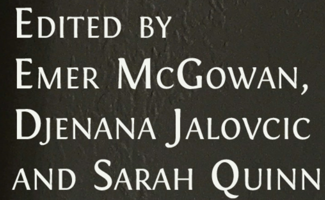

A Practical Guide for Interdisciplinary Health and Social Care Teams

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7. Evidence-Informed Practice and Learning Through Critical Reflection

Emer McGowan and Sarah Quinn

> I think that health personnel who work with refugees must be aware of which group they are working with. It is a very good feeling when someone comes, and you see that they have received the right treatment. That you have helped them with the problems they had. It creates a very good feeling.
>
> —Female nurse from Bosnia living with refugee status in Norway

Taking an evidence-informed approach and reflecting critically on service provision are two practices that can be employed to ensure quality in the care provided to people with refugee experience. When working with potentially vulnerable populations, like people with refugee experience, evidence-informed practice highlights the importance of attending to the needs of individuals and integrating their narratives into the use of practices that are evidence-based (Nevo & Slonim-Nevo 2011; Kumah et al. 2022). This chapter argues for the adoption of evidence-informed practices in work with people with refugee experience as more appropriate than the traditional and well accepted evidence-based practice model. The complementary practice of critical reflection is an internal process that helps refine understandings of an experience, potentially leading to changes in perspective and future actions (Mann et al. 2009) and supporting the development of services responsive to the needs of people with refugee experience.

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Evidence-Informed Practice

Across the recent past, efforts to improve quality, reliability, and service-user outcome and experiences, have promoted the move away from practices based on tradition and rituals, towards the implementation of best available evidence in guiding interventions (Kumah et al. 2019). Health and social care professionals are expected to apply the best available evidence to inform their clinical decision-making, roles, and responsibilities (Kelly et al. 2015; Andre et al. 2016; Kumah et al. 2022). The many advantages to the service user, professional, organisation, and health and social care systems of the use of best available evidence have been espoused. These include improved outcomes for service users and increased transparency, enhanced cooperation between professionals, greater job practitioner satisfaction, and improved system efficiency (Tickle-Degnen & Bedell 2003; Nevo & Slonim-Nevo 2011; Kelly et al. 2015).

Two main concepts have been associated with the application of evidence into healthcare practice: evidence-based practice and evidence-informed practice. Evidence-based practice (EBP) is well-established in health and social care and regarded as the norm or gold standard for the delivery of effective healthcare (Kumah et al. 2022). The universally accepted definition of evidence-based practice (EBP), adapted from the definition of evidence-based medicine, is "the conscientious, explicit and judicious use of the best evidence in making decisions about the care of the individual patient" (Sackett et al. 1996). In recent times, the concept of evidence-informed practice is increasingly being adopted instead of evidence-based practice (Kumah et al. 2022). Evidence-informed practice (EIP) has been described as the "assimilation of personal judgement and research evidence regarding the efficiency of interventions" (McSherry et al. 2002). It is an approach to care that involves combining research evidence regarding the efficacy of interventions with the professional's experience and judgement and the client's preferences and values, while demonstrating cognisance of the context of the situation (Nevo & Slonim-Nevo 2011).

Best evidence, from an EBP perspective, is categorized in a hierarchy of quality (Evans 2003). Systematic reviews or meta-analyses are considered to be the gold standard in EBP. Randomized controlled trials

are thought to provide strong evidence and are rated as second-level evidence. Evidence, believed to hold less value in EBP, include surveys and all forms of qualitative research. In this regard, EBP has been criticized for privileging statistical and meta-analytical techniques over qualitative research and interpretive, discursive, or narrative approaches to knowledge, which can simplify and distort complex situations (Morrell & Learmonth 2015). The term evidence-informed practice (EIP) grew out of a need for a more inclusive understanding of evidence (Davis et al. 2000). This has been contested as the debate about what constitutes best evidence for EBP has become more sophisticated over time and additional forms of evidence in informing the delivery of healthcare have gained recognition (Rycroft-Malone 2008). Acknowledging that EBP traditionally based clinical decision making on empirically supported treatments, protocol adherence, and standardisation, the American Psychological Association (2006) consider the application of EIP to be more comprehensive, describing the process as a synthesis of empirically supported treatments with client characteristics, culture, and preferences. Both EBP and EIP aspire to incorporate evidence to improve quality of care and the terms are often used interchangeably in the literature (Gambrill 2007).

