Nursing Practicum Reflection on COVID 19 Care

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During my nursing practicum, I had the opportunity to work closely with a preceptor in a hospital setting while the healthcare team continued to manage and prevent COVID-19. The experience allowed me to connect classroom knowledge with direct patient care and to observe how clinical decisions, communication, infection prevention, teamwork, and leadership affect outcomes. My original reflection focused on professional practice, personal strengths and weaknesses, leadership, current healthcare disparities, access to resources, and new approaches to care. Those themes remain central because the practicum did not simply teach me a set of procedures. It showed me how professional nursing requires continuous judgment, ethical accountability, and willingness to learn from errors.

The most important lesson was that safe nursing care depends on accurate information and clear communication. During the practicum, I recognized a weakness in the way I collected and confirmed patient histories. In one situation, incomplete communication about previous medical information contributed to mild allergic reactions after care was provided. Although the reactions were not severe, the incident was serious and could not be treated as a minor misunderstanding. It taught me that allergy status, current medications, previous reactions, and other essential history must be verified through the patient, available records, family or caregivers when appropriate, and the supervising clinical team before medication-related decisions are carried out. The correct response to such an event is immediate assessment, escalation, documentation, disclosure according to policy, and learning under supervision rather than personal reassurance that the reaction was mild.

Professional Practices

The healthcare system changed significantly during the COVID-19 pandemic. Hospitals faced rapid changes in infection-prevention guidance, shortages of equipment and staff, high patient acuity, visitor restrictions, communication challenges, and uncertainty about treatment. These conditions sometimes compromised continuity and created risks of substandard care, but they also accelerated collaboration and evidence-based practice. During my practicum, I observed that professional nursing required staff to apply current guidance while continuing to meet the wider needs of patients who were frightened, isolated, or managing other illnesses.

COVID-19 prevention involved more than asking patients to follow standard operating procedures. Nurses assessed respiratory symptoms, used appropriate personal protective equipment, followed transmission-based precautions, supported testing and treatment, and educated patients about isolation, medication, warning signs, and follow-up. Current infection-control practice also treats

respiratory-virus prevention as part of routine healthcare safety rather than as a temporary pandemic activity. Standard precautions, source control according to facility risk assessment, ventilation, environmental cleaning, hand hygiene, and appropriate placement of patients remain important. The practicum taught me that infection prevention is a professional responsibility shared across the care team, not a rule that can be delegated to the patient alone.

Evidence-based practice was particularly visible because recommendations changed as scientific understanding developed. Nurses had to distinguish evidence from rumor and explain changing guidance without weakening patient trust. I learned that evidence-based practice combines the best available research, clinical expertise, patient circumstances, and individual values. A research article cannot be copied automatically into practice; staff must consider whether the evidence applies to the patient, whether the organization can implement it safely, and whether another condition changes the risk-benefit balance.

Patient-centered care was equally important. Some patients were worried about isolation, family separation, financial pressure, or stigma. Others had limited health literacy or language barriers. Nurses needed to communicate in a form each patient could understand, invite questions, and involve the patient in decisions. During COVID-19, it was easy for infection-control procedures to dominate the interaction. My preceptor demonstrated that safety precautions should not remove compassion. Eye contact, explanation before touching or entering personal space, and arranging communication with family could reduce the emotional distance created by masks and isolation.

Medication Safety and Allergy Verification

The allergic-reaction incident became the clearest patient-safety lesson of my practicum. Before administering or supporting administration of a medication, the nurse must verify the correct patient, medication, dose, route, time, indication, documentation, response, and relevant allergies according to organizational policy and scope of practice. Allergy information can be incomplete, duplicated, or recorded differently across electronic systems. The nurse should not rely on one unchecked field when the patient can provide additional history or when previous records indicate a discrepancy.

Medication reconciliation is a structured process for obtaining the most accurate possible medication list, comparing it with current orders, and resolving unintended differences. It becomes especially important at admission, transfer, and discharge. During my practicum, I learned that a rushed history can miss over-the-counter drugs, supplements, recently discontinued medicines, or the difference between a true immune-mediated allergy and another adverse effect. Even when a patient uses the word “allergy,” the nurse should document the medication, type of reaction, severity, timing, and source of information rather than dismissing or reclassifying it independently.

