

Lucretia Shafer  
Journal 2  
February 22, 2007

1. Description of new learning (for example, new skills, new ways of doing things that you have done before, new information, a new role, an awesome moment).

There was a lot of new stuff this past couple of weeks since St Francis is new to me. First of all, the fact that most of the pts are hooked up to Tele is brand new to me. Just learning how to put on the leads, take off the leads, read the monitors, and include the data in my charting are all new and somewhat confusing. I asked Diane how to go about disconnecting a pt from Tele when they were being discharged. She said to just pull them off the pt. The next day, I was helping someone into the shower and so I pulled her wires off but got to thinking that the person monitoring might get worried about the lack of signal. When I asked again, I was told to first tell the monitor then pull the wires. Another new way of doing things is putting heparin into the central lines. I have always used just saline to flush. Diane had me look it up in the policies and procedures manual. I printed it out and it turned out to be 12 pages! I am wading through the paperwork. Since it was close to end of shift, Diane showed me how to do it in about 3 minutes.

2. Describe the most challenging moment or event you experienced during the week. What specific actions (based on literature) are you taking to improve the outcome in future situations or to prevent recurrence of the situation?

Actually my most challenging moment was my first day. I did not have time to get oriented to the unit or even time to think through what it would mean to work on a med/tele unit. Start time is earlier than I have worked before so my timing was off (and still is off). I keep thinking that I have more time to finish my tasks than I really do because the shift ends earlier than I am used to. Diane had a heavy load that first day and so she did not have time to orient me to the unit. Everyone is new to me so I know no names and have to ask for every little thing. There are a lot of students from various schools on the floor so all the staff is asked tons of questions. They are very nice about it however and I rarely feel like I am in the way. I have not started reading Benner yet, but I am sure that she has a lot to say about my feelings right now as a very novice nurse. I am anxious to get that book started! I am working hard at learning names and asking a ton of questions and slowly beginning to figure a few things out. I am continually reminded how much I need to learn.

3. Describe an example of critical thinking that you did this week. The example should include a description of the situation, alternatives that you considered, and rationale for your decision.

I cared for a young man with pancreatitis who was on a PCA for pain. When I went in to do the morning assessment he was pretty sleepy. He said that he had not slept much the night before so I was not too worried. He checked out fine except that he said that his pain was 8/10 and that he was quite nauseous. However, he had no real signs of these things. He had no guarding of his abdomen, he was chewing tobacco, and got up to go to the bathroom with no problems. I talked to Diane about him and she reminded me that we have to believe that pain is what the pt says. I was still uneasy about him so I went in and watched him sleep. I counted his respirations and they were 7. Knowing that that was not good, I told Diane and we immediately stopped his continuous dilaudid and paged his dr. I checked his O2 sats and they were at 99%. (I should have done this when I checked his respirations!). His doctor checked him over and promptly d/c'd him. The pt was upset but I think the dr made the right call.

4. What evidence did you draw upon for the care of your patient? During the semester, you must answer this question at least 3 times with a short review of a journal article that incorporates research relevant to your practice area. Cite/reference any journal articles.

I have cared for at least one pt with DM each shift I have worked. Studies have shown that good glycemic control in a hospital setting enhances healing. Additionally, pt blood sugars are frequently not as easily controlled in a hospital setting as they are in a home setting. According to Lewis, Heitkemper, & Dirksen (Medical-Surgical Nursing, 2004; pg 1285) acute illness, surgery, and injury can evoke a counterregulatory hormone response which results in hyperglycemia. My first pt was a brittle diabetic and her blood sugar ranged from 47 up to 485 in one shift. I learned how to give insulin based on carb counting with her.

7. Describe a situation where you worked with family and/or involved community systems.

I had a pt who spoke only Spanish. Her son spoke English but the pt was angry with him because she wanted to go home to Arizona rather than to a local SNF to regain strength. He was frustrated with his mom and worried about all the work he was missing. We had to call in Social Services, a psych consult, and an interpreter to help the family figure out how best to proceed. In the end, the pt was convinced to go to the SNF but she still was not very happy about it.

## 8. Describe an ethical conflict you experienced.

The pt with pancreatitis had an interesting home situation that only became apparent when his mom and sister arrived to pick him up from the hospital. He immediately left the room and his mom began to intimate that their relationship was very rocky and she was very tired of her son's actions and attitude. It was my 2<sup>nd</sup> day at the hospital and I chose to listen but not try and find out if there was anything I could do to help with the situation. I wish I had of taken more time to see if there was something we could have done to help this obviously dysfunctional family.

Lucretia Shafer  
Journal 3  
3/12/07

### N499 CLINICAL JOURNAL

#### 1. Description of new learning (for example, new skills, new ways of doing things that you have done before, new information, a new role, an awesome moment).