The EBP model described a five-step procedure beginning with the development of an evidence-based clinical question used to guide the search for evidence (Taylor, 2007). The application of such a procedure is dismissed under the EIP model. Instead, EIP is guided by a client-centred question, and advocates a more encompassing, interpretative view of evidence with greater flexibility in its selection for use in guiding practice (Nevo & Sloim-Nevo 2011). The contrast between sources of evidence acceptable in EBP and EIP is presented in Table 7.1. In EIP, evidence is seen to enrich, but not limit, practice (Epstein 2009). Using this lens, findings obtained through case studies, qualitative or mixed methods research, clinical narratives, and experiences are seen as important sources of evidence as well as those arrived at by randomized controlled trials. A wide range of information sources is acceptable in EIP and advised to be used creatively and sensitively in service delivery. The appropriateness of research evidence and clinical protocols or guidelines to the service user's experience and changing needs must be judged by the professional rather than applied objectively and allowed

to dominate practice (Nevo & Sloim-Nevo 2011). EIP acknowledges the importance of additional factors in the implementation of evidence such as the therapeutic relationship, service-user motivation, and assessment procedures. While quality is important, EIP evidence is not in a hierarchy. EIP requires a broad knowledge of empirical evidence and clinical experience to be applied to a therapeutic process in a manner that is sensitive and creative, and in this respect it is a more appropriate practice to use with persons who have refugee experience.

What counts for evidence.........		
In evidence-based practice?		In evidence-informed practice?
	Levels of evidence	Many forms of evidence:
I	Systematic reviews or meta-analysis of randomized controlled trials.	• Research articles, both quantitative and qualitative.
II	Randomized controlled trials.	• Clinical guidelines and protocols.
III	Non-randomized experimental studies.	• Books.
IV	Non-experimental studies (e.g., surveys, qualitative research).	• Conferences and webinars.
V	Respected opinion (world leaders).	• In-service training.
		• Self-generated data e.g., surveys, audits.

Table 7.1 Summary of evidence in EBP and EIP.

Lack of knowledge of their rights and entitlements, combined with unfamiliar professional practices and behaviours, may compound the vulnerability of groups within a system, such as those with refugee experience whose status is compromised and whose options for alternative care are minimal (Rycroft-Malone 2008). Difficulties navigating health and social care systems, language and culture-related differences, and fear of stigmatisation, contribute to barriers this population face in accessing and using services (Asgary & Segar 2011). Although the use of evidence to inform intervention is essential, the process of employing evidence in practice should be flexible and responsive in order to meet the ongoing and changing goals, conditions, experiences, and preferences of service users (Isakson et al. 2015). EIP

is driven by a client-centred approach, offering an integrated, inclusive process to the application of evidence into practice, appropriate to the provision of health and social care for people with refugee experience (Nevo & Slonim-Nevo 2011). Working with refugees requires adoption of a socioecological perspective that demonstrates an appreciation for the individual's narrative—their history, culture, community, and current work or school context—and an understanding that, in addition to resettlement stressors, such as language and poverty, the individual may be experiencing secondary stressors like the loss of loved ones and reminders of trauma (Isakson et al. 2015). In EIP, the professional integrates the service user's perspectives, in this case the person with refugee experience, and uses their issues to drive the search for evidence. It does this by emphasizing the development of client-driven questions rather than the search for randomized control trials to answer evidence-driven questions, as in EBP, that may or may not speak to the service user's actual issues (Nevo & Slonim-Nevo 2011).

