EXAMPLE COMPLETED TEMPLATE FOR INTERN REFLECTIVE STATEMENT – ITA REFLECTIVE PRACTICE – WRONG CUSTOMER SCENARIO

Intern name	Intern	**Ahpra registration**	PHA0000XY234DR
Intern training program	XYZ ITP	**Stage of internship**	☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☒ 9-12 months
Date and location of activity/event/incident	xx/xx/xxxx, ABC pharmacy, Medicine issued to wrong customer		

About this form

This form is to be used to structure the reflective process for the intern following a specific activity, event or incident.

Instructions for interns

Use this template (or equivalent) to write a reflective statement. If you are familiar with other structures, then use the model/approach you are most familiar with. You may also adapt this template as needed. Complete sections 1 to 5 of this template (or the equivalent if using a different template) as soon as possible after an event or incident which is the target of your reflection. Schedule a discussion with your supervisor, where your supervisor can provide feedback and create a Development Plan with you to improve your skills. Complete sections 6 to 8 (or equivalent) after this discussion with your supervisor. Keep the records of this reflection in a place where you can easily retrieve them, and complete Sections 9 and 10 if there are opportunities to use the learning from this refection in the future.

Instructions for supervisors

Ask interns to use this template if they are not familiar with developing a reflective statement using an alternative approach. After the intern has completed sections 1-5, arrange a time to discuss the reflective statement, and provide feedback to the intern using the Assessment and Feedback form.

Initial reflection by intern (sections 1 to 5). Complete these sections soon after the event/incident.

Section 1: DESCRIBE WHAT: What happened (Brief description of the details of the activity/event/incident and the outcome)?
The dispensary assistant handed out prescriptions to a customer without checking the full name. Although the patient was a regular, his surname was not well known, and the assistant relied on the first name being unusual and therefore not likely to be the same as any other patient waiting to collect medications. However, there was such a patient with the same first name, and the wrong prescriptions were handed out. The error was only detected at the cash register when the patient questioned some of his medications.

Section 2: DESCRIBE HOW: How did you respond (your thoughts, feelings, and emotions)?
Fortunately, I was only observing, so it was not my error, but I was a little shocked at how easily it could happen. I felt very sorry for the assistant, who was really upset and shaken, and quite embarrassed as she knew the patient and still made the error. I thought that it was possible I could also have done the same thing and was quite relieved that it wasn't me who did it.

Section 3: UNDERSTAND and LEARN: Why did this happen (what led to the activity/event/incident) and what did you learn?
A part of the problem was that we were under heavy COVID-19 restrictions, and so we were not asking patients to sign their prescriptions because of fear of transmission of the infection through pens – because of this we had taken the repeat forms out of the basket before giving the medications to the patient. Another problem was that the patient had asked for some OTC items which had been placed on top of the prescription medications so he could not see what had been dispensed. I learned that when normal processes are changed (e.g., by COVID) we need to work out what risks this creates and make changes to other parts of our processes to ensure we minimise those risks. I also learned that it is important not to be embarrassed to check a patient's name, even if they are a regular customer and we think we SHOULD know their name.

Section 4: GOAL: What will you do OR what should be done differently next time?
We discussed this near miss and decided that we will leave the repeat forms in the basket until the patient collects their medications, so we have their full name and address details to check with them. We also revised our written procedures to make it clear that we must NEVER rely on our own memory of patients' names, and always use some form of checking that they are the correct ones picking up their scripts.

Section 5: DEVELOPMENT (SMART) PLAN: What do you need to do or learn so you can respond differently next time? It is important to include a timeframe for carrying out the plans as well as what will actually be done.
We have already re-written the procedures, but we need to make sure everyone knows about them and follows them. I have taken on the responsibility of training all the dispensary technicians and assistants about this. I plan to do this training within the next 6 weeks. I do not think I need to do any additional study about this, but just to make sure I am also very vigilant when handing out prescriptions.

Discussion with supervisor (sections 6 to 8).

Section 6: With whom and when did you discuss this reflection?
I discussed this with my preceptor a couple of days after the incident.

Section 7: What were the key points that arose?
My preceptor agreed that we need to be more proactive about assessing the risks when we change processes and remove checking points. We agreed that someone in the pharmacy should undertake some formal risk assessment training, though that would not be me as I need to concentrate on my other intern assessments. However, once the staff member has been trained, then we will all do staff training.

Section 8: Did the discussion change any of your responses above, and if so, how?
Not really, though I thought the idea of having someone trained in risk assessment was excellent and I am keen to be trained by this person once they have been trained.

Future follow-up, if possible (sections 9 to 10). It may not be possible to use the learning from this reflection in a future episode; however, interns should be alert for any such possibility.

Section 9: Did you have a chance to use what you learned in a later incident, and if so, how?
It is now six months later, and we have not had another similar incident in that time. One of the pharmacists has finished their risk assessment training and has trained us all on how to think from a risk perspective. We have all been encouraged to share any thoughts we have where we think a risk might occur and I was able to suggest a slight change in how we use our communications diary to make it less likely that urgent messages slip through without someone dealing with them as soon as possible.

Section 10: Any other notes or comments relating to this activity/event/incident/reflection (e.g., performance outcomes addressed)
This was a useful learning opportunity, made even better by the fact that I could learn from someone else's error. Performance outcome 4.11 talks about being proactive in the identification, assessment, monitoring and management of risk, and I believe this incident and the follow-up has shown that I meet this performance outcome.