

Lucretia Shafer  
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The question that we are to address today is, “How will my university classes that are not within the nursing program be used in the field of nursing?” That is a difficult question for me to answer because I took those classes so many years ago. The past 3 years have been spent in pursuit of a nursing degree. However, I know that I will be a better nurse for having had such a rich life experience. I am able to relate to my patients in ways that I would not have imagined as a 20 year old. I know and understand so much more about emotions, choices, similarities and differences between people and how to interact with them. A liberal arts education can begin the process of peeling back the complex layers of human interactions and how we relate to ourselves and with others.

History broadens my perspective and at times has even given me a glimpse of the future. Global studies and geography remind me that I am not alone in this world and that my priorities and desires are terribly selfish most of the time. Psychology has shown me that “normal” does not really exist. That said, however, it has also shown me the power and strength of the human spirit and the depths to which we can sink and the heights to which we can soar. English and Literature to me are the backbone of education. If I couldn’t read, my worldview would be terribly limited. Math has become such a part of my life that I don’t even realize how much I use it in my day-to-day life. Art is often overlooked and under appreciated but for me it reminds me of how much I don’t know. When I take the time to learn about something that I know nothing about, I am always amazed at the complexity and depth of something that had previously bored me. Music is so powerful that it can instantly transport me back to a place or time that I had forgotten about or call up in me emotions that I had not thought were so close to the surface. The list can go on and on.

I think what I am trying to say is that no learning is ever wasted. Nursing is an art and a science. It’s ultimate goal is to care for the whole person. If I am to be an excellent nurse, I need to have a basic understanding of the amazing complexity of human beings and be able to vary my approach to care giving in ways that will provide the best care for each patient. Life experiences and education together provide that understanding.

Lucretia Shafer  
Med/Surg Clinical Journal Week 2  
September 11 and 12, 2006

### **(1) What situations "went well" during this week’s clinical shifts?**

It was wonderful to be back on the floor. I really do love Med/Surg nursing. I was pleased that my experience this summer had the desired effect of making me feel more competent. Because we were given no direction about where to start or how to do things I am especially glad that I worked during the summer. I don’t know how I would have

done if my last adult clinical would have been J-term which some of my classmates are experiencing. Monday was spent getting oriented to the unit, beginning to form a relationship with my nurse and working through the charting and various systems that will need to be mastered. I took care of one patient, which went just fine. I really like the look of TG—it seems new and friendly for the patients.

(2) What concerns did you have during the shift and did they change as the shift progressed?

My main concern during the shift was the condition of one of my nurse's patients. He was extremely hard to arouse and was obviously in pain at times. He was receiving the max dose of morphine and Adivan but they were not alleviating his symptoms. My nurse was concerned, but the doctor told her it was "the way he is", good one day and not the next. The charge nurse watched the patient for about three minutes and said that his restlessness was caused by his sleep apnea. Throughout the morning I went into his room and watched him for a few minutes at a time, wiped his brow, arranged his bedding, took his pulse but I did not really do anything for him. I asked my nurse if there was a pain team that she could call for some help but she said no. I told her that if he was my patient I would be on the phone to the doctor every 2 hours until he gave me an satisfactory way of helping the patient. When we left the floor at noon, nothing had changed. However, at 1530, the evening nurse called for a Rapid Response Team (RRT). When I heard the call overhead in the OR, I was relieved. The pt was transferred to ICU. As I look back on the situation, there are a number of things that I wish I had done.

- ⊖ Took his vitals q 1 hour
- ⊖ Put his CPAP mask on him (he refused to wear it when coherent)
- ⊖ Remembered the RRT option

**(3) Patient #1** (This is my only pt. I have taken way too much time working on this journal.)

71 year-old pt, 3 wks post proctocolectomy with iliostomy, returned to hospital for tx of wound infection. Pt reports that he was healing nicely until a week ago. At that time, he noted redness, tenderness of lower abdomen, fatigue, occasional nausea, slight fever. Incision and drainage (I & D) along surgical incision midline, lower abd on 9/8/06, antibiotics started.

**Primary dx:** Infection of surgical site (which turned out to be MRSA)

**Secondary dx:** Proctocolectomy with illiostomy July 13, 2006, chronic nephritis, DM controlled with oral meds, HTN, total L knee replacement, cardiac stent placement 1997, gout

The transmission of infection is well understood and is commonly referred to as the Chain of Infection (1). It is circular and includes an Infectious agent, Reservoir, Portal of exit, Means of transmission, Portal of entry, and a Susceptible host. Take away any link in the chain and infection is prevented. This pt's infection was probably transmitted at the hospital since it is MRSA. This means that the bacteria was transmitted at the time of surgery or during his post-op care on the floor.

The pt's pre-existing conditions probably contributed to his susceptibility to infection. HTN, DM, cardiac and renal problems all interfere with the healing process. The presence of these four diseases in one person is not rare. HTN speeds up the process of atherosclerosis which damages blood vessels and is a major risk factor for coronary artery disease (CAD). Renal dysfunction is the direct result of ischemia caused by the narrowed lumen of the intrarenal blood vessels and HTN is one of the leading causes of end-stage renal disease. When the kidneys are not working properly, there can be fluid build up and chemical imbalances in the blood. HTN also has adverse affects on glucose and insulin metabolism. This results in damaging fluctuations of fuel for the body's cells (2, pg 781-783). The combined result of these diseases is a decrease in the body's ability to fight infections and heal itself.

Anytime items penetrate the skin or mucous membranes or enter a sterile body part there is a high risk of contamination (1). Surgery is one example of this. Age also affects infection rates. Nosocomial infections are more common in older pts. (2, pg 72). Also, the older pt is usually less stable at discharge than younger, healthier pts. Since this pt has a new ileostomy, his diet was probably inadequate for optimal healing.

Pt afebrile, no c/o pain, vital signs stable. Nausea with emesis in AM. Pt refused nausea meds. Dressing changed. Removed packing. Scant amount of serous drainage along old incision. Surrounding skin intact, reddened, firm, nontender. Repacked with wet to dry packing, vasoline gauze on incision line, covered with gauze bandage. Pt blood sugar elevated. Insulin admin per order, pt diet changed to ADA diet.

