Reflection is an essential skill that enhances the nursing profession. It is the process of creating meaning from interpreting experiences through purposeful thought that guides decision making. Reflective process provides an opportunity to improve communication among hospital staff as well as between healthcare providers and families of infants who are born prematurely or critically ill. Reflection enhances self-knowledge as well as providing a venue to support the caregiver’s increased understanding of infants’ experiences. Nurses in leadership positions often struggle to create and carry out reflective strategies in clinical practice. Reflective strategies provide integral support for staffs who are attempting to make a major change—in our case, implementing an individualized developmentally supportive care program in the newborn intensive care unit (NICU). This article will discuss various reflective strategies utilized in a tertiary regional referral NICU, as a formal initiative was implemented to support individualized developmental care (IDC) practices for infants and their families.

Keeting⁴ wrote that nurses who are critical thinkers are better able to solve problems, improve clinical reasoning, and enhance decision making. Critical thinking is defined as a higher order of rational thinking that occurs when it is fair minded and grounded in intellectual integrity. Reflective strategies are one way to help develop critical thinking skills by facilitating the raising of appropriate questions, gathering and assessing relevant information, and then logically coming to a conclusion. This skill helps us include the perspectives of others and provides opportunities for healthcare providers to consider new ideas. Both Roger’s Theory of Innovation⁵ and Lewin’s Change Theory⁶ tell us that time and work are needed to implement change. Reflection, too, is essential in the change process. A clinical dilemma may prompt critical reflection and the development of new ways of interpreting an experience.

Unexpected events may impact adults in differing ways, which causes them to critically reflect upon their current beliefs and assumptions. When critical reflection occurs, a person’s perspective is then transformed and the situation becomes better understood. Reflective learning challenges the validity of presumptions from prior learning, thus creating a perspective transformation.⁷

By nature and history, newborn intensive care is technology focused and crisis driven. It is a highly stressful environment that demands technical competence while, at the same time, the emotional wherewithal to ensure that infants are cared for in an environment, which values their basic humanness.⁸
Individualized developmentally supportive care is an approach to care that guides caregivers to view and closely consider each infant as an individual, challenging the caregiver to understand the uniqueness and personhood of the infant. Relationships between the caregivers and between the caregivers and families play a major role in successfully supporting such a change. Individualized developmental care seeks to understand infants’ neurobehavioral agenda, while appreciating the infants’ individual strengths. Individualized developmental care challenges caregivers to consider the role relationships play in supporting the infants’ development. Reflective strategies may be utilized to enhance the professional caregiver’s understanding and perceptions of the emotional experience in the NICU. A main concept in learning about IDC is for the caregiver to closely consider his or her own experiences and how this relates to the infant’s experience.

With the help of a reflective process consultant, the developmental leadership team in the NICU embarked on the Newborn Individualized Developmental Care and Assessment Program Training Process to enhance developmental care practices. Initially a social worker, with a background in working with family dynamics and supporting the systems, or staff that worked with families began biweekly 1.5-hour sessions with the developmental leadership team. The majority of topics identified during these sessions were within the context of challenges that arose because of the change process. The objective was to discuss topics to enhance the overall systems integration of IDC principles rather than focusing on the individual staff member’s experience. This consultant worked with the developmental leadership to increase their self-knowledge and skill set in diffusing emotional tensions associated with an active change process. Within a few months, outside variables removed this reflective process facilitator from the system. The nursery leadership group took a step back and articulated the desirable characteristics necessary to identify a new reflective process facilitator. We wanted to ensure continuous improvement in implementing individualized developmentally supportive care into nursery practices.

A PhD-level psychologist within the Department of Psychiatry was then identified and began to meet with the developmental leadership team a few times a month for 2-hour sessions. Reflective techniques such as guided dialogue, role-playing, journaling, and guided imagery were utilized. Formalized reflective process support was a new experience for the nursery staff and proved to be invaluable by the participants. Guided discussions provided opportunities to expand mindfulness on the participants’ own experiences as well as broadening their perspectives to include the experiences of others. Identifying internal triggers facilitated changes in the responses and ultimately the communication patterns. Guided imagery was used as a tool to reduce the perception of irresistible apprehensions and anxieties related to a change process. Reflective strategies provided a venue or an opportunity to deal with the generic communication issues and staff’s relationships with each other. When challenges with communication and labile emotions were identified within the larger nursery staff, the concept of facilitated reflective strategies was expanded to include additional leadership members of the NICU staff. We now added the NICU manager, 4 assistant nurse managers, a clinical nurse specialist, the manager of the advanced practice group, a developmental specialist, a developmental nurse educator, and the clinical service coordinator. In an effort to support safe trusting relationships, an additional psychologist was engaged to work with this group. The second psychologist was also identified to work with the broader nursery staff to facilitate various reflective initiatives. The leadership group met every 3 months for 1.5 hours. Identifying the second psychologist to facilitate the meeting rather than utilizing the nurse manager helped immensely, as this allowed the manager to participate within the group and allowed for developing more cohesive communication among the group.

