



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 (e.g. personnel / 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?

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>In this scenario the patient was diagnosed with urosepsis. I had to play the role of the nurse and the other two individuals played the role of the patient and the observer. By playing the role of the nurse I was expected to give medications, understand universal competencies, and maintain asepsis. This included me having to go in and out of the patient's room and into the med room to get supplies needed. The results included giving the appropriate medications, making sure the patient was safe the entire time, and making sure I did not break asepsis.</p>	<p>Step 4 Analysis</p> <p>I can apply my previous knowledge on how urosepsis is caused and what signs and symptoms arise from this. The most important knowledge I feel I have for this scenario was knowing lab value and vital sign ranges. For example, if the WBC count is high that shows infection is still there. Broader issues that arise from this scenario could be the patient getting out of bed and falling because they could not reach the call light. I feel as though maybe some others made the same mistake as me, missing an important safety step. The impact of different perspectives are very important because another nurse would probably take different steps to protecting the patient or realizing what medications to give than me.</p>
<p>Step 2 Feelings</p> <p>At the beginning I was feeling nervous and was thinking about how I can prioritize the patient's needs, keeping the patient safe, and what medications to give. This event made me feel nervous and like I was missing something. The words of the patient made me feel as if they were agitated or possibly in pain, this made me feel like I could be more friendly and try to understand why they were agitated with me. I felt angry with myself about the outcome, this is the most important feeling because I missed one simple but very important step.</p>	<p>Step 5 Conclusion</p> <p>I could have made this scenario better by engaging more and paying better attention to things I should have. I don't think the others could have done anything better, they played a good role in being the patient and observing. I know I could have been less nervous so that I didn't make little mistakes that I knew. I was just disappointed in myself because I knew what I did wrong and acknowledged it at the end of the scenario instead of right when I did it. I have learned to always prioritize patient safety no matter what, to always be sure they have their call light, and to maintain eye contact when teaching so you know that they understand.</p>
<p>Step 3 Evaluation</p> <p>I felt as though I prepared the medications and knew them all very well. I knew which medications to give and which ones to not give. I interacted with the patient in a very friendly manner. The bad thing I did was forget to give the patient the call light before I left to go into the med room, and I feel as though I could've maintained better eye contact with the patient. The most difficult thing was trying to remember to do things while being nervous. Other than forgetting the call light one time I made sure the patient was safe, I asked the 4 P's. I felt like the others played a good role in answering the questions I was asking to the patient. I expected to do better because I know all of these things it was just very nerve wracking and I had everything to do written down. I think I forgot the call light the first time because of how nervous I was. I contributed by acknowledging that I messed up in the end.</p>	<p>Step 6 Action Plan</p> <p>Overall, I think that I performed very well in this scenario besides the one mistake. I would triple check universal competencies next time because I feel as though they are easy to miss when you are nervous but they are also the most important. After doing this I will always remember to give the patient their call light before I leave and make sure they are safe. I will be sure to always maintain eye contact when teaching. This has taught me how important it is to know what medications you're giving and why. This has also taught me how important patient safety really is. This has taught me to slow down when doing things and really pay attention to the little things. I will use this experience to further my teaching on medications and to increase my knowledge on when not to give medications. After making that mistake I feel as though I will always remember to do patient safety.</p>