**Critical reflection**

**Introduction**

Critical reflection is essential to ensure that patients get optimum health care from their health care providers. It is essential for health care providers to always give maximum care to their patients by following the correct procedures provided in their manual. Failure to do so may cause consequences that are unavoidable causing damage to both the patient and the care provider. It is essential to nurses that they learn critical reflection. Critical reflection is, therefore, a tool that nurses should be equipped with so that they can give proper care to their patients.

**Description and feelings**

On April 4th, 2001 Ruth Sophie Stoll died at the Wakefield Hospital due to acute haemolysis and severe anemia (ABC news, 2003). Before her death, Miss Stoll underwent a procedure done by Mr. John Stubberfield a cardio-thoracic surgeon. She had developed an aneurysm of the aorta that was liable to rupture after an aortic valve replacement surgery carried out in 1993. According to Mr. Stubberfield, her surgery was difficult as she had severe bleeding during her operation due to abnormal clotting factors (Chivell, 2003). Blood type A was transfused to Miss Stoll during the surgery. She was put in the intensive care unit after her surgery in a somewhat unstable condition after Mr. Stubberfield was able to stop the bleeding.

 However, she passed on later as her condition deteriorated since the blood was not her type leading to incompatible transfusion which lead to multiple system failure and acute haemolysis. The blood type A was later found to belong to another patient Mrs. Kovendy who was with Miss Stoll when the nurse was taking their blood samples. I feel upset about the incident as the wrong blood transfusion mainly caused the death. I feel this way because the consequence of the mismatch would have been avoided if the blood transfusion was compatible. I feel satisfied that the Wakefield Hospital decide to do a follow up after Miss Stoll's death to determine how her blood was mismatched.

**Evaluation**

The mismatch of the blood type that occurred had a negative impact on Miss Stoll and her family. First, she died due to a mistake that could have been avoided if the health care provider would have followed the correct procedure for taking blood work (Healy, 2016).  Second, her family, Mrs. Roma Stoll her sister-in-law that accompanied her to the hospital suffered the loss of someone close to them. Despite the negative impact, one advantage was that Miss Stoll family was able to get the closure they needed to grief her death peacefully by the case being taken to court. Therefore they would be able to get justice.

**Analysis**

The registered nurse that took Miss Stoll details including her blood was Sally Gilbert of Clinpath Laboratory LTD that is a tenant of Wakefield hospital. The Clinpath Nurse Procedure Manual requires RN Gilbert to follow a particular procedure when taking details from a patient that she did not follow from her confession given. From this, I see that in my nursing career healthcare institutions will have to thoroughly train their RN's before allowing them to work as a caution to make sure they follow the manual. RN Gilbert had been trained and retrained after it was discovered she did not follow the procedure in a previous incident. She took details of Mrs. Kovendy, who was also at Clinpath that day, and Miss Stoll at around the same time and that is when the mismatch happened. It is important therefore that all nurses are monitored after a training session to make sure that they are at purr with what is expected.

If a nurse is not following the procedure given in their manuals, then the consequences of their actions should be constructed according to Australian Commission on Safety and Quality in Health Care (ACSQHC, 2017). Policy changes need to be made by Nursing and Midwifery Board of Australia that provide implications for not following procedure. This way all nurses will be disciplined as they will not want to suffer the consequences. This will change how I work when I become an RN, and it will make me extra cautious when dealing with patients. When taking patient details, nurses must always ask the patients to spell out their name to make sure it is correct, and they must engage the patient when taking details (Nursing and Midwifery Board of Australia, 2014).  This is something that RN Gilbert failed to do and that caused the mismatch. Hence it is essential to make policy changes that will ensure nurses are liable when such mistakes are made (ACSQHC, 2015.)

**Conclusion**

From this incident, I learned a few things that will benefit me in my nursing career in the future. I was able to determine that it is essential to get the correct name and details of the patient. Always ask the patient to spell out their name even when you are sure of the spelling to be safe (NMBA, 2016). I also learned that dealing with one patient at a time is vital as it reduces the chances of a mismatch or mislabeling. Nurses are required to deal with one patient at a time and do all the labeling while with the patient instead of doing it in the lab with all the samples (NMBA, 2008). I perceived that this is where RN Gilbert went wrong by labeling later when the patient is absent which might have caused her to mismatch he samples between Miss Stoll and Mrs. Kovendy. Therefore in my future nursing career, I will be able to apply this knowledge effectively to provide optimal health care.

**Action plan**

Some of the actions that I will take to ensure that I provide optimal care to my patients are:

1. I will carry out critical reflection to ensure that I provide proper care to my patients. Critical reflection is essential in nursing care (Rolfe et al., 2011).

2. When I become a registered nurse, I will follow the instructions in the manual provided by the facility that I work for. Following the standards and procedures of a healthcare facility are important for nurses to ensure that they provide optimal care (Mannion et al., 2016).

3. I will read ACSQHC before I become an RN so that I can gain knowledge of the policies that were required to follow. ACSQHC provides policies and procedures that health care providers need to follow to provide optimal care (Standard, 2012).

4. To prevent such an error from occurring again I will always confirm the patient's name by asking them to spell out their name.

Therefore, by taking these actions am comfortable that I will prevent such future errors from happening when I become an RN.

**Conclusion**

In conclusion, critical reflection is essential to all nurses when they become registered nurses. It is vital that they learn critical reflection. By following procedures mistakes will be minimal and therefore offer proper care to patients.

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