ITA intern reflective statement exemplars

Exemplar 1: Medicine issued to wrong customer

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.

Exemplar 2: Interaction with a prescriber

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)

I received a prescription for a Schedule 8 medication which was missing some of the legally required details. It did not have the quantity written in words and figures which made it invalid, and I was not allowed to dispense it. I called the prescriber to let him know and to ask for a new prescription. He was very rude to me and told me he had been writing prescriptions for years without anyone ever challenging him about this before. He refused to send a new prescription and said he would tell his patients to go to another pharmacy in future.

Section 2: DESCRIBE HOW: How did you respond (your thoughts, feelings, and emotions)?

This was the first time a doctor had responded to me like this, and I was shocked and very upset. I didn't know what to say, so I wasn't as assertive as I should have been. I thought I was right, but the doctor made me doubt myself. I felt like the doctor was disrespectful of my knowledge and competence. It left me really worried and intimidated about having to contact a prescriber again, especially him. However, I went and checked the legislation straight away, and checked with my preceptor, and I was reassured that I was right from a legal point of view.

Section 3: UNDERSTAND and LEARN: Why did this happen (what led to the activity/event/incident) and what did you learn?

The key issue was that I was not as prepared as I thought I was to speak to the prescriber, and when I was challenged, I panicked, which only made things worse. I learned that I needed to be better at getting my points across to the doctor, and to be more aware of how I say things as well as what I say, as I may have come across as a little aggressive. I also learned that it would be good for me to be absolutely confident that I am right and on top of my facts before calling the doctor so I can stand my ground if they argue with me.

Section 4: GOAL: What will you do OR what should be done differently next time?

I will definitely be better prepared next time. I will practice what I want to say before I actually make the call, and I will be 100% sure of my facts.

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.

I would like to do some role plays with my preceptor or other pharmacists where the other person is being difficult or disagreeing with me. That way I can build my confidence to handle real situations where the other person is difficult. We have scheduled these for our weekly meetings in 2-, 4- and 6-weeks' time.

Discussion with supervisor (sections 6 to 8).

Section 6: With whom and when did you discuss this reflection?

I was very shaken by the incident, so I told my preceptor straight away. She suggested I take a break to compose myself, and then write up the incident as a reflection. Once I had written the reflection, I discussed it again with my preceptor in our next weekly meeting.

Section 7: What were the key points that arose?

We agreed that I needed some more practice at handling difficult conversations. We went through some strategies that my preceptor had found useful in the past for defusing situations, and some words I could use which were less likely to be inflammatory.

Section 8: Did the discussion change any of your responses above, and if so, how?

Not so much change as add to what I thought previously. My preceptor was really helpful as she was able to share her own experiences and how she had learned from them also.

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?

I discovered a webinar recording called “How to manage difficult conversations in pharmacy”, which I found very helpful. Although it was mostly about difficult conversations with patients, the speakers were excellent and I was able to see how I could adapt their ideas to conversations with prescribers, especially about how to de-escalate a situation. I also learned that I should keep a record of the incident as soon as I can in case the doctor wants to complain about me.
A few weeks later I had to contact another prescriber about a similar sort of issue with a Schedule 8 script. I was much better prepared, stayed calm and was able to communicate much more confidently. The prescriber was initially reluctant to do what I asked but I eventually persuaded her to send me the new script.

Section 10: Any other notes or comments relating to this activity/event/incident/reflection (e.g., performance outcomes addressed)

Performance outcome 1.4 requires me to act legally, and 2.1 covers appropriate communication. I believe my skills in both of these have improved because of this incident.