Delayed surgical recovery r/t infection of proctocolectomy site AEB redness, tenderness, firmness, nausea, drainage, decreased mobility, presence of MRSA. (5)

- ⊖ Surgical incision will begin healing by 9/14/06.
  - Assess vital signs q 8 hours
  - Change dressing q 12 hours
  - Administer antibiotics as ordered by Dr
  - Assess wound q 8 hrs
  - Provide proper diet
  - Encourage fluids
  - Assess for n/v, adm nausea meds as needed
  - Monitor labs
  
- ⊖ MRSA will not be transmitted to other pts
  - Use standard precautions
  - Follow hospital policy regarding MRSA precautions
  - Provide pt/family and friends with info about MRSA and answer questions
  - Teach and use proper handwashing technique
  - Keep pt in room
  - Ensure proper room cleaning after discharge

(4) Discuss the status of at least one of your patient's desired outcomes.

My pt said that he was very hungry for breakfast since the day before he had experienced n/v. When it came, he sat up, took one bite and immediately felt nauseous. Soon after, he began to vomit. Disappointed, we talked about what he could do about it. I offered to give him some of his prn nausea med. which he refused. I offered him some 7-up which he said yes to. We also talked about sitting up slowly, and taking small bites and sips slowly. Before lunch I checked on him again and he reported that he had slowly eaten about 50% of his breakfast and that the 7 up did not work because it was not diet. I had forgotten that he was a diabetic.

**(5) [SOAPIE: a systemic method of charting].**

(S/O) Pt denies pain, nausea. Reports decreased tenderness in lower abdomen. BP 124/84, HR 92, temp 37, RR 18, O2 97% RA. Incision: scant amount serous drainage, surround tissue red, non-tender, firm to touch. Wet to dry packing in wound, vasoline gauze over incision line, 4/4 gauze bandage.

(A) Incision site is healing, redness, tenderness decreasing, still firm to touch. Pt tolerating antibiotics.

(P) Will switch to PO antibiotics per Dr orders in PM.

(I and E) IV saline locked. Administered PO antibiotics. Will continue to monitor for healing, decrease infection and antibiotic tolerance.

**(6) Discuss the nursing research article you found to incorporate into your care for Tuesday?**

Plastic Apron Wear During Direct Patient Care. J. Candlin and S. Stark. (3)

The aim of this small-scale documentary analysis study was to identify factors that influence nurses' use of gowns during direct patient care. The literature review showed that gowns are required during direct patient care and evidence-based practice promotes their use. However, policies regarding their use are not being enforced.

The authors analyzed 15 nursing research articles about "personal protective clothing" and "infection control". All data is secondary and therefore not generalizable. However, this thematic, qualitative analytical approach provides insights on the issue and topics for further study.

Three themes were found to run through the 15 articles: 1) knowledge of infection control, 2) symbolism and 3) ritualistic practice. Knowledge of infection control among nurses was found to be lacking. Gowns are seen to symbolize cleanliness and purity with infection control a secondary concern. Patients may view the use of protective clothing negatively (being treated as if they are dirty). Ritualistic practice covers habits. Lack of clear local guidelines for use of gowns, lack of infection control education for nurses and

the time and bother involved in gloving and gowning all affect policy implementation and new habits.

This study found that the use of gowns continues to be ineffective despite the fact that health and safety regulations, hospital guidelines, and infection research emphasize the need for gowns during direct patient care. It also found that evidence-based research promoting the wearing of gowns is scant. Policy implementation is inadequate and more research needs to be done to determine the causes and remedies for this.

It ends with a call for minimum standards to be set for the provision of uniforms, laundry and changing facilities to minimize the potential for the spread of healthcare-associated infections.

I chose it because my pt was found to be MRSA positive on the third day of his hospitalization.

(7) What nursing conceptual framework and/or philosophies do you think you are using?

Nursing as Informed Caring for the Well-Being of Others by Kristen Swanson (4).

I try to use Kristen Swanson's theory of informed caring in my practice. Her definition of nursing is, "informed caring for the well-being of others" and her structure of caring consists of five caring processes. It begins with "Maintaining Belief" and moves through "Knowing", "Being With", "Doing For", "Enabling" and the intended outcome is "Client Well-being".

Every nurse adds to the "values, history, expertise, knowledge and universality and passion" of nursing and is a part of the profession's commitment to caring, preserving human dignity and enabling well-being for all. According to Swanson, in informed caring there is room for novice to expert nurses. This means that everything that I do as a nurse, from the first day of my practice to the last day, should be aimed at supporting and caring for the whole person, encompassing body, mind and spirit. "Person" can and does include individuals, families and even communities. Also, everything that I have learned and experienced comes with me to the bedside. My practice as a nurse is grounded in science, humanities, personal insight and personal experiences and I need to approach the patient as a whole person myself.

Maintaining belief is the foundation of caring. It says that I, as a nurse, believe that there is personal meaning to be found in whatever health condition or developmental challenge the client is facing. It is the fuel that powers my commitment to serve humanity.

Knowing is a bridge between maintaining belief and the other steps in the caring process. It is the understanding of the realities of all aspects of the client's condition from the client's point of view. It establishes the hopes and desires of the client, not the nurse. Where maintaining belief is idealistic in nature, knowing is realistic in nature.

Being with conveys the message, “I care about you.” It involves giving of time, active listening, and timely and appropriate physical and verbal responses. However, it also establishes the boundaries and guidelines for the therapeutic relationship.

Doing for and enabling are the parts of the caring process that people typically think of when they describe nursing. Doing for is best described by quoting Virginia Henderson’s definition of nursing. “The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.” (4, page 356). It involves both action and patience on the part of the nurse. Sometimes nurses do for the client when the client would be best served by doing it themselves. Enabling includes coaching, informing, explaining, supporting, assisting, guiding, offering feedback, and validating the client’s reality. It’s intended function is to “facilitate the client’s passage through difficult events and life transitions” (4).

