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NURS 3020

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Clinical Reflection #2

 My acute placement on B4 at PRHC has been very informative, insightful and has overall increased my confidence in my own skill set for future placements. I have experienced many new clinical situations/scenarios, new patient diagnosis’s I have never dealt with and also a perception of what acute nursing looks like. It is a very fast-paced floor with something always going on. Before experiencing nursing personally, I did not expect it to be as fast and busy as it is, which caused me to quickly increase my organization and time-management skills in first year. In school we are constantly taught throughout our program about med errors and how to prevent them. We go into our clinical practice with this embedded in our brains to ensure we do all of our checks before administering medications to our patients. Being a student we get an extra set of hands and assurance from our instructors when administering our medications to help to ensure the prevention of medication errors. As a student, I expected medication errors to come from students or new nurses as they have the least experience and knowledge, but during my placement at B4 my views of this were changed. One shift I experienced my primary nurse make a medication error of her own on my patient. She administered a drug that my patient was allergic too. He was wearing a medical alert bracelet and there was no order for this medication in his MAR. My primary nurse had also not informed me that she had made this error as I found out from overhearing my patient tell his wife. According to the Colleges of Nurses of Ontario [CNO] (2015), outlines three principles that are the practice standard for medication administration for all nurses, which include, authority, competence and safety. Similarly the guidelines also state that, nurses must report all errors/near misses and are required to collaborate in the development, implementation and evaluation of system approaches that support safe medication practices within the health care team (Colleges of Nurses of Ontario, 2015). Through reflecting back on this situation, this nurse failed to adhere to the guidelines by not informing me of her medication, which is also not safe practice. Reflecting back on this experience also allowed made me to realize how easy it is for even the most experienced nurses to make mistakes, and how important it is to do your proper checks/right to make sure you are administering the right medication, to the right patient etc. It made me realize how critical it is to preform this for every patient you have as eventually I won’t have an extra set of hands/eyes to help prevent these mistakes. It also allowed me to see the importance of notifying others of your mistakes to ensure that everyone working with the patient has the same information.

References

College of Nurses of Ontario (2015). Practice standard guideline: Medication. *College of Nurses of Ontario.* Retrieved from <http://www.cno.org/globalassets/docs/prac/41007_medication.pdf>