

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, 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. <u>Remember to 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 eg. personal / patients / colleagues' perspectives?
<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 my CPE, I was assigned to complete a medication pass and ensure patient safety with a mannequin while being evaluated by my instructor. I successfully completed the seven rights of medication administration and followed universal competencies. However, I forgot to give the patient the call light when I stepped out of the room to retrieve the medication. This mistake resulted in me not passing the safety portion on my first attempt.</p>	<p>Step 4 Analysis</p> <p>Patient safety is the number one priority in nursing practice and forgetting the call light could put a patient at risk in a real setting. From my studies, I know that safety measures like call lights, bed alarms, and side rails are critical to preventing falls and ensuring patient autonomy. This situation showed me that being competent in technical skills is not enough—attention to safety details is equally important. It also highlighted how stress can impact performance and why practice is essential for building confidence.</p>
<p>Step 2 Feelings</p> <p>At the beginning, I felt nervous but also confident that I was prepared. When I realized I had forgotten the call light, I felt disappointed and frustrated with myself. The instructor’s feedback made me reflect on how such a simple safety step can make a big difference. My strongest emotion was discouragement at first, but I also felt motivated to improve and not make the same mistake again.</p>	<p>Step 5 Conclusion</p> <p>I could have improved the situation by slowing down and mentally checking safety measures before leaving the room. The instructor could not change the grading outcome, but their constructive feedback guided me to focus more on safety in the future. I learned that patient safety is a continuous responsibility, and no step should ever be skipped. This experience reinforced the importance of prioritizing safety above all else.</p>
<p>Step 3 Evaluation</p> <p>The good part of the event was that I demonstrated competency in medication administration and patient care skills. The difficult part was maintaining focus under pressure, which led to me forgetting the call light. Even though I failed the safety portion, I did well in maintaining professionalism and accuracy with the seven rights. I learned that even small details in patient safety are just as important as larger skills.</p>	<p>Step 6 Action Plan</p> <p>Overall, this experience taught me to integrate safety checks into every patient encounter. Next time, I will make it a habit to always assess the environment and ensure the call light is within reach before leaving the room. I will practice using a mental checklist that includes both the seven rights of medication and universal safety steps. In the future, I will apply this lesson in both clinicals and practice to become a more mindful and safer nurse.</p>