The cultural competence of health and social care professionals is essential when working with people with refugee experience (Szajna & Ward 2014). Missed cues can occur when the practitioner does not understand the background and cultural practices of a service user or is not cognisant of their own cultural biases. Disconnect between service user and practitioner can result from differing views on health and illness across cultures (Englund & Rydstrom 2012). Addressing cultural preferences is integral to EIP. Recognizing that the priorities of service users and their families are not necessarily those of the professional and having open, culturally sensitive discussions of therapeutic goals in intervention planning facilitates quality care (Isakson et al. 2015). Similarly, measurement of progress may vary across cultures. For example, progress, and a positive outcome from engaging with a service for the service user might mean finding a job, not just feeling well. Such considerations reinforce the importance of culturally sensitive consultation with service users to ensure that the professionals' understanding of evidence for the effectiveness of practice is in line with the experiences of the service user.

Professional expertise is necessary to make decisions that integrate the best available research evidence with client characteristics and preferences. To this end, the professional needs skills to enable them to access, understand, and apply evidence. Developing a level of skill

and confidence in accessing and interpreting the best available evidence is required (Brangan et al. 2015). Translating the evidence in a way that is meaningful to the practice context is of particular importance in EIP. The generation of evidence from within a given practice context through the evaluation of practice outcomes offers an alternative means of applying evidence for best practice that does not rely on access to the literature. Adopting best-practice standards can also involve auditing services, conducting satisfaction surveys, using guidelines and outcome measures as deemed appropriate. In the application of clinical guidelines and protocols, cognizance of the dynamic and changing nature of health and social care, the needs of the service user, and the cultural context are required. To ensure that the integration of evidence into practices is flexible, especially with traumatized and vulnerable groups, the expertise and sound clinical reasoning of the professional is crucial.

Evidence is believed to be socially and historically constructed, meaning that it is contextually bound and interpreted to be made relevant to individual contexts. In this respect, evidence is not static or value-free (Rycroft-Malone 2008) but a catalyst to the process of healthcare decision-making and delivery (Gabbay et al. 2003). Several factors including the culture, leadership, and teamwork within the health or social care context plays an important role in the successful implementation of evidence in practice. The barriers to implementation include time and accountability pressures (Metzler & Metz 2010). Given that organisations' values vary in emphasis, factors to consider include the culture of the organisation and professionals' freedom to adapt services to suit the particular needs of service users. Adaptation of services may include the adjustment of an organisation's protocols to better support people new to a health and social care system to attend appointments. Permission from organisational leaders to increase a professional's autonomous use of time to reflect and think creatively around problems, to collaborate, and to search for evidence may need to be negotiated. The professionals' cultural competence and self-awareness can also act to facilitate or inhibit EIP and an individual's use of services (Szajna & Ward 2014). An awareness that our systems and services do not operate in a cultureless environment, a consciousness of the form of health and social care we deliver, and an appreciation of the possibilities for change within services is important when trying to adopt best practices to meet the needs of people with refugee experience. Whole

organisational change can be required, in the implementation of EIP, for the construction of a sensitive and culturally aware context with strong consensus-informed governance (Rycroft-Malone 2008). To enhance the success of implementing evidence in practice "the interaction of various ingredients" is required (Rycroft-Malone 2005: 1) and, in EIP, service user, practitioner, and contextual factors drive the identification of relevant evidence and are crucial to its creative and flexible implementation.

Critical Reflection

In healthcare, critical reflection is seen as integral to professional learning as it supports the analysis and evaluation of practice experience (Eaton 2016). Improving critical reflection skills has the potential to improve professional practice and enable better management of complex service users and healthcare systems (Désilets et al. 2022). Reflective writing is a key feature in most healthcare professional portfolios and commonly used as evidence of competence and continuing professional development (Eaton 2016). Reflective practice can lead to better quality care as it can enable better learning (Börjesson et al. 2015), develop emotional competency and communication skills (Harrison & Fopma-Loy 2010), and encourage critical thinking (Kinsella 2006).