I finally had a break through regarding charting. I have a mental block about charting resulting probably from my Assessment class back in Soph II. Everything was so new-- the terminology, techniques, and diseases along with the difficulty of nursing school in general. We were all freaked out. Anyway, coming up with the right words is like pulling teeth for me and I agonize about it a lot. Consequently, I spend too much time trying to say the "right" thing and so nothing get put on the paper. I find myself not trusting my words and I look back over what has already been written and find myself wanting to copy what was said before.

Last week, I decided that I needed to trust my judgment, use the words that I know and ask when I can't think if the word I am looking for. I think I gave myself permission not to be perfect. And now my morning charting is going much better! I am glad that I do not have to write an end of shift evaluation of each pt. I did that at Virginia Mason this summer and had great difficulty prioritizing and deciding what needed to be said. I probably should do that now just for the practice....

#### 2. Describe the most challenging moment or event you experienced during the week. What specific actions (based on literature) are you taking to improve the outcome in future situations or to prevent recurrence of the situation?

My most difficult moment was an incredibly difficult day. I had taken an 87 yo Russian speaking pt in for altered mental status. She had bradyed down into the high 20's once during the

night shift but seemed to be stable at change of shift with a HR in the 50's. I performed my morning assessment on her with great difficulty because of the language barrier, the restraints and her decreased LOC. However, she did acknowledge me when I called her name and she repeated my name when I told it to her. I had to take her B/P by hand because the Dynamap could not do it.

When I spoke with the Tele monitor he explained that she had a type 2 heart block. I wasn't too sure what that meant except that I knew that it wasn't very good. I also had a second pt who was being d/c'd to a SNF that afternoon. I had not done that type of discharge yet. Needless to say, the elderly pt's HR dropped into the 30's and became more and more incoherent. Her family spoke only Russian so we were not sure they understood the gravity of the situation. The hospital people who spoke Russian could no longer understand her and the nurses were debating if she was converting to third degree heart block.

It went from bad to worse and I was way out of my league. I felt totally useless and very much in the way. Fortunately, Diane took over for me. The nurses were frustrated because the Dr would not work with them, there were no beds in ICU, which was where she should have been moved and she was full code and they would have to perform CPR etc if she coded which is way too much intervention for an 87 yo in her condition.

I think what made it so challenging was that it showed me how far I have to go. Am I fooling myself thinking that I can be a nurse? I had problems just trying to d/c someone to a SNF let alone trying to save someone's life. To tell you the truth I did not even understand how sick this lady was.... I think that is what disturbs me the most. In the past I have at least been able to tell if some one is really sick. I may not know what to do about it but I know that they need something.

When it was all over, I went to my notes from the ACLS class that I took over J-term and reviewed what to do about bradycardia. We did push atropine and the Dr was talking about a pacemaker. The family changed her code status to DNR when it was all explained to them.

3. Describe an example of critical thinking that you did this week. The example should include a description of the situation, alternatives that you considered, and rationale for your decision.

We have many pts that are insulin dependent. This means that they need to have their blood sugar levels checked before meals and then if coverage is needed they get it when their tray arrives. This was the case with one of my pts last week. I had completed the AccuCheck and

they did need insulin. However another pt had a test they were getting ready for and all the charting needed to be up to date and vitals taken. I had to decide which task was most important at that time. I decided that the pt going to the test was first priority because the timing of the test was critical, and others were waiting on me. The pt's blood sugar level was elevated but not critical so they got their insulin a bit late. (Diane helped me to think through this one—I was really focused on getting the pt their insulin.)

4. What evidence did you draw upon for the care of your patient? During the semester, you must answer this question at least 3 times with a short review of a journal article that incorporates research relevant to your practice area. Cite/reference any journal articles.

I cared for three MRSA pts this past couple of weeks and one was d/c'd from MRSA isolation while still in the hospital. I have cared for many MRSA pts but never had one taken off isolation while still in the hospital. I also observed many breeches in the isolation protocol and came up with numerous questions about the precautions. (Are the curtains and drapes disinfected after each pt? Why do the meal trays get returned along side all the others? If MRSA is found in the nares why isn't the pt on droplet precautions? How does a MRSA positive pt get enough exercise if they can't go out of their rooms?) Diane also has questions and concerns about MRSA and I have decided to do my poster project on the latest findings for handling MRSA positive pts in the acute care setting.

**Plastic Apron Wear During Direct Patient Care.** (from Candlin, J., & Stark, S. (Sept 21, 2005). Plastic apron wear during direct patient care. *Nursing Standard*, 20(2), 41-46.)

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 am gathering research and clinical articles that took at best practice for MRSA control in a hospital setting in hopes of answering my question. I will also talk to the infection control person at St Francis to discover his focus concerning this huge problem.

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5. Describe an example of leadership that you observed or demonstrated during the week. The example should include a description of the situation, application of a leadership theory to analyze and critique the interaction(s), and what you learned from the situation that would be helpful to you in the future.

