

# Covenant School of Nursing Reflective

*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><b>Step 1 Description</b></p> <p>My nurse and I were making rounds on our patients, as we went into one of the rooms we asked if they needed anything or if they were in pain. The patient mentioned that he was in pain and wanted some pain medication. We went to the medication room to withdraw some pain medication pills. I was watching my nurse pull the medications from the pixis system when I noticed that he was pulling medications from the wrong patient profile. He was getting the correct medication, but from the wrong patient. As soon as I realized this, I spoke up and the nurse thanked me for catching the error. He went back and returned the medication and went back into the correct patient's name and withdrew the medication. It was something small at the time, but could have been something bigger later.</p>	<p><b>Step 4 Analysis</b></p> <p>Ensuring that you go through ALL seven rights of medication administration is a literal life or death thing every time you administer medication. This particular situation wasn't as serious because it was the same medication but two separate patients. But what if it was the wrong medications for the wrong patient? This is something that should be caught by the computer system when scanning the patient and the medication, but then again, if you forget to verify the patient's name in the med room, there's a chance to forget to scan things and put it in the computer before administering. Small missteps can easily turn into big ones if they aren't acknowledged and corrected.</p>
<p><b>Step 2 Feelings</b></p> <p>It's crazy to me that even nurses that have been working on the floor for a few years can make mistakes, but it also shows how sometimes nurses can get into a rhythm that they get comfortable in and stop really checking all of their boxes before moving on. I also understand that there are always going to be those days that brain fog can get the best of people, but those are the days that they need to take the extra time to ensure they have all their bases covered. I felt good that I was able to catch this error before we left the medication room, because it may not have been easy to catch since we were getting the same medication.</p>	<p><b>Step 5 Conclusion</b></p> <p>I feel that I made the situation better by speaking up and making sure the nurse knew that he was pulling a medication from the wrong patient's file. I may have a tendency to not always speak up when I should, and I am working to correct this and make sure I advocate for the patients, but this is a time I went outside of my comfort zone and corrected my nurse.</p>
<p><b>Step 3 Evaluation</b></p> <p>This medication error could have gone bad if the first (wrong) patient asked for pain medications and the pixis may not have let the nurse pull any more out because it would not have shown as available within the dosage window. The nurse was lucky that the medication was the same for both patients but paying closer attention to which patient you're pulling from can make the difference on what's available to pull from the system.</p>	<p><b>Step 6 Action Plan</b></p> <p>I am learning that even though the nurses have already been through this whole education, we are all human and everyone can overlook things. This is why it is that much more important to not fall into a rut and always check all of the boxes and not cut corners. I hope that this can stick with me and remind me why I take the time to check everything before rushing to the next task.</p>