

U.S. copyright law (title 17 of U.S. code) governs the reproduction and redistribution of copyrighted material.

**Rapid #: -3182864**

**Ariel**  
**IP: 138.86.116.15**

---

**CALL #:** <http://ezproxy.baylor.edu/login?url=http://ejournals.ebsco.c...>  
**LOCATION:** **IYU :: Main Library :: EBSCOhost EJS**  
TYPE: Article CC:CCG  
JOURNAL TITLE: Public health nursing  
USER JOURNAL TITLE: Public health nursing (Boston, Mass.)  
IYU CATALOG TITLE: Public health nursing (Boston, Mass.)  
ARTICLE TITLE: ""Reflective Practice Enhances Public Health Nurse Implementation of Nurse-Family Partnership.  
ARTICLE AUTHOR: Beam, Rita J.,  
VOLUME: 27  
ISSUE: 2  
MONTH:  
YEAR: 2010-03-01  
PAGES: 131  
ISSN: 0737-1209  
OCLC #:   
CROSS REFERENCE ID: 62948182  
VERIFIED:

**BORROWER:** **COV :: Main Library**  
**PATRON:** **Wenger, Mary Beth**  
PATRON ID: 800434244  
PATRON ADDRESS: \*  
PATRON PHONE: \*  
PATRON FAX: \*  
PATRON E-MAIL: weng5324@bears.unco.edu  
PATRON DEPT: \*  
PATRON STATUS: \*  
PATRON NOTES: \*



This material may be protected by copyright law (Title 17 U.S. Code)  
System Date/Time: 2/22/2010 4:21:42 PM MST

---

# Reflective Practice Enhances Public Health Nurse Implementation of Nurse-Family Partnership

Rita J. Beam, Ruth A. O'Brien, and Michelle Neal

**ABSTRACT** Reflective practice is defined as a cyclical process involving a series of phases in which an individual describes a salient event, attends to his/her positive and negative feelings about the event, and ultimately reexamines the experience in an effort to understand and to plan how he or she would act in a similar situation in the future. This paper describes how the concept of reflective practice is integrated into the evidence-based Nurse-Family Partnership (NFP) program. The pivotal role of the nursing supervisor in guiding nurses to engage in reflection on their work with families is emphasized. Exemplars drawn from the experience of 2 NFP nursing supervisors are presented to illustrate how reflection in the NFP program is operationalized. The benefits as well as the challenges to the use of reflective practice are also discussed. While anecdotal comments from NFP nurses and supervisors are cited to suggest how the regular use of reflective practice has the potential to improve implementation of the program with families, the authors further propose that research is needed to more rigorously examine the benefits that reflective practice may have on the quality of program implementation, family outcomes, and the retention of nurses working in the NFP program.

Key words: clinical learning, nurse professional development, reflection, supervision.

Public policy initiatives have begun to incorporate requirements that interventions show strong evidence of effectiveness before there is expenditure of limited public funds. The Nurse-Family Partnership (NFP), a home visiting program for low-income parents expecting their first child, has been identified as a preventive intervention that meets high evidentiary standards as a result of findings from three randomized

trials with diverse populations (Olds et al., 1997, 1998, 2002). Over the past 10 years, many public health departments and community-based organizations have chosen to initiate the NFP in their local communities to address maternal child health concerns. Yet, programs found to be efficacious in controlled, randomized trials are not always effective when implemented in actual community settings through existing service organizations.

Although staff competence is frequently identified as key to the effective implementation of innovations, how this competence is generated and sustained is poorly understood (Olds, Hill, O'Brien, & Racine, 2003). The implementation of an innovative program model requires new learning by staff. According to Donald Schon (1983), learning is an iterative process of action and reflection, in which action is taken, assessed, and modified to produce outcomes. He describes these learning behaviors as the hallmark characteristics of “the reflective practitioner.” Reflection as a tool to enhance learning and professional

*Rita J. Beam, M.S., R.N., is Nurse Manager, Perinatal Services, Tri-County Health Department, Greenwood Village, Colorado. Ruth A. O'Brien, Ph.D., R.N., F.A.A.N., is a Professor, College of Nursing, University of Colorado Denver, Aurora, Colorado. Michelle Neal, M.S., R.N., is a Nurse Consultant, Invest in Kids, Denver, Colorado.*

*Correspondence to:*

*Rita J. Beam, Tri-County Health Department, 4857 South Broadway, Englewood, CO 80113. E-mail: rbeam@tchd.org*

development has received heightened attention in recent years.

