Script for Reflective practice and reflective writing for nurses, AHPs and other staff.

Housekeeping – ask trainee(s) if they wish to do hands up, if they need to be muted, do they want to communicate via Chat.

When sharing screen and presentation ensure that on sharing tray the “Include Computer Sound” button is clicked into the On position.

Slide 1. Introduction.

This workshop aims to give an overview of reflective practice and writing as tailored to the point of view of nurses, allied health professionals and other healthcare staff.

Slide 2. Learning outcomes.

The learning outcomes from this session are as follows:

Describe reflective practice:
- Understand drivers and benefits
- Consider different types and models of reflection
- Demonstrate how to carry out reflective practice
- Overcoming barriers to reflection
- Reflective writing
- Academic reflective writing

Slide 3. What is reflective practice (share definitions sheet – read out a couple of definitions)

Have a look at the definitions sheet – in addition:
A way of raising awareness of why things have occurred;
To examine your experience to look for the possibility of other explanations and other ways of doing things;
Making sense of events around us;
Learning from experience

In 2019 the Nursing and Midwifery Council along with 8 other regulators signed a joint statement on the benefits of becoming a reflective practitioner and stated on their website:
“Reflection is how health and care professionals can assess their professional experiences – both positive and where improvements may be needed – recording and documenting insight to aid their learning and identify opportunities to improve.

Reflection allows an individual to continually improve the quality of care they provide and gives multi-disciplinary teams the opportunity to reflect and discuss openly and honestly.

The statement makes clear that teams should be encouraged to make time for reflection, as a way of aiding development, improving wellbeing and deepening professional commitment.”

Reflection can be said to be related to experiential learning – the process whereby an individual has an experience, reviews and describes it, then analyses it to draw conclusions and plan the next steps – which can be ideally considered as a continuous learning process.
The HCPC website also supports the joint statement and adds:

The statement affirms that reflection plays an important role in healthcare, and brings benefits to service users, by:

- Fostering improvements in practices and services;
- Assuring the public that health and care professionals are continuously learning and seeking to improve.

The statement reinforces that reflection is a key element of development and educational requirements and, in some professions, for revalidation as well.

It also makes clear that service user confidentiality is vital, and that registrants will never be asked to provide their personal reflective notes to investigate a concern about them.

How reflection is carried out varies and is personal to the individual, but there are a variety of tools available. It is important that time is given to reflection and group reflection often leads to ideas and actions that can improve care. The healthcare team as a whole should have opportunities to reflect and discuss openly and honestly what has happened when things go wrong (and also when things go well).

However, reflection should not substitute or override other processes that may be necessary to validate or discuss significant events and serious incidents.

It is important to know that a reflective note does not have to capture full details – it should capture learning outcomes and future plans.

**Slide 4. Why do it?**

Reflection is required by healthcare professions:

- Nurses are required to do it by the Nursing and Midwifery Council (NMC) and for AHPs the Health and Care Professions Council (HCPC) recommends it; they offer support and guidance to do it.
- Can help with the day to day stresses of being a healthcare professional.
- Part of training for HCPs.

The Royal College of Nursing and other professional bodies also offer support and guidance for reflective practice. The Chartered Society of Physiotherapists also offers support https://www.csp.org.uk/system/files/documents/2018-10/6._looking_backwards.pdf as does the General Pharmaceutical Council https://www.pharmacyregulation.org/regulate/article/focus-reflection

Reflection could be a particularly valid tool at this present time – when the CoVid pandemic is having such an effect on healthcare professionals. The Royal College of Nursing published guidance on reflective practice during a time of CoVid in May 2020 – available on the Nursing Standard website https://rcni.com/nursing-standard/features/how-to-use-your-covid-19-experience-reflective-practice-160601 mentions how reflecting regularly can help build resilience. In HCP training reflective practice is often taught together with critical thinking – which could be said to be the art of asking and answering questions to get to the truth, systematically and asking the
most useful questions in the best sequence to yield a credible and coherent narrative. Both techniques try to deal with matters as they are and not how we would like them to be. See the attached handout for more details. (Reference http://www.learnhigher.ac.uk/wp-content/uploads/Critical_Thinking1.pdf)

There are also e-learning some modules available at www.e-lfh.org.uk – which can be accessed via an Athens account – to set up an Athens account register at http://openathens.nice.org.uk – contact ESNEFT Libraries for more details.

