

Nursing Practicum Reflection on COVID 19 Care

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Introduction

During my nursing practicum, I worked closely with a preceptor in a hospital setting while the healthcare team continued to manage COVID-19 and other respiratory infections. The experience connected classroom learning with the complexity of direct patient care and showed me that professional nursing depends on judgment, communication, teamwork, safety, evidence, quality improvement, and informatics rather than on technical procedures alone. The Quality and Safety Education for Nurses framework identifies patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics as core competencies for preparing nurses to improve healthcare systems (Quality and Safety Education for Nurses, n.d.). My practicum made those competencies concrete. I learned that reliable care requires current information, careful assessment, accurate documentation, willingness to ask for help, and respect for the patient's circumstances. The most important turning point involved incomplete communication about health history that contributed to mild allergic reactions. Although the reactions were not severe, they demonstrated how quickly an apparently small information gap can become a patient-safety event and how reflective practice should lead to specific changes in future behavior.

Professional Practice During COVID-19

The pandemic changed the conditions under which nurses delivered routine care. Hospitals experienced staffing pressure, changing infection-prevention guidance, shortages, high acuity, visitor restrictions, communication difficulties, and uncertainty about how rapidly emerging evidence should be incorporated into practice. In that environment, I saw that professional nursing required adaptation without abandoning fundamental safety principles. Current CDC guidance continues to place respiratory-virus prevention within standard healthcare practice rather than treating it as a temporary emergency response. Standard Precautions apply to all patients and include hand hygiene, risk-based use of personal protective equipment, respiratory hygiene, safe injection practices, environmental cleaning, and appropriate handling of equipment (Centers for Disease Control and Prevention, 2024). CDC also recommends administrative and engineering controls, attention to indoor air quality, source control when risk is elevated, and transmission-based precautions according to the suspected diagnosis (Centers for Disease Control and Prevention, 2025). My practicum therefore taught me that

infection prevention is a shared clinical responsibility. Nurses must interpret current guidance, apply it to the patient and setting, and explain precautions in ways that maintain trust and dignity.

Evidence-based practice was particularly visible because recommendations changed as knowledge about SARS-CoV-2 developed. I learned that evidence-based nursing does not mean applying every new article immediately or treating one guideline as universally applicable. It requires combining reliable research, clinical expertise, institutional policy, the patient's condition, and the patient's values. Current CDC guidance for healthcare personnel with respiratory viral infection illustrates this continuing need for judgment because work restriction, return-to-work timing, and source control depend on symptoms, recovery, and risk factors rather than on one permanent rule (Centers for Disease Control and Prevention, 2026). Patient-centered care remained equally important. Isolation, masks, staff workload, and reduced family presence could make patients feel that infection control had replaced human interaction. My preceptor demonstrated that explanation before entering personal space, eye contact, clear teaching, and safe communication with family could reduce that distance. The experience showed me that scientific guidance and compassion are not competing priorities. Safe care requires both: technical measures reduce transmission, while respectful communication helps patients understand why those measures are necessary and participate in their own care.

Medication Safety and the Allergy Incident

The allergic-reaction incident became the clearest lesson about medication safety, communication, and accountability. Before medication administration or participation in medication-related care, the nurse must verify the patient, medication, dose, route, time, indication, relevant allergies, documentation, and expected response according to organizational policy and scope of practice. Allergy information can be incomplete, copied forward incorrectly, recorded differently across systems, or described by the patient with terminology that needs clarification. I learned that one electronic field cannot be treated as automatically complete when the patient, previous records, pharmacy history, or family can provide additional information. When a patient reports an "allergy," the nurse should document the medication involved, the type and severity of the reaction, timing, and source of the information rather than independently deciding that the reaction is unimportant. In my situation, incomplete history verification contributed to mild reactions, and the correct lesson is not that the outcome happened to be minor. It is that the same communication failure could have produced a more serious event, making verification a clinical safety process rather than a conversational courtesy.

Medication reconciliation provides a structured way to reduce these risks during admission, transfer, and discharge. The Agency for Healthcare Research and Quality describes reconciliation as comparing the patient's current medication regimen with admission, transfer, or discharge orders so discrepancies can be identified and resolved; the process includes prescription medicines, over-the-counter products, vitamins, supplements, and other therapies (Agency for Healthcare Research and

Quality, 2012). During my practicum, I became more aware of how easily a rushed history can miss a recently stopped medicine, duplicate therapy, supplement, or prior reaction. If a reaction occurs, immediate priorities include assessment of airway, breathing, circulation, vital signs, skin findings, mental status, and progression, followed by appropriate escalation, treatment under orders or emergency protocols, documentation, and safety reporting. The event should also prompt examination of contributing factors such as workflow, electronic alerts, communication, supervision, and documentation. This systems perspective does not remove individual responsibility. Instead, it separates blame from learning and asks how both professional behavior and the care process can be strengthened to prevent recurrence.