As stated above, the goal of the caring process is the client’s long-term well-being. As I grow in my nursing experience, I regularly need to step back from my care delivery at the hospital or in the community, and remember that nursing is so much more than tasks. I am dealing with human life that is like me in ways and yet so very different than me in ways that I can only begin to imagine. True caring begins with hope, believes in miracles, and then takes root in reality but always sees possibilities and holds on to hope. With this perspective, even death is not failure.

(8) What did you learn from the patients, families, hospital staff or anyone else?

I learned that 6 patients is a good way to make a good day bad. I also learned that a nurse needs the support of fellow nurses to make it through the day. The PCT and the RN work as a team. That’s good! I also found out that doctors do not know everything and don’t want to know everything. One that I talked to did not know much about MRSA precautions and how it affected the pt. She told me to ask the infectious disease doc.

(9) How does this experience contribute to the ultimate N440 Objectives & clinical outcomes and the PLU School of Nursing Program outcomes to graduate?

**In clinical this week I think that I fulfilled most of the outcomes and objectives through the hands-on care of my patient and in the study and writings for this journal. Outcome #4 is met through my participation in school, clinical experiences, and the life I lead outside of PLU.**

(10) What clinical learning needs do you have for future weeks and how do you intend to accomplish them?

I need to learn to care for more than one pt. at a time. I also need to figure out where the emergency light is in a pt’s room. I will come on Monday ready to learn and ask my nurse for 2 pts.

## References

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Lucretia Shafer  
Med/Surg Clinical 9/18-9/19  
Journal 3

### **(1) What situations "went well" during this week's clinical shifts?**

On Monday I had the opportunity to observe two surgeries—a partial left knee replacement and an arthroscopic repair. I was amazed at how similar knee surgery and woodworking are—many of the same principles, tools and techniques are used. The surgeon said that it is not unusual for retired orthopedic surgeons to engage in woodworking as a hobby. I did not realize that the companies that supply the tools and parts for various surgeries provide a representative to help the surgeons and the surgical nurses use it all properly. He told the nurse what instrument was going to be needed next, used a laser pointer to show her where it was located and answered questions that the surgeon had about it all too.

The arthroscopic surgery was very interesting because the surgeon took the time to show me the interior of the knee—the meniscus, ACL, the bones, etc. It was like a laparoscopic surgery in that all the action took place on the monitors. That surgery was really fast. In fact it took longer to prepare the patient for surgery than the surgery itself.

On Tuesday I worked with a veteran nurse. She has been at TG for over 30 years. As a side note, she is having a biopsy of her thyroid for possible CA. If she has it, she thinks it may be related to her career—exposure to x-rays, drugs, or something. I wonder what I am being exposed to that will one day be found to be detrimental to my health? Anyway, her LPN has been at TG for over 40 years. They work as a team. I am not sure if these teams are the best form of floor organization. It seems like it would foster teamwork, but in reality, the teams do not go out of their way to help out other teams.

We finally got our Pixis access numbers. That is wonderful. Sure wish I could get to the machine without having to be let in everytime. Also, we can now get to the patient info on the computers but cannot access the references or the wealth of patient education information that is online. One step forward, two steps backwards.

I took care of two very easy patients. Both were ambulatory and able to perform their ADLs on their own. I did provide the one with probable cholecystitis printed info about her condition, possible treatment options and self care strategies. The pt with pyelonephritis and hydro was having pain issues that I wanted to be able to treat more aggressively. He rated his pain at 5+ and the prescribed dilaudid did not ease it. We gave him his doses as ordered but my nurse seemed to think that because of his ureter stent, he was destined for pain. Her husband had gone through the same procedure and experienced a lot of pain. This is the second time that my nurses have let patients remain in pain.

As I was on my way home I realized that I did not chart any progress notes on my patients. I had written them up for my nurse to read and then forgot to show her or to chart them. I did give report for both my pts though.

(2) What concerns did you have during the shift and did they change as the shift progressed?

See (1) above.

\*(3) Describe at least 2 specific patients.

**Patient #1**

**General pt info**

30 something yo female Tonsillectomy 2004, appendectomy 2005, C/O rt knee pain, knee locks occasionally. Fell on both knees several months ago

**Primary dx**

Torn meniscus Rt knee

**Secondary dx or ongoing conditions and significant past medical/surgical hx**

none

**Pathophysiology for 1° and up to 4 of the 2°**

The meniscus is fibrous cartilage in knee and other joints. It can be damaged or torn from rotational stress when the knee is flexed and the foot fixed. This action traps the meniscus between the head of the femur and the tibia resulting in a torn meniscus. (2)

### **Etiology (causes) and risk factors**

Athletic injury, trauma, wear and tear on the knee (age)

### **Incidence**

Common in athletes and the elderly

### **Clinical Manifestations or signs & symptoms**

Localized pain, some swelling

Pain when leg is abducted or adducted at the knee

Unstable feeling, clicking and occasional locking of the joint

### **Diagnostic workup**

X-rays, MRI, exploratory arthroscopy

### **Usual outcome medical-surgical management**

Meniscus removed or repaired, depending on the location and size of tear; femur head smoothed. Pain and discomfort gone. If removed, pt is at a greater risk for arthritis in the knee

### **Specific nursing diagnoses R/T and AEB**

\*Pain r/t surgical procedure AEB pt report, inc BP, inc HR, pt body language.

\*Risk for infection r/t surgery AEB open incision, redness, pain, swelling, fever >100.5, inc drainage or purulent drainage.

\*Decreased mobility r/t knee surgery AEB pain, dec flexibility, lack of knowledge about recovery plan.

### **Nursing outcomes & interventions**

∞ Pt's pain will be adequately controlled during recovery.

