# Reflection on Radiographic Practice

**Word Count: 2098** **SCRE2UD5**

## Introduction

Reflection can be described as; “a state of mind, like a quiet eddy in a fast moving stream, a place to pause in order to consider the fast moving str eam and the way self swims within it. The space of guided reflection can be viewed as a space of stillness that enables the practitioner to reconstitute the wholeness of experience, a place to bring the heart home.” (Johns, Joiner, & Stenning, Guided Refle ction, 2002, p. 11) The Gibbs Reflective Cycle (Johns, Becoming a Reflective Practitioner, 2000, p. 49) describes a 6 stage process for reflection; Description; Feelings; Evaluation; Analysis; Conclusion; and Action plan. This paper will describe two inci dents that I have experienced within the clinical environment, which I will then reflect upon utilising the Gibbs cycle.

## Incident 1

### Description – What happened

At 1400 on a Monday in early October 2008, a 57 year old man was presented to the imaging department. Earlier that day the patient had been repairing a roof of a porch. After working for some time the man had become tired and had taken less care and fallen to the ground, resulting in injury to his wrists. The patient also complained of pain to his ribs. The request was read by a supervising trained radiographer, who deemed it to be an acceptable request. I was then supervised performing an ‘anterior-posterior’ and lateral projections on both wrists. The left wrist lateral projection had be to repeate d as a true lateral projection had not been achieved. The repeat showed a hairline fracture which was not clearly visible with the initial lateral image. The right wrist was an undisplaced longitudal fracture of the distal radius . The

images were ‘red dotted’ and the patient was returned to the casualty department for further treatment.

**Feelings – What were you thinking and feeling**

The patient was in pain but not unduly so. He joked about being able to get home to complete his work on the roof. This suggested to me that a more light hearted approach to the patient might be the best means of setting him at rest and to ensure both projections that I need to complete the imaging procedure were taken. This appeared to work as the patient did everything exactly as I described to him, any physical contact was kept to a bare minimum, which prevented me from inflicting any further pain, from moving him myself. Infection control was a potential risk, not so much for the patient, but for subsequent patients. The patient was slightly dirty from his manual work and fall to the ground, myself and the radiographer made a stringent effort in cleansing the imaging room, after imaging (particularly the imaging paddle). Radiation protection to the patient and the radiographic staff is always a concern whilst imaging. As the patient was still reasonably mobile the legs were made clear of the central ray, to prevent any undue direct exposure to the ionising x ray radiation. The exposures were made only when the staff were clear behind the radiation protection barrier, in front of the imaging console. This ensured that the concept of ALARA (as low as reasonably achievable) was followed. (Prasad, 2004, p. 98)

**Evaluation – What was good and bad about the experience**

The wrist projections were performed (Carver & Carver, 2006, p. 47), even though I felt that I had followed the literature. The left lateral projection was rotated. With guidance from the radiographer the positioning was adjusted to give an adequate

image. This was invaluable as this demonstrated the fracture which would have been hard to see on the initial image. After the imaging the radiographer again explained to me the ways to adjust wrist positioning, and they suggested that I use the textbooks more i.e. by reading; “Common error - Radius appears posteriorly in relation to ulna: Possible reason – excessive external rotation.” (Carver & Carver, 2006, p. 47) this would have minimised the chance of a poor image I produced which gave me a feeling of ‘uselessness’ as I felt I had tried my best but it was still not good enough. The incident has made me realise how to remedy another problem of the same nature.

All the images had a good adequacy of image, and the correct area of concerned as imaged. An exposure of 54 KVp and 3mAs was used, the good image contrast confirmed to me that I had chosen a good level for exposure. Not only for image quality but to ensure that only exposure to radiation as low as reasonably practicable had been achieved for the patient. This factor combined with the operators being behind the safety screen, meant this too had happened for the operators. As a repeat had to be carried out the ALARA (Prasad, 2004, p. 98) principle was diminished slightly, had a correct position been achieved a repeat would not have been required, ensuring that the patient and staff only receive a very minimum dose of radiation.

**Analysis – What sense can you make of the situation**

I can use the advice of going to literature as a method of aiding problem solving in other areas not linked to positioning. The radiographer acted in an extremely professional manner, this has given me increased confidence in going to trained members of staff without fear of ridicule. I feel as this may be a more valuable tool

going to trained personnel, instead of reading literature, as experience of different situation can provide a substantial depth of knowledge, unlike a limited book, which may only describe actions for ideal situations i.e. some patients find moving into certain positions described in books almost impossible, and alternative methods are required.

By Keeping a daily clinical log this gives me a sense of improvement in my clinical abilities in various areas. For example I can see if I am improving in performing wrist projection, sometimes it feels as though I am not progressing, but if I refer back to when I started the course, I can see that I progressed significantly. Also the use of the log is giving me a sense of achievement, by looking back at the positive things being written about my work as well as the negative, gradually my positives are outweighing my negative considerably.

**Conclusion – What else could you have done**

The repeat exposure was the major factor that would have improved the patients journey. In hindsight, I should have improved my knowledge further before carrying out the exposure. It may have been a sense of overconfidence that caused this. Too many unchallenging patients may have caused me to fall into the 'trap' of thinking I knew what I was doing when I should be thinking through all exposures in more depth.