Communication, Leadership, and Teamwork

My strongest learning style is hands-on observation followed by supervised practice and feedback. During the practicum, I watched how experienced nurses prepared medications, assessed patients, used infection-control measures, documented findings, and communicated with patients and other professionals. I also recognized that willingness to accept correction is a professional strength. After the allergy incident, I became more deliberate about asking focused questions, confirming information with the preceptor, and pausing when the available history was incomplete. My main weakness was moving too quickly through conversations when answers were brief, unclear, or affected by illness. I now understand that communication is part of clinical reasoning because missing information can change medication decisions, infection-control plans, dietary care, discharge teaching, and escalation. A safer approach is to explain the purpose of questions, use open and focused prompts, avoid unnecessary jargon, repeat key information back to the patient, compare the account with available records, and escalate discrepancies. Confidence should come from preparation and verification, not from acting quickly in order to appear independent.

Communication also has to be adapted to the patient rather than delivered in one fixed style. Hearing loss, vision impairment, pain, anxiety, respiratory distress, cognitive changes, limited English proficiency, and health literacy can all affect understanding. During COVID-19, masks and distancing added further barriers, while family members were not always physically present to clarify baseline information. I learned to use teach-back rather than relying on a yes-or-no question such as “Do you understand?” Teach-back asks the patient to explain the plan in their own words and frames the exercise as a test of my explanation rather than a test of the patient. Family members can provide useful history and support, but confidentiality and consent still govern what information can be shared. Qualified interpreters should be used when language differences could affect safety instead of depending on relatives for complex clinical interpretation. The practicum showed me that patient-centered communication is not simply being polite. It is a safety intervention that makes assessment more accurate, exposes misunderstanding, supports informed participation, and reduces the chance that a technically correct plan will fail because it was never truly understood.

I also began to see leadership as behavior rather than title. Transformational leadership appealed to

me because it connects daily work with a larger purpose, encourages participation, and supports professional development. In the clinical setting, however, leadership did not mean taking authority beyond the role of a student nurse. It meant preparing for the shift, reporting concerns, accepting responsibility, asking for supervision, and treating every member of the team as relevant to patient safety. COVID-19 care made interdisciplinary collaboration especially visible. Nurses depended on physicians, respiratory therapists, pharmacists, infection-prevention specialists, laboratory staff, environmental services, dietitians, social workers, and case managers. My preceptor modeled respect for each contribution: pharmacists could clarify interactions and allergy concerns, respiratory therapists brought expertise in oxygen delivery and airway support, and environmental-services staff were essential to infection control. Handoffs were another leadership test because responsibility cannot be transferred safely without understanding. A useful handoff communicates current condition, recent changes, medications, allergies, isolation status, pending tests, risks, and required follow-up rather than offering a vague summary.

Equity, Quality Improvement, and Informatics

The practicum also made health disparities visible at the bedside. Some patients reached care later because they lacked primary care, transportation, insurance, paid leave, or a realistic way to isolate. Others faced language barriers, crowded housing, unstable internet access, or mistrust based on previous healthcare experiences. A discharge plan can look complete in the chart yet remain impossible for a patient who cannot afford medication, obtain food, travel to follow-up, or use telehealth privately. I learned that nursing assessment should include practical barriers and that social services, interpreters, case management, community resources, and realistic scheduling can be as important as written instructions. Nurses cannot independently solve structural inequity, but they should avoid describing a patient as “noncompliant” without examining whether the plan was feasible. Patient-centered care therefore includes respect for values and preferences as well as attention to material circumstances. Quality should be evaluated through safety outcomes, patient experience, access, and equity. An intervention cannot be considered fully effective if it works only for patients who already possess the resources needed to use it.

Quality improvement gave me a framework for converting one safety event into a question about the care process. The allergy incident could support a local project examining how allergy information is collected, verified, displayed, and transferred across settings. A team might audit records, observe admission workflow, identify recurring discrepancies, and test a standardized verification prompt or electronic change. Measures could include completion of reaction details, unresolved discrepancies, medication-related alerts, and adverse events. A Plan-Do-Study-Act cycle could test a small change before wider adoption. This differs from research, which is designed to produce generalizable knowledge; quality improvement focuses on improving a local process while still using evidence and systematic measurement. A just culture is also relevant because healthcare organizations need to distinguish human error, risky shortcuts, and reckless behavior. Incident reporting should support learning rather than encourage concealment, while serious disregard of clear safety processes still

requires accountability. The experience changed my view of errors: reporting and analysis are not admissions that improvement is impossible; they are mechanisms through which safer systems are built.