Slide 5. Requirements for nurses, AHPs and others.

- NMC revalidation requirements (2016) – 5 written reflective accounts on Continuing Professional Development (CPD) feedback. Templates, guidance, examples and forms for this are available on the NMC website.
- The HCPC encourages reflective practice as one of the CPD activities to be used as evidence when renewing professional registration (HCPC website, 2019).

The NMC and issues detailed guidance on reflection for revalidation – which can be found on their website http://revalidation.nmc.org.uk/what-you-need-to-do/written-reflective-accounts.html - complete with a proforma form to complete and examples of reflective accounts. The key points for revalidation for the NMC are the following: what you learned, how it improved your practice and how it relates to the NMC's Code. The RCN also issues some useful guidance attached to its website https://www.rcn.org.uk/professional-development/revalidation/reflection-and-reflective-discussion - including examples of reflective practice models.

For other professionals the HCPC offers guidance on the CPD part of their website https://www.hcpc-uk.org/cpd/cpd-audits/completing-a-cpd-profile/how-to-complete-your-cpd-profile/cpd-sample-profiles/ and professional associations will offer relevant advice e.g. Chartered Society of Physiotherapy https://www.csp.org.uk/frontline/article/reflection-action

Slide 6. Where to do it

- As an individual
- In pairs – with a “critical friend”
- Mentor and mentee discussion
- One-to-one or facilitated group supervision
- Audit/QI/Meetings
- At work or at home
- Written or verbal

Slide 7. How and when to do it

Make reflection a daily habit
Reflection is personal – there is no one way or framework to reflect
Clarify the purpose of your reflection and reflect when you are most ready – it can be uncomfortable.
Allocate time for it
Create reflective records
Respect the rights and privacy of others
  • Reflective notes can currently be required by a court
  • Don’t record actual personally traceable details in reflective discussions – these should be recorded elsewhere
  • Seek advice from a supervisor or appraiser if in doubt about the content

Slide 8. Types of Reflection
Clinical
Team
Self
Self reflection – individual practice, can be done alone or with support of a manager e.g. can keep a reflective journal and discuss one at supervision. Can be related to clinical the clinical incident but is more related to self (reactions, behaviours, thoughts, confidence).
To promote healthy relationships, with self and others. Those who are self-reflective benefit patients by practicing the art and heart of caring. Those who self reflect have more capacity for empathy, self-awareness. (emotional intelligence).
• Encourages a level of self-awareness and consciousness about practice
• Enables you to identify areas for improvement and also areas where you are strong
• Allows you to recognise what works and what doesn’t with students
• Enables you to think deeply about students reactions to your teaching

Clinical – A clinical reflection is a description about an event during the clinical day. It is a powerful tool for development of novice critical thinking skills. It facilitates active learning, as well as professional growth, in a non-threatening manner.

Team (clinical or non-clinical) – can be related to a subject or an event. Helpful to be done to discuss an event such as when a team worked very well together or there has been a complaint or an incident/accident. Closely linked to debriefing (this is normally done after a traumatic event). Both need to be facilitated properly so everyone gets a say, domination, blame, emotional and learns.
Schwartz rounds – form of team reflection (not clinical). They have been held in this Trust, usually monthly on a lunch-time period on a particular day of the week in each hospital. Watch out for them starting up again! They are often related to experiences and feelings, providing a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in health care (reference https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/) They will cover topics such as “When I made a difference” and 3 or 4 stories will be told per round.
Slide 9. It does not have to be formal!

E.g. journals, blogging, creating mind maps, poetry, photography, story telling. Please see the examples later in the presentation – including an online blog and a video compiled by a physiotherapy student reflecting on a placement.

Slide 10. Types of reflection (Schon 1991)


Reflection in action – during the event:
- The experience itself
- Thinking about it during the event
- Deciding how to act at the time
- Acting immediately

Reflection on action (after the event)
- Reflecting on something that has happened
- Thinking about what you might do differently if it happened again
- Thinking about how new information could have influenced feelings and actions

Slide 11. Reflective models and frameworks

Many of the reflective models and frameworks around to help with the active process of reflection are rooted in domains of the theory of education and psychology. Healthcare professionals (particularly in the nursing field) have also contributed to the literature on the subject. Some major reflective practice models are as follows:

- Gibbs’ reflective cycle (1988)
- Johns’ model for structured reflection (1994)

No one framework is the right one to use – it depends on the individual.