This paper describes the development and integration of reflective practice as a foundational concept of public health nursing practice in the NFP program. The pivotal role of the nursing supervisor in guiding nurse home visitors to engage in reflection on their work with families is emphasized. Exemplars drawn from the experience of two NFP nursing supervisors are presented to illustrate how reflection in the NFP program is operationalized. To provide a context for the discussion of reflective practice within the NFP, a brief description of the key components of the program model is presented before elaboration of conceptualizations of reflective practice.

### **The Nurse-Family Partnership**

The NFP works with low-income first-time parents and their families during pregnancy and through the first 2 years of the child's life to accomplish three goals: (a) improve pregnancy outcomes by helping women alter their health-related behaviors, including reducing use of cigarettes, alcohol, and illegal drugs; (b) improve child health and development by helping parents provide more responsible and competent care for their children; and (c) improve families' economic self-sufficiency by helping parents to develop a vision for their own future, plan subsequent pregnancies, continue their education, and find work.

Each full-time nurse carries a caseload of 25 families. Although nurses have a structured set of visit-by-visit guidelines, they adapt them as needed to address the individual needs of families. On average, nurses visit weekly for the first month in order to establish a relationship, then every other week throughout pregnancy. Following the birth of the infant, weekly visits are resumed for the first 6 weeks postpartum and then decrease to every other week until the child is 21 months old. To facilitate termination of the relationship, nurses visit monthly through the child's second birthday.

Central to the successful implementation of the NFP is the establishment of a trusting relationship with the family. Nurse home visitors utilize a strength-based approach directed toward optimizing the family's sense of efficacy. Four strategies intrinsic to this strength-based approach are: (a) listening to what families want and starting there; (b) believing

that families are the experts on their own lives and are capable of making choices to attain desired goals; (c) expanding families' visions of the options available to them; and (d) helping families set small and reasonable goals that, when attained, contribute to their growing sense of efficacy (O'Brien & Baca, 1997).

The challenges of creating effective working alliances with young vulnerable families, like those served by NFP nurses, led the ZERO TO THREE National Center for Infants, Toddlers and Families to assume a leadership role in advancing reflective supervision as an essential best practice in the early intervention field. ZERO TO THREE advocates that reflective supervision is key to creating a context and an interpersonal environment that fosters self-reflection on one's practice, resulting in experiential learning—a process, which in turn, enables professionals to help parents to expand their capacity to nurture their young children's development (Eggbeer, Mann, & Seibel, 2007).

### **Conceptualizations of Reflection and Reflective Practice**

Early references to the role of reflection in learning can be traced back to Socrates, a Greek philosopher, and educators, such as John Dewey, who advocated that learning was best achieved through questions and feedback (Dewey, 1933). However, the emphasis on reflection in nursing education and practice owes its origins to the seminal text, "The Reflective Practitioner," by Schon (1983). He postulated that the challenge for and the primary focus of educators of professionals was the facilitation of reflection (Schon, 1987). Benner (1984) further noted that practice was the *raison d'être* of nursing education; therefore, reflection was critical if learning was to result from practice. More recently, Tanner (2006) noted that reflection is critical for the improvement of clinical reasoning and the development of clinical knowledge.

Boyd and Fales (1983) defined reflection as "the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective" (p. 100). Grimmett and Erickson (1988) elaborated that reflection is a reconstructing experience, the end of which is the identification of a new possibility for action. Johns (1995) argued that reflecting on one's experience

enables the practitioner to assess his or her own behavior to expose the contradictions between the ways he or she practices and what he or she aims to achieve. Since Schon's (1983) seminal studies of professional practice and the role of reflection in professional learning, there has been a growing body of nursing literature on reflection. Two recent reviews provide an excellent synthesis of this literature (Kuiper & Pesut, 2004; Ruth-Sahd, 2003).

