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 were administering medications for one of our patients. The gentlemen had a Nicotine patch from the night shift that needed to be removed and a new Nicotine patch was going to be placed on the opposite shoulder. I did my two patient identifiers (name and DOB) and confirmed known allergies with the patient. I scanned my multiple medications and did my teaching with the patient regarding the medication, dosage, route, reason for the medication and any important signs to watch for. The patient gave consent to take the medications discussed and received his oral medications with no difficulty. I prepared patient's new Nicotine patch by cutting the package and warming it up slightly in my hand for optimal adherence. Upon removing the old Nicotine patch from my patient's shoulder, I discarded the patch in the trash can. My nurse instantly instructed me to stop what I was doing and retrieve the old Nicotine patch from the trash can. She began to inform me why by no circumstance should a medication that has a black box warning, such as a Nicotine patch, be thrown away in a patient's room due to safety concerns and to protect myself (the nurse) from any dishonest actions on the part of the patient or any family members in the room visiting.	Step 4 Analysis: Once I completed the remainder of my medication administration and left the patient's room, my nurse explained the rationale behind discarding medications in the black box disposal located in the med room. She informed me that even though the Nicotine was an old patch, there have been instances where the patient will retrieve the discarded medication and try to receive more of the medication if able. She also informed me that sometimes it may not be the patient but a family member that is in the room visiting at the time. My nurse explained also that it is protecting me and my license when I begin practicing as the joint commission does pop up visits and sometimes performs "sit in" visits within the patient's room to observe the work of the nurse. She gave me a suggestion such as if I am ever in doubt if something can be disposed in the patient's room, to just take it with me and dispose of it once in the med room to be safe.
Step 2 Feelings: In the beginning of the administration process, I felt confident. I understood why the patient was receiving the medication that he was, and I was able to effectively teach the patient about the medication. I understood what lab values and vital sign results needed to be reviewed prior to administration as well. Once I discarded of the Nicotine patch in the trash can, I instantly felt like I had no idea what I was doing anymore. It made my confidence level go down significantly and caused me to be frustrated at myself for being careless and not thinking about the safe way to dispose of it.	Step 5 Conclusion: Though the outcome of the situation was not how I thought it would go, I was able to learn a lesson and take that information away with me to implement in the future. I have learned to never let my guard down when it comes to patient safety and policy and procedures, even if I think no one is watching me. Something I could have done differently was ask my nurse if the Nicotine patch was something appropriate to throw away in the patient's room rather than assuming that action was correct. It never hurts to get clarification on an action prior to going through with it.
Step 3 Evaluation: The situation caused my confidence to drop significantly, and I started to feel myself shut down out of frustration and embarrassment that I made such a mistake, especially this far into my education. I felt my nurse did a good job on reassuring me clinicals is the time to make such mistakes because you always have a nurse beside you to watch and correct you if needed. She explained it was a mistake that was made, and it was corrected and now I know for next time. I was not anticipating making such a mistake when initially preparing to administer his medication, so my outcome was different than intended going into the patient's room.	Step 6 Action Plan: Overall, I think the situation was a necessary stumble for me to make and learn from. I would rather be corrected by my nurse for my mistake than leave myself open to consequences that could have came from that mistake. Next time, if I am not 100% sure on something I will ask my nurse for clarification before performing the task. This is a lesson I will carry with me into future modules and within my career. Being aware and cautious is always the better alternative than having a careless mistake jeopardize something I have worked so hard to achieve.