Communication between the patient and myself was fine, however I neglected the communication to other members of staff, I should have communicated more with the trained radiographer. This could have prevented the repeat exposure, and create an improved team bond to increase our workflow in the future.

**Action Plan – If it arose again what would you do**

For all areas of my clinical experience I need to start accessing more information( i.e. literature) from having this I will have an increased base of knowledge, and have a greater array of tools to 'arm' myself with to find solutions to problems that stand in my path, not just as a student but also as a trained radiographer.

I need to concentrate on my workplace communication, this will lead to less mistakes being made, with a synergy within the workplace being made which will lead to improved patient journeys and enhanced career development for myself.

**Incident 2**

**Description – What happened**

At 2300 on a Thursday evening in early October 2008, a 26 year old man was presented to the imaging department. Earlier in the evening the patient had been struck in the eye with a snooker cue during a violent attack at a well known drinking establishment. The patient had been requested for an orbit x ray to be performed. The supervising radiographer deemed this to be a n adequate request. I supervised the radiographer in the examination as I had not previously seen the projections carried out before. 'OM' & 'OM 30°'. The radiographer explained to me why this imaging set was to be performed for this injury. "A non penetrating blow to the eye may produce herniation of the orbital contents inferiorly through a blow -out fracture in the thin floor of the orbit into the maxillary sinus." (Moore, 2006, p. 990) The radiographer also showed me the department protocols which then detailed which

projections were to be performed and why. The radiograph showed no fluid level within the maxillary sinus. The patient was returned to the A & E department.

**Feelings – What were you thinking and feeling**

The patient's inebriated state was a relatively new situation for me to deal with. Particularly with the history leading to the patient being presented to the department. I felt there was a potential for a violent situation arising between staff and the patient, because of this I felt the need to be particularly understanding to any pain or difficulty in the patients understanding in what I wanted him to do. As the patient had been bleeding, the staff and I paid attention to cleansing the imaging room after the patient had been imaged. We found the use of gloves for this examination beneficial, in minimising contamination of ourselves and equipment. The positioning of the patient made things awkward, he kept moving, as we need to maintain that the patient so that they only receive as low as possible dose of radiation (Prasad, 2004, p. 98), we could only expose when the positioning was correct. This involved the patient being held in the correct position, the x ray tube being prepared and the radiographer rushing behind the screen before the patient had a chance to move. This took several attempts but was a success eventually. There must be an alternative method to this technique? I have asked around but yet to learn of any.

**Evaluation – What was good and bad about the experience**

The skull examination that I had observed previously had all been performed supine, I had been advised this aided in the stabilisation of the patient. However for this patient I was informed doing it erect was a preferred method as any fluid levels in the sinuses would be visible, which was an area that I had not thought of previously.

The inebriated state of the patient was new to me, something that I felt I dealt with reasonably well. This will give me confidence in dealing with similar patients, and give me more confidence dealing with others such as children, where I continue to have a lack of confidence, due mainly to my unfamiliarity.

I would have liked to be more of a participant in the situation, due to my lack of experience in 'skull work' this made it very difficult, the situation has increased my skull proficiency, and since the incident I have found myself being of more use in the imaging department. I believe incident, this to be a key part in my skull knowledge development, as it opened my eyes to diverse nature of the topic.

**Analysis – What sense can you make of the situation**

The challenging state the patient was in, made the incident testing but has given me confidence in dealing with diverse patients. I have been told that skull projections are becoming increasingly less common, so any that I can participate in will only aid in my development. The unorthodox nature of the examination (to prevent the patient moving) has made me want to find an ideal solution to prevent patients from moving. I now find myself watching other examinations that I am not part of, in an attempt to gain techniques that I can use for future situations I may find myself in.

**Conclusion – What else could you have done**

It was difficult to ascertain how to deal with the patient, I presumed him to be fairly inebriated. I feel it was wrong for me to assume anything about patients, and maybe I should have given him the benefit of doubt and treated him the same as any other. However, alcohol does increase violent situations (www.homeoffice.gov.uk, 2007) so

maybe there should always be a sense of caution whilst dealing with intoxicated patients.

I feel as though I could have looked at the subsequent patient journeys. In doing this it could aid in my understanding into processes and patient care outside of the imaging department, I can then use this to participate greater within the multidisciplinary team environment.

**Action Plan – If it arose again what would you do**

I need to get involved in as many skull examinations as possible this will increase my confidence and usefulness to the department for these examinations. Doing more out of hours clinical work would increase my chance of working with intoxicated patients, which will improve my proficiency dealing with patients of this type, which I can use in other areas to i.e. paediatrics.

There needs to be further investigation into the follow treatment of patients, currently I am working as though I am only interested within imaging. This needs to change not only to enhance my personal development, but to aid the patient care for the patients that I encounter.

**Conclusion**

These two reasonably normal incidents have been vital in my development toward being an autonomous practitioner. They exposed me to situations that have cemented my knowledge and aided toward my confidence in the imaging department. They have been particularly useful as I feel that I can approach others for advice, in fact by not doing this is harmful to the experience that the patient is receiving, and damaging my own personal and professional development. .

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