θ Dilaudid and visarol for pain

θ Ice on rt knee

θ Coach pt in deep breathing, relaxing during pain episodes

θ Explain what is being done for her while she is waking up from surgery

### **Discuss the status of at least one of your patient's desired outcomes [what the patient told you they wanted to accomplish during your shift].**

Pt said that she had a high tolerance to pain meds. She was concerned about her pain after surgery and wanted some extra-strength vicoden to take home. Dr. told her to take two at a time if needed. When she was waking up from surgery, she was in a lot of pain, tensing up, restless, moaning, swearing, praying. The nurse gave her pain meds every 10 minutes or so and administered vistaril to enhance the dilaudid and relax her. We put ice on her knee and I held her hand, and talked to her, explaining what was going on. I helped her breath through the pain, and relax rather than fear it. After a half hour or so she calmed down and was able to breath through the pain she was experiencing rather than fight them. I am sure that the drugs were helping also

### **(5) SOAPIE charting**

Post op recovery, pt restless, moaning, crying, asking for pain meds. Vitals are (do not have actual info PB, HR, Temp, RR, O2 sats). Pt did not verbalize a pain score. Admin pain meds as ordered by dr. Applied ice to leftt knee. Held pt's hand, encouraged controlled breathing, and relaxation until meds took effect. Pt verbalized relief from pain and appears relaxed. Vitals (do not have info). Pt resting comfortably. Will continue to monitor closely.

## **Patient #2**

### **General pt info**

60 something yo male, fell from ladder 15 ft. Multiple fx. Rt wrist, left femur. Open reduction and internal fixation (ORIF) of both 4 days ago, developed pulmonary embolism (PE) yesterday

### **Primary dx**

Fx of Rt wrist and Lt femur with ORIF

### **Secondary dx or ongoing conditions and significant past medical/surgical hx**

DVT LLE and PE RLL

### **Pathophysiology for 1° and up to 4 of the 2°**

Blockage of pulmonary arteries by thrombus, fat or air emboli, and tumor tissue. Most c/b DVT in the legs. Others from heart (esp atrial fib), upper extremities (rare), pelvic veins. Clot breaks loose and travels through heart and lodges in narrow part of circulation system, usually lower lungs. However can also be c/b fat emboli (long bone fx), air emboli (IV therapy), bacterial vegetations, amniotic fluid and tumors (primary or metastasized).

### **Etiology (causes) and risk factors**

See above for causes. Risk factors are Virchow's Triad: 1. venous stasis, 2. injury to blood vessel walls 3. hypercoagulability of blood

### **Incidence**

Most common pulmonary complication in hospitalized pts. Est 50,000 deaths/year, 650,000 non-fatal/year (2, pg 938)

### **Clinical Manifestations or signs & symptoms**

Anxiety or an impending sense of doom

Sudden onset of unexplained dyspnea, tachypnea, or tachycardia

Cough, pleuritic chest pain, crackles, fever, change in LOC from hypoxemia

Large emboli can cause sudden collapse, crushing chest pain, shock severe dyspnea, right sided heart failure

### **Diagnostic workup**

Hx and physical (past DVT puts pts at greater risk)

d-Dimer level (looks at level of fibrin in blood, which is a component in clotting) suggests PE

Lung scan (ventilation/perfusion) test, Pulmonary angiography, spiral CT scan

### **Usual outcome medical-surgical management**

Clot is dissolved, Lung fx returns to normal

### **Specific nursing diagnoses R/T and AEB**

- ⊖ Impaired gas exchange r/t pulmonary embolism AEB SOB, pleural pain, lab and test results, immobility.
  - ⊖ Admin O2 via , position in semi-Fowlers, bed rest to facilitate breathing, provide cluster care
- ⊖ Risk for injury r/t heparin therapy AEB inc PTT, bruising, bleeding
  - ⊖ Pad side rails, provide nightlight, keep clear path to bathroom
  - ⊖ Assist with transfers, ambulations, showers
  - ⊖ Keep protamine sulfate on hand
- ⊖ Anxiety related to hypoxemia AEB restlessness, agitation, verbal statements about fear, worry.
  - ⊖ Admin O2
  - ⊖ Assess anxiety levels
  - ⊖ Encourage family, friends to stay with pt for comfort
- ⊖ Pain r/t PE AEB pt report, inc BP, inc RR, pt posturing, pleural pain

See previous journal (week 2)

**Nursing outcomes & interventions**

Pt will demonstrate improved gas exchange and not hemorrhage while in hospital. Additionally, pt will remain calm and relaxed and his pain will be below 4/10 through out his stay.

**Discuss the status of at least one of your patient's desired outcomes [what the patient told you they wanted to accomplish during your shift].**

**(5) SOAPIE charting**

**What is the subjective/objective (S/O) assessment of a patient's nursing diagnoses?**

**What is your analysis (A) of a patient's nursing diagnoses [better, worse, stable] in meeting the outcomes for discharge?**

**Regarding the nursing care you planned (P) and did (I) the next day or suggested for the nurses following you, how would you evaluate (E) the results?**

(4) Discuss the status of at least one of your patient's desired outcomes [what the patient told you they wanted to accomplish during your shift].

(5) What is the subjective/objective (S/O) assessment of a patient's nursing diagnoses? What is your analysis (A) of a patient's nursing diagnoses [better, worse, stable] in meeting the outcomes for discharge? Regarding the nursing care you planned (P) and did (I) the next day or suggested for the nurses following you, how would you evaluate (E) the results? [SOAPIE: a systemic method of charting].

(6) Discuss the nursing research article you found to incorporate into your care for Tuesday?

*Effectiveness of a Behavioral Change Intervention in Thai Elders After Knee Replacement (6)*

This longitudinal quasi-experimental, pretest-posttest control group design study uses Bandura's social cognitive theory of behavior to enhance adherence to physical therapy regimen post total knee replacement surgery. Participants received various forms of teaching, discussion, interaction, and information about the importance and benefits of exercise on full recovery. The behavioral change intervention was found to be effective in increasing compliance and therefore recovery.

This study further validates the importance of education and coaching by nurses. I think it also identifies a need for programs and materials that are tailored to specific patient needs. Not everyone can read at the same level and not everyone learns at the same rate. However, every one deserves to be as healthy as possible.

(8) What did you learn from the patients, families, LPNs, PCTs, Support staff (transport), Unit clerk RNs, Case Manager, Clinical Nurse Specialists, Charge RN, physicians, pharmacists, faculty, or anyone else?

I learned that certain antibiotics cannot be administered with dextrose and that lactated ringers does not have dextrose in it. I also learned how to send and receive things from the tube system. I am still trying to figure out the pumps. The nurses go so fast and do it for me, so when I try to do it again, I have forgotten the sequence....

