



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.

<p>Step 1 Description A description of the incident, with relevant details. Remember to <u>maintain patient confidentiality</u>. 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</p> <ul style="list-style-type: none"> • 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? 	<p>Step 4 Analysis</p> <ul style="list-style-type: none"> • 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 (e.g. personnel / patients / colleagues)?
<p>Step 2 Feelings Don't move on to analyzing these yet, simply describe them.</p> <ul style="list-style-type: none"> • 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? 	<p>Step 5 Conclusion</p> <ul style="list-style-type: none"> • 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?
<p>Step 3 Evaluation</p> <ul style="list-style-type: none"> • 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? 	<p>Step 6 Action Plan</p> <ul style="list-style-type: none"> • 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.

<p>Step 1 Description</p> <p>During CPE, I was the student nurse, and my goals were to do an assessment and give medications according to recent vitals, labs, and orders from the Dr. I was given 20 minutes with the updated chart to decide what assessments I was going to perform and see what medications I would be giving. After the 20 minutes were up, I decided on performing a pain assessment and giving the medications lisinopril and levofloxacin. When I first went into the room to assess the patient's pain, I didn't realize that one of the side rails were down. Since this patient was a fall risk, two side rails are supposed to be up to prevent falls and I did not put it up before leaving the room. At the end of my CPE, I was asked if I had forgotten anything and I did mention the side rail. After performing the pain assessment and giving those two medications, I was making sure the patient was safe to leave and going through the universal competencies. When I thought I was finished, I told the proctors I was done without providing the patient with the call light. This causes risks for falls because it can make the patient feel like they have to get up to do things themselves or to grab help. Because of this, I had to come back to reperform the universal competencies for the patient.</p>	<p>Step 4 Analysis</p> <p>The last week of clinicals, I had a patient who was confused, on fall precautions, had an above the knee amputation, and wanted to call his daughter every hour. He had his call light right next to him in his bed, but he didn't see it and tried to grab the phone on his own. Luckily, I was walking down the hallway when I saw him trying to get up out of bed. Because he didn't see his call light, he felt the need to get up on his own which could have resulted in a fall. Call lights themselves don't prevent falls but the response time in which a nurse or aid answers that call light, or bed alarm, can. As well as reteaching the patients to use the call light if they do need to get up. But some broader issues stemming from this are short-staffed hospitals and more patient to nurses ratios. With a higher patient load and a small number of nurses on the floor, the incidence of falls can increase because there is no one to answer the call lights in time. After leaving CPE, I had found out I wasn't the only one who had forgotten to give the patient the call light. This just goes to show we needed to slow down and go through our universal competencies more often to increase patient safety.</p> <p>CY, T. H. M. Y. (2009, September 4). <i>Relationship between call light use and response time and inpatient falls in Acute Care Settings</i>. Journal of clinical nursing. Retrieved February 20, 2023, from https://pubmed.ncbi.nlm.nih.gov/19735337/</p> <p>Galinato, J., Montie, M., Patak, L., & Titler, M. (2015, August). <i>Perspectives of nurses and patients on Call Light Technology</i>. Computers, informatics, nursing : CIN. Retrieved February 20, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4546527/</p>
<p>Step 2 Feelings</p> <p>At the beginning of the CPE, I was very nervous and thinking I would miss something important because of those nerves. Because I forgot to give the call light to the patient, I felt almost embarrassed because the big things, like standard precautions and the seven rights of medication administration, I got correct. My proctors were very sympathetic because they know that performing under pressure like that can make someone forget something as small as the call light, and that made me feel better about the situation. Because I missed the call light, I had to go back and reperform the universal competencies. On the second try, I passed. Because I did miss an important safety measure, it made me feel inadequate and ill-prepared. I wouldn't say that that feeling was the most important, but it makes me want to do better next time.</p>	<p>Step 5 Conclusion</p> <p>I could have made the situation better by having more confidence going into the CPE, which would have calmed my nerves down. I could have also looked around the room before saying I was done to double check everything was correct. I could have also thought about all the universal competencies that I would have needed to complete during prepping time such as safety. With all of these, I shouldn't have forgotten the call light, but this has taught me to value the safety of my patients and to make sure they have everything they need before I leave the room.</p>

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Step 3 Evaluation	Step 6 Action Plan
<p>The good thing you could say about forgetting the call light this time, is that I will never forget it again. That's because instead of getting the whole scenario correct the first try, I had to come back just to correct the call light. Forgetting safety measures like the call light and the side rails was bad on my part, and I will look out for those things in the future.</p> <p>I wouldn't say anything in the scenario was easy because you had to use critical thinking for most of it and when you are focused on making sure you give the correct medications to the correct patient at the correct time, it can be challenging to remember everything else. The only difficult thing was managing my time. I only had 20 minutes to perform an assessment and give medications, while worrying if I did everything else correctly. In my opinion, I think that I performed the assessment well and gave the medications in a time efficient manner.</p> <p>If I had to choose one thing that I thought would go wrong before I took the CPE, it would have been something with the medications because that was the main part of the scenario. I didn't think before that I would have missed something I do all the time in clinicals, but its okay because it was a learning experience.</p>	<p>Overall, I'm proud of myself for administering the medications safely to the patient using my critical thinking skills and managing my time effectively enough to where I did not go over. I could have done better by practicing the safety part of the universal competencies efficiently while I was in the room. In hindsight, I should have remembered the call light the first time I left the room which would have helped me remember to do it the last time before I left the patients room and finished the scenario.</p> <p>This is a very good lesson learned because I saw how my actions could have potentially caused harm to my patient and I will make sure this doesn't happen to a real patient while I'm working in the hospital. Being the primary total patient care nurse for a patient can be hard with time management, safe medication administration, and overall safe quality care. I don't have enough experience to take on several patients by myself yet but with this CPE, it showed me I'm learning and with more practice I will be a good nurse who values safety for my patients.</p>