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.

Step 1 Description A description of the incident, with relevant details. Remember to maintain patient confidentiality. 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 • 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?	**Step 4 Analysis** • 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 personal / patients / colleagues'
Step 2 Feelings Don't move on to analyzing these yet, simply describe them. • 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?	**Step 5 Conclusion** • 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?
Step 3 Evaluation • 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?	**Step 6 Action Plan** • 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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I was taking care of a patient who was found at home on the ground by his wife whom brought him to the ED. The patient has a history of dementia, renal cell carcinoma with metastasis to the lungs, and sleep apnea. The suspicion was a TBI in such that the patient had bruising and swelling on the left side of his face. The patient was immediately taken to CT and the results were a 10 mm right subdural hematoma. The patient was given tranexamic acid in the ED to slow the breakdown of blood clots, which helps to prevent prolonged bleeding. The patient was then transferred to the ICU to be evaluated for possible evacuation of the hematoma. The patient was showing symptoms of confusion, headache, dizziness, and incoordination. The patient would then go on to receive three more CT scans to evaluate the progression of the bleed and the fourth CT scan revealed it had decreased to 2 mm which was a sign that surgery would not be indicated at this time. I was feeling eager in the beginning because I enjoy caring for neuro patients. I was thinking that this patient was going to be taken to surgery because he was experiencing receptive aphasia in such that he could not interpret the difference between left and right when asked to raise his arms. He was presenting with a left drift which made sense because the hematoma was compressing the right side of the brain. The event made me feel anxious for the patient in such that he was constantly straining, moving around, and trying to get out of bed which was impeding treatment and putting stress on his brain. We eventually had to start precedex at a rate of 0.2 mcg/min after giving a bolus because the patient was constantly trying to get up out of the chair without assistance. He was threatening to leave the hospital against medical advice because he stated, “the service at the airport was terrible and we would be going to court for incivility and malpractice.” This also triggered the initiation of a tele sitter and a posey vest because frequent reorientation from the staff and his wife were not enough for him because of the constant fluctuation of changes in mood and behavior. The wife was asked if these interventions would be okay and she agreed. The good thing about the event is that the patient was able to rest while on the precedex drip, and his head of the bed was also able to be maintained at thirty degrees to prevent an increase in intracranial pressure. The bad thing about the event is that the patient had to be restrained. I feel like I tried my best to reassure and reorient the patient

frequently to his surroundings; however, the wife seemed to be triggering the patient further even though she was only trying to help. The interdisciplinary team performed very well in such that they explained the purpose of the sedative medication to the wife and patient and the reason behind the interventions that were initiated. Overall, I think the situation was handled appropriately in such that the patient was putting his life at risk by trying to frequently get up which would more than likely cause a fall if there were no one in the room to assist him. I have learned from this situation that teamwork is an excellent and reliable asset and that it is needed to handle situations like these. I praise the ICU for their teamwork because I see everybody helping everybody no matter what the situation is and that is the skill I strive to master. I will take this event to help me become a better nurse in the future by communicating and working as a team more efficiently and effectively.