Adapted by Colin Melville 2018

Slide 12. Model of reflection – Gibbs’ Reflective Model – very well known – (need to click to get each sentence to show due to formatting on Powerpoint):
The following few slides will cover the Gibbs model of reflection in more detail with a worked up example to help show how reflection can work in practice.

- Broken down into six steps.
- Research based, formal, straightforward, systematic and well structured.
- Clear description of experience and leads you through different stages to make sense of that experience. BUT:
- Detailed steps - overlapping – a simpler framework may be easier to use.
- Cyclical – so no closure – which is sometimes necessary.

**Slide 13. Gibbs Reflective Cycle**


**Slide 14. Exercise – an example. (share scenario and Gibbs cycle framework form for completion or email them)**

- Please read and listen to the scenario.
- Then using Gibb’s reflective cycle, work through the cycle and complete the attached handout using the following slides as a guide.
- 5 mins – then report back.
- YouTube video link [https://youtu.be/-00-rSck2cE](https://youtu.be/-00-rSck2cE)

**Slide 15. Step 1. Description (Scene setting) (need to click to get each sentence to show due to formatting on Powerpoint):**

First describe the situation in detail. What happened. Stay to the point and keep it simple.

– When and where did this happen?
– Why was the healthcare professional there?
– Who else was involved?
– What happened?
– What did he/she do?
– What did other people do?
– What was the result of this situation?

Slide 16. Step 2. Feelings (need to click to get each sentence to show due to formatting on Powerpoint):

• Thoughts and feelings (before, during and after)
  – What did the HCP and the patient feel before this situation took place?
  – What did they feel while this situation took place?
  – What do you think others felt during this situation?
  – What did he/she feel after the situation?
  – What does he/she and others think about the situation now?
  – How has this incident impacted on him/her?

Slide 17. Step 3 Evaluation (What) (need to click to get each sentence to show due to formatting on Powerpoint):

• Was the experience good or bad.
  – What was positive about this situation?
  – What went well and not so well? In what way?
  – What have he/she learnt?
  – What did he/she and other people do to contribute (positively or negatively)?

Slide 18. Step 4. Analysis/Exploration (Why) (need to click to get each sentence to show due to formatting on Powerpoint):

• What sense can you make of the situation.
  – Why was the event positive/negative
– Tries to explain the causes and consequences of things that happened during the event.
– What could have been done to avoid negative consequences or improve positive consequences.
– Was the HCP’s part useful, have you been in similar experiences, were your actions/reactions similar or different to this?
– What has the HCP and you learned from your experiences.

Slide 19. Step 5. Conclusions (So What) (need to click to get each sentence to show due to formatting on Powerpoint):


• Once you’ve evaluated the situation, you can draw conclusions about what happened.
  – What did the HCP learn about him/herself, (negative and positive)
  – What skills does he/she need in order to avoid or improve the outcome of a similar event.
  – What could she/should she have done differently.
  – What are the barriers for doing this.
  – Strengths and weakness of his/her practice
  – Did it meet any competencies or learning objectives

Slide 20. Step 6. Action Plan (Now what) (need to click to get each sentence to show due to formatting on Powerpoint):


• This states a plan of action for the future to improve your knowledge, ability and competency and sums up your entire piece.
  – What specific training, shadowing, knowledge does the HCP require.
  – What areas of development should he/she prioritise.
  – Even if positive – how could he/she improve it more, and what steps does he/she need to reach this.
  – What else could he/she do to be more prepared in the future.

Slide 21. Feedback on the exercise (10 minutes) (share handout – worked validation form example or email it or copy and paste it into chat)


• Website of worked example (also see handout)
  www.eel.nhs.uk/reflection
• Share what you observed with each other
• What have you learnt?
• How did it feel using the model?

Slide 22. Examples – also see handout.

• https://www.youtube.com/watch?v=Z4uBXJlk8CA – a student physiotherapist video – it does not have to be written!
• Jennifer Moon - a well-writer on reflective practice identified 4 levels of reflection and recommended that only the last two – the deeper levels be used in reflective writing. More information is available in her article in the journal Radiotherapy (complete with an exercise and example):

Slide 23. More examples.

• Website of worked example (also see handout) https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/clinical-topics/older-people/care-home-journey/danilo-reflective-account.pdf?la=en – please note that this example is an NMC revalidation form and so might not fit the Gibbs cycle workings exactly, but Nurse D would have had to work through something similar to come to the conclusions outlined in the form. It also gives an idea of how a revalidation form might be completed.