If a reaction occurs, patient assessment comes first. The nurse evaluates airway, breathing, circulation, skin findings, vital signs, mental status, and progression, then activates the appropriate

response and notifies the preceptor and responsible clinician immediately. Treatment depends on severity and orders or emergency protocols. The event should be documented accurately and reported through the safety system so that the organization can examine whether communication, electronic alerts, workflow, or supervision contributed. My reflection is not that better conversation alone would solve every allergy risk. It is that communication must be embedded within a reliable verification process.

Personal Strengths and Weaknesses

One strength I identified is that I am a hands-on learner. I understand procedures more deeply when I observe a competent practitioner, perform an appropriate part of the task under supervision, and then receive feedback. During the practicum, I paid close attention to medication preparation, patient assessment, infection-control steps, documentation, and the language experienced nurses used when explaining care. This approach helped me connect theoretical knowledge with the pace and complexity of the hospital environment.

Another strength is willingness to accept correction. After recognizing the communication weakness that contributed to the allergy incident, I did not want to conceal the problem or blame the patient. I began asking more focused questions and confirming information with the preceptor before proceeding. The experience made me more aware that confidence in nursing should come from preparation and verification rather than from acting quickly to appear capable. A student nurse must know when to pause, ask for help, and work within supervised authority.

My principal weakness was incomplete communication, particularly when gathering health history from patients whose answers were brief, unclear, or affected by illness. I sometimes moved to the next task without confirming that I understood the information accurately. This was not only an interpersonal issue; it was a clinical reasoning weakness. Communication provides data for assessment. Missing data can alter medication decisions, infection-control planning, dietary care, and discharge education. I therefore developed a more systematic approach: introduce the purpose of the questions, use open and focused questions, avoid medical jargon, repeat key information back to the patient, consult the record, and escalate discrepancies.

I also recognized that anxiety about making a good impression could make me hesitate to admit uncertainty. My preceptor’s guidance helped me understand that safe practice values questions. A student who asks before acting demonstrates accountability, while a student who guesses creates risk. I now plan to use brief self-checks before important tasks: What information do I have? What is missing? What must be verified? Is this within my current competence and authority? Who needs to be informed?

Communication With Patients and Families

Effective communication is not a single skill used in the same way with every patient. Some people need an interpreter, written material, pictures, repetition, or additional time. Hearing, vision, cognition, pain, respiratory distress, and anxiety can affect understanding. During COVID-19, masks and distance made communication more difficult, and family members were not always physically present to clarify baseline information. Nurses had to find safe ways to preserve participation.

I learned to use teach-back rather than asking only, “Do you understand?” Teach-back invites the patient to explain the plan in their own words and allows the nurse to correct unclear teaching. It should be presented as a test of the explanation, not a test of the patient. For example, after discussing isolation or medication, I could say, “I want to make sure I explained this clearly. Please tell me how you will follow this plan when you return home.” This approach reveals misunderstandings that polite agreement may conceal.

Family communication also requires consent and confidentiality. Relatives may provide valuable history, but the nurse must confirm who is authorized to receive information and respect the patient’s preferences. During isolation, telephone or video communication could reduce distress, though technology should not replace professional updates or become a barrier for families without suitable devices. My practicum showed that family involvement can support care when it is organized ethically and clearly.

Leadership

Through the practicum, I began to identify transformational leadership qualities in myself, particularly motivation, conflict resolution, and commitment to improvement. Transformational leadership encourages a team to connect daily tasks with a larger purpose, invites participation, and supports professional growth. In the COVID-19 setting, effective leaders did not simply issue instructions. They explained why procedures mattered, listened to staff concerns, and adapted workflows as evidence and resources changed.

I also learned that leadership begins before a person holds a formal management title. A student demonstrates leadership by reporting a concern, preparing for a shift, helping maintain a safe environment, and treating team members respectfully. Leadership is not taking authority beyond one’s role. It is accepting responsibility within that role and supporting the team’s purpose. After the allergy incident, leadership meant acknowledging the weakness, seeking supervision, and changing my process.

Conflict resolution became important because pandemic pressure could create disagreement over workload, personal protective equipment, isolation procedures, and patient priorities. I observed that effective leaders separated the problem from the person. They asked what information each team

member possessed, clarified responsibilities, and focused discussion on patient safety. Avoiding conflict may preserve temporary calm but allow risk to continue. Respectful communication enables disagreement without humiliation.

My area for further development remains interpersonal communication. I want to become more comfortable speaking with patients, physicians, pharmacists, and senior nurses when information is incomplete or a decision appears unsafe. Structured tools such as SBAR—situation, background, assessment, and recommendation—can help organize urgent communication. The tool does not replace clinical thinking, but it ensures that the receiver understands why the call is being made and what response is needed.

