Reflective Journal

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Clinical Placement Reflections

This journal is to reflect on the situations that have taken place during my first clinical placement at Sir Charles Gardiner Hospital (SCGH). All reflections are based on the Gibbs Reflective Cycle (1988) model. The Gibbs reflection model consists of six stages to complete one cycle, which facilitates in my ability to improve my nursing practice continuously and learning from the experiences for better practices in the future. The cycle starts with a description of the situation, analysis of the feelings, an evaluation of the experience, an analysis to make sense of the experience, a conclusion of what else could I have done and final stage is an action plan to prepare if the situation arose again. Reflection is to generate practice knowledge, assist an ability to adapt new situations, develop self-esteem, adding value and professionalizing practice. However, Siviter (2004) as cited by O’Connor explain that reflection is about gaining self-confidence, identify when we need to improve, learning from our own mistakes, looking at other perspectives, and improving the future by learning from the past experiences. Using a model of reflection enables me to explore and evaluate all previous clinical experiences. The model allows me to develop the skills to evaluate and navigate myself through the reflection process and identify areas of weakness or vulnerability, and laying a platform to upgrade skills to overcome these deficiencies. Cornerstone to the reflective process is also understanding the Australian Nursing & Midwifery Council (AMNC) national competency standards for registered nurses. These core competency standards by which a nurse’s performance is accessed in obtaining and retaining a license to practice. Linked together with evidence based theory and practice, reflection will assist me in my professional development towards becoming a more competent nurse.

Reflection One

One of the most common activities carried out by nurses is the administration of medications. During a morning shift on clinical placement, I was in the process of gathering a patient’s medications from the medications room, according to the medications chart in the patients file. One of the drugs charted, the drug name was very unclear, and the doctor’s handwriting was very poor and just not legible at all. It also did not state the dosage of the drug to be taken. Most
common medication errors occur at any point in process, namely, ordering, transcribing and dispensing. Medication errors are one of the most common types of medical errors in our health care system. Medication errors are caused by numerous elements, which include poor hand writing, inadequate documentation and working stresses.

Initial feelings as a student nurse were to ask preceptor, who could through their experience identify the drug name according to the total drug therapy outlined and familiarity with doctors poor hand writing. On evaluation, the tendency was to follow preceptors advice and proceed with which seemed the correct intended drug. Time in clinical practice setting is very precious, so there is a tendency not to want to hold up proceedings to long. I became anxious as I was acutely aware that a delay could snowball on further delays in planned patient care set out in our care plan time chart. Although after discussions with preceptor, we had a pretty good idea of what drug may be, there was still a percentage of doubt in my own mind, as I was not familiar with these drug therapies.

I made my preceptor aware, that the fact that I was collecting medications, as a part of my professional practice, it was therefore my responsibility to ensure we were selecting the correct medications. We agreed and proceeded to utilize the online MIMS program - a leading supplier of quality, independent medical information to Australian healthcare professionals, to ascertain in more detail on possible drug and dosage. Accessing the online MIMS, we identified the possible drug; however it was still unclear and dosage not known. The prescribing doctor was no longer working on this ward, so we proceeded to contact the pharmacist, who duly checked and confirmed drug name to be Frusemide, and dosage of 40mg PO tablets. The pharmacist went further to update medications chart and clarified the doctor's name on medications chart.

On analysis this event proved that accuracy was paramount, and that I was to ensure that the correct procedural tasks are performed, as set out by the ANMC competency standards, standards which we are required to withhold at all times (ANMC Competency elements 1.1-3, 2.1-7, 3.1-3.5, 4, 6-1-4, 9, 10). From the MIMS online resource I gathered further information on the drug in concern and then utilized the collaborative efforts of allied health team and pharmacist to confirm the correct drug medications had been selected. It also reflected to my preceptor the level of professionalism I would want to assume in my practice, ANMC Competency elements 1.1-3,2.1-7 are required to be adhered to and hence possibly induce a reflective process within themselves with regarding to the event that had occurred. As a
registered nurse it is also a competency requirement that I prevent de-skilling, and continue to practice, refresh and update my skills knowledge regarding medication administration.9

