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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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 During report, my nurse and I were informed that our patient had a PEG tube inserted the day before. We checked on our patient and the condition of his PEG insertion site, then we went to prepare our meds. When beginning to pull the meds out of the Pyxis, my nurse and I discussed how since he had PO meds yesterday and that we would crush them and dissolve them in water to be administered in the new PEG. In the computer, the medications were still listed as having a by mouth order rather than for the peg tube. My nurse said she would contact the doctor to get it fixed once we were finished passing meds. However, I noticed as we were pulling the medications that the aspirin ordered was enteric-coated. I pointed this out to my nurse and questioned if we should still be crushing it. She agreed that we needed to hold off the medications that were PO and contact the patient's doctor to get all medications changed to the correct route to be safe and reflect the route that we intended to give medications rather than PO. After contacting the doctor, the aspirin was changed to a chewable tablet that was appropriate to crush and the other medications were corrected to the right route for accurate documentation.	Step 4 Analysis Previous knowledge applied in this situation was an understanding of medication administration for PEG tubes, and in this case, it was vital to know what medications cannot be administered in this route such as enteric-coated or sustained-release tablets as their proper method of action would be disrupted if the coating was not intact. In this situation, the patient had not had any medications, other than IV fluids, administered as the PEG was inserted the previous afternoon, so the patient was not given incorrect medications on a previous shift as this was a change in the care required for the patient. Knowledge of how to get medication orders changed and a willingness to give the patient the best care possible are important in this situation as it would be easy to glaze over the issue and get it fixed for the next dosage instead.
Step 2 Feelings Since it was the first day back after a school break, I felt apprehensive that I would forget important details of medication administration, especially since I haven't had any experience with a PEG tube outside of SIM in Module 2. However, when in the med room and pulling medications, I became more confident in my ability to properly administer PEG medications as I reviewed it in my head. I was very glad that I had caught that the one medication was enteric-coated, and I am glad we were able to get the medication order changed quickly and administer his meds closely to their scheduled time. I was proud of myself for catching the error and thankful that it was identified before administration.	Step 5 Conclusion I could have made the situation better by prioritizing checking the seven rights of medication administration before going to the med room. Despite that this was not my primary patient, I was still providing care and should always treat every patient as my primary one. In this situation, the medications had the wrong route of PO listed in the eMAR, and while my nurse and I discussed that this was incorrect and needed to be fixed, we initially thought that it could be altered after we were finished passing medications. While many PO meds can be crushed, it would not have been good to document that we administered PO meds to a patient that could have nothing by mouth due to a decreased level of consciousness. While we knew we planned to crush the medications and properly administer them through the PEG tube, the documentation for the medications would be incorrect and if someone were to look at the chart alone, it would look like there was an error on the nurse's part. I learned from this event that I should not assume that I can just give PO medications through the PEG tube and if needed, the doctor or pharmacy should be consulted to ensure the patient is getting the proper medications for the administration routes that they need.
Step 3 Evaluation It was good that we did not administer a crushed enteric-coated medication as the medication would not have worked properly and could affect the patient's safety. However, I should have noticed this error before we were even in the medication room. Since this patient was not my primary patient, I did not research the medications for this patient to verify the seven rights of medication administration. Sometimes I find it difficult to have time to look up the medications I am unfamiliar with when helping my nurse pass medications since I do not want to slow them down a lot. I contributed to this situation by speaking up when I noticed that the aspirin was different from the chewable ones that I had administered before. I had never seen the process in real life of getting a medication order changed, and it was easy and less daunting than I expected to get the error fixed. My nurse did a good job communicating with the doctor promptly to ensure the patient would get their medication as soon as possible. I thought she was a very good example for me of an assertive patient advocate.	Step 6 Action Plan I can use the lessons I learned from this event in the future by always ensuring the seven rights of medication administration are correct, no matter the patient or day. Since the patient did not have a PEG tube the morning before, it had been acceptable to administer the enteric-coated aspirin, but the day after, his needs had changed, so the rights should be checked every day. In regards to professional practice, this has taught me the importance of being prompt and informative to provide the best, most efficient care for the patient. Doctors and nurses should work together as part of a care team for the patient, so in any case of potential error, I should be confident in talking to peers, nurses, doctors, pharmacy, or whoever is needed to be informed and give safe care. Furthermore, the aspect of documenting that PO medications were given could have been bad as this was not accurate and it could not be verified that the meds were given through the PEG if it was not documented. This gave me insight on the importance of accurate documentation and the implications of assuming that others will trust you did something despite it not being recorded. This lesson spans beyond this situation to other reporting, such as getting insulin signed off on before administration.