Covenant School of Nursing Reflective Practice

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 on page 2, document each step in the cycle. The suggestions in each of the boxes may be used for guidance but you are not required to answer every question. 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 experience, 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 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 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 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' perspectives?

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 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?

Adopted: August 2016

Covenant School of Nursing Reflective Practice

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Use this template to complete the Reflective Practice documentation. Use only the space provided. Information that is not visible is lost.

Step 1 Description

I have been in the Adult ED for 4 shifts now with my preceptor. Yesterday we had 3 STEMIs within 2 hours of each other. We were in A pod, all of the nurses, doctors, and other important members of staff were there to help stabilize patients. I was able to help get patients on the monitors, assist with medications, and get report from EMS. Others did similar tasks as I did, and everyone helped out where it was needed most. The patients were all three able to get to the cardiac cath lab.

Step 2 Feelings

In the beginning I was not too worried because only one had shown up and I knew that we would be able to get this patient quickly up to cath lab to have the procedure done and the patient stabilized. Although it is a little bit choatic and fast paced it is very educational on all the steps that are needed before the patient can be cleared to go to the procedure room. I think everyone helping out eachother was great to watch and learn from. I felt a bit nervous but relieved that all the patients had gotten the procedure, but was concerned how their cardiac health will be after, since one patient had to wait 2.5 hours to get to the cath lab. The most important feeling was probably empathy, because all 3 patients needed the cath lab but only one can go at a time so we have to prioritze based on acuity and who needs care the quickest.

Step 3 Evaluation

I think the communication and how quickly everyone worked as a team was the best part. I think the fact that no other cardiologist was able to come in to do the final cath was the worst thing and the patient in turns had to wait. I think hooking the patient up to the monitor was easy, as i do that everyday to every patient. I think I was able to help out where I was needed and grab supplies and help anyone who needed the help promptly. I think others were able to determine who needed care quickest and prioritize. I was expecting another cardiologist to come in and get the last patient to the cath lab, but that did not happen and the cardiologist had to care for all 3 patients. I contributed by taking report, running labs, hooking up the patient amongst other things.

Step 4 Analysis

I can apply the STEMI protocol knowledge, EKG interpertation, and quick patient care to this situation. Yes, the 90 minutes from door to balloon. Time is heart, the patients were all experiencing complete arterial occulsion and needed the occlusion to be broke up in order to allow for blood to properly flow through the heart in a timely manner. Broader issues are the fact that we had to put a patient who was brought to us sooner behind another patient because he was more critical cause he had coded prior to arrival to the ED. I believe others had the same experience. I think different perspectives were super important in this situation because we needed to determine which patient got to go to cath lab first and what we could do to stabilize the other patient while they had to wait for their procedure.

Step 5 Conclusion

I dont think that there was anything in this situation that I could have done to make this situation better. I think that the only thing that could have helped this situation would have been to have another cardiologist come in and do the third procedure, other than that I believe that everything was handled as good as it possibly could have been with the limited resources that were avaible to us. I learned more about prioritization, and a lot about the medications given, and the process of what needs to happen in order to quickly and safely get the patient to cath lab.

Step 6 Action Plan

Overall it was a great learning experience. I drew the conclusion of we did everything that we could have done, and the patients were cared for as best as possible for the situation. I dont think there was anything me or any of the nurses could have done differently. The lesson of prioritization and stabilization. It has taught me how important quick reaction time and quick patient care is so important when it comes to critical patients and how team work is so necessary in quickly stabalizing patients. I will just continue to learn and be a team worker for the best outcomes possible for my patients.