Teamwork and Collaboration

COVID-19 management required interdisciplinary work. Nurses collaborated with physicians, respiratory therapists, pharmacists, infection-prevention specialists, laboratory staff, environmental services, dietitians, social workers, and case managers. Each profession saw a different part of the patient's condition. Safe care depended on information moving across these boundaries.

My preceptor modeled respect for every team member. Environmental-services staff were essential to infection prevention, while pharmacists could identify medication interactions and allergy concerns. Respiratory therapists provided expertise in oxygen delivery and airway support. The practicum taught me that nursing leadership does not require possessing every answer. It requires recognizing when another professional's expertise is needed and ensuring that the relevant concern reaches that person.

Handoffs were another critical point. A handoff should communicate the patient's current condition, recent changes, medications, allergies, isolation status, pending tests, risks, and required follow-up. A vague report transfers responsibility without transferring understanding. I became more attentive to documenting and verbally emphasizing information that could cause harm if missed.

Inquiry Into Current Practices

The original reflection identifies health disparities as differences in health, healthcare access, quality, utilization, and insurance coverage among population groups. The practicum showed that disparities are visible in daily clinical care. Some patients arrived later in illness because they lacked primary care, transportation, paid leave, or insurance. Others had difficulty following isolation advice because housing was crowded or employment could not be performed remotely. Language barriers and mistrust influenced communication.

Inquiry into current practice requires asking whether policies work equally well for different patients. A discharge plan may appear complete but fail when the patient cannot afford medication, access the

internet, or isolate safely. Nurses can screen for practical barriers, involve social services, use qualified interpreters, and advocate for realistic plans. They cannot solve every structural problem individually, but they should not describe nonadherence without examining whether the plan was feasible.

Quality of care should be evaluated through outcomes, safety events, patient experience, and equity. COVID-19 revealed how chronic disease, occupational exposure, neighborhood conditions, and unequal access can shape risk. Evidence-based practice must therefore include population evidence as well as individual treatment studies. A clinically effective intervention does not produce equitable benefit if access is restricted.

Quality Improvement

Quality improvement differs from research although both use evidence. Research seeks generalizable knowledge, while quality improvement examines local processes and tests changes intended to improve care. The allergy incident could support a unit-level inquiry into how allergy information is collected and displayed. The team might audit records, observe admission workflow, identify discrepancies, and test a standardized verification prompt. Measures could include completion of reaction details, unresolved discrepancies, and allergy-related events.

A Plan-Do-Study-Act cycle could test the change with a small group before wider implementation. The purpose would not be to prove that one person was careless. It would be to strengthen the system while maintaining individual accountability. If several staff members make the same mistake, the workflow may be confusing or poorly designed. If one person knowingly bypasses a clear safety process, coaching or disciplinary action may also be appropriate.

The practicum taught me to see incident reporting as a learning tool. Staff may avoid reporting when they fear punishment, but hidden events cannot improve the system. A just culture distinguishes human error, risky shortcuts, and reckless behavior and responds proportionately. Students should learn reporting processes early so that transparency becomes part of professional identity.

Additional Resources

The original reflection states that nurses should have access to research journals, technology, specialists, and pharmaceutical information. Access to current resources is essential, but the source must be reliable and free from inappropriate commercial influence. Peer-reviewed databases, clinical guidelines, drug-information systems, institutional policies, infection-prevention experts, pharmacists, and continuing education support safer decisions. Pharmaceutical representatives may provide product information, but promotional material should not replace independent evidence or formulary guidance.

Technology can improve care through electronic records, clinical decision support, medication scanning, telehealth, and access to guidelines. It can also create alert fatigue, documentation burden, and false confidence. An allergy alert is useful only when information is accurate and clinicians read and act on it. Nurses should participate in technology design because they understand how systems behave at the bedside.

Mentorship was one of my most valuable resources. My preceptor did more than demonstrate tasks; the preceptor explained reasoning, asked questions, and helped me reflect after difficult moments. I need continued mentorship as I develop, especially in medication safety, communication, and prioritization. Simulation can supplement clinical experience by allowing students to practice emergencies, SBAR communication, allergy response, and infection-control procedures without exposing patients to risk.

