The role of a nurse as a first assistant essay sample

‘ Reflection is the process of reviewing an experience of practice in order to better describe, analyze and evaluate, and so inform learning about practice.’ Boud et al(1985)

Many authors have utilized frameworks and models to guide reflective practice. Attached are a number of different models:

Suggested Reading:

Schon D (1983) The reflective practitioner, Temple Smith London;

Drischoll D(1994) Reflective Practice in practice Senior Nurse 13, 7, 47-50.

Description of incident:

I was asked to check in a patient Mrs Jones for the vascular theatre. Mrs Jones was 65 yrs old lady admitted for thyroidectomy. Mrs Jones was already waiting in the reception area. I took the patient notes from the ward nurse to confirm the patient identity and to check the pre op-check list. During this time I asked Mrs Jones that if she has any medical problems.

Mrs. Jones told me that she had chest pain this morning, that’s the same time when nurse told me that at the time of chest pain they have done an ECG and they were trying to get contact with the anaesthetic but they could not, and also patient didn’t have her heart medicine this morning and the nurses didn’t know whether to give the medicines or not. I told to this patient and the nurse that I have to speak to these anaesthetics before I could proceed. When I showed the anaesthetic the ECG and told her that the patient had chest pains in the morning. She went and showed the ECG to the

senior consultant who noticed some changes in ECG and decided that this patient should not have the operation because it is too risky. The consultant went and apologized the patient that she has to refer to cardiologist.

Feelings:

I felt very angry, powerless and was deeply troubled about what happened. This followed by the disbelief that something like this should be allowed and happen . I felt sad that the patient had to go through all those preparations (coming to theatre) which could have been avoided if nurses on the ward had made sure that anaesthetic has seen this ECG report . I felt as the patient advocate that the nurses in the ward failed in their duty to check and contact the anaesthetic.

Evaluation:

The experience was terrifying as I feel helpless. The only consolation was that the patient’s operation was cancelled. The patient expected that the important things were over- looked. We were we deeply sorry that it happened. I learnt not to take things for granted or to assume that if one of my colleagues says a patient is ready for theatre, it does not mean that all documents are correct and signed. Schon(1983) call the process reflection in practice. I also learnt the importance of thoroughly checking all the important documentation and asking the patient the right questions before he is taken to the anaesthetic room.

Analysis:

To analyze the incident, it is important to focus on the importance of checking the patient for surgery and patient advocacy. I also realize that thorough checking of patient uncovered the problem and enable me to intervene appropriately. I also learnt the importance of communication between members of this multi-disciplinary team. Bines (1992), Scon (1981), Watson (1991) showed that professionals in their everyday practice face unique and complex situations which are insolvable by technical or rational approaches alone. Therefore it is important that the staff should work together in helping the patient (Hodge 1994).

The feeling that I was able to identify the problems act as a patient advocacy in this incident draws attention to the way some practitioners deal with situations of uncertainity, instability and uniqueness (Schon 1998). This also made me question my self-awareness as a competent nurse. Atkin (1993) stated that self awareness enables a person to analyze feelings.

It involves an honest examination of how the situation has affected the individual. Fardel (1991) points out that individual awareness is essential in recognizing personal abilities and short comings and Barnard and Chapman (1990) remind us that without self-awareness, we are blind because of this blindness; probably less effective in our delivery of care. Although the patient has been seen by the anaesthetic in the morning, provision should have been on how to contact the anaesthetic and the surgeon if there are any changes.

Conclusion:

The incident has changed my way of thinking and practice. I now routinely check all the documents for my patients regardless of whether my colleagues say that everything is ready. Looking back on the situation I have learnt the importance of checking the documentation before taking Mrs. Jones into the operating theatre. However I feel that there is no justification for the ward’s nurses’ actions. I have learnt from it and will ensure that systems are put in place to avoid any incident to happen again.