

## 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.

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

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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.*

<p><b>Step 1 Description</b></p> <p>On Saturday, October 17 on South 5, a patient pulled out her Dobhoff a fair amount. The patient had a family member in the room with her throughout the day and she also had a TeleSitter. Because of the patient's labs and confusion, she was not a candidate for a J-tube or a PEG. The patient was confused and kept trying to take out the Dobhoff so we had the patient in soft wrist restraints on both upper extremities. We informed the family member to use the call light when the patient would start slumping and leaning toward the side to get at the Dobhoff with her restrained extremity. I was downstairs at ultrasound with a different patient and preceptor. A different nurse on the floor was the person who informed me and my preceptor of what had occurred. Once we got back on the floor, my preceptor and I went to check on the patient. We contacted the doctor for further instruction on whether to replace the Dobhoff or take it out completely.</p>	<p><b>Step 4 Analysis</b></p> <p>What I applied from my previous knowledge and lectures, was when a patient is in restraints, it's important to remove them every 2 hours and check on them every 30 minutes. Broader issues that could arise from this event are the restraints being too tight compromising circulation to the extremities. The only sense of the situation I can make is because of the patient's confusion and her determination of trying to get at the Dobhoff, we should have gone into her room more often. The patient's confusion, determination to remove the Dobhoff and not knowing why the Dobhoff needed to stay in place, led to her taking out the Dobhoff. The doctors and family members had different perspectives, both of which were important in their own ways. The doctors' perspective caused them to have an open door to revisit the idea of hospice and the family members' perspectives caused them to be understandably upset.</p>
<p><b>Step 2 Feelings</b></p> <p>At the beginning of the situation, I felt bad because this happened to our patient when we were downstairs in ultrasound with a different patient. I was thinking that the family members were going to be upset. The event made me feel bad. My preceptor said I shouldn't feel bad because she had a feeling that the patient was going to pull it out regardless. I know the patients' family members were blaming me and my preceptor as well but didn't say anything to us. That also made me feel bad. I contributed to the final outcome by repositioning and retightening the restraints more often after the event occurred. I think the most important feeling I had was feeling bad about the event. This was the most important feeling because given the patient's condition and the feeling I had in my gut telling me she might pull the Dobhoff out, I should have given the patient even more of my time and visited her room more often.</p>	<p><b>Step 5 Conclusion</b></p> <p>The situation could have been made better by checking on the patient more often. We could've gone in repositioned the patient and retightened the restraints more often than we did. When we went down to ultrasound with our other patient, we could have thoroughly informed one of the other nurses of the patient's situation, so she could've kept a better eye on them. I have learned the importance of trusting your gut and following through. Even though we had five patients that day, we should have prioritized visiting the patient's room more often than the others.</p>
<p><b>Step 3 Evaluation</b></p> <p>The bad thing about the event was that the patient pulled out her Dobhoff a fair amount. It was easy to reposition her and retighten her restraints. It was difficult because the patient had to stop her tube feeding before this event occurred. She was aspirating and could not tolerate the feeding. The event complicated the plan of care for the family. The doctors had discussed plans with the family of putting the patient in hospice. The family was in denial and believed the patient would get better. I believe, in the end, what went well, was that this event opened the door to revisit the idea of what the family wants and what the patient needs. My preceptor and I did well in keeping the family up to date and keeping an open line of communication on the plan of care after the event and what the patient and family members could expect. I don't think I expected a different outcome. Throughout the day, I kept feeling something was off when I went in the patient's room. I think, in my gut, I had a feeling the patient would end up pulling the Dobhoff out. What went wrong was that she did end up pulling it out a fair amount. I contributed by keeping a closer eye on the patient and revising her room more often to ensure she wouldn't pull the Dobhoff out even more.</p>	<p><b>Step 6 Action Plan</b></p> <p>Overall, I have not experienced anything like this happen to a patient. I think, in my gut, because of the way the patient was, it was bound to happen, but it also made me feel bad that it happened on our watch. In conclusion, I do think there were pros and cons to the event. The pros were that it would lead the family to come together and make a concrete decision regarding the patient and the cons were that it even happened in the first place, leading the family members to become upset. In hindsight, I would go into the patient's room more often, repositioning and retightening her restraints. I can use the lessons learned from this event in the future by trusting my gut and taking action. I can apply these learnings to other patients who are in restraints or confused. It's important to give these patients even more time than other patients. What this has taught me about professional practice is that if something feels off, it's essential to listen to your gut and give that patient or situation extra time. I will use this experience to further improve my practice in the future by listening to my gut to gain knowledge and critical thinking.</p>