Reflection is described as "a metacognitive process including connecting with feelings that occur before, during and after situations with a purpose of developing greater awareness and understanding of self, other, and situation, so that future encounters with the situation including ways of being, relating, and doing are informed from previous encounters" (Wald 2015). Critical reflection contributes to conceptual understanding of health-and-social-care-related issues and has the power to transform experiences into meaningful learning. To reflect critically involves more than pausing, thinking back over events, problem solving, and planning future practice based on what is already known and how issues are typically managed. Additionally, it demands critically appraising the content, process, and premise underlying the experience to make better sense of what has happened and reach a better understanding of the experience. Reflection has scope to give meaning to experience, turn experience into practice, link past and present experiences, and prepare us for future practice.

Why practise the skill of critical reflection?

It encourages independent learning—reflection can help us to identify areas or skills where we require further development. By intentionally evaluating our knowledge, behaviours, and competencies we will be better able to see what we can work on to improve our practice in future.

It helps order our thoughts and problem-solve—as we reflect, we re-order our minds which can make it easier to reframe problems and consider alternative solutions.

It helps achieve deep as opposed to surface learning—thinking over complex issues as we reflect, facilitates abstract conceptualisation which enables deeper learning.

It helps identify our personal strengths as well as areas for development—reflection involves critical self-assessment and should highlight what we're doing well in addition to what we need to improve.

It helps challenge our assumptions and recognize multiple perspectives—critical reflection can help us to become aware of our innate or unconscious biases and how these influence our behaviours. It can also make us more cognisant of the viewpoints of others and the impact that cultural context can have on different situations.

It helps in exploring new ways of doing or thinking about things—reflection can allow you to be more creative in considering possible action plans to address complex problems.

How Critical Reflection Works

Reflection, in helping to improve self-awareness and encourage critical thinking (Ghanizadeh 2017) may improve our ability to learn (Mann et al. 2009). By linking concrete real-world experiences to professional knowledge, it can help make sense of practice situations.

Fig. 7.1 How critical reflection aids learning and sense-making.

Theorists (e.g., Brookfield; Schön; Kolb; Gibb; Mezirow) have each emphasized aspects of the reflection process they consider important and developed methods of reflecting that encourage analysis of experiences to enhance learning. For instance, Schön (1991) emphasizes Reflection-in-Action and Reflection-on Action. Reflection-*in*-action encourages practitioners to think about what is happening during the interaction or event—thoughts, feelings, decisions, actions, consequences, and meaning. Reflection-*on*-action encourages practitioners to consider the events at a later time, allowing time to process experiences, feelings, and actions while taking into account new information and an opportunity to link the experience of theory and knowledge.

Brookfield's reflective theory (Brookfield 1995) requires the identification of significant events within an interaction or experience: it encourages practitioners to think about what happened in the event; feelings, thoughts, and actions during the event; what happened after the event; and the learning from that event. Brookfield also recommends accessing different perspectives and questioning assumptions. Gibbs (1988) highlights the importance of identifying other possible behaviour or action choices. Kolb (1984) proposed the experiential learning cycle, which emphasizes the role of reflection in learning. In this model, learning begins with an event (concrete experience) which the individual reflects upon (reflective observation). The reflection leads to the formation of new ideas (abstract conceptualisation) which can then be applied in the future resulting in new experiences (active experimentation). Knowledge gained from reflection does not arrive in a logical and structured fashion but instead requires an active participatory element (Eaton 2016).

Reflection and Professional Identity

Reflective practice helps people to achieve a deeper understanding of their profession (Ng et al. 2015) and has been found to facilitate healthcare professionals in the development of their professional identity (Binyamin 2017). An individual's professional identity encompasses the beliefs, values, attitudes, motives, and experiences through which they define themselves in a professional role (Ibarra 1999). It reflects the professional's concept of who they are and their perception of what it means to be and act in their professional role (Mackey 2006). As such, it

impacts what they do and how they practice their profession (Binyamin 2017). Understanding who one is as a health and social care professional has an impact on the provision of care and influences the effectiveness of service delivery (Best & Williams 2019).