While reflection is a skill, reflective practice is the application of that skill to one's practice to improve performance (McDonald & Glover, 2000). Reflective practice has been more fully explicated as a cyclical process involving a series of phases in which the individual describes the salient event, attends to his/her positive and negative feelings about the event, and ultimately reexamines the experience in an effort to understand and to plan how he or she would act in a similar situation in the future (Taylor, 2000). The beginning of a reflective episode is triggered by a sense of discomfort within self that is attached in some way to an event or experience, an awareness that something does not fit with our expectations (Boyd & Fales, 1983). Schon (1987) differentiated among three different methods of reflection: reflection-in-action, reflection-on-action, and reflection-for-action. Reflection-in-action is a spontaneous reflection in the midst of the action itself, that is, the nurse's ability to sense how an individual is responding to the nursing intervention in the "here and now." In contrast, reflection-on-action is thinking through a situation after it has occurred; one reevaluates the experience to decide what needs to be done differently. Reflection-for-action is the desired outcome of these first two approaches and engages one in reflection to guide future action (Schon, 1987).

The literature includes a number of specific models of reflective practice, including Kolb's (1984) Cycle of Experiential Learning, Gibbs' (1988) *Learning by Doing: A Guide to Teaching and Learning Methods*, Fenichel's (1992) *Learning Through Supervision and Mentorship to Support the Development of Infants, Toddlers, and Their Families: A Sourcebook*, and Johns's (1993) *The Model for Structured Reflection*. The reflective cycle, elaborated by Gibbs (1988), and the elements of training advocated by ZERO TO THREE (Fenichel, 1992) have guided the approaches used by The NFP in integrating reflective practice as a key component in clinical supervision of its home visitors.

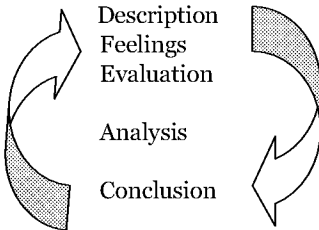
## Essential Features of Reflective Practice in the Nurse-Family Partnership Program

The use of reflective practice with nurses implementing the NFP program was initiated during the first randomized clinical trial conducted in the late 1970s. Nurses' comments, such as "I'm not sure I'm effective" and "I'm taking two steps forward and three steps back" (Dawley, Loch, & Bindrich, 2007, p. 62), led the nursing supervisor to build reflective practice into the program. Over the next two decades, approaches to the use of reflective practice were refined and Gibbs' reflective cycle became the foundation for clinical supervision within the NFP program (Dawley et al., 2007).

As shown in Table 1, the reflective cycle explicated by Gibbs begins with a critical incident that the nurse experiences in working with a family in practice and seeks to discover new possibilities for action if facing similar circumstances in the future (Gibbs, 1988). There are six phases to the reflective cycle: (a) *description* of the critical incident, (b) expression of *feelings* about the situation, (c) *evaluation* of the positive and challenging aspects of the experience, (d) *analysis* of what the nurse learned from the situation, (e) formulating a *conclusion* as to what the nurse could have done differently, and (f) developing an *action plan* for the future. It is a nonlinear process with nurse and supervisor moving back and forth among the various phases until there is clarity. The ultimate goal is experiential learning to improve public health nursing implementation of the NFP program.

The Nurse-Family Partnership National Service Office (NFP NSO) provides education for nurse home visitors and nurse supervisors from communities that

TABLE 1. *The Nurse-Family Partnership Model of Reflection*

Phase	Open-ended questions	
	Description	What happened?
	Feelings	What were your feelings?
	Evaluation	What was good about the experience? difficult?
Analysis	What did you learn from the experience?	
Conclusion	What could you have done differently?	
Action Plan	If it happens again, what would you do?	

have chosen to adopt the program. To promote the use of reflection by new nurse home visitors and their supervisors, NFP NSO educators introduce the concept of reflective practice and the role of the supervisor in facilitating reflection to staff as they attend educational sessions to learn how to implement the program and provide ongoing consultation in the process as needed through periodic conference calls.

Building on the guidelines advanced by the ZERO TO THREE Center for Program Excellence (Parlakian, 2001), regularity, collaboration, mutual respect, and open communication are essential principles of the NFP nurse-supervisor relationship for reflective practice.

