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Covenant School of Nursing Reflective

Step 1 Description Today we had our graded CPE in SIM Lab for Module 4. I had my CPE at 11:45 am. In the room it was me and 3 other instructors watching/grading me. The patient I had, was admitted due to an infection and the patient had a low blood pressure that greatly determined which medications to give and which ones to hold. Also, the patient had low platelet counts too which caused an anti-platelet medicine to be held as well. When I went into the room, I did a neuro/respiratory assessment on my patient and gave narco. I also hung a IVPB of levofloxacin which was the antibiotic. Towards the end of the CPE, I was unable to find the call light for the patient and unfortunately resulted in an unmet. However and thankfully I was able to learn from my mistake and was able to redo the safety part for the CPE.	Step 4 Analysis What I can apply to this situation, is the Universal Competencies and how we need to ALWAYS keep the patient safe. Those 7 rules are very important and they contain research and evidence that surround the call light. Also, the call light is part of the Red rules as well. The broader issue that arise from the call light deals with the safety of the patient and is something that must be followed no matter what. People's experiences are the same that the patients safety is a must! The impact of it is the same as well.
Step 2 Feelings I was feeling nervous at the beginning because I didn't know what to expect exactly. Just the information that was given to us last night. I also felt nervous the whole time as well. I was a little sad that I missed something as simple as the call light though. But I was happy because I was able to learn from my mistake and I feel like that is what counts plus it was in the SIM lab. I was happy though that I was able to fix my mistake and I was able to learn from it and redo part of the scenario again.	Step 5 Conclusion How I could have made the situation better, is I should have gotten the call light and put it in the patient's hand. There was no one else that could have made the situation better because it was my personal CPE and my own personal responsibility. What I could have done differently, was to have found the call light and put it in the patient's hand. What I learned is that putting the call light in the patient's hand is a very important safety measure that should not be taken lightly and should never ever be skipped or missed. This was a valuable lesson learned for myself.
Step 3 Evaluation What was good about the event is that I was able to learn from my mistakes and I was also able to see if I knew my skills good as well. It also showed me things I need to work on and improvement needed. I feel like the assessments were easy. I don't feel like there was anything that was difficult though. It was overall a good experience that I learned from. On the outcomes, at the beginning I expected to make a met instead of an unmet. I guess I expected a different outcome, because you always hope that everything will be okay and that you got it. What went wrong is that I did not find the call light to give the patient when I should have because it is a very important part of patient safety.	Step 6 Action Plan I think that overall this was a great and valuable lesson learned for myself. The conclusion that I learned is that this was a very critical and important aspect of patient care. With hindsight, I will make sure that call light is in the patient's hand and that it is a must! I learned from my mistake and I will always apply it to other events as well. It has taught me a very valuable lesson for sure.