

Covenant School of Nursing Reflective



Learning to be a reflective practitioner includes not only acquiring knowledge and skills, but also the ability to establish a link between theory and practice, providing a rationale for actions. Reflective practice is the link between theory and practice and a powerful means of using theory to inform practice thus promoting evidence based practice.” (Tsingos et al., 2014)

Using the Reflective Practice template, document each step. The suggestions in the boxes may help you as you reflect on the incident. This Reflective Practice document will be reviewed by faculty and then you will post the final reflection in your LiveBinder folder.

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| <p>Step 1 Description A description of the incident, with relevant details. Remember to <u>maintain patient confidentiality</u>. Don't make judgments yet or try to draw conclusions; simply describe the events and the key players. Set the scene! It might be useful to ask yourself the following questions</p> <ul style="list-style-type: none"> • What happened? • When did it happen? • Where were you? • Who was involved? • What were you doing? • What role did you play? • What roles did others play? • What was the result? | <p>Step 4 Analysis</p> <ul style="list-style-type: none"> • What can you apply to this situation from your previous knowledge, studies or research? • What recent evidence is in the literature surrounding this situation, if any? • Which theories or bodies of knowledge are relevant to the situation – and in what ways? • What broader issues arise from this event? • What sense can you make of the situation? • What was really going on? • Were other people's experiences similar or different in important ways? • What is the impact of different perspectives eg. personnel / patients / colleagues? |
| <p>Step 2 Feelings Don't move on to analyzing these yet, simply describe them.</p> <ul style="list-style-type: none"> • How were you feeling at the beginning? • What were you thinking at the time? • How did the event make you feel? • What did the words or actions of others make you think? • How did this make you feel? • How did you feel about the final outcome? • What is the most important emotion or feeling you have about the incident? • Why is this the most important feeling? | <p>Step 5 Conclusion</p> <ul style="list-style-type: none"> • How could you have made the situation better? • How could others have made the situation better? • What could you have done differently? • What have you learned from this event? |
| <p>Step 3 Evaluation</p> <ul style="list-style-type: none"> • What was good about the event? • What was bad? • What was easy? • What was difficult? • What went well? • What did you do well? • What did others do well? • Did you expect a different outcome? If so, why? • What went wrong, or not as expected? Why? • How did you contribute? | <p>Step 6 Action Plan</p> <ul style="list-style-type: none"> • What do you think overall about this situation? • What conclusions can you draw? How do you justify these? • With hindsight, would you do something differently next time and why? • How can you use the lessons learned from this event in future? • Can you apply these learnings to other events? • What has this taught you about professional practice about yourself? • How will you use this experience to further improve your practice in the future? |

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Use this template to complete the Reflective Practice documentation. Do not exceed the space in each box. Any information not visible to you is lost.

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| <p>Step 1 Description</p> <p>My patient was complaining of nausea while I was assessing her, but she said she was alright enough for me to finish so I went on with the assessment. I almost got done when she suddenly starts acting like she was going to throw up so I quickly grabbed her emesis bag and raised the head of her bed so that she could more easily vomit. Right after she ended up not being able to reach her water, so I quickly helped her get it. I then made sure she was alright, and the patient told me she had urinated on herself because of the vomiting. She also complained of intense pain in her hip and back because of the movement while she vomited. It hurt too much for her to turn even slightly. I made sure she was alright again then ran and grabbed anyone that could help her. I ended up being able to grab an aid who was able to help me a little with figuring out the situation. After I was able to find my nurse who was able to get the patient some nausea medicine and medication for the pain. We still were not able to move her and change the wet pad, but my nurse told me she would get some people to help her, but the patient was still just lying in it.</p> | <p>Step 4 Analysis</p> <p>I applied my previous knowledge of the risk of aspiration to help move the patient to a position to limit this risk. The only recent evidence of this in our books would just be when we read about nausea and pain medications. Knowledge of aspirations and pressure ulcers due to the skin being wet is relevant since they both could have occurred. This event just shows the issue of what to do when you can't move a patient, but they need to be moved. I just got the sense that certain situations are hard to figure out the way to go about them. The only thing really going on was the fact that it was hard figuring out how to deal with the wet pad. The patient's experience was the only one really significant since she was the one that had to go through it and sit on the wet pad. The impact of the different perceptions showed teamwork and how situations can be perceived as difficult by different people.</p> |
| <p>Step 2 Feelings</p> <p>In the beginning, I felt terrible because I thought it was my fault since I was still doing her assessment and did not get help sooner. I thought that I could finish quickly then get her the help she needed since she told me she was good enough for me to finish. I quickly got it under control, so I felt a little better in the middle of it. The actions of others made me think that this situation is easy to deal with but also it made me feel bad that she still had to sit in the urine because she had to wait for help. I feel good and bad about the outcome since we were able to get her help, but she was still sitting in the urine. The most important emotion I had was feeling bad about the situation because it made me want to help the patient out even more. I feel like this was the most important feeling because it made me want to help her and learn more ways that I could improve future situations like this.</p> | <p>Step 5 Conclusion</p> <p>I could have helped make the situation better by getting help faster. As soon as she said she was nauseous I could have gotten the nurse and got the nausea medicine then completed my assessment. The aid and nurse could have made the situation better by getting help faster and figuring out how to replace the pad, so she did not have to be on it as long. I could have helped the patient faster and figured it out. I have learned that you should not wait when a patient complains about something.</p> |
| <p>Step 3 Evaluation</p> <p>What was good about the event was that I was still in the room, so I was able to help her vomit and get help faster as soon as I knew she was safe. What was bad was the fact that she had to sit in her urine for an extended period since we could not change it. The easiest part was finding meds, cleaning her after, and helping her vomit. The hardest part was figuring out how to change her pad. The whole process went well with her vomiting and getting help but the pad changing did not go well. The aid explained what to do well and the nurse got the patient's medications fast and helped her out quickly. It went as I expected it to because the nurse was able to figure the rest out and deal with it, but the pad was the only problem. After I continued to check on the patient to see if she was still nauseous or felt pain.</p> | <p>Step 6 Action Plan</p> <p>Overall, I think the situation could have been handled better especially with what I did. In conclusion, I think that some situations are hard to figure out when the solution is another problem the patient has. I mainly would just notify the nurse faster next time so that the vomit could have been avoided. I can use this in the future to help my patients when they need it so further problems do not happen. I can apply what I learned to all patients needing help or complaining of something. Professional practice should be done right and in a timely manner. I will use this experience to better myself with how I deal with patient problems.</p> |