(9) How does this experience contribute to the ultimate N440 Objectives & clinical outcomes and the PLU School of Nursing Program outcomes to graduate?

Through my care plans and concept maps; actual care given to the pts; my working relationships with my nurse and PCT, fellow classmates, professors, and other healthcare providers; the reading and application of research articles for clinicals and in

furthering my own studies; my journaling; and my participation in classroom readings and lectures, each day I embody the goals and objectives of PLU SON.

## EXPECTED CLINICAL OUTCOMES FOR N440 CLINICAL EXPERIENCE Nursing Situations with Individuals/Adult Health II: Senior I Semester

**Clinical Outcomes: as observed and reflected in your electronic journals:**

1. Become more aware of at least 10 more medical and nursing diagnoses and explain how the different complex alterations in health affect the patient personally and the family as a unit in the future.

Working on it.

2. Explain how the patient's recovery process from the primary admitting diagnosis is affected by the secondary diagnoses. How is the generic or textbook care changed for meeting your patient's specific needs?

I automatically do this. No one is a textbook example.

3. Develop and deliver nursing care interventions using the critical thinking, ethical practice, and nursing process with more complicated patients/families at a higher broader level to at least two or more patients per shift.

Yes.

4. Demonstrate competency with an expanded number of clinical skills as a result of seeking out opportunities for this self-education. The skills you should seek include:
  - Initial & ongoing shift physical assessment & chart changes Yes
  - Document what the patient wants to accomplish this shift yes
  - Coordinate the daily AM/PM care and meds for 2-3 patients yes
  - Discuss and plan discharge with patient/family and document in chart Not at TG yet.
  - SVN treatments
  - Glucometer checks the lab does these. I have done them in the past.
  - Check all meds with Professor/RN Partner Yes
  - IV meds ALWAYS in presence of Professor/RN Partner Yes
  - Central line meds via SASH ALWAYS in presence of Professor/RN Partner No
  - Assist RN Mentor in blood administration No chance yet
  - Observe/assist PCT/RN drawing blood PIC line blood draw
  - Request to join & observe the IV RN's Yes
    - I/O's yes
    - Clear pumps yes
    - Chart to include patient/family's status of patient issues/diagnoses yes
    - Chart status pain& IV status at least q 4 hours yes
    - Receive and give Intershift report
    - Provide planned pain management yes
    - Isolation yes, MRSA
    - Dressing changes yes
    - Staple removal no
5. Uses verbal and nonverbal communication skills during the delivery of patient/family care, among team members and other health care providers, during Intershift report, and with fellow peers in the electronic journals. Yes. However, we do not use electronic journals and I do not think that a person's journal is meant to be read by anyone but themselves and the professor.
6. Determines what teaching to include aspects of health promotion is appropriate, delivers the teaching according to patient/family needs, coordinates it with the other healthcare providers, assesses the level and success of learning, and documents this on the chart. Yes
7. When caring for a specific type of patient/family with a specific problem, researches the literature to determine what is the best Evidenced Based Practice (EBP); researches the literature to supplement one's understanding of the clinical environment and its dynamics; and notes how research outcomes could be measured on a hospital nursing unit. Yes
8. Compare assigned nursing unit with other hospital nursing units at MHS/TG and elsewhere in order to participate in the goals to enhance the health care delivery system. This requires reflection of what factors influence organizational culture that affects the RN's ability to deliver competent organized nursing care to meet the satisfaction needs of patients/families, staff, and administration. Boy do I ever.

9. Act accountable and responsible by being on time for clinical, presenting a professional appearance, submitting assignments, completing, documenting, and reporting status of patient care; and maintaining the confidentiality of patients, families, peers, staff, and what happens in the clinical setting. **Yes**
10. Explain professional nursing service roles you anticipate as an RN and give examples of such service provided by individuals in the hospital health care setting where the student has clinical. **Not sure what this means.**

(10) What clinical learning needs do you have for future weeks and how do you intend to accomplish them?

**I want to see and experience the big picture of what a med/surg nurse at TG is responsible for. There seems to be a lot that we are not privy to right now. What is “acuity”? Where are the longer, more in depth charting details about the patients? How is a pt admitted and discharged here? Why don't the PCT's do chem. sticks? Are the nurses notified if the blood sugar is high on a pt or do they have to remember to check every pt? Are there standard orders for the hospital or for each doctor regarding nursing duties, prn drugs, care plan pathways, etc?**

**I think that I will have to continue to ask a million questions.**

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Lucretia Shafer  
Med/Surg Clinical 9/25-9/26  
Journal

### **(1) What situations "went well" during this week's clinical shifts?**

This was a very different week than any other that I have had before. I cared for two men, both in their 40's, both old before their time because of choices that they made for themselves. One was

a homeless IV drug addict and the other was an HIV+ guy who was recovering from an ileostomy takedown.

The IVDA guy was the nicest guy. Everyone who took care of him commented on how kind and appreciative he was. It was fun to bring him coffee because he really loved the luxury of coffee. I think the thing I learned from him was how judgmental we can become in the healthcare field. Someone put an isolation cart by his room and hung up a contact precaution sign before any results had come back from his cultures. Nurses were stereotyping him in the med room, asking about his maintenance and pain med requests. I was told to “just wait until he was switched to PO” then we would see his true colors. I talked to him about his hx and addiction and he expressed interest in getting some help. I hope that the social worker had time for him because he asked me about it twice before I left for the day. I am afraid that because of his hx, she isn’t going to do all she can for him. I know that I am a novice, and very idealistic but this guy was truly interested in getting some help.

My other guy was an interesting case. On Monday, everything went well. He was having some nausea issues and having trouble with abdominal discomfort and distention. We were advancing him from IV pain meds to PO and also advancing his diet from clear liquids to regular diet per Dr orders. Monday was fine. However, when we came in on Tuesday morning, we were told that his IV had infiltrated and that he was refusing to get a new one. The transition to reg diet had not gone so well and he had vomited several times during the night. He was discouraged, angry, and in pain when we took over.