- Regularity of supervision allows the nurse to experience consistency, develop trust, and build a relationship that will mirror what he or she will provide to clients.
- Collaboration provides a sense of shared responsibility and support, and enables the nurse to learn from and with the supervisor, thus improving critical thinking skills and competency.
- Mutual respect accepts individuals for both their strengths and their vulnerabilities.
- Open communication reflects a belief in the value of others' thoughts, ideas and feedback; it is characterized by active listening that encourages the reflector to develop their own insights and solutions.

The principles of regularity, collaboration, mutual respect, and open communication are integrated into the NFP program through one-on-one reflective supervision, case conferences, and consultative/joint home visits with supervisors and/or peers (Table 2). The NFP NSO educators have worked with more experienced nurses and their supervisors to develop

videos to illustrate interactions of the use of reflective practice during one-on-one supervision and case conferences.

### Exemplars of Reflective Practice in Nurse-Family Partnership

NFP nurse home visitors encounter clients and families with complex lives impacted by poverty. They often struggle to remain nonjudgmental and client-centered when clients make decisions that are not in line with the nurse's goals. The supervisor is responsible for providing a safe environment in which reflection and collaboration can occur. The time set aside for reflective supervision is focused on the nurse's issues, with the supervisor using active listening skills and open-ended questions to keep the process nurse focused and client centered. As the nurse shares her thoughts and feelings, the supervisor uses affirmation to support the nurse's emerging self-awareness, insights, and solutions for the future. Three exemplars of reflective practice are presented to illustrate its application in practice.

#### *Nurse-supervisor reflection*

The following exemplar of reflective practice demonstrates how a supervisor used the reflective cycle during one-to-one supervision to facilitate the nurse's reflection.

**Description of concern.** The nurse described her work with a 15-year-old client, in her last trimester of pregnancy. The client lived in a group foster home because her mother had failed to protect her from becoming involved with a much older male (27 years) that resulted in her becoming pregnant. The father of the child was later incarcerated. During the

TABLE 2. Nurse-Family Partnership Components of Reflective Practice

Component	Requirements	Description
Reflective supervision	1 hr, once a week, time is uninterrupted and routinely scheduled	1:1 supervision
Case conference	1-1 1/2 hr weekly, regularly scheduled	Team has multidisciplinary meetings to review client cases
Joint visits	Three times a year (or more as needed) with supervisor. Clients are informed about joint visits upon program enrollment, and visits are arranged with the client ahead of time	Home visits with supervisor, peer visits may be conducted as desired

one-on-one reflective session, the nurse confided to her supervisor that she constantly worried about this client and felt her worries were affecting her own life. She had children, including a 15-year-old daughter.

**Feelings.** The nurse described feelings of anger toward the client's mother. She knew she would never allow a situation like this to happen to her own daughter. The supervisor was empathetic, acknowledged the nurse's anger, and validated that this was a very difficult case for the nurse. The supervisor acknowledged that caring for a 15-year-old client, while mothering a 15-year-old daughter, was difficult. The nurse confided that she felt personally responsible for the client because the client's mother was not involved. Furthermore, the client's social worker had not yet established a relationship with the client.

**Evaluation.** The nurse was able to identify many positives about her work with the client. She had been able to establish trust, the client appeared engaged in the home visits, and was taking steps to prepare for her baby. Through active listening and reflection, the supervisor helped the nurse process the complexities related to caring for this client. It became clearer that since the nurse was experiencing role confusion, it was difficult to maintain her professional boundaries. Furthermore, the nurse felt alone with the burden of care for this young woman. She also feared that this young mother might never be able to successfully support and care for her baby.

**Analysis.** The nurse revealed to her supervisor that she was becoming more aware of her own tendency to become a surrogate mother for her clients. She realized the perceived responsibility was adding too much stress to her life, rendering her less effective with her clients and her own family.

**Conclusion.** The supervisor and the nurse developed a list of priorities. The first priority was to alleviate the nurse's feelings of sole responsibility for this client. The supervisor asked the nurse to identify what decreased responsibility would look like. She replied that other professionals would be more knowledgeable, interested, and involved with the case.

