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 Today on the floor my fellow student and I rounded with our nurse before we chose which patients we would take care of and assess. I heard in report that one patient would be needing his JP drain removed and thought this would be an exciting opportunity. I chose him as my primary patient and the time to remove the drain finally came around. My nurse asked me if I was familiar with removing sutures, to which I responded yes- we learned this skill in the simulation lab a couple of weeks ago. My fellow student, the nurse, and the patients wife all watched closely as I grabbed the suture and clipped the opposite end. Since this was my first time performing this skill on a live patient I was extra cautious of what I was doing with my instruments. As soon as I pulled the suture out the JP drain came out entirely. My nurse looked at it slightly stunned and asked if I had accidentally clipped the tubing of the drain. I was sure I hadn't, but began to question myself when she told me the tube should have been much longer. After consulting the charge nurse, HCP and assessing the cite we determined that I had not left any tubing inside the patient- the tube was just sutured in very close to the end of the drain and was more superficial than we had expected it to be.	Step 4 Analysis Since the removal of the drain was a simple process that I had seen before, I was able to refer to my prior experience to complete it. According to UCDavis.edu, it is standard to "remove the bulb when drainage is below 25 ml per day for two days in a row." This is relevant because the drain was not inserted as deeply as the patient's provider thought it was, therefor the amount of drainage measured may not have been accurate and a new drain may need to be inserted. This is important because if the serosanguineous fluid is not drained as the provider intended, the patient is at higher risk for infection. While the doubt from my nurse did cause some nervousness in myself and my patient, her perspective was helpful, because she was merely looking out for the patient and ensuring that he wasn't placed at further risk for infection or injury. *After surgical procedure instructions ... - UC davis health*. (n.d.). Retrieved December 16, 2021, from https://health.ucdavis.edu/surgery/specialties/oncologic/jp_instructions.pdf
Step 2 Feelings When I initially heard that the drain needed discontinuing, I felt very excited and hopeful that I would be the one to remove it. I had seen it done before and it was simple enough. I felt confident that I could do it as it is a quick skill that I had recently practiced in our simulation center. When the time rolled around, I remained confident and excited. Being watched by my peer, nurse, and the patient's wife didn't make me nervous as I had expected it might. The only hesitancy I had was around the thought that I might accidentally poke the patient when I went to clip the suture. When my nurse asked if I had clipped the drain, I felt sure that I hadn't so at this point I was still feeling good. Upon hearing the concern in my nurse's voice, my patient began to express concern- this is when my feelings started to change. I wanted the patient to trust me and feel as confident in my skills as I did. As I went to find the charge nurse, I felt a sense of urgency, as I wanted the situation to resolve and the patient to have peace of mind. Upon returning to the patient's room, I began to feel nervous- multiple peers of mine and other nurses from the floor were now in the room. I felt relieved and proud of myself when the situation was resolved and I was assured that I had done everything in my power right.	Step 5 Conclusion I feel that this situation was handled as well as it could have been by all parties given the circumstances. In hindsight, I could have observed and let the nurse remove the drain herself which would have let her be more confident that the tube was not damaged at all. However, if I could redo it I would not have done that any differently. I am glad I had the experience and am grateful to have had such an understanding patient and an incredible staff of nurses, peers, and providers that resolved the situation quickly and professionally. I learned that sometimes things go wrong that are not in my control, it is important to measure and document the length of tubes before insertion, so that they can be compared when removed.
Step 3 Evaluation A few good things came from this incident. Firstly, I got to perform a new skill. Secondly, I learned to trust myself. I was confident that I had done everything correctly and, in the end, I did. Even when there was doubt from my nurse, which was understandable given the circumstances, I knew that I had performed as I should have. It was also a great opportunity to practice open communication with the patient and his wife. By keeping them involved and in the loop I was able to ease their worry. After the conclusion of these events, the wife pulled me aside and told me that she had watched me closely and knew I couldn't have done anything wrong. She told me she was grateful for my help and that she appreciated my confidence. The most difficult part of this event was knowing I had not clipped the tube, when there was doubt in my nurse. I didn't want to sound arrogant, disrespectful, quarrelsome or wrong. However, I was sure I had only clipped the suture and I did not want my patient to be stressed out over something that never actually happened.	Step 6 Action Plan Overall, the situation was not as bad as it seemed in the moment. From the very beginning I was confident in my abilities, and I wouldn't have agreed to remove the tube if I wasn't sure I could do it properly. When future events inevitably occur, I will remember the chain of command and look to my peers if I need help to resolve these incidents. This taught me that when there is doubt about the outcome of a procedure, it is okay to bring in someone with more experience to verify. There is no shame in having someone verify that everything has gone as it should. It is important to advocate for a patient if you have any kind of doubt surrounding their care.