Kirstin talked to him first and she told me not to even talk to him about an IV restart. I went in and did my assessment and found his lungs diminished in the bases with coarse crackles and a slight fever. I told him that he needed to use his incentive spirometer and get up to his chair and walk. I also told him that he needed to drink about 3 cups of fluids during my shift to replace what his IV had been doing for him. He basically kicked me out of his room, claiming that I too, was forcing him to get a new IV. He refused most of his morning meds, and after consenting to new IV so he could get some pain meds, kicked out the IV therapist when she arrived. His girlfriend took time off from work came in and chewed out Kristi and me for not taking good care of him.

This was the first time I had been yelled at by a pt. It was interesting because Monday had gone so well with him. Hospitals are very stressful and they also take away a person’s autonomy. I kind of got the feeling that he needed to let us know who was in charge. I don’t think he chose the best way of doing it, but hopefully he felt better for doing it. By the end of the day, we were finally able to get his back pain under control and he was almost ready to cooperate again.

(2) What concerns did you have during the shift and did they change as the shift progressed?

When the guy was refusing all meds and demanding that we call his Dr and get him released and saying other somewhat inflammatory things about the hospital and our care of him, I wanted to be sure and give him good care within the limits he was imposing and make sure that the record was clear on the situation. I charted a lot on the situation, trying to be factual, not angry. I think I did well. I also wanted to be sure that the social worker was able to get the homeless guy information about addiction recovery. I charted in a couple of places about his desire. Hopefully someone saw it.

(6) Discuss the nursing research article you found to incorporate into your care for Tuesday?

### *Transdisciplinary Pain Management: A Holistic Approach (7)*

This paper is about a pilot project that the Hospice of the Western Reserve conducted to better screen, document, treat and educate their patients' pain. JACHO standards on pain require organizations to:

1. Recognize the right of pts to assessment and management of pain
2. Screen all pts for pain
3. Perform a comprehensive assessment if pain is identified
4. Educate providers in pain assessment and management
5. Establish policies and procedures to support appropriate ordering of pain medication
6. Provide education on pain assessment and management to pts and their caregivers or family
7. Monitor the quality of pain management

The Hospice of the Western Reserve developed a tool that enabled them to comply with JCAHO's standards. This form documented the physical, psychological, social, and spiritual aspects of pain. The single form was used by all healthcare providers and was found to provide significant improvement in pain scores of the patients at a 6-week evaluation. Implementation required an intensive education process beginning with the philosophy and practice guidelines of transdisciplinary pain management. Further education about pain myths, realities and responsibilities of the healthcare team was provided. Finally, pain management competence is incorporated into staff evaluations.

Pain is costly to both the patient and the healthcare system. JCAHO has established standards and we as healthcare workers need to work together to improve pain management for our pts.

(8) What did you learn from the patients, families, LPNs, PCTs, Support staff (transport), Unit clerk RNs, Case Manager, Clinical Nurse Specialists, Charge RN, physicians, pharmacists, faculty, or anyone else?

See #1

(9) How does this experience contribute to the ultimate N440 Objectives & clinical outcomes and the PLU School of Nursing Program outcomes to graduate?

Through my care plans and concept maps; actual care given to the pts; my working relationships with my nurse and PCT, fellow classmates, professors, and other healthcare providers; the reading and application of research articles for clinicals and in furthering my own studies; my journaling; and my participation in classroom readings and lectures, each day I embody the goals and objectives of PLU SON.

### **EXPECTED CLINICAL OUTCOMES FOR N440 CLINICAL EXPERIENCE Nursing Situations with Individuals/Adult Health II: Senior I Semester**

**Clinical Outcomes: as observed and reflected in your electronic journals:**

11. Become more aware of at least 10 more medical and nursing diagnoses and explain how the different complex alterations in health affect the patient personally and the family as a unit in the future.

*Working on it.*

12. Explain how the patient's recovery process from the primary admitting diagnosis is affected by the secondary diagnoses. How is the generic or textbook care changed for meeting your patient's specific needs?

*I automatically do this. No one is a textbook example.*

13. Develop and deliver nursing care interventions using the critical thinking, ethical practice, and nursing process with more complicated patients/families at a higher broader level to at least two or more patients per shift.

Yes.

14. Demonstrate competency with an expanded number of clinical skills as a result of seeking out opportunities for this self-education. The skills you should seek include:
  - Initial & ongoing shift physical assessment & chart changes Yes
  - Document what the patient wants to accomplish this shift yes
  - Coordinate the daily AM/PM care and meds for 2-3 patients yes
  - Discuss and plan discharge with patient/family and document in chart I helped with an admit.
  - SVN treatments Finally figured out what this was... Yes
  - Glucometer checks the lab does these. I have done them in the past.
  - Check all meds with Professor/RN Partner Yes
  - IV meds ALWAYS in presence of Professor/RN Partner Yes
  - Central line meds via SASH ALWAYS in presence of Professor/RN Partner No
- Assist RN Mentor in blood administration No chance yet
- Observe/assist PCT/RN drawing blood PIC line blood draw
- Request to join & observe the IV RN's Yes
  - I/O's yes
  - Clear pumps yes
  - Chart to include patient/family's status of patient issues/diagnoses yes
  - Chart status pain& IV status at least q 4 hours yes
  - Receive and give Intershift report yes
  - Provide planned pain management yes
  - Isolation yes, MRSA
  - Dressing changes yes
  - Staple removal no
15. Uses verbal and nonverbal communication skills during the delivery of patient/family care, among team members and other health care providers, during Intershift report, and with fellow peers in the electronic journals. Yes. However, we do not use electronic journals and I do not think that a person's journal is meant to be read by anyone but themselves and the professor.
16. Determines what teaching to include aspects of health promotion is appropriate, delivers the teaching according to patient/family needs, coordinates it with the other healthcare providers, assesses the level and success of learning, and documents this on the chart. Yes
17. When caring for a specific type of patient/family with a specific problem, researches the literature to determine what is the best Evidenced Based Practice (EBP); researches the literature to supplement one's understanding of the clinical environment and its dynamics; and notes how research outcomes could be measured on a hospital nursing unit. Yes
18. Compare assigned nursing unit with other hospital nursing units at MHS/TG and elsewhere in order to participate in the goals to enhance the health care delivery system. This requires reflection of what factors influence organizational culture that affects the RN's ability to deliver competent organized nursing care to meet the satisfaction needs of patients/families, staff, and administration. Boy do I ever.
19. Act accountable and responsible by being on time for clinical, presenting a professional appearance, submitting assignments, completing, documenting, and reporting status of patient care; and maintaining the confidentiality of patients, families, peers, staff, and what happens in the clinical setting. Yes
20. Explain professional nursing service roles you anticipate as an RN and give examples of such service provided by individuals in the hospital health care setting where the student has clinical. I hope to do some mission work. I would like to take part in some kind of change project at the hospital that I would at if they have any.

