Covenant School of Nursing Reflection

Rafael Alegre
March 23, 2022

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 For this week's clinical, I made a crucial error when I drew up medication. Together with my nurse, we finally convinced one of the patients to take his 0900 medication at 1320. We need to give him his dose of morphine in exchange. After multiple bouts of his hypotension, his blood pressure went up to a 100 so we decided to give the morphine to the patient. I drew up the morphine, wasted half of it, and recapped it with a sterile blue cap. As I piled up the used needle and swab, I accidentally included the morphine vial and threw it in the sharps. My nurse was so surprised, and I ended up apologizing to her and the charge nurse for my actions.	Step 4 Analysis In module 2, we had a lecture regarding drug diversion. Drug diversion is a crime involving healthcare workers "diverting" the use of controlled substances that was legally prescribed to a patient to another person for illegal use. One of the most common diverted drugs is morphine. To prevent this medication from being diverted, it needs a witness when removed, drawn, and wasted. Upon administration, scanning the vial is vital for documentation. This was where I messed up. Without the vial, my nurse will be audited for not scanning a narcotic medication. This can greatly impact her future. Because of that reason, I did not hesitate to admit my mistake to the charge nurse.
Step 2 Feelings I felt confident as I drew the medication up initially. I thought to myself that I've done these multiple times and I got it in the bag. As soon as I dropped the vial in the sharps container, my heart dropped as well. My nurse panicked and said, "we need a screwdriver to pick it retrieve it". I thought to myself that I am going to be doomed. In the end, I went to the charge nurse and admitted my mistake. To my surprise, they all had a good laugh. Collectively, they all said that it is just going to be a learning experience for me and to avoid it from happening again.	Step 5 Conclusion In conclusion, I would need to be more prudent. The next time I draw up medication, I will immediately place the empty vial in the patient's tray after labeling the syringe. In that manner, I can eliminate the risk of accidentally throwing the vial. This event has taught me that doing the same activity multiple times will not make it error free. This is a learning experience to me and will make sure that this will be the last occurrence.
Step 3 Evaluation The good in the event was that I learned two things: be prudent when preparing medications and be responsible when owning up to mistakes. What's bad was that I seemed to go autopilot when drawing medications that I mistakenly threw an important piece of documentation. Remarkably, the easiest thing was owning up it to the charge nurse. I expected to get a write-up or a written report from her about how much I messed up, especially the safe handling of narcotics. To my surprise, they just warned me to be more careful. This will be a lesson that I'll take into heart.	Step 6 Action Plan In hindsight, I would prepare my medications far from the sharps container to eliminate risks. After labeling my syringe, I'll tape up the syringe with the vial container to make sure that everything is accounted for. Lastly, I will double check my "trash" pile before I proceed to discard these on their corresponding receptacles. In a way, this clinical has humbled me and it felt quite refreshing. Yesterday, I attempted to place a bed pan multiple times on another patient because I can't get it centered. Today, I threw the vial. These experiences will form me into a better, more compassionate and confident nurse ins the future.