

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. personal / 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</p> <p>Upon receiving bedside report from the night shift nurse, my nurse and I gathered all the information for the following four patients that we had for the day. We went into each patient's room identifying ourselves and wrote on the board. Soon after we went to the nurse's station to gather more information about our patients and what their labs looked like. After we took a look at labs, my nurse and I were heading to one of the patients' room to do an assessment. Shortly after finishing our assessment, we went to the med room to pull out his medications. While pulling medications, we noticed that there was a package with two meds in it. When there is only supposed to be one pill.</p>	<p>Step 4 Analysis</p> <p>From this occurring and seeing this happen firsthand made me realize how often errors are made. Sometimes from others or ourselves. It's extremely important that we are aware that this could happen, then be our mistake as well for not checking to see if there is one med only. Pharmacy is the one who loads the pixes up with medications so its important to always check and use our seven rights. We don't want to make a medication error on our patient.</p>
<p>Step 2 Feelings</p> <p>My nurse and I stopped for a second and chatted about the importance of looking at the med, dosage, and reviewing it back on the screen. At this time, I felt worried and didn't realize that mistakes like this can happen and it's our responsibility to be checking what is inside the package. Of course, don't open the package but be on the lookout for mistakes like this. Matter of fact for any mistake because anything can happen.</p>	<p>Step 5 Conclusion</p> <p>In conclusion, it's our responsibility to be on top and making sure the right medications are given. Once we review labs and other important information regarding our patient then it's are duty to make sure they're receiving the right medications when it comes time. It's important to not just look at the lab and dosage nut also what's inside.</p>
<p>Step 3 Evaluation</p> <p>Overall, the situation was a good learning experience with the medications in the pixes. Reminding everyone to look at the package and the quantity as well because this this could easily cause a med error. The medication was correct and the dosage on the label, but what was inside the package was not and anyone who was in a rush could have made the mistake of not checking to see.</p>	<p>Step 6 Action Plan</p> <p>From this situation, I learned to always be open to unexpected errors to occur. In no means is this okay but should always be ready. Address the error and learn from it. It was not the nurses' or my fault, but it would've been our fault had we administer the medication. So always be on top and alert.</p>