**Action plan.** In collaboration with her supervisor, the nurse developed a plan to invite the client's current caseworker, the foster mother, and the client's therapist to come together to discuss the client's needs and the roles and responsibilities of each of the

professional providers. Additionally, the plan called for frequent communication among all of the professionals to coordinate information and build the client's personal and professional system of support.

**Supervisory summary of session.** In bringing the session to a close, the supervisor asked the nurse to reflect on how she was now feeling about the situation. The nurse shared that she felt her feelings and concerns had been validated, leaving her less anxious about being solely responsible for the client's well-being. She was energized by having a solid plan to increase the involvement of other professionals. Furthermore, she felt she had gained increased awareness of the importance of setting clear role expectations for her self and clients and maintaining personal and professional boundaries. This form of supportive engagement between nurse and supervisor can prevent nurse burnout and promote professional boundaries when caring for families with complex needs and few resources.

### *Case conference reflection*

Case conferences provide a rich environment for nurses to share expertise and support with each other. However, the supervisor must support a team culture where the process of exploring areas of uncertainty and lack of knowledge can safely occur. The case conference is also a venue that can reveal a need for more clinical education and practice to increase nursing competency. In addition, discussion of complex cases can generate distress and bring up ethical and value issues. A supervisor may have to step out of her comfort zone to support risk taking and exploration of difficult issues. At times, an outside professional expert may be invited to join the nurses and the supervisor. The following is an exemplar that demonstrates how case conferences using the reflective process can support nursing competency and improve program outcomes.

**Description.** A nurse presented a case involving a client who lived alone with her 18-month-old baby who was manifesting delayed growth since birth. Although the father of the child was not a consistent presence in their lives, the client did have support from her family and the father's family. The nurse reviewed the multiple interventions that had been implemented in an effort to improve the child's weight gain. She stated that she was considering referring the

family to social services for investigation of possible child neglect.

**Feelings.** The nurse shared with her peers that she worried so much about this client that she felt it was affecting her own mental health. She acknowledged that one of her own children had problems with gaining weight as an infant. When she left her last visit, she felt she had not been helpful to the client and felt hopeless about being able to effect any improvement. She worried that a referral to social services might affect her future relationship with the client. Her supervisor and team validated how difficult this situation must be for her.

**Evaluation.** The nurse was able to identify many positives about her work with this client. She had been able to establish a trusting relationship and the client actively engaged in the home visits. A Nursing Child Assessment Satellite Training (NCAST) feeding scale had been completed with this mother and child and had been within normal limits. Overall, the nurse felt that the client was a very loving and caring mother. As she processed the situation with her supervisor and peers, the nurse realized the complexities involved in the situation. It became clear that she was experiencing frustration over telling the client over and over to do the same things that the Women, Infant and Child (WIC) educator and the child's pediatrician were telling her to do, with little results. She questioned her nursing judgment. Her team was empathetic and supportive.

**Analysis.** The nurse expressed to the team that her constant concern for this family and child was why she brought the case to them. She was uncertain as to what more she could do and was looking for suggestions from her peers.

**Conclusion.** As her peers asked for more information about the client's economic resources for food and the toddler's other developmental patterns, the nurse began to feel angry. She had many years of home visiting experience, and of course, had assessed these areas with the client. She then realized that she was feeling as angry and frustrated as her client must have felt when she told her nurse that "the pediatrician told me that I'm not feeding my child right" and "the WIC educator said that I should stop giving her the bottle." As the discussion proceeded, the supervisor suggested that they break and watch a video that used principles of motivational interview-

ing to see whether the latter might offer new approaches to the situation.

**Action plan.** Using the motivational interviewing principles demonstrated in the video, the team strategized with the nurse about potential communication techniques that she could use on her next visit with this client. It was suggested that when the client said "they told me that I'm not feeding my child right," a good response might be "That must be really hard to hear that. You have tried so hard to help your child to eat well and gain weight? Do you want to talk more about it?" Other suggestions included asking the client: "Are there times when the child has less difficulty eating? What is different about those times? What kinds of things have you tried that have been successful?"