New Practice Approaches

The original essay identifies community-based care, evidence-based practice, and patient-centered care as important new approaches. These remain relevant, though they are now established foundations rather than entirely new concepts. Community-based care recognizes that health is shaped outside hospitals and that prevention, follow-up, vaccination, education, and chronic-disease support should reach people where they live. During COVID-19, community clinics, public-health departments, home-care teams, schools, and local organizations played essential roles.

Patient-centered care means respecting each person’s values, needs, culture, and goals. It does not mean granting every requested treatment regardless of evidence. The nurse provides accurate information and supports shared decision making. In infection control, patient-centered care might involve explaining why precautions are required, addressing discomfort, arranging communication, and revisiting the plan as the patient’s condition changes.

Evidence-based practice requires nurses to ask answerable questions, search reliable evidence, appraise quality, integrate findings with expertise and patient preferences, and evaluate outcomes. My practicum helped me see that evidence is not only for assignments. It informs decisions about respiratory protection, isolation, medication, mobility, and discharge. The skill I need to strengthen is moving efficiently from uncertainty to an appropriate source rather than relying on memory alone.

Telehealth and remote monitoring became more visible during the pandemic. They can improve access and reduce unnecessary travel, but they may exclude people without devices, internet, privacy, language support, or digital skill. New practice approaches should therefore be evaluated for equity and safety. Technology is valuable when it expands care, not when it transfers responsibility to patients who cannot use it.

Informatics and Documentation

Accurate documentation supports continuity, legal accountability, quality improvement, and communication. During the practicum, I learned that documentation should be timely, objective, and relevant. Copying old information without verification can perpetuate an incorrect allergy or omit a new reaction. Electronic records should be reviewed critically rather than treated as automatically complete.

Informatics also includes the ability to retrieve data and recognize patterns. A unit can examine infection rates, medication discrepancies, readmissions, and patient outcomes. Nurses should understand how documentation choices affect those measures. A problem not recorded may disappear from the dataset even though it affected the patient. Conversely, excessive documentation can distract from care. Systems should make essential information visible without requiring repetitive entry.

Professional Ethics

The nursing profession places patient dignity, safety, advocacy, and trust at the center of ethical practice. The 2025 American Nurses Association Code of Ethics emphasizes relationships between nurses and recipients of care and reinforces responsibilities involving safety, equity, integrity, and professional environments. During the practicum, ethics became concrete. Telling the truth after an error, protecting confidential information, respecting isolation while reducing loneliness, and speaking up about risk were not abstract values.

Ethical practice also requires self-awareness. Fatigue, fear, and workload can influence decisions. Nurses have a responsibility to recognize when they are unable to practice safely and to seek assistance. Organizations share responsibility by providing staffing, equipment, training, and a culture in which concerns can be raised. Individual resilience cannot compensate for unsafe systems.

Goals for Continued Development

My first goal is to improve medication-history and allergy verification. I will practice structured interviewing, review institutional medication-reconciliation policy, learn common reaction terminology, and seek preceptor confirmation whenever information is uncertain. I will treat discrepancies as unresolved safety questions rather than selecting whichever record seems most convenient.

My second goal is to strengthen concise interprofessional communication. I will use SBAR during simulations and clinical reporting, prepare key information before contacting another professional, and state clearly what action or clarification I need. I will also improve patient communication through

teach-back and qualified interpretation resources.

My third goal is to develop evidence-searching skill. I will become more familiar with clinical databases, professional guidelines, and institutional protocols. For each significant clinical question, I will identify the source and publication date rather than relying on unsourced online summaries. Finally, I will continue reflective practice through debriefing and written analysis that protects patient privacy.

Conclusion

My COVID-19 nursing practicum connected professional practice, evidence, communication, leadership, equity, and safety. Working with a preceptor allowed me to observe how nurses adapt to changing infection-control conditions while continuing patient-centered care. My strengths include hands-on learning, motivation, attention to practice, and willingness to improve. My most significant weakness was incomplete communication and verification of patient history, which contributed to mild allergic reactions and taught me that medication safety requires structured processes rather than assumptions.

The practicum strengthened my interest in transformational leadership, but it also clarified that leadership begins with accountability. I must communicate concerns, accept supervision, collaborate with the team, and protect patients before trying to appear independent. Continued access to evidence, technology, pharmacists, mentors, and simulation will support development. Community-based, patient-centered, evidence-based, and technology-enabled approaches can improve care when they remain equitable and safe. The experience did not make me a finished nurse. It gave me a more honest understanding of the competencies I must continue building and of the responsibility attached to every nursing decision.

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