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 had come into our patient's room to give them their morning medications. One of the medications to be given was a pain medication and this patient just happened to have two different kinds on board to help with pain management. Though, when looking at the eMAR, it showed that one pill was due in that moment and the other pill was due in 45 minutes. My nurse and I pulled the pill that was due right then to give, but the patient let us know that they needed the other one first for proper pain management. After discussing with the patient, we went back to the med room to grab the correct pill. At this point, all of the pills had been popped out into the medication cup, including the pill that the patient was not wanting at the time. Upon leaving the patient's room to get the necessary pill, I asked my nurse how we should go about wasting the pill and documenting it, since it had already been removed from its packaging. This is when my nurse made the decision to hold onto the pill until the patient said they were ready for it, instead of going through the proper wasting procedures.	Step 4 Analysis Medication errors happen on a daily basis and although this isn't what I would typically think of when thinking of a medication error, it did involve a medication and an error. Much like all other medication errors, this error was completely avoidable. People get in a hurry, they cut corners, and sometimes they don't use the best judgement. Although that may be okay in normal day to day life, that gets really tricky when you're taking care of people and their lives are in your hands. Every decision has to be made with the patient's best interest in mind and with safety at the core. When things like this happen however, that's when you have sentinel events and things of that nature. Awful things that could've been avoided. It's hard to make sense of any situation like this one, where something is done that shouldn't have been. Although I've been racking my brain trying to come up with an easy explanation, I don't think there is one. You never know what may be going through someone's head or even in someone's life when doing questionable things and although this may have just been a misstep that the nurse would've never done before, it still shouldn't ever happen and needs to be prevented.
Step 2 Feelings When it came to pulling the medications for this patient, everything was fine, and I felt confident in myself and my abilities. Once we came into the patient's room however, and began trying to administer their medications, that's when I began to feel very apprehensive. The patient and their visitor were going back and forth with my nurse about the medication at hand and in that moment, all I felt I could do was listen and watch. Once we left the room, I was very uncomfortable with what had just happened and almost even more so confused. I didn't quite understand why there was an issue with the order we were trying to give the medications, but that was due to not having proper explanation for the pain management purposes. When it came to getting the proper pill and my nurse making the decision to hold onto the previous one, that's when I felt like I was beginning to panic. As a student in that situation, I felt almost powerless because although I knew what was right and what wasn't, I didn't know how I was supposed to go about getting my nurse to recognize what I was recognizing. Once everything was said and done, I felt sick to my stomach with worry over how everything had played out.	Step 5 Conclusion Although I felt fairly helpless in this situation, looking back at it, I should've spoken up more than I did in the moment. I don't know that it would've changed anything, but I still feel like I had and have an obligation to the patient, student or not. I should've pushed harder to get the nurse to realize that what they were doing was wrong and instead, get them to do what was necessary and best practice. I've learned a great deal from this experience. One of the biggest things being, that sticking to what I know is right is likely always going to be safest practice. I need to continue pushing back when someone tries to get me to do something that isn't right and continue looking out for the best interest of my patients and myself.
Step 3 Evaluation In regard to this situation, I have a lot of feelings. The good thing about it was that I was able to recognize immediately when something wasn't right. The bad thing about it was that my nurse didn't recognize the issue with me, and instead proceeded with doing what they were doing. Moreover, the bad thing was that the actions that took place put the patient at risk and were completely avoidable. I found it easy to see the errors and missteps in what happened, and I even found it easy to see a resolution that wouldn't have put anyone at risk. It was difficult recognizing those things, but it was also difficult recognizing that I am a student and even though I may ask a question or point out the obvious to the nurse, I'm still met with being treated as if I don't have a say because I'm a student. Ultimately, the situation didn't go as I thought it would, but especially not as I knew it should. The pill was still given to the patient later on, even though it had been handled outside of a package and although the patient was fine, it should've never happened in the first place. I didn't know what to do in regard to this situation or even if there was anything I could do. So, I brought it to my instructor's attention, to ensure someone else was aware and so I could get some guidance.	Step 6 Action Plan Overall, this situation was a very uncomfortable one and not something I ever saw myself having to witness as a student. We're taught to watch out for nurses cutting corners and doing things to save time, etc. I think this situation definitely falls under that category, but I also feel like there was something more going on. Burnout is a very real thing and it's why we have to be so vigilant in not only our patient care, but also our own personal care. There are always going to be good and bad days, but it's how we choose to deal with those days that make the difference. This was a situation where the wrong choice was made, and it unfortunately could've had a very negative impact on the patient. In this profession, we can't have that happen, slip ups can't happen, missteps can't happen. We have to be observant and aware of what's happening in each moment, so that we can best protect those around us. If there's one positive that I will take away from this situation, it will be the effect that it has had on me and will have on me to be a better caregiver in the future. Seeing this all unfold and knowing what could've happened as a result, I know now how easily things can change in and happen in this profession without even skipping a beat.