**Supervisor summary of case conference.** Supervisors working within the NFP are encouraged to elicit feedback from nurses at the close of the case conference about the discussion. The nurse who shared her case expressed relief that her feelings and concerns had been respected and stated that she was energized by having a solid plan to use with the client at the next home visit. Her peers also noted that it had been a learning experience for them as they thought of ways to use motivational interviewing techniques with their own clients.

### ***Joint home visits***

Lastly, another component of reflective practice that the NFP model encourages is joint home visits by the nurse and the supervisor conducted quarterly. Time spent in reflective supervision in individual sessions with the nurse and during case conferences builds the trust between the supervisor and the nurse that is necessary for the nurse to feel comfortable having her supervisor join her on home visits. Joint visits provide the supervisor with the opportunity to evaluate the nurses' practice skills in the context of a nurse-client interaction.

The following client scenario illustrates how a supervisor used her observation of nurse-client interaction during a joint home visit to help a nurse step back and reexamine her practice following the visit. The visit involved a young client who had struggled to reenroll in school after the birth of her baby.

Nurse: "How's school going?"

Client: "It was too hard, I dropped out . . . I'll get my G.E.D. later."

Nurse: "I'm so disappointed, you've worked so hard. You can't drop out. Let's call the principal right now and get you back in."  
 Client: "No, I can't go back now."

The supervisor sensed the tension between the nurse and the client for the rest of the visit. Following the visit, she used the reflective cycle to process the visit with the nurse. The nurse was able to recognize that her immediate response in suggesting that they call the principal to get the client back in school had shut down communication, and therefore, the client did not reveal the details of her decision. Moreover, by reflecting on the incident, the nurse also realized that there was probably more to the story and factors that contributed to the client's decision than were shared once the client sensed the nurse's disappointment. In thinking about what she might have done differently, the nurse identified that she could have responded using a solution-focused response such as "I know that finishing school is very important to you. You must have really put some thought into this decision. Will you tell me about it?" The nurse and the supervisor decided that she would try this approach at the next visit to engage the client in discussing her progress toward her goal.

## Challenges to Implementation

Challenges to integrating reflective practice need to be identified and addressed from both an agency and a programmatic perspective. The value of reflective practice must be recognized and supported by agency administration if NFP nurses and their supervisors are to give the practice priority. From a programmatic perspective, there may be logistical challenges for a nurse and a supervisor to arrange time to meet once a week. Nurses carrying a full caseload of 25 families may cover large geographic areas, particularly in public health agencies serving populations in rural areas. Similarly, nursing supervisors may have other agency meetings and role responsibilities unrelated to the NFP program. Some NFP sites have attempted to address these challenges by using teleconferences for nurse-supervisor one-on-one sessions or meeting less frequently for longer periods of time.

Developing a supervisor's skill and comfort in facilitating reflection with staff is sometimes a challenge as well. It takes time and patience to learn active listening, the powerful use of questions, modeling strength-based behaviors, and learning to sit with

complex issues until the nurse finds her way to a solution. Recently, the NFP NSO educators have developed online learning modules and exercises to provide program staff with more opportunities to gain experience with use of the reflective cycle.

## Implication for Public Health Nursing Practice

Public health settings require a great deal of autonomy in nursing practice. The environment of home visiting and clinic settings does not provide the consistent peer interaction that naturally occurs in acute health care facilities. Participation in reflection and dialogue with peers and supervisors allow nurses to debrief experiences, develop skills in clinical reasoning, and identify best practices (Tanner, 2006). Strengthening public health nurses' clinical reasoning skills, in turn, has the potential to promote better outcomes for families.

In light of the nursing shortage, the encouragement of reflective practice in public health settings may also help to reduce staff burnout and turnover. Public health nurses provide care and support to the most vulnerable and fragile families in their communities. The secondary trauma to which they are exposed daily can be very stressful and emotionally draining. The debriefing that occurs through reflective practice can be supportive to nurses in managing the stressors and emotions that are triggered by the demanding situations they encounter in working with highly vulnerable populations, such as domestic violence, child abuse, and sexual abuse. When practiced consistently, a nurse who otherwise might feel ineffective receives support and guidance that could minimize the intent to seek a less demanding position. The cost savings to public health agencies from nurse retention could be enormous.

