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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Step 1 Description On Tuesday 5/11/21, I walked out of the patient room I was in to wash my hands. When I was washing my hands, I could hear a beeping noise and could not tell if it was an IV pump or a call light. So, I followed the sound and when I turned to the patient room it was coming from, I saw the patient lying on the floor not moving and the IV pole was knocked over. Immediately I shouted for help and when I looked in the hallway there was no one there. So, I ran down the hall and luckily the charge nurse had just come out of a patient room and I told her the patient was on the floor. She immediately ran back down the hallway and into the patient room with me and by that time a few other nurses had followed us in. One nurse checked for a pulse and started compressions, while the charge nurse called for a code blue. Another nurse got an ambu bag and started to use it on the patient. The code blue team arrived and continued to work on the patient. During that care, the patient was intubated, and epinephrine was given. After the defibrillator was used and a numerous of compressions were done, one of the physicians was able to find a pulse. The patient was then transferred to the bed and in a short amount of time was transferred off the floor. After, I talked to my nurse about the events that took place and then we continued our care for the other patients.	Step 4 Analysis I was able to apply my previous knowledge of CPR and why it is crucial to act quickly. Although I did not participate in the CPR process, I was able to make a connection between what was happening in this event and what I learned in CPR training. For example, the nurse that started chest compressions checked the patient's pulse prior to initiating the compressions just like we were taught. She also did them at a depth of at least two inches like we were taught. This event was very time sensitive because I have learned that the body and more specifically the brain is very time limited as to how long it can go without oxygen, so starting chest compressions to circulate the blood needed to be initiated quickly. I have also learned that it is important for the patient to receive epinephrine because it increases myocardial and cerebral blood flow.
Step 2 Feelings When I first saw the patient on the floor, I felt like my stomach dropped to the floor. I thought I was answering a normal call light and I was not expecting to see a patient lying on the floor not moving. In that time, I felt scared and anxious. I did not know if the patient was going to regain a pulse and I prayed to God to be with the patient and everyone working on him. When I saw all the people doing their part of the CPR process, I felt hopeful that they were going to be successful. When a pulse was detected, I felt relief, but I also still felt worried about how long the patient was down and without oxygen to the brain and other organs before CPR was started. After the patient was transferred and I talked to my nurse, I was in disbelief of what had happened. I had never experienced a code blue from the start. The most important feeling I had about this event was feeling hopeful that a team of skillful people could potentially save a life. This was the most important feeling to me because it kept me calm in the situation that I did not have control over.	Step 5 Conclusion There are a few ways I could have made the situation better and that I could have done differently. I could have been reviewing CPR practice more frequently to be prepared for these situations. I also could have implemented the first step of CPR procedure which is to assess the patient/pulse and then call for help. Being a nursing student and having limited experience, I was concerned about getting the patient help right away. I was also unsure of my permission to initiate CPR and I did not have details about this patient's code status. The people in charge of stocking the crash cart could have made the situation better by having the crash cart stocked. From this event, I learned that communication is important in a code blue. It is important to know when the last dose of epinephrine is given.
Step 3 Evaluation One good thing about the event is that I was able to witness how a code blue is ran in the hospital as a student rather than a new nurse on the floor. I was able to see the different roles of each team member. One bad thing about the event was that the crash cart was not stocked properly. For that reason, time was lost when the defibrillator pads had to be found. For me, the easy part was witnessing and learning from this event, but for anyone working to revive the patient was the most difficult part because it is unknown if revival or death will be the outcome. Something that went well in this event was that each team member did their part. For example, the nurse in charge of compressions started as soon as she received permission from the charge nurse and the nurse who oversaw airway started using the ambu bag right away. I did not know what outcome to expect in this event. I did not expect for the crash cart to be missing supplies because I have learned crash carts should always be stocked properly. I contributed to this event by getting help for the patient once I found him. I also contributed by moving items out of the way and preparing the bed to transfer the patient from the floor to bed.	Step 6 Action Plan Overall, I never imagined that a code blue could happen so quickly. One moment the patient is here and the next, the patient is fighting for their life. This event was also a good learning experience, and it has prepared me for future code blues. It was also a good way to witness teamwork in the hospital setting. Looking at the big picture of the event, one thing I would do differently is to be more helpful. I could have offered to assist with chest compressions to give those who were doing them a break and for me to gain experience. Being able to witness what each team member's role is during a code blue has given me insight of what I can do in the future for when I am a nurse on the floor. This experience has taught me that as a nurse, we always need to know what do in every situation and we need to be able to think quickly. For my practice in the future, I will work on being prepared as best as I can for situations I do not find myself in often, because this event proved to me unexpected situations can happen at any time.

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.

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