# 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.

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| **Step 1 Description**<br>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<br>• What happened?<br>• When did it happen?<br>• Where were you?<br>• Who was involved?<br>• What were you doing?<br>• What role did you play?<br>• What roles did others play?<br>• What was the result? | **Step 4 Analysis**<br>• What can you apply to this situation from your previous knowledge, studies or research?<br>• What recent evidence is in the literature surrounding this situation, if any?<br>• Which theories or bodies of knowledge are relevant to the situation – and in what ways?<br>• What broader issues arise from this event?<br>• What sense can you make of the situation?<br>• What was really going on?<br>• Were other people's experiences similar or different in important ways?<br>• What is the impact of different perspectives eg personal / patients / colleagues' |
| **Step 2 Feelings**<br>Don't move on to analyzing these yet, simply describe them.<br>• How were you feeling at the beginning?<br>• What were you thinking at the time?<br>• How did the event make you feel?<br>• What did the words or actions of others make you think?<br>• How did this make you feel?<br>• How did you feel about the final outcome?<br>• What is the most important emotion or feeling you have about the incident?<br>• Why is this the most important feeling? | **Step 5 Conclusion**<br>• How could you have made the situation better?<br>• How could others have made the situation better?<br>• What could you have done differently?<br>• What have you learned from this event? |
| **Step 3 Evaluation**<br>• What was good about the event?<br>• What was bad?<br>• What was easy?<br>• What was difficult?<br>• What went well?<br>• What did you do well?<br>• What did others do well?<br>• Did you expect a different outcome? If so, why?<br>• What went wrong, or not as expected? Why?<br>• How did you contribute? | **Step 6 Action Plan**<br>• What do you think overall about this situation?<br>• What conclusions can you draw? How do you justify these?<br>• With hindsight, would you do something differently next time and why?<br>• How can you use the lessons learned from this event in future?<br>• Can you apply these learnings to other events?<br>• What has this taught you about professional practice? about yourself?<br>• 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.*

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| Step 1 Description<br><br>Patient came into the emergency department with N/V, HTN, confusion, and a UTI, after being examined he was diagnosed with urosepsis. I was the nurse who was treating the patient. The result was that the patient needed medications such as antibiotics to help rid the infection and get him back to his health before the incident occurred. | Step 4 Analysis<br><br>What was really going on is that even though the patient came in with HTN and had a history of it, the blood pressures that where being obtained were not high and he did not need his medication because it would have made it dangerously low. The impact of different perspectives is that someone else might see something that you missed, and it can lead to being very helpful in accurately treating the patient and helping them get back to their health. |
| Step 2 Feelings<br><br>At the beginning I was nervous but as I started doing it, I felt more confident. During the event I was just thinking about everything I had practiced and tried to make sure I didn't miss a step. I felt really good about the final outcome and did not feel like I missed a single step. | Step 5 Conclusion<br><br>What I could have done differently was not put the table across the bed as I did not realize that it could count as a restraint, instead I should have just put it next to the bed so they can still reach it but not be restrained by it. I learned how to use my critical thinking in deciding what meds do and do not need to be given. |
| Step 3 Evaluation<br><br>What I did well was deciding which meds needed to be given. Using the report, I was able to decide which meds were appropriate for the patient and which ones they did not need. What was good about the event is that I gave all the correct medications and did all the safety precautions, this helped ensure that the patient was kept safe and was given the proper medications to help treat them and not put them at greater risk for something else. | Step 6 Action Plan<br><br>I can use these lessons learned from this event in the future by knowing which information is important to gather regarding med admin and which objective data is important to look at. This learning can be applied to other events because when you look at the other factors contributing it can help you determine what is going on with the patient and might even show something you missed. |