Covenant School of Nursing Reflective

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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. <u>Remember to 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

- 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 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 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 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 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 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

I had gone in to assess my patient for the day when upon entering, the child was in a lot of distress and crying intensely. Using the FLACC scale I determined that the patient was at a pain level of 9 out of 10. His mom was extremely worried about his discomfort and was asking what needed to be done to make him feel better. I knew that the pt had a prn pain medication available. The pt had one available for mild to moderate pain and one for moderate to severe pain. I let the mother know that he had a pain medication available to give for severe pain and that I was going to leave the room to get it prepared for administration so that he could get relief. After preparing and administering the pain med I knew that the patient had an IVPB antibiotic that was due. I let mom know that I was going to finish my assessment of the patient and then go get the medication prepared. Once I got the IVPB primed and ready for administration I went back to the patient's room. I knew that the patient's IV was INT, but I had forgotten that the fluids he had running before was discontinued. I checked the bag, and it didn't show expired, so I went to administer the fluids. I didn't realize by re-starting the fluids I was basically administered a new med that was not ordered.

Step 2 Feelings

I was feeling really confident that I was giving good patient care. I felt as though I was okay re-starting the fluid because the patient needed fluid going so that the full amount of medication could be flushed through once the med stopped. I was thinking that since I had checked the dates on the bag and tubing, and it wasn't expired, that I was good to go ahead and start the fluids. I was thinking I was doing good practice by flushing the IV initially and having one going for when the med stopped. When the mom asked me if it was okay to give the fluid because it had been there a while, I was thinking I was giving her good reassurance by letting her know that I had checked the bags and they weren't expired. When the simulation stopped, and we got debriefed, I realized the magnitude of what I had done. It made me really scared to know that I had basically restarted a new medication on a patient without an order and I could have really brought harm to my patient who I was there to care for and protect. The most important feeling I had about all this was how scared I was to realize I could have caused harm. This was important because this feeling will forever stay with mead n remind me of the. Steps that I need to take to keep my patient sage and how careful I need to be.

Step 3 Evaluation

What was good about the event was that I stayed calm when the patient was exhibiting symptoms of severe distress. I was able to give lots of education and information to the mom about what I was doing and what care I was delivering. What was bad is that I didn't listen to her concerns fully about the fluid enough to make me think maybe I should just start the medication with a whole new fluid bag. What was difficult was remembering to keep everything in my mind in order as far as how I had planned out the care before going in the room. It was hard because I got so nervous with all that was actually going on in the room that I felt a little bit jumbled. What went well was that I was able to recognize how much of a priority it was to treat the pain that the patient was experiencing. I think this though is what overshadowing all of my other thinking, because that's all that my mind had focused in on once I entered the room. I did really good about reassuring mom that I was still going to give her teaching and education when it comes to the colostomy bag that the child had just gotten placed. I did expect a different outcome because I wouldn't have expected myself to do something as big as restarting fluids that had been discontinued. I think if I had taken a second to gather my thoughts, I would have realized the better decision would be to get a whole new bag.

Step 4 Analysis

What I could have applied from previous experiences is all of the research we had to do on situations where nurse made similar medication errors. Things such as scenarios about situations where we see that a patient already had an increased potassium level and the nurse administered fluids with potassium and that put the pt at a critical level. What I could have done differently was pay more attention to the order instead of having tunnel vision and focusing just on the pain. This would have allowed me to see everything as a while and see that making sure that I administered the proper fluids was just as important, if not more important, than making sure that the patient got pain medication at a prompt time. Broader issues that arise from this event are that are extremely critical such as lawsuit, criminal charges, and even the risk of losing your nursing license. There are multiple experiences that have been documented that are very similar to this one, In instances where nurses were written up or even put on probation and they have to do remediation in order to keep their license. This impacts me greatly because along with knowing that I put a patient in harm I also realize that I put my whole nursing career at risk for something that could have been avoided.

Step 5 Conclusion

I could have made this situation better by looking over the patient's orders once more before preparing the medications, as opposed to just checking the pts medication with the medication administration record. I'm not sure that anyone else could have made this situation better other than myself. The medication error of administering the wrong fluids falls completely on myself. It is my responsibility to be thorough in making sure that I am delivering the proper medications and fluids to the patient. As my instructor noted if the patient's potassium level had already been a little high and I administered more potassium I would have put that patient at a huge risk and caused great harm. I have learned the importance of delivering thorough care instead of just prompt care. I have also learned the importance of why the rights of medication are drilled into us so much and why it is a good idea to go over those each day as we start a shift or prior to preparing medications. I could have easily just grabbed a new bag to run with the medication, the only reason that I didn't was because I didn't see in normal saline bags in the pyxis. This is also a good reminder that just because something isn't there doesn't mean I should go without using it. I should have called pharmacy for a bag.

Step 6 Action Plan

Overall, I don't feel as bad about this simulation performance as I had felt initially. I know the things that it highlighted that I need to work on such as controlling my nerves and reviewing orders once more completely before I deliver a medication to a patient. It has also taught me for my own practice that if I ever have a fluid discontinued on my shift I will just go ahead and dispose of that fluid at that moment instead of disconnecting them and leaving them hanging. Yes, I would do things differently. In a situation where a lot of things are going on I will do my best to take a moment to catch my breath and recollect my thoughts if time permits. I will also use this experience to be more thorough with my patient care such as reviewing orders and hanging new fluids each time I hang a med where fluids aren't already running. I can definitely apply these events to future events as these situations are extremely likely to arise. This has taught me that I should always look further into why parents of a patient are questioning the methods I am using. If I would have looked a little more into the fluids, I was restarting it would have just triggered me to go ahead and start new ones. I will use this experience to make sure that parents are heard a little more and not brushed to the side. I will also use this to remember the necessity of being thorough in my review of pt care.