(10) What clinical learning needs do you have for future weeks and how do you intend to accomplish them?

I am still working on organizing my time. The afternoon gets away from me. The paper work always seems to pile up. I know it is partly not knowing the flow of things, but somehow, I need to get a grip on it. I will never be able to take care of 5 or 6 pts at this rate!

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Lucretia Shafer  
Med/Surg Clinical Journal Week 5  
October 2, 2006

Today I felt kind of detached from the whole clinical routine. It was actually a good thing because it gave me a little taste of what a “real job” may feel like. In some ways I can’t wait to become accustomed to the routine of working—knowing where everything is, knowing whom to call to make something happen, and knowing what is coming next. It was also good because I had time to stop and think about exactly what I was trying to accomplish for my pts.

One of them had a list of problems a mile long and I was a little overwhelmed by them. However, when I determined that he was in for an infection, I was able to focus on that. My care for him focused on assessing and clearing up the infection with the secondary issues (which were huge) only as complicating factors.

He needed a nasojejunum tube placed. Kirsti has never been successful at placing an NG tube so she tried. There were three of us students in the room. It hurt the pt and ended up coming out his mouth. The charge nurse came was successful, but she is not a very good teacher. I think the trick is to not rush (even if it hurts) and to get the pt to swallow it down. I wonder if there is any way to numb the nose before placement? Sure seems like a good idea.

I am getting better at communicating with someone who can’t converse normally. I ask too many complicated questions of people who can’t talk and so I am working on asking one (or 2) yes or no questions at a time. It is easy to overwhelm or frustrate pts with too many questions or with questions that are hard to answer.

Today Kirsti had an elderly pt who was very limited in speech and she asked me to look in on him when she went to lunch. It was clear to me that he was very uncomfortable but he could not tell me why. I noticed that his mouth was very dry and cracked so I swabbed it out and suctioned him. He sighed with relief and was obviously comforted with this care. I told him that I would be back in a while to do it again. Kirsti and I went back and suctioned him again and we thourally cleaned his mouth again. He was missing a lot of teeth, probably had dentures but the ones that were still in his mouth were covered with guck. I was shocked when I figured out that they were teeth (I uncovered a gold crown). No one had cared for his mouth in quite a while. I think there needs to be some kind of “pride of good pt care” around good ol’ TG. I am seeing too many shortcuts and it is the pts who suffer as a result.... Anyway, he was much more comfortable when we were done.

One of my pts refused her early morn meds and Kirsti said that she had refused a lot of them yesterday too. I decided to talk to her and find out why. She said that she wanted relief from her n/v but she was refusing most of her meds because of the n/v. It was kind of a catch 22. I explained to her that most of her PO meds were to prevent nausea, not necessarily to take it away. The best way to stay on top of it was to take them as

scheduled—not to refuse them because she did not like taking meds when she was sick. In the end she took all the PO meds but refused the suppository. I think that was because of the route—when I was a teen I would have been embarrassed to get meds that way too! By the end of shift, she had not experienced any N/V and had eaten a small bowl of mashed potatoes. Her Dr is planning d/c to home with TPN tomorrow.

Discuss the nursing research article you found to incorporate into your care.

When I got to clinical this morning at 0630 there was a pt out in the lounge sitting on the couch. I asked him if he was having trouble sleeping. He said he wished that he could sleep but that his roommate was having diarrhea and their room smelled horrible. He was unable to remain in the room. I saw him later in the shift, sitting in the hallway.

Nurses' Perception of single-occupancy versus multioccupancy rooms in acute care environments: An exploratory comparative assessment. From *Applied Nursing Research*

Seventy-seven nurses from four Pacific NW hospitals were surveyed to gather an experienced-based assessment in regard to single-occupancy versus double-occupancy rooms. The majority favored single-occupancy for the following reasons: flexibility in accommodating family, suitability for examination of pts by health care personnel, pt's comfort level, pt's recovery rate, less probability of med errors, and less probability of diet mix-ups. These results support the findings suggested in the lit review. Further studies are needed to look at issues of operating costs, infection control and staff efficiency as well as other considerations.

**What clinical learning needs do you have for future weeks and how do you intend to accomplish them?** I need to be involved in an admission and a discharge. I think I will take a pt being d/c'd and hopefully the bed will fill on my shift so I can do an admission on the same day.

#### References

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Lucretia Shafer  
Med/Surg Clinical Journal Week 6  
October 9, 2006

(1) What situations "went well" during this week's clinical shifts?

This week was an eye-opening week for me. On Monday I cared for a 20 something yo person in sickle cell crisis along with pneumonia and possible PE. He had a couple of other issues that were not related to

SC that were interesting to read about. However, when I wrote up his case on Monday evening, it was like an epiphany—almost everything that was wrong with him went right back to his SCA. I realized that this young person's life was pretty much controlled by his disease and that he would probably die an early death from SC complications. It was really sobering to actually have a face and a name when I read about the disease process and all the potential adverse affects. All of the sudden it stopped being blah, blah, blah and became reality—this really does happen... It is hard to put into words.

On Tuesday I volunteered to care for woman who was admitted early that morning for an apparent CVA. I was kind of reluctant to care for her because I have never had the opportunity to assess and care for a neurologically impaired pt before (anyway one who was brand-new). When I analyzed my reasons for shying away from her, I decided that they were pretty silly. How am I supposed to learn if I turn down opportunities?! Anyway, I told Kirsti that I wanted to care for her.