Professional identity formation has been described as a transformative journey from being a lay person to "becoming" a professional (Poole & Patterson 2021). Health professionals' development of their professional identity is moulded by a range of different factors including critical experiences in clinical education, exposure to role models, professional socialisation (transmission of professional values), interactions and relationships with service users and professionals from other disciplines, and ongoing self-enquiry (Binyamin 2017; Poole & Patterson 2021). Identity formation is an ongoing process of reflecting on who one is and who one wants to be (Binyamin 2017). The literature suggests that the most powerful influences on professional identity formation are role models or mentors, and experiential learning in both clinical and non-clinical scenarios (Monrouxe 2016) but that it is reinforced by reflection on these learning experiences (Mann et al. 2009; Cruess et al. 2019). Critical reflection on learning experiences, whether from observing role models or through direct experience, means that information that would otherwise remain tacit becomes explicit (Cruess et al. 2019).

In a study investigating the role of reflection in the development of professional identity, Désilets et al. (2022) conceptualized and implemented a reflection process comprised of four elements: relationship with self (identification with a role), situations (clinical, learning), profession (appropriation of values and norms), and society. To foster the development of reflection skills, they advocated for the importance of providing a safe environment, mentorship, peer support, time to reflect, and helping students to see the potential benefits of reflective practice (Désilets et al. 2022). Being secure and confident in one's professional identity better enables health professionals to collaborate with other professionals in the multidisciplinary healthcare team (Porter & Wilton 2019).

Reflection and Interprofessional Collaboration

Reflective practice has been recognized as central in the development of good collaboration practices for health and social care professionals and

is a key aspect of interprofessional education (Richard et al. 2019). It has been recognized by the World Health Organisation as one of the main interprofessional learning domains (WHO 2010). In a review of reflective practice in interprofessional education and practice, Richard et al. (2019) made three recommendations for implementing reflective practice in interprofessional education and collaborative practice (IPECP):

- Use meaningful clinical situations and rely on IPECP theory and evidence (theory to practice).
- Engage a well-trained facilitator during group discussions or two facilitators with complementary expertise (IPECP and critical thinking), where possible.
- Support the reflective approach using a rigorous and explicit process based on precise criteria. To achieve critical reflection, planning and explicit training in critical thinking are key.

The usefulness of reflective practice in complex or challenging situations where there are multiple perspectives and factors to consider has been recognized (Kinsella 2010; Kuipers et al. 2014; Richard et al. 2019). Similarly, the greater the complexity of a clinical situation, the more important it is for healthcare professionals to engage in effective interprofessional collaboration (Kuipers et al. 2014; World Health Organization [WHO] 2010).

Reflective Writing

Thinking reflectively usually involves looking back at something, analysing an idea, experience, or event, and thinking carefully about its meaning. Committing this reflection to paper involves an exploration and an explanation of events, not just a description of them. Reflective writing is not a straightforward description of an event to convey information or support simple decision-making, but a critical practice with a consequent utility to improve health and social care. Reflective writing requires the professional to see and understand what is happening above and below the surface. Situations must be analysed critically to uncover assumptions, biases, motives, and understand others' perspectives, taking time to consider how thoughts and feelings interact to influence behaviour.

Adopting this approach facilitates the professional to learn more about themselves, the situation, their practice, and others.

Application of Reflective Writing in Practice

The event	A student met an asylum seeker in a Direct Provision Centre to prepare a meal together.
Reflective report	So, we met at the centre and I was a little apprehensive. We'd decided to cook together, a meal from her country. I worried that this might be too spicy for me and that I would have to tell her I didn't like it and I would find that difficult to do. I had organized with the centre manager for us to use the kitchen. Usually, residents have all their meals prepared for them. I had shopped on my way to the centre for the ingredients of the meal we were to prepare. Once we were in the kitchen my partner examined all the food I had bought. She was disappointed that I couldn't get certain vegetables that she thought were essential, but I explained that I would have needed to go to the Asian shops for those, which I didn't have time to do. Plus, I didn't know what they were so I couldn't get something similar.
	I helped prepare the raw ingredients and then she cooked. I tried to help turn things on the pan but she said she'd better do it so I sat down. The manager came in when we were cooking and complained about the spicy smells. I said there was nothing we could do about it but that we'd be finished soon. My partner told me when the manager had left that the dish needed time to simmer. This was a bit annoying. I wish she had told me that before I had told him we were nearly finished as this didn't make me look very good in his eyes. My partner also got worried that the manager would be angry and take this out on her later somehow. I told her this was unlikely. In the end we had a cup of coffee while we waited for the food to be ready, staying in the kitchen out of sight of the manager. It felt as if we were hiding which was a bit strange. After our meal was finished, which I surprisingly liked very much, I brought a plate of food out to the manager by way of apology. It would be nice to cook together again though, because of the manager's attitude, it might be some time before we can.