Slide 24. Blocks and barriers (need to click to get each sentence to show due to formatting on Powerpoint):


• Self motivation
• Knowledge and skills
• Resources
• Time
• Accommodation
• Staffing
• Fear of being judged
• Organisational culture
To recap somewhat, some key pointers related to reflection are listed below:

- Discussing or writing down reflections as part of education, training and development.
  - Focus equally on positive encounters and achievements, not only incidents or complaints. See the NMC revalidation example for a generally positive reflection. Many examples seem to deal with negative situations, but a positive experience can be just as helpful as part of the learning and development process.
  - Emphasis on quality rather than quantity
  - Structure a note and capture learning outcomes and future plans
  - Anonymise reflective notes as far as possible
- Need time and space for individual and group reflection

**Slide 25. Reflective writing**

The last few slides of this presentation aim to give a more in-depth approach to reflective writing, including information and techniques to aid in the development of the craft.

“Reflective writing involves engaging in and completing the reflective cycle using the processes of writing as an instrument to help you learn” (Jasper, 2013).


This statement can be broken down as follows and more on reflective writing will follow later in this presentation.

- To record an event or experience and learn from it – evidence of reflective thinking
- To engage in deep learning processes
- To enhance other forms of learning
- Contributes to personal and professional development

Jennifer Moon, a well-writer on reflective practice identified 4 levels of reflection and recommended that only the last two – the deeper levels be used in reflective writing. More information is available in her article in the journal *Radiotherapy* (complete with an exercise and example):


**Slide 26. Useful phrases for writing**

The phrases below are useful to include in a passage of writing which might for example, be part of an e-portfolio or revalidation submission as they convey a more reflective, analytical tone than a very direct, chatty style.

I thought – I felt – I realised – I noticed
I was uncomfortable about – I did not question – I was aware/I was unaware
At the time – looking back – I now see
Having realised – learned – observed – discussed – applied
I now... feel – consider – question – know – wonder – will need to

**Rather than describe, you need to evaluate** – this is linked to developing critical thinking.

**Slide 27. An example – before.**

About a week ago I went to see Mrs X about getting a bed and a commode for her downstairs which is what her GP (Doctor Jay Jones) said she needed. I knew that her mobility was poor as her doctor had told me this and she was having problems getting up and down stairs. I don’t really know why people have to live in such unsuitable houses, but it was not my business to say this. I was short of time but asked the key questions. Her husband was out at the time or not around, anyway which
was strange considering she said that he was really good. I expect he got fed up with her dithering about.
I got a rather muddled response and the lady seemed to be working herself up into a bit of a state, which was completely unnecessary. I think she might have had a bit of Alzheimer’s as she did not really understand that the GP had clearly said she needed a bed and a commode downstairs. Basically, if she didn’t there was a good chance of her ending up in the ED with a #NOF and needing a protracted LOS. I was able to reassure her that having such equipment to hand was something lots of people did.

I really don’t know why the complaint came through, except to say that her husband Jim is a difficult person at the best of times.

Slide 28. An example – after.

Last week I had an appointment to see Mrs X (name and personal details anonymised for reasons of confidentiality and data protection). I had assumed that the visit was organised in advance by her GP and communicated to her and her husband by our admin team, which turned out not to be the case. I now understand that this should have been checked before I arrived. I was told to do a quick assessment about getting a bed and a commode in downstairs for Mrs X. Her husband was not present and I did not ask where he was, but I did ask her about how he was managing. It would have been better if I had spoken to him directly, either when the patient was present or in some other way, possibly by telephone just before or after the visit.

There were some basic details on the computer and I needed to read as I went along; I now realise that I should have read more about the case before I arrived. What happened subsequently has made me think very hard about my communication and listening skills, at the time I felt annoyance because it seemed that the patient was not listening to me, in fact it should have been me that was giving a willing ear to the patient.

I did not question the suggestion that a downstairs bed and commode would be the best arrangement for the patient and I was unaware of her confusion and distress about an uncertain future. I now consider that I was poorly informed and that my actions at the time did not improve the situation, with hindsight it would perhaps had been better if I had contacted the GP before the visit or just after to discuss alternative options.