She was scheduled for a number of tests that day that I thought would be interesting to watch. After report, I found her on a stretcher in the hallway, waiting to be taken down to Vascular Med for a Doppler of her carotids. We had been told that she was kind of out of it, with rt sided weakness, but she was way worse than I had been led to believe. Her breathing was very fast and labored, and she seemed anxious and uncomfortable. I could not hear her heart because of the noise of her breathing. I did not like what I saw, but everyone around me (we were right by the nurse's station) seemed unfazed and not concerned by her condition. I stood by her for a minute, just watching her while I tried to decide what to do. Finally, I decided that it was a good time to get Kirsti! She too was very concerned and got the charge nurse. They decided that she was too sick to go off the floor so we took her back to her room and administered a breathing treatment and lasix. Within 20 min, she was breathing much easier and had calmed down.

I am glad that I chose to care for her and that I sort of knew that she was in trouble when I first met her. I talked to Kathy about my feelings of doubt and inadequacy that I had that morning—trying to figure out if the patient was in bad shape and needed extra attention or if she was “normal” for someone who has just had a stroke. There is so much that I don't know about caring! I am very glad that Kirsti was there! At the end of the day the woman's husband came and I had the opportunity to talk at length with him. She has been a semi-invalid for a number of years and he has taken care of her by himself. He was scared, and worried and it was so obvious that he loves his wife deeply.

When I get a glimpse of the patient as a person, in the context of their family and friends, my delivery of care takes on a new dimension. I am energized to go the extra mile knowing that this pt could be my mother or sister or child, and that she deserves the best from me. He watched us work with his wife and thanked us profusely. He said that he could tell that she was right where she needed to be--in kind capable, caring hands. I hope that all who care for this lady in the coming days do their jobs well.

(2) What concerns did you have during the shift and did they change as the shift progressed?

See #1

(8) What did you learn from the patients, families, LPNs, PCTs, Support staff (transport), Unit clerk RNs, Case Manager, Clinical Nurse Specialists, Charge RN, physicians, pharmacists, faculty, or anyone else?

See #1

(9) How does this experience contribute to the ultimate N440 Objectives & clinical outcomes and the PLU School of Nursing Program outcomes to graduate?

See previous journals

(10) What clinical learning needs do you have for future weeks and how do you intend to accomplish them?

See journal week 5

Lucretia Shafer

Med/Surg Clinical Journal Week 7

October 17, 2006

**(1)** What situations "went well" during this week's clinical shifts? (also includes all the other reflective questions too!)

This is the last week of med/surg clinicals. In some ways I am very happy. I will now have at least 25 extra hours a week to work on my other classes. We already scheduled Leadership meetings for Tuesdays from 9000-1430. I am sure that Monday will go fast too. I don't know how the people that have clinical starting now are going to get everything done and study for finals, too. On the other hand, I am sad to be finished once again. I will not be back in the hospital for another 3 months. But then, I will be finished and then I will be saying I want a break!

I am not sure how much I learned this time. I think that since I worked this summer, I had a confidence about my abilities that I did not have for med/surg I. I like having the feeling that I am competent at some things. On the other hand, I think I spent more time learning the "system" at TG, rather than learning what nursing is all about. I wish I had been given more opportunities to talk to Drs, and learn who to call when. I don't think I really figured out what the secretaries were doing. I know that they are very busy because they sure don't want to be bothered!

I can't wait to begin my career as a nurse and finally become comfortable with the whole job of nursing.

I think that the required clinical paperwork is an artificial way of working through the nursing process. If we had more opportunity to talk it through on the floor while we are working we would become more conditioned to thinking on our feet through out the day. Concept maps are great and I learned to think through them but since they took so long for me to do each night, I think that I must be doing them wrong. I cannot spend hours thinking through each pt—I will never get anything else done!

I took three pts on Monday and it went well. I did not go as much of the PCT's job but I really wanted to raise my pt load by the end of the clinical session. It was not too hard, but I have to add that the three that I had were not very labor intensive. I finally got to help with a discharge—actually 2 of them. One went to a SNF and the other was d/c'ed to home. There is a lot more work to send someone to a nursing home. I can understand the necessity for the extra paperwork, but I wonder if the nurse should be the one to do it all. I know that when they are finally computerized, they will be very happy! The fact that they have to hand-write the med list for any pt going home is really incredible. It seems to me that is a med error just waiting to happen.

On Tuesday morning, I had the opportunity to watch a cardiac catheterization, which included angioplasty and stent placement. I was amazed by the tech. She knew what was going to happen next and seemed to be able to do 3 things at once. She was very informative and great at explaining what was going on through out the procedure. I was amazed that the pt was sedated but not put under and could answer questions during the procedure. Her heart just kept on beating even when they were running wires through it and messing with the vessels. The tech told us that it was very important for the pt to remain lying flat on her back for 4 hours after the procedure to prevent bleeding from the femoral puncture site. She said that people at TG have died from that.

After that I had the opportunity to follow the IV therapist. That was very interesting. She let me help with little things like filling syringes with lidocaine and taking out the old IVs. I watched another PICC line placement and talked to a rep about a new tool that will help with PICC placement at the bedside. It will guide the line from the coracoid process to the heart, and let the IV nurse know when it is coiling up or going somewhere it shouldn't go. X-ray confirmation of placement will still need to be done but there will be time saved and much less change of things going wrong by using this system. It is called Sherlock.

I enjoyed talking with Mary Ellen and getting her view of the part that an IV nurse plays in the life of the hospital. They even do rounds every day, trying to check on every IV in the hospital everyday. She said that it is not unusual for them to have to call a Rapid Response Team and even occasionally to find that a pt has died. She feels that her desire to interact with the pts is met through this job and that she can be a good pt advocate even if she is not a floor nurse. She is really good at walking into a room and seeing right where the pt is and what they need. And, she is a PLU nursing graduate!

So anyway, this is the end.... It feels strange not to even have time to say good-bye... I am going to get a card and a small thank you for Kirsti and Sabrina. They were wonderful to work with. The PCTs are amazing when you find one like Sabrina. I love the fact that they are tough enough to get the pts up and walking and cleaned up and yet care about the color of the bedspreads and the curtains being opened. They are a vital part of the health care team!

This time next year I will be getting paid to be a nurse!