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?

Covenant School of Nursing Reflective

Brock Fitzgerald, IM4

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 An 82-year-old male patient presented with a fever, confusion, chills and fatigue to the ED yesterday morning from an assisted living center. A preliminary diagnosis of urosepsis was given at the time before being transferred to the med-surg unit at 1000. Levofloxacin was started in the ED through the 20-gauge IV access on the right arm. I was the oncoming nurse for the morning shift the following day. The patient was ultimately treated with antibiotics for the infection as well as analgesics for pain management.	Step 4 Analysis The overall sense I could gather from this CPE was how safe and efficient can you be as a nurse given the skills and knowledge we have gathered up to this point. From what I have learned from my peers this was also their experience with this simulation, especially the patient safety aspect. Allowing different perspectives on this type of simulation can provide awareness of scenarios that may develop under your supervision that allow for different approaches for a successful interaction. The broad issue that arises with this is how universal competencies are there to protect your patients and your license.
Step 2 Feelings I was unsure of what to expect once the scenario began. Managing time efficiently was my initial concern. However, as I entered the simulation, I felt confident in my skills and communication with the patient. I believe having confidence allows me to focus on the patient rather than second guessing every intervention, which could ultimately lead to an error. Over confidence can allow for simple tasks to be overlooked or not prioritized as they should be. Finding balance between stress and confidence is the key to being prudent nurse.	Step 5 Conclusion Patient safety and security need to be a priority in every patient interaction. From patient identifiers on re-entry to the call light within reach every time you leave the room, have to be followed by the book all the time. I should have ensured the fall bundle was thoroughly intact prior to my exit to the medication room. This mistake I made during the simulation will be a lesson that I will be aware of in all my clinical and simulation days going forward.
Step 3 Evaluation I believe my medication administration skills and patient teaching were up to par and done within a timely manner. Communicating with the patient during the simulation felt easier than it was in previous simulations. I did poorly on the universal competency of safety/security. I did not ensure the complete fall bundle was in place before leaving the room (call light not within patient's reach). It was an unfortunate error that put the patient in harm, but a learning experience nonetheless.	Step 6 Action Plan This has taught me that a simple task such as placing the call light within reach and checking that the patient has access to it prior to leaving can put the patient in jeopardy. Patient safety is of the utmost importance because a subsequent accident or fall due to my negligence could seriously harm the patient and affect my license in the future. Being overly prudent in all aspects of the nursing process and skills are required to give the patient a positive outcome. This mistake is not something I take lightly and will work harder to prevent this from ever recurring.