I have spoken to my line manager about the need for better communication within our team and have requested that I shadow one of our occupational therapists when they next carry out a patient assessment for equipment. In agreement with my line manager I have booked to attend a trust sponsored communication and listening course, along an extra e-learning module on Person-Centred Approaches (PCT) which is available via the E-learning for Health portal, as supported by Health Education England (HEE). I have also done some reading around trust guidelines on record-keeping and the importance of dignity and compassion in a patient/healthcare professional interchange.

Now armed with useful websites such as https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/household-gadgets-and-equipment-to-make-life-easier/ I now know that information is available from organisations such as the Disabled Living Foundation. Also, that Mrs X and her husband could have applied
to their local council for a home assessment, and help with possible alterations such as an extra stair rail and suitable adjustments in the bathroom to help maintain the patient’s independence. My intention is to prepare a leaflet listing this information and local details, to give to patients and families or carers when having this type of discussion in the future.

**Slide 29. What is the difference?**

Less superficial – more depth

Analysis of situation – awareness of change in perspective of self

Not just description

Multiple perspectives of others taken into account

Consideration of how learning from incident will impact in future

To summarise: reflective writing is written evidence of reflective thinking:

Look back at an idea, event or object

Analyse the event or object in depth and from different perspectives

Consider implications for future practice/self development – what have you learnt?

(Hampton, M. 2010, pp. 1)


**Slide 30. Examples – see also handout.**


Videos to help with reflective writing and academic reflective writing from Rebecca Rowe, Clinical Librarian at Royal Papworth Hospital (2019) Academic writing: [https://youtu.be/HTdU_I1PCkU](https://youtu.be/HTdU_I1PCkU)

Reflective writing: [https://youtu.be/XR6XMsXz_4A](https://youtu.be/XR6XMsXz_4A)

**Slide 31. Things to avoid when writing reflection.**

The list below helps to underline what has been said above in terms of the style that can be adopted in written reflections.

- Too much or too little detail
- If it is not your own personal diary try to avoid writing too informally
- Moralising or being judgemental
- Sarcasm or irony or “know it all”
- Revealing confidential information about patients, colleagues or yourself
- Using obscure jargon or abbreviations
**Slide 32. Academic reflective writing**

This is taking reflective writing one stage further – for example if a reflective piece has to be submitted for a particular qualification – in which case the following will apply:

**Things to consider:**
All of the above – plus:
- Demonstrate the ability to apply theory
- Show your familiarity with relevant literature
- Connect the literature with your experience
- Reflect on your practice and how aspects are relevant to the literature
- Show your learning and make recommendations
- Whether or not to use first person singular in reflections – it is usual to do this but follow the guidelines of your academic institution on this.

**Slide 33. Academic example page 1.**

There are many definitions of reflective practice, but a useful definition of *critical reflection* could be said to be the following, as outlined by Roberts (2015, p. 21) – it is defined as: “...that activity in which experiences are considered in order to identify the assumptions influencing the thoughts, feelings and actions in a given situation. These assumptions are then rigorously questioned and challenged with a view to developing alternative ways of thinking, feeling and acting in future situations.”

What follows is a critically reflective piece with the intention of meeting the requirements of this definition. The author will use the singular personal pronoun throughout, which is the convention for a piece of reflective writing (University of Adelaide, no date) and has already analysed the events that are described below with the use of the Gibbs Cycle (Gibbs, 1988) – a well-established standardised model of reflection which represents the process as cyclical.

**Reflection**

Last week I had an appointment to see Mrs X, whose name and personal details have been anonymised for reasons of confidentiality and data protection, as outlined by Baez (2002, cited in Kaiser, 2009, p. 1638). I understood that the visit was organised in advance by her General Practitioner (GP) and assumed that the date and time had been communicated to her and her husband by our admin team, which turned out not to be the case. I now understand that this should have been checked before I arrived.

I was told to do a quick assessment about getting a bed and a commode in downstairs for Mrs X. Her husband was not present and I did not ask where he was, but I did ask her about how he was managing. It would have been better if I had spoken to him directly, either when the patient was present or in some other way, possibly by telephone just before or after the visit.

The importance of good communication as part of compassionate care is emphasised by Gault et al. (2017, p. 4); in this respect I now comprehend that my actions fell short of what was required.

