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.

Step 1 Description	Step 4 Analysis
While following a nurse who was caring for a patient who had a finger amputated after a sawing accident, I quickly learned how easily it is to make a medication error. The nurse who had been caring for the patient was extremely busy with multiple patients who were all requiring quick assessment & interventions. The nurse had orders from the patients dr. to hang LR in order to try to correct the patients low blood pressure of 94/26 before they were discharged home. Because she was in a hurry, she went to the med room and grabbed secondary tubing and the fluid that had been ordered and proceeded to the room. I followed closely behind her. She went in, explained the situation to the patient and his wife and proceeded to scan the patients arm band & spiked the fluid without ever scanning the fluid. It wasn't until she had already primed the fluid and piggy backed it to the heparin drip that she realized she could soon be making a big mistake. She clamped the tubing, told the patient she would "be right back after checking on something" and asked me to follow her.	I have learned the seven rights to medication administration in the modules leading up to this event and it has only made me that much more aware of the importance. We could have caused a really bad chain or reactions had we not caught ourselves and returned to the compatibility chart in the med room and/or followed protocol for IV therapy.
Step 2 Feelings	Step 5 Conclusion
In the beginning I was honestly feeling accomplished, we were busy yes, but I was proud of how well she was managing her workload. When I noticed that she didn't scan the fluid before spiking and piggybacking it to the heparin I wondered to myself if ever, when I would be able to "memorize" what medications are compatible with what fluids. Then I began to feel a little uneasy with the piggy back preparation because of the big red sign on the heparin bag that said "HIGH ALERT AGENT."	What could have made the situation better would have been for us to follow protocol from the beginning by not trying to cut corners to save time. For future reference I will be sure to exercise the seven rights to medication administration no matter how busy the workload can get. I will be sure to double check meds/fluids that either I or my preceptor have prepared before I attempt to administer to a patient and make certain not to rely on the knowledge and experience of others to keep my patient (or anyone for that matter) safe.
Step 3 Evaluation	Step 6 Action Plan
The good thing about this incident is that it was a big eye opener and learning experience for not only the nurse but for myself as well. Not only did I learn that medication errors can happen so easily, especially when the seven rights to medication administration are not being followed. I also learned that no amount of experience can prevent you from making such mistake. I am extremely happy that she caught her mistake and was able to fix it before it happened. I have also learned that although workload can become heavy and hectic that it is never okay to cut corners or work out of order. Had we scanned the fluid prior to priming and piggybacking the fluid it could have alerted us of the incompatibility as well as saved us time from priming the wrong tubing.	This situation will stick with me for a long time to come. It was most definitely a learning experience that I will take with me forever. I will make sure to be more thorough and intentional with my actions in the clinical setting.