## Conclusion

Reflective practice is a cyclical process involving a series of phases in which a nurse, in interactions with a supervisor and peers, describes a salient event, attends to his/her positive and negative feelings about the event, and ultimately reexamines the experience in an effort to understand and to plan how he or she would act in a similar situation in the future. Three exemplars of how the NFP program has integrated reflective practice into ongoing program

implementation are presented. Anecdotal comments from NFP nurses and supervisors are cited to suggest how the regular use of reflective practice has the potential to improve implementation of the program with families. The authors also theorize that the debriefing that occurs through reflective practice can be supportive to nurses in managing the stressors and emotions that are triggered by the demanding situations they encounter, and thereby, potentially reduce nurse home visitor turnover. Research is needed to further examine and document the benefits that reflective practice may have on the quality of program implementation, family outcomes, and the retention of nurses working in the NFP program. Likewise, the application of reflective practice in programs other than the NFP needs to be explicated and examined.

## Acknowledgments

The authors would like to acknowledge Christine Russell, B.S.N., Nursing Supervisor at Tri-County Health Department, for contributing to the exemplars describing reflective practice in the NFP program. We acknowledge Richard L. Vogt, M.D., reviewing the manuscript.

## References

- Benner, P. (1984). *From novice to expert: Excellence and power in nursing practice*. Reading, MA: Addison-Wesley.
- Boyd, E. M., & Fales, A. W. (1983). Reflective learning: Key to learning from experience. *Journal of Humanistic Psychology, 23*(2), 99–117.
- Dawley, K., Loch, J., & Bindrich, J. (2007). The nurse-family partnership. *American Journal of Nursing, 107*(11), 60–67.
- Dewey, J. (1933). *How we think, a restatement of the relation of reflective thinking to the educative process*. New York: D.C. Heath and Company.
- Eggbeer, L., Mann, T. L., & Seibel, N. L. (2007). Reflective supervision: Past, present and future. *Zero to Three, 38*(2), 5–9.
- Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families. A sourcebook*. Arlington, VA: ZERO TO THREE.
- Gibbs, G. (1988). *Learning by doing: A guide to teaching and learning methods*. London, UK: Further Education Unit.
- Grimmett, P. P., & Erickson, G. L. (Eds.). (1988). *Reflection in teacher education*. New York: Teachers College Press.
- Johns, C. (1993). Professional supervision. *Journal of Nursing Management, 1*, 9–18.
- Johns, C. (1995). The value of reflective practice for nursing. *Journal of Clinical Nursing, 4*(1), 23–30.
- Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall.
- Kuiper, F. A., & Pesut, D. J. (2004). Promoting cognitive and met cognitive reflective reasoning skills in nursing practice: Self-regulated learning theory. *Journal of Advanced Nursing, 45*, 381–391.
- McDonald, J., & Glover, D. (2000). Reflection in supervision. *Nursing Times, 96*(12), 49–52.
- O'Brien, R. A., & Baca, P. (1997). Application of solution-focused interventions. *Journal of Community Psychology, 25*(1), 47–57.
- Olds, D., Eckenrode, J., Henderson Jr., C. R., Kitzman, H., Power, J., CoLe, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect; 15-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*, 637–643.
- Olds, D., Henderson Jr., C. R., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D., et al. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*, 644–652.
- Olds, D. L., Hill, P. L., O'Brien, R., & Racine, D. (2003). Taking preventive intervention to scale: The nurse-family partnership. *Cognitive and Behavioral Practice, 10*, 278–290.
- Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson Jr., C. R., et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*, 486–496.
- Parlakian, R. (2001). *Look, listen, and learn: Reflective supervision and relationship-based work*. Washington, DC: The ZERO TO THREE Center for Program Excellence.
- Ruth-Sahd, L. A. (2003). Reflective practice: A critical analysis of data-based studies and implications for nursing education. *Journal of Nursing Education, 42*, 488–497.
- Schon, D. (1990). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

- Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.
- Schon, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*. San Francisco, CA: Jossey-Bass.
- Tanner, C. A. (2006). Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 45(6), 204–211.
- Taylor, B. (2000). *Reflective practice: A guide for nurses and midwives*. Buckingham, UK: Open University Press.