

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>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.

<p>Step 1 Description I made a medication admin error, my nurse told me to add the medication on the counter and put it in to the cup to admin through a PEG tube. Without thinking I added an IVP med into the cup with a crushed-up pill and water.</p>	<p>Step 4 Analysis I can apply the seven rights of drug admin, which are right patient, right drug, right dose, right time, right route, right reason and right documentation. This was relevant because if we didn't check for the right route we could have caused harm to the patient.</p>
<p>Step 2 Feelings I felt terrible because we were already behind and the med that was in the cup was a controlled substance that had to be requested from pharmacy and my patient wasn't able to get her meds on time. During the time I was just following instruction and wasn't thinking about what meds should have been added to the cup and the route of each admin.</p>	<p>Step 5 Conclusion Next time while I am scanning the meds I should double check the route of administration before preparing them. I have learned to always clarify something if I am unsure of what my nurse means to ensure clear communication.</p>
<p>Step 3 Evaluation It was good that we caught the mistake and did not give the IVP med through her tube. My nurse was really helpful and understanding and explained that we all make mistakes and its how we learn.</p>	<p>Step 6 Action Plan Although this error could have been worse, I am glad I was able to correct and learn from my mistake. Next time I will ensure the 7 rights of drug admin for each medication ordered to give. I also. Learned that its ok to ask questions if I am unsure or don't know, this will minimize mistakes that could be made.</p>