Informatics is part of this safety work because electronic records, medication scanning, clinical decision support, telehealth, remote monitoring, and digital guidelines influence nearly every nursing task. Technology can reduce error and improve continuity, but it can also create alert fatigue, duplicate documentation, outdated copied information, and false confidence that the record is complete. An allergy warning is useful only when the underlying information is accurate and clinicians notice and interpret it correctly. I learned to treat the electronic record as an important source that still requires clinical verification. Informatics also allows units to examine patterns in infection rates, medication discrepancies, readmissions, and patient outcomes. Documentation therefore affects both individual care and the data used to evaluate the system. Entries should be timely, objective, relevant, and specific enough for another professional to understand what changed and what remains unresolved. Telehealth and remote monitoring can expand access, but they can also exclude patients without devices, broadband, privacy, language support, or digital skills. Technology should be judged by whether it makes safe care more accessible, not merely by whether it is available.

Ethics and Goals for Continued Development

Professional ethics became practical during the practicum rather than remaining an abstract classroom topic. The American Nurses Association's 2025 Code of Ethics emphasizes nursing relationships, safety, equity, integrity, and the conditions required for ethical practice (American Nurses Association, 2025). I encountered those responsibilities in decisions about truthfulness after an error, confidentiality, infection-control restrictions, communication with families, and speaking up when information was incomplete. Ethical nursing also requires self-awareness because fatigue, anxiety, workload, and fear of looking inexperienced can influence decisions. Individual resilience cannot compensate for an unsafe system, so organizations share responsibility for staffing, equipment, education, supervision, and a culture in which concerns can be raised. My own responsibility is to recognize when I am uncertain, remain within my scope, and seek assistance before uncertainty becomes harm. The practicum helped me understand that accountability is not the opposite of compassion. A nurse can acknowledge an error, protect the patient, report the event, and participate in improvement without reducing professional identity to one mistake.

My first development goal is to strengthen medication-history and allergy verification. I will practice structured interviewing, review institutional reconciliation procedures, learn to document reaction type and severity accurately, and treat discrepancies as unresolved safety questions until they are clarified. My second goal is to improve concise interprofessional communication. I will use SBAR—situation, background, assessment, and recommendation—in simulation and clinical reporting, prepare essential information before contacting another professional, and state clearly what action or clarification is needed. My third goal is to become faster and more discriminating when searching for

evidence. I will use clinical databases, professional guidelines, institutional protocols, pharmacists, and infection-prevention specialists rather than relying on memory or unsourced summaries. Mentorship remains essential because my preceptor's most valuable contribution was not demonstrating tasks but explaining reasoning and helping me reflect after difficult moments. Simulation can supplement clinical experience by allowing practice of allergy response, SBAR, medication safety, and infection-control scenarios without exposing patients to risk. These goals translate reflection into observable behaviors that can be evaluated during future clinical experiences.

Conclusion

My COVID-19 nursing practicum connected professional practice, infection prevention, medication safety, communication, leadership, teamwork, equity, quality improvement, informatics, and ethics. Working with a preceptor showed me how nurses apply changing evidence while protecting continuity, dignity, and patient participation. The allergy incident was the most important safety lesson because it revealed that incomplete communication and verification can turn a routine task into an adverse event. It also showed me how professional accountability should work: assess the patient, escalate appropriately, document accurately, report the event, examine contributing factors, and change practice. My strengths include hands-on learning, willingness to accept feedback, motivation, and growing awareness of system factors. My continuing weaknesses involve communication under uncertainty and the temptation to move too quickly when information is incomplete. The practicum did not make me a finished nurse, nor should reflection pretend that professional development has an endpoint. It gave me a more disciplined understanding of safe nursing: verify before acting, ask when uncertain, communicate clearly, use evidence responsibly, and treat every clinical decision as part of a larger system of patient protection.

References

- Agency for Healthcare Research and Quality. (2012). *Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation*.
- American Nurses Association. (2025). *Code of Ethics for Nurses*.
- Centers for Disease Control and Prevention. (2024). *Standard Precautions for All Patient Care*.
- Centers for Disease Control and Prevention. (2025). *Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings*.
- Centers for Disease Control and Prevention. (2026). *Viral Respiratory Infections*.
- Quality and Safety Education for Nurses. (n.d.). *QSEN Competencies*.