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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Jonni Keith

I was assigned a ventilated patient with a primary nurse with many years of experience. This nurse had not had this patient before, so was not up to date on his condition. At the beginning of shift we received a poor report that focused on the second patient assigned that had a lower acuity. The report contained little information regarding the vented patient including the care that provided on the previous shift. When we entered the room to do an assessment, I, also, observed an oral care kit that still contained 3 of the containers for oral care. The kits are usually replaced in the mornings, so it should have been used. I asked my nurse if we needed to do oral care on the patient; however, we did not do it for several hours. Finally, around 1045, I explained to the instructor that oral care had not been performed on my assigned patient and that he was vented. I had been there since 0630, so I know it had not been done in the 4 hours. I was able to perform oral care for the patient with the assistance from the instructor, as it was my first time doing so on a vented patient. As I cleaned the patient's mouth, I cleaned a copious amount of brownish-black mucous and saliva from his mouth. At the beginning of the oral care, I felt frustrated and slightly angry because it seemed as if oral care had not been a priority for this patient even though the care, he needed focused on prevention and comfort. I felt like this task had been ignored, and that made me feel terrible for that patient and his family. I was thinking that if oral care had been done as scheduled, he would not have had so much build up in his mouth nor would he have been having difficulty that required a lot of suctioning. The actions and words of the primary nurse from the previous shift and the current shift made me think that they did not consider this part of care to be a priority. The most important emotion that I felt about the event was empathy for the patient and his family. I know there were multiple times while I was there that the nurse and I could have completed the task with ease because there seemed to be excess time that was used to socialize with other nurses, and the report was excessive regarding the comical behavior of the second assigned patient that did not require the same amount of attention. The good thing about the event was that it humbled me and allowed me to feel empathy for a patient for the first time in nursing school. It brought to the forefront of my mind that these patients cannot do for themselves, so they are reliant on us as nurses to provide them the best care that we are capable. I contributed by providing oral care to the patient that was much needed, and it seemed to ease the daughter a bit when she saw that I wanted to provide the best care for her father. Best practice for ventilated patients is to provide oral care every 4 hours to prevent ventilator associated pneumonia. From previous observation of report in nursing school, I feel that continuity of care between nurses is achieved with a good report that uses the basis of SBAR and informing the relieving nurse of any care that was missed on the previous shift. The broader issue that arises from this situation is poor, unfocused communication results in things being missed in the care of the patient that could lead to more serious problems. What was really going on in this situation, was the second patient's behavior was more entertaining and consumed a large portion of the thought and actions of the primary nurse, so it left deficits in care for the other more severe patient. I feel like I could have made the situation better by asking more questions in report when provided the opportunity that focused the attention of report back to the important facts regarding patient care. I, also, feel like I could have brought my concerns to the instructor sooner to seek advice in how to manage the situation better. The lessons I learned from this situation regarding focused, concise information in report and prioritization, I will apply to my practice in the future. This has taught me that professional practice sometimes requires a nurse giving or receiving report to focus or redirect the other nurse to important information and priorities rather than the entertainment value and speculations of behaviors exhibited by a patient that have been stated once. I learned that I have a lower tolerance to unprofessional behavior and failing to complete essential tasks, and that I prioritize things differently.