There were some basic details on the computer and I needed to read as I went along; I now realise that I should have read more about the case before I arrived. What happened subsequently has made me think very hard about my communication and listening skills, at the time I felt annoyance because it seemed that the patient was not listening to me, in fact...
it should have been me that was giving a willing ear to the patient. The value of listening and questioning in demonstrating that a professional is interested in the patient and focused on them is outlined by Schmidt Bunkers (2010, as quoted by Gault et al., 2017, p. 17) and further underlined through the findings of Myers et al. (2020) in their recent study of empathetic listening behaviours from the point of view of the patient. This is a key part of the concept of person-centred care, as discussed in the nursing literature through the pivotal book written by McCormack and McCance (2010).

**Slide 34. Academic example page 2.**

I did not question the suggestion that a downstairs bed and commode would be the best arrangement for the patient and I was unaware of her confusion and distress about an uncertain future. I now consider that I was poorly informed and that my actions at the time did not improve the situation, with hindsight it would perhaps had been better if I had contacted the GP before the visit or just after to discuss alternative options. Useful guidance in relation to risk, assessment and items of equipment is available from organisations such as the Royal College of Occupational Therapists (RCOT) as described in the latest edition of their practice guideline on the prevention and management of falls (RCOT, 2020).

I have spoken to my line manager about the need for better communication within our team and have requested that I shadow one of our occupational therapists when they next carry out a patient assessment for equipment. In agreement with my line manager I have booked to attend a trust sponsored communication and listening course that uses the SAGE & THYME communication model as developed by Connolly et al. (2010); along an extra e-learning module on Person-Centred Approaches (PCT) available via the E-learning for Healthcare portal, as supported by Health Education England (HEE) in partnership with the National Health Service (NHS) and professional bodies (HEE, 2021). I have also done some reading around guidance on record-keeping (Andrews, 2020) and the importance of dignity and compassion in a patient/healthcare professional interchange (Gault et al. 2017).

Now armed with useful and easily accessible websites such as the patient facing NHS.uk page *Household gadgets and equipment to make life easier* (NHS, 2018), I now know that information is available from organisations such as the Disabled Living Foundation (DLF) who provide a comprehensive online resource (DLF Shaw Trust, 2021). Also, that Mrs X and her husband could have applied to their local council for a home assessment, obtaining contact details via the Gov.uk portal (*Apply for equipment for your home if you’re disabled*, no date), and help with possible alterations such as an extra stair rail and suitable adjustments in the bathroom to help maintain the patient’s independence. My intention is to prepare a leaflet listing this information and local details, to give to patients and families or carers when having this type of discussion in the future.

In conclusion, the writing of this critical reflection has led to the identification of weaknesses in practice: both for the individual and the wider team and to the generation of a suitable action plan to address these issues, therefore improving teamwork and patient care.

**Slide 35. Academic example page 3.**

**References**

Apply for equipment for your home if you’re disabled. (no date) Available at: https://www.gov.uk/apply-home-equipment-for-disabled (Accessed: 07 April 2021).


Slide 36. Examples – also see handouts

- https://libguides.scu.edu.au/reflectivepractice/examples - American but includes useful examples
- https://arro.anglia.ac.uk/id/eprint/705768/6/Fox_2020.pdf - wordy, but example of published article – this version is in draft form.
The library can help...


Information queries: e.g. what sort of models are there? What do Schwartz Rounds do? What is the original reference for the Gibbs’ reflective cycle?

Sourcing documents – articles/books/etc.

Training on searching the literature

Literature/evidence searches to support your practice

Help with referencing

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**Slide 38. ESNEFT Library and Evidence Service contact details**

**Colchester Healthcare Library**
Villa 8, PGMC
Colchester Hospital
[Library.services@esneft.nhs.uk](mailto:Library.services@esneft.nhs.uk)
Tel: 01206 742146

**Ipswich Hospital Library**
Education Centre
Ipswich Hospital
[Hospital.library@esneft.nhs.uk](mailto:Hospital.library@esneft.nhs.uk)
Tel: 01473 702544 (Ext. 1544)

Website: [www.eel.nhs.uk/esneft](http://www.eel.nhs.uk/esneft)
Intranet: [https://intranet.esneft.nhs.uk/pages/library-ESNEFT](https://intranet.esneft.nhs.uk/pages/library-ESNEFT)
Secure email: chu-ftr.libraryservices@nhs.net

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**Slide 39. Any questions?**

Any questions?

Thank you!

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**Slide 40. Acknowledgements.**

I would like to acknowledge Julia Harriss, Lindsey Mellon and Kim Swan for permission to use material prepared for their community staff reflective practice course.