After solidifying the reflective meeting for the leadership group, the process of reflective support was expanded to the general nursery staff utilizing guided small group discussions. Although the group was open to all staff, nurses were the primary participants, yet occasionally a nurse practitioner or physician’s assistant participated. The strategy of using action learning circles with a clinical focus or discussions about critical incidents facilitated the sharing of perspectives in a safe and trusting manner. Each meeting lasted about an hour and began with a review of the ground rules for discussions and what would be allowed in terms of how people in the group shared information. Individual opinions were respected and the facilitator ensured that the process was constructive and forward moving. Overall, the staff responded very well to the clarity of expectations the facilitator articulated and did not discuss the contents of the meeting in the general nursery environment. These discussions provided a venue for the staff to appreciate alternative perspectives on complex challenging topics. The physical environment of the meeting was also given attention and thoughtful consideration; a private yet convenient space was identified close to the nursery yet was not in the nursery. Comfortable chairs facilitated discussion, and lighting as well as the overall ambience of the room was also attended to. The staff found these meetings productive and useful as they were very well attended by the nursing staff. At times, specific cohorts within the nursing staff, such as a group of
7 or 8 new nurses just off their orientation, were identified and met with the psychologist to support the integration of reflective strategies into the overall nursery. Once this was established, additional venues were created to enhance multidisciplinary participation, address more complex team communication issues, and expand the use of self-awareness as a means to enhance overall care to infants. Reflective strategies then were infused into the concept of patient care conferences. These conferences were initiated as difficult circumstances were identified by the staff in caring for medically complex infants and their families. We had such a conference to help us in caring for a medically complex infant whose mother also had considerable mental health issues. The format of having a process facilitator who ensured clear ground rules as well as meetings that began and ended on time enhanced the participation by the staff. The meetings lasted 1 hour. Again the developmental leadership attended to the physical and emotional environment of the room as well as speaking at length with the staff prior to the meeting to ensure that the staff was clear on the meetings’ objectives and priorities. After a few months, weekly patient care conferences were utilized to bring the team together and discuss the medical and emotional issues needed to care for critically ill infants and their families. Identifying a qualified facilitator, in this case a psychologist, allowed the attending physician to be a group participant with a specific perspective rather than the leader of the group, which was pivotal to the success of the process. A rotating member of the group presented a brief overview of the challenging issues to the participants; the remainder of the hour was utilized by the staff to articulate their perceptions of what the challenges provoked in them as they provided care to this particular infant and family. The process fostered mindfulness throughout the entire team as they expanded their thinking about not only their own experience yet also from the infant and family’s perspective as well.

In conclusion, utilizing a variety of reflective process strategies is essential to make changes in a structured setting such as the NICU. We were able to enhance developmentally supportive care practices in the NICU, as we enhanced supportive strategies for ourselves. Healthcare providers who utilize critical thinking skills enhance the care they give to premature and critically ill infants. NICU leadership support is crucial to the success of reflective process. Consistent messages and behind-the-scenes dialogues provide a venue for the staff to better understand the objectives and goals of the reflective strategies. Essential components of reflective process consist of a qualified facilitator, clear consistent communication as well as attention to the physical and emotional environment. A multifaceted approach to reflective process strategies such as critical incident debriefings, patient-care conferences, guided dialogues with a qualified facilitator, journaling, and guided imagery are useful mechanisms to enhance reflection and critical thinking in healthcare professionals.

Acknowledgments
The author expresses appreciation to Susan Sampl, Gwyn Muscillo, Rachel Schmitt, and Karen Steinberg for their vision, dedication, and generosity. The author also appreciates Cathy Daguio for her tireless commitment to developmental care.

References