My future action plan should this event re-occur, will be the ability to at once know the competency standards that are required of my practice, and consult pharmacist or consulting doctor on hand for immediate clarification and correction. Multi disciplinary approach and communication is essential in reducing the incidence of medication errors.7 Thus prevention of medication errors requires collaboration amongst all health team members, which is a core competency element requirement as a registered nurse.3, 7 Nurses play a key role in the process of medication administration and therefore cornerstone to able to prevent medication errors in practice.5, 10 Critical thinking and experience are core themes to medication errors, and care competency standards all nurses need to uphold constantly.3, 4, 11

Reflection Two

Globally heath care services are experiencing serious shortages of nurses.12 Relatively few men compared to women enter the nursing profession. Men only make up 10% of the workforce in the UK, USA and Canada.12 On the commencement of my first clinical placement, I was acutely aware of the significance of been a male nurse, and how this would translate into real clinical practice, as the nursing profession is largely female dominated.13, 14 Studies have pointed out that men are reluctant to enter nursing due to role stereotyping and gender biases.14 Although history shows that males have worked as nurses for hundreds of years, very few males are actually aware of contributions made to the nursing profession.13 Negative perceptions of male nurses been feminine or even gay exist, because they possess the element of care. Caring is a more perceived female trait.13, 14 I was fortunate enough to be placed with a male preceptor, which made the orientation a lot easier and less stressful. According to Kelly (1994) as cited by Grady14, obstacles that face male nurses, are the limited opportunities to work with male nurses in clinical practice.14 I addition, the sense of “being thrown into the deep end”15 in over whelming, as you are now confronted with an array of situations and unfamiliar tasks.15

I was in the process of caring for a 92 year old lady, who was incontinent and wore a disposable pad. This patient was a very proud woman, and at most occasions preferred not to soil the pad, but use the toilet instead. She was unfortunately very limited in mobility and required the aid of two assistants to hold her up and change pad before placing her on the commode. During the
afternoon, the patient rang the call bell and requested that she required the use of the toilet. However, assistant staff was busy and not currently available to attend. She would continuously say “Sorry to be a pain, I don’t want to disturb you busy people”. The nurse assistants that had taken here to the toilet on previous times were females, and I began to become anxious in the possible event of me – a male nurse having to take her to the toilet, as I knew she was very proud woman and got embarrassed easily.

My anxiety level was high, and I did not want to have to place her into an embarrassing situation, as I assumed her preference would be, to be assisted by female assistants. Been my first clinical placement, I was feeling very anxious regarding the appropriate use of touch, or lack of guidance in this area. But I had no alternative, and decided to take her to the toilet by myself as no assistants were available. I reflected on my own feelings of anxiety and then confronted the patient and in an honest, caring manner, advised her that it was my profession, and that I was skills trained in been able to fulfill this task, and that even as a male, had the ability to perform the highest level of patient care, responsibly and ethically (ANMC Competency elements 1.1-3, 2.3 3.1-4, 7.1-8, 9.1-5.). After a brief discussion, we dually agreed, she consented and I undertook task of taking her to the toilet and replacing her pad as required.

On evaluation and analysis, this event turned out to be very successful, and the patient was extremely pleased and satisfied with care provided. A therapeutic bond of trust was formed, and we both had a good laugh and discussion during the intervention. I realized that my own emotions had probably clouded my judgment, and automatically assumed that she would prefer the care of a female nurse. However, after coming to terms with my own feelings, I realized that she was not really concerned if the nurse was male or female, but as long as she received the highest level of caring service. ANMC competency standard instill in all nurses to deliver the most appropriate care, encompassing ethical and cultural issues, and best care practices (ANMC Competency elements 1.1-3, 2.3 3.1-4, 9.1-5.).

In future, my action plan will reflect that I have come to the realization and understanding that patient care is paramount and it is not gender specific. After this event and reflection, I became more confident, and trusted myself in delivering appropriate care to the opposite gender. Males in nursing are still faced with barriers such as the accusations of sexual appropriate by female patients, lack of male nursing professors and clinical instructors, however a study conducted by Fotter (1976) as cited by Roth showed that large majority of nurses and patients had positive experiences with male nurses. Males are capable of as much emotional richness and interest
as women are. Promoting mentorship programs, and the history of men in nursing should be discussed more often, and with these elements reduce mis-conceptions and perceptions on males in nursing.

References
3. ANMC. In: National Competency Standards for registered nurse. 2011


