examination and be able to formulate and communicate a management plan that prioritises the adult's and, where relevant, the family's choices that are in their best interests, knowing when to seek help

*During my time as a tACP I have developed the skills required to obtain patient histories for cases of different complexities and with different patient groups. The CbD from 6/7/24 highlights how I have refined my history taking from majors cases to resus cases by adapting my pace and modifying my approach. The WBAs demonstrate my ability to perform systematic and detailed clinical examinations to help formulate a differential diagnosis. I have become confident in communicating management plans for a wide range of patients and potential diagnosis uncertainty. The MiniCEX from 1/4/25 demonstrates my ability to communicate with patients and families from differing backgrounds, and the use of a telephone translation service. The MiniCEX from 3/5/25 illustrates how I used shared decision making and managing patient preferences.*

*I am aware that to continue to finesse this skill I need to continue to consider the patient's and their relatives' needs and adjust my communication to their context – in some cases this means focusing more on the social and psychological effects rather than the practical treatments, in others patients simply want facts and to know when they can go back to work. Trying to tune into the patient's level of understanding and focus is important to allow that flexibility. The reflective practice log from January 2025 shows also how involving a different practitioner can sometimes defuse situations and allow patients to make a different choice.*

**Example E: CSC for SLO11** Participate in and promote activity to improve the quality and safety of patient care, **KC1***:* contribute effectively to a departmental quality improvement project

*As a tACP I participated in the RCEM audit on XXX (evidence ACP audit document upload 4/7/24). This gave me exposure to interrogating patient records, working as a team and identifying where the standards were not met in our ED. I was then able to apply what I had learnt about engaging the team and gathering information in the quality improvement work around YYY. In my reflection (reflective practice log 4/5/25) I have thought about the challenges of instigating change in a busy ED, particularly around sustaining that change. Informal networking, culture and role modelling appear as important, if not more important, than simply*

*writing policies. Overall, my engagement in this improvement activity has been rewarding. I have learnt how to use standard tools, and developed analytic skills in applying data, but I have also learnt a lot about managing my own workload. Learning how to rely on others, delegate, and allow competent team members to get things done - even when they do it differently to how I would do it - has been really valuable for the rest of my professional activities.*

### 3. Action points from WBA

#### Example F: Reflection on actions from a WBA

*In the MiniCEX of 4/5/24 we agreed my action points would be to refresh my understanding of the NIH stroke scale. In looking at the literature and exploring easy tools to remember this, I have found that MedCalc has a tool that is easy to use on a mobile and desktop. This has not only proved valuable in the clinical arena but has been a boon to me in learning and developing this assessment which I felt quite overwhelmed with previously. I have now used it on three patients since the MiniCEX and been able to more confidently refer and discuss possible options for management with the stroke team on the other site as I "talk their language" now.*

### 4. Other activity

#### Example G: Reflection on a directorate quality and safety committee meeting

*I attended the meeting to present our audit but also to learn about how the senior team manage quality and safety. I now realise the effort that goes into reviewing all the incidents and complaints, and how these are used to prioritise improvement actions or write new policies. This has shown me how leadership is more than just being "senior" but requires you to think outside the box and have that continued sense of wanting to do the best for all the patients.*

## Resolution Comments (ACP Educational Supervisor)

Whilst clearly the ACP Educational Supervisor's comments are the business of the supervisor, your own content and reflection on the WBAs, and the CSC, helps the ES to triangulate their perception and your evidence. What you write in your reflections can be supported by the ES notes.

**Example H: Resolution Comment for SLO1 KC1** (using the evidence the supervisor has reviewed to support the comments)

*X has developed clear history taking and examination skills as a tACP. As X has reflected on in her CSC, she has moved from a predominately "recipe driven" approach to assessment to a more flexible, responsive and independent structure that brings benefits as focused history taking and examination whilst not missing vital clues. These WBAs clearly demonstrate progress in this area. The WBAs by Dr Y 3/5/25 and Dr Z 18/4/25 demonstrate X's ability to use the information gathered in the consultations to formulate clear, well thought out management plans that clearly include patients' ideas, concerns and realistic expectations within the department. X communicates clearly with all patient groups. They are working at entrustment level 2b.*