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 On the first day of clinicals this week, I had a patient with osteomyelitis. My patient's infection was located in her lumbar spine, so she had excruciating pain if she stood, sat up, or even had the head of her bed raised over 30 degrees. My nurse and I gave her medications at 9:30 that morning and I was meant to come back one hour later to recheck her blood pressure. When the time rolled around, I heard screams coming from the patient's room. Upon entering, the CNA had my patient sitting up in her recliner while the bed linens were being changed. I asked what was happening and how I could help. The CNA informed me that the patient had thrown up on herself and that it would be best if I could take off the patient's TLSO brace, remove her shirt, clean her up and redress her in a fresh T-shirt and gown. Due to the nature of my patient's pain, she was hardly able to bear sitting at a 90-degree angle. I tried to recline her chair, but it was not low enough to provide any relief. I sat her back up and removed her brace. Since the pain was so intense, she gripped my hand and yelled, "faster, faster! I can't do this! It hurts too bad!" I notice the lumen of her dialysis port sticking out of her sleeve, under her armpit- but it was too late. She yanked the shirt off herself, pulling the catheter out	Step 4 Analysis When the catheter was ripped out, I realized I never learned what to do in this exact situation, but my first thought was "what do you do when you remove a peripheral IV?" "What about a CVAD?" "What about if a chest tube gets accidentally pulled out?" The answer was "apply pressure." At this point, my nurse had entered the room. I explained what happened and showed her the tubing and minimal bleeding, She told me to leave the dressing on as it seemed to be holding enough pressure on the cite. I immediately helped the patient back into bed and laid her completely supine. Having my nurse come in at the exact right moment was helpful, as I felt shocked and in disbelief. I am pretty sure the CNA thought I pulled the catheter out, so I am glad that the patient clarified on my behalf. *Procedure: Removal of central venous catheters (jugular, subclavian, femoral)*. LHSC. (n.d.). Retrieved January 12, 2022, from https://www.lhsc.on.ca/critical-care-trauma-centre/procedure-removal-of-central-venous-catheters-jugular-subclavian
Step 2 Feelings My first thought was "I hear screaming. She is in pain and this will not be an accurate reflection of her blood pressure." When I entered the room and saw the scene, I felt it best to reprioritize and help fix the situation, once things were rectified and the patient had a chance to stabilize, I could then acquire a more accurate blood pressure. I felt awful seeing my patient in so much pain. I had never seen a patient under my care in that much agony. All I wanted to do was give her some relief and the sense of urgency I felt was almost overwhelming. When she begged me to go faster, I felt bad- I knew I could move more quickly, but once I noticed the lumen, I knew the shirt would get stuck on it. I could sense my patient becoming frantic when she noticed I was moving her shirt back down instead of off. When she took her shirt from my hand I watched her pull it off with speed that I have never seen before- yet it felt like slow motion in my mind. I felt horrified when I saw the tubing hit the floor. My fears were coming true and it was so much worse than stuck… It was ripped out! I felt some relief when I saw that there was not too much blood. This was the first time that I desperately wished my nurse was in the room to help with a simple emesis clean up. Luckily, she appeared, and I felt relieved.	Step 5 Conclusion I feel that I definitely could have prevented the patient ripping out her dialysis catheter if I would have noticed it poking out just a little earlier, or if I would have moved a little quicker. The CNA also could have changed the patient before the bedding, this would have dramatically reduced the time that the patient was sitting up straight in a recliner. If I could go back and do it differently, I would not have tried to recline the patients chair, I would have just removed the brace and T-shirt immediately. These solutions wouldn't have helped much with the patient's pain, but it would have prevented the catheter from dislodging. However, without the dislodging, the patient wouldn't have received a covid test, as she either was asymptomatic or her symptoms were masked by all of her pain medications or her preexisting conditions.
Step 3 Evaluation One good thing from this event was that the patient ended up being covid tested before she could get her dialysis port replaced- her test came back positive. While a positive covid test is not in and of itself a good thing, it gave us a clearer picture of how best to care for her and to apply the proper isolation precautions, therefor preventing the spread of infection. Another good thing, from a learning perspective, is that once we did get her changed and back into bed her pain subsided, and I was given an opportunity to hold her hand and be her emotional support. While I regret the circumstances, I always love when I have an opportunity to be the one to console my patients. I love the trust they place in me and I feel so blessed to be involved in such a vulnerable moment. The best action on my part occurred after the fact, when I was able to help her calm down. I wish I could have moved more quickly and prevented this situation entirely. The CNA involved did a good job of changing the linens quickly and I am glad that I was there to allow her to focus on that. I initially expected to obtain a simple blood pressure, but this was a lesson that things never go as planned when you are on the floor.	Step 6 Action Plan This situation was hectic and I regret that the patient was put through this. If a similar situation ever arises I will certainly move more quickly and jump into the situation without asking what I should do first. Additionally, I will check that all tubing is where it should be and isn't tangled up in clothing or blankets before I leave a patient's room. I think that having an experience like this under my belt will remind me in the future to finish the task at hand before moving on to the next thing, as far as patients in pain go. Working with patients in the hospital, situations tend to be complex, and all patients are different- hopefully something like this wont happen again on my watch, but if it does, I will be prepared.