

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>When passing 9:00 meds this morning with my nurse, we were administering to a patient who had a lot of meds, that had to be crushed for administration. I was scanning the meds and crushing them. I had scanned the patient's blood pressure medication and had to enter the patient's pulse into the computer. I had already grabbed the next med when I was entering the blood pressure medication information into the computer. The med I had in my hand was Furosemide. After I entered the information I was already holding the Furosemide, so I assumed that was the med I had just scanned and did not scan the Furosemide. The nurse was in the room with me, but she was doing her physical assessment on the patient so she did not catch the mistake right away. Later on, she realized the Furosemide had not been documented and asked me if I remembered giving it, which I did. She was able to correct the error and document that the Furosemide was administered.</p>	<p>Step 4 Analysis</p> <p>Based on my knowledge, I know that med errors are common and happen to everyone at some point. I know that getting in a rush and not double or triple checking yourself can cause errors. If the nurse had not caught my mistake, the patient could have ended up getting a double dose of Furosemide, because it was not documented that it had already been administered. My nurse told me that she had experienced the same mistake before, and that is why she always double checks her charting after administering meds. She makes sure that she writes down everything she gave the patient and then goes and checks that it is all accurate in the eMar and all of the administered meds have been documented and saved.</p>
<p>Step 2 Feelings</p> <p>When I first realized the mistake I had made, I was worried that she would not be able to fix it and frustrated that I had made that mistake because I got in a rush. At the time, I knew my nurse was behind and she was in a hurry to get caught up on her work, which made me rush through scanning the meds. She told me that it would be an easy fix and she could document the med administration as long as I remembered giving the Furosemide, which I did. I was relieved that she was able to correct the mistake and I was grateful that she was kind about it and let me know that it was okay, and things like that will happen.</p>	<p>Step 5 Conclusion</p> <p>I could have avoided this situation by taking more time to check each med I was scanning and making sure that the med I was holding was the med I had scanned. The nurse was in a rush because she was behind, so while I was scanning meds, she was doing an assessment. She was not monitoring me closely or she may have caught the mistake as it happened. I learned that being thorough and double checking yourself is necessary, even if you are behind, because mistakes will happen very easily when you get in a rush.</p>

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Step 3 Evaluation	Step 6 Action Plan
<p>The good thing about the event, was that I learned that I need to take the time to pay close attention to the meds I am scanning and make sure I am scanning and documenting each med that I am administering. One thing I did well, was verbalizing each med I was administering, so when she asked me if I gave the Furosemide, I was able to remember giving it, because I remembered saying it to the patient. The nurse handled the situation well. She caught the error just a few minutes after we left the room. She was very thorough on her documentation so she was able to spot the error quickly and correct it.</p>	<p>I think that overall, this situation made me realize how easily medication errors can happen. We have been told that they will happen at some point, but it was a good learning experience for me today, because I saw first-hand how getting into a rush can cause a mistake. It also showed me the importance of checking your documentation. If she had not gone back and looked on her documentation for the meds on that patient, she may not have caught my error. I will apply this mistake to my practice in the future by taking my time when giving and documenting meds, and always double checking my documentation after administration.</p>