



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>The CPE patient had urosepsis that was noticed due to altered LOC. The pt was confused as to place and events and had cloudy dark urine. I was in charge of further recognition of LOC state and administering medications pertinent to pt status. I was also in charge of pt safety.</p>	<p>Step 4 Analysis</p> <p>From this situation I can take a feeling of the importance of properly paced care, I cant do everything all at once and expect to do all of it properly. The broader issue of this is the potential to introduce further complications in my patients and decreasing their quality of care and healing.</p>
<p>Step 2 Feelings</p> <p>At the beginning I was feeling calm and prepared, my mind was very focused on checking loc and administering medications efficiently and properly. Initially my final outcome was very poor due to a few careless mistakes I made as well as running out of time to fix one of the mistakes. My most important feeling related to the event was almost a feeling of loneliness, once I messed up my IVPB, although I caught it instantly I still felt flustered as there was no one I could fall back on.</p>	<p>Step 5 Conclusion</p> <p>I could have planned out my steps more specifically and taken time to focus on all of my individual steps individually. If I take care of the pieces the whole will come together rather than the other way around.</p>
<p>Step 3 Evaluation\</p> <p>My clinical and medication critical thinking and reasoning was on point but my execution was poor. I fell back on the ideal situation in a hospital where the last nurse gave the pt the call light and I foolishly and carelessly connected my IVPB under the pump. I am proud of my easy identification of what meds to give and not give as well as why I do or don't give them. I most certainly expected a different outcome, one where I had slowed my thought process enough to take patient care one step at a time.</p>	<p>Step 6 Action Plan</p> <p>I think overall I am happy with my critical thinking outside of the room but I am ashamed of my action process inside the room. I can use the feelings and lessons from today to learn to let my thought process lead my actions instead of the other way around. I think I have also learned a more proper and effective way to view my process of healthcare. I will implement these lessons by slowing down and trusting my knowledge and leaning on my team around me when I can.</p>