To summarize the student's reflections	Feelings and thoughts: "I was a bit worried. I didn't think I'd like it because I don't like spicy food." Actions: "We cooked together." Learning: "I liked this." Plan: "I hope we do it again sometime"
Now ask yourself:	Has the report produced new understanding of situations or reinforced knowledge already understood? Has the student objectively considered her own thoughts, feelings, and behaviour in the situation and reached new understandings? Has the student tried to understand the event from the asylum seeker's perspective? Is there learning that can inform the student's practice? Will this learning make a meaningful difference to the asylum seeker's life? Is this a deep reflection?
What level of depth has this student reached in her reflections?	
	This was a basic reflection. Descriptive or/and emotive. No useful learning was concluded. She did not: Ask herself questions about the event. Make connections between behaviours, emotions, ideas. Assess impact of behaviours, emotions, ideas, & contexts. Identify useful learning. Consider implications of this learning on practice.
How could the student reflect at a deeper level?	
	She might have asked… Might her partner have been worried too? Her partner usually has little choice in food—what does that mean for her? Might gathering the correct produce have been important & why?

	Her partner usually has little opportunity to cook—what does this feel like? How did the manager's interruption impact the activity? Was this interruption justified? What she might have learnt… Be open minded towards things (even food) that are different to what she's used to. Preparation is important—effort is required in setting expectations, in gathering supplies etc. The impact & experience of events varies depending on our personal histories/circumstances etc. Ideas about things to do differently next time… Might they shop together? Much more empowering and inclusive and could lead to higher success. Consult with her partner before answering for her. Support her to answer the manager herself. Apologize to the manager for not being clear about their expectations and to the partner. Ask her partner how she would like to manage the confrontation with the manager.

Table 7.2 Reflective writing in practice.

To ensure reflections are critical and not merely descriptive, the professional might consider applying the guidance in this list:

- Use description only to serve the process of reflection.
- Show awareness of one's thoughts, values, attitudes, assumptions—ask oneself questions about the event.
- Identify the impact of emotion but don't be emotive.
- Make connections between behaviours, emotions, ideas.
- Recognize possible change.
- Show evidence of valuable learning.
- Identify the implications of this learning on practice.

Further prompts that can be used to structure reflective writing, to help ensure reflection goes beyond description and demonstrates critical thinking, are outlined in Table 7.3.

<table>
<tr><td>EVENT

What happened? Be specific, relevant, concise in detail.</td><td rowspan="2">OTHER INFLUENCES

How did the physical space impact what people did or said?

How have your cultural norms influenced how you thought & behaved?

How might others have experienced the event given their cultural background?

What are the everyday practices of the organisation/community and how did these shape the event?</td></tr>
<tr><td>FEELINGS AND THOUGHTS

How did you feel & what did you think before, during, & after the event?

Had you any assumptions about how this event would transpire?

What are your values & beliefs?</td></tr>
<tr><td>ACTIONS/BEHAVIOURS

How did you react during the experience? How much of your behaviour is habitual and influenced by your values?

How did you interact with others? How did your behaviour influence others’ experiences of the event?

What was the result of your or others’ actions/behaviour?

What went well or badly? Why?

What else could you have done? What could have been done differently to improve outcomes?</td><td>LEARNING

What did you learn about:

• yourself as a person (e.g., your privilege, your cultural norms, your values given your age, gender etc);

• others (both service-users and other professionals);

• your professional skills/ knowledge/attitudes from this experience?</td></tr>
<tr><td colspan="2">PLAN: What would you do if a similar situation arose again?</td></tr>
</table>

Table 7.3 Prompts to aid critical reflection.

