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Covenant School of Nursing Reflective

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 eg personal / 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?

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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.

Step 1 Description	Step 4 Analysis
What happened? I was in CPE and was given a folder on a patient and had to use critical thinking and knowledge to decide if the patient needed certain medications or not. The patient was assessed before I was given report, but their pain was not assessed. The patient had two possible PRN pain medications that could have been given. What was the result? When meeting the patient and assessing their pain they said it was a 5 which would mean I would give the lower dose PRN medication. Because the medication was on a scale from 4-6. If I wouldn't have assessed the patient for pain I would have not known, and they would have been in pain without being treated.	What can you apply to this situation from your previous knowledge, studies or research? I was able to provide my knowledge of the medications I worked up for the scenario to the patient. Because I knew of the side effects and contradictions and nursing interventions for the medications I was giving the patient would be getting the correct care and they would know the possible side effects. What was really going on? The patient was suffering from urosepsis and as part of my job I was having to decide if medications needed to be given or held because of her medical conditions and labs.
Step 2 Feelings	**Step 5 Conclusion**
How were you feeling at the beginning? In the beginning of CPE, I was feeling very stressed and nervous because I did not want to miss a key point. I also did not want to administer the wrong pain medicine. How did you feel about the final outcome? I felt very good about the final outcome because I was able to finish CPE and administered the right medication off of critical thinking and what was provided in the patients' folder.	What have you learned from this event? I've learned to always assess patients' pain. If I weren't to have assessed their pain the patient may have not told me and suffered under my care. How could you have made the situation better? I could have made this situation better by being less nervous and just focusing on the assignment and care of the patient because nervousness made me almost run out of time.
Step 3 Evaluation	**Step 6 Action Plan**
What was difficult? The biggest difficulty for me was trying to get everything done in 20 minutes. It seems like a lot of time but preparing meds and assessing the patient's safety takes a while. What did you do well? I think I talked to the patient very well about his medications and over the 7 rights of medications. I think my teachings were pertinent for the scenario.	What do you think overall about this situation? I think it was a great situation and the CPE really made me use my skills ive learned this semester to treat the patient. I think focusing on safety should be a priority and this CPE scenario helped with that. How can you use the lessons learned from this event in future? After this I will always remember to check safety of patient in the room because their call light was not in reach and a side rail was down. If I wasn't focusing on that the patient could have fallen and it would have been horrible.