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 My nurse and I had a patient who was on multiple medications to treat high blood pressure. Before administering medications, my nurse and I went through the patient's chart and reviewed his vital signs. His most recent vital signs were taken at around 0330, and rather than going ahead and administering meds, knowing a nurse aid would soon be going around to check vitals, my nurse made it a priority for us to check his vitals ourselves since his medications would have effects on his blood pressure. We found that his blood pressure was at 133/58. Since this was lower than the blood pressures he had previously had recorded, my nurse discussed with me that she thought we should hold some of the blood pressure medications as she did not want to cause him to experience a quick blood pressure drop after multiple medications were given. We discussed the mechanism of action for the different medications he was on and administered the beta-blocker that he was prescribed as my nurse explained we did not want to skip a dosage of that particular medication if possible. She then had me follow up and check his vital signs 30 minutes later to ensure the patient was safe and reacting well to the medication administration decision that was made.	Step 4 Analysis The bodies of knowledge that were important in this situation were understanding medication pharmacologic effects as well as specific patient information and history. What may be appropriate to give to some patients may not be good practice for another patient. A broader issue that arises from this event for me is that many patients receive multiple medications that have similar effects on the body, such as multiple heart medications or blood thinners. I realized that I should be analyzing patient medications thoroughly all the time rather than assuming that something is correct simply because the order is in the computer. While I may not be deciding to hold medications for every patient, it is important as a patient advocate to always be aware of every single medication and if I have any questions, ask a more experienced nurse, doctor, or pharmacist to ensure that I know what my patient is receiving and how it may affect them.
Step 2 Feelings In the beginning, I did not feel confident in my understanding of the medications. I knew that they were blood pressure medications, but I did not know the methods of action for each medication. I looked at the monographs in the eMAR to have a deeper understanding of the medications, so when my nurse talked through her decision-making process, I began to feel more confident in why we administered what we did. I was very appreciative of my nurse for including me in her decision process and making sure that I understood the reasoning while holding me accountable for learning the medications for myself as well. I was happy with the final outcome since the patient had good blood pressure that was not too low and I was able to take away a lesson from this for future patients.	Step 5 Conclusion In the future, I can be more proactive in my patient's care by developing a deeper understanding of their particular medications before the nurse asks me about it or before I prepare to administer medications myself when I am a nurse. I was reminded about the different ways that blood pressure can be managed and how to look at a patient's information and determine if the medication is necessary for their care. This was so helpful for me in seeing the critical thinking of my nurse and improving my abilities to evaluate situations holistically.
Step 3 Evaluation Something good about the event was that my nurse recognized that it was important to get the patient's most recent vitals rather than just basing decisions off the vitals from 4 hours ago. With this action, she was able to make critical decisions for patient care with the most accurate information. While I did not necessarily make a decision myself on the medication administration, I feel that it was good that I took the time to look further into the medications' method of action and classification so that I could further my understanding of medications. I had a surface-level view of the medications being for blood pressure and the patient having hypertension, so I initially thought this was the right reason, I could just administer the medications. It would be difficult for me to decide whether or not to hold a medication if I do not understand it well enough. Ultimately, my nurse's concern for the patient and knowledge of medications helped this patient to have a good outcome and avoid hypotension caused by administering medications that were not needed at the time.	Step 6 Action Plan Overall, I can use the lessons from this event in the future for all of my medication administration. It is imperative to follow the 7 rights of medication administration, and the "right reason" can require further research and critical thinking to be sure that it truly is the correct reason for the patient. For example, my nurse determined that the medication that was a beta-blocker was more essential to manage the patient's current state rather than the diuretic type of hypertension medication so that the blood pressure was still managed but not overcorrected. These medications are very commonly administered, so I can very easily apply this knowledge to other patients in the future and continue to broaden my understanding of medications as a whole the more I am exposed to them. I am thankful for the lessons my nurse gave me and hope that I can reflect that same attention to detail in patient care as I prepare to be a nurse.