Critical Reflection in Refugee Health

Reflective practice is a useful approach to assist in improving treatment outcomes and to enhance clinical practice when working with population

groups, like refugees, where there may be increased complexity (Brooks 2018). In the provision of health and social care, professionals need to be aware of a range of personal and contextual factors that can impact the delivery of that care. To be culturally competent and aware, healthcare professionals need to be mindful of and reflect upon the unique context and personal experience of each person to whom they provide a service. When working with people with refugee experience, it is important to consider:

- The impact of power and privilege of a majority/dominant culture (likely the health/social care professional's) on the professional's behaviours—are they collaborative or autocratic—and on the behaviours of the refugee/asylum seeker—are they confused, quiet, subservient, angry?
- How the spaces, regulations and routines of where the refugee/asylum seeker lives might impact behaviours and mood during interactions.
- How the refugee is experiencing difference; think about their norms and how their current situation differs from these.
- How they are experiencing: autonomy, adjustment, assimilation, identification, inclusion, community.

Working in a multi-disciplinary team, professionals need to think critically about how they work with their colleagues and how well they function as a team. When being critical across disciplines, the wellbeing of the refugee remains the central focus. Colleagues' behaviour should be considered in the context of their disciplinary background, experience, professional bias, and expertise. It is important to appreciate the different perspective they bring to any situation so that mutual understanding of the problem can be found. Future interactions should be planned on the basis of what is learned from critical reflection on collaboration.

The environment beyond that of the immediate setting in which an event took place can impact the behaviours and activities within the micro level setting. Cognizance of and reflection on wider contexts in which services operate can assist more meaningful problem solving and future planning. Potential factors to consider at these levels are displayed in Figure 7.2.

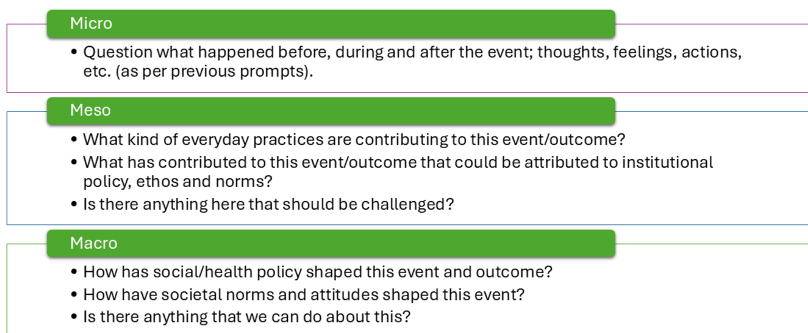

Fig. 7.2 Critical reflection at micro to macro levels.

Below there is a suggested activity to practice critical reflective writing related to interactions with a service user who has refugee experience.

Critical reflection activity:

Use your reflective writing skills to describe and critically appraise how a person from a refugee community might experience your health/social care work setting. Select three events (points of contact by the person with your work setting), ideally ones in which you were present.

Appraise each event in turn by:

1. Explaining the context of the events, providing an objective account of each,
2. Identifying your thoughts, feelings & behaviours,
3. Recognizing multiple perspectives & influence of cultural factors,
4. Evaluating the learning you have gained,
5. Considering what might be done differently or repeated in the future.

Remember:

Ask yourself questions as you reflect that challenge your values, beliefs, and habitual ways of thinking and behaving.

Be succinct. Use writing to help you decipher your learning but synopsize this before including it in your reflective report.

Conclusion

This chapter has outlined two important practices that health and social care professionals can implement to ensure quality in their practice and to improve the services that they deliver. Through critical reflection on their experiences of working with people with refugee experience, professionals can become aware of areas that work well, in addition to those where further development is needed. Taking an evidence-informed approach enables the individual service user's unique experiences, conditions, goals, and preferences to be taken into account when delivering and planning care. Integrating these approaches into their practice can help to ensure that health and social care professionals are able to strive to deliver optimal care for people with refugee experience.

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