I think one thing that I like most about St Francis is the way that the floor works as a team. There are certain things that only RN's can do and certainly job descriptions for each different position but everyone seems to look out for each other. If the job is difficult there is someone willing to help. If one person has a heavy load they look for ways to help out. The day that we were caring for the unstable Russian pt, by the end of shift Diane and I had her and one other pt to care for. The other nurses had seen Diane's precarious position and stepped in to help her. I have also experienced this helpful attitude. I was being verbally backed into a corner by an agitated pt and the charge nurse came to my rescue quickly and naturally, rescuing me and calming the pt. The care assistants appreciate the help that I give and are very willing to teach me what I do not know.

I think 3<sup>rd</sup> floor provides an example of Relational Leadership, which places a high value on collaboration and teamwork. Relational leadership provides flexible systems that empower health care workers, patients and their families. This leads to better patient care in a caring, non-competitive setting (from Sullivan, E. and Decker, P. (2005). Effective Leadership and Management in Nursing. Upper Saddle River, New Jersey: Pearson Education Inc. pg 54-55).

6. What barriers did you experience and what facilitated your learning during clinical this week?

7. Describe a situation where you worked with family and/or involved community systems.

I had a pt who was going to be discharged but he had no one who could give him a ride home. He had a little money but it was locked up in the hospital safe. Diane told me to ask him if he would like a taxi ride home, paid by the hospital. He was very relieved and quickly agreed to the help. I called the Hospital ? (I have forgotten what their title is...) and within minutes, the pt had a taxi voucher in hand. I don't know if that is normal for a hospital but I was impressed. The pt had anxiety issues along with his admitting dx and something as simple as a ride home positively impacted his stay at St Francis.

8. Describe an ethical conflict you experienced.

9. Other comments, feelings, frustrations, and/or emotions about the week.

One of my biggest frustrations is giving report. I understand how to do it at the end of shift. At SF we use taped reports and then touch base with the nurse taking over at shift change. I am not very organized for the taped report but I am getting better. I am going to develop a form for taking and giving report so I do not miss anything important. My bigger problem is giving report for transfers. Right now I say that I am a student nurse and ask them to let me know what they need to know. However, I feel really unprofessional doing that and they all seem to ask for different things. Can I give too much info? I know I can give too little. How much do they need to know about the pt's psyche and how much about the physical?

The worst is when they want to know something simple, like how much the pt weighs or the IV gauge and I have no idea where to find the info. I do not like appearing foolish.

10. How is your patient care linked to Healthy People 2010?

Every pt's MAR has a screening question for influenza and pneumococcal vaccinations. Healthy People 2010 objective 14-29 is to "increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease" (from Healthy People 2010 website: <http://www.healthypeople.gov/document/html/objectives/14-29.htm>). If the pt has not had their shots they are encouraged to get them while in the hospital.

11. Read Benner (2001) on your own during the term. In observing the nurses in your clinical area, reflect on their practice and relate it to Benner's Novice-to-Expert continuum. Give specific examples of both practice and Benner's framework. As an alternative, describe how you view your developing practice in relation to Benner's continuum.

Lucretia Shafer  
Journal 4  
April 3, 2007

## CLINICAL JOURNAL

2. Description of new learning (for example, new skills, new ways of doing things that you have done before, new information, a new role, an awesome moment).

I had the opportunity to float twice in the past 2 weeks, once to ICU and once to ER transition care. The nurses hate to float especially to the ER but what surprised me was that what bothers them the most is the way I feel and what I deal with everyday that I work.

They are very competent doing the pt care and knowing what needs to be done in what order and they can deliver that care in any situation or setting. What drives them crazy is not knowing where things are kept, how to access Pyxis, how to find a doctor, and how and what to chart. They are out of their comfort zone and unless they don't mind asking a thousand questions, they become frustrated and feel rather stupid.

I enjoyed the day in the ER transition care because I got to see how an experienced nurse deals with the kind of things that I struggle with every day.

12. Describe the most challenging moment or event you experienced during the week. What specific actions (based on literature) are you taking to improve the outcome in future situations or to prevent recurrence of the situation?

I had a pt who was being discharged at 0930 via ambulance. That meant that we had to have all paperwork, teaching and meds taken care of by then. You can't keep the ambulance waiting. I was doing fine until I looked at his MAR. It was very long and had several meds that I had never heard of and a couple of respiratory meds that I had never given even or seen given. To pull them, I needed to access the pt's bin, the refrigerator and assemble a couple of different inhalers. I got his meds with the help of another nurse who was waiting for the Pyxis. There were so many that she showed me how to put them in a bag rather than the small med cups. Then when I was checking the meds against the MAR I discovered that I had only taken one rather than two pills for a correct dose. I had to find Diane to get back into Pyxis—but that meant that I had to gather up all the meds, put them back in the bag so I would not leave them laying around unattended. I was trying to hurry but that just made me more crazy. Diane was trying to gently hurry me on, the CNA was trying to get him shaved and dressed and the pt was pretty grumpy. We made it through but I was disappointed because I had recognized the priority for this man over my other pts but had basically failed at achieving what I desired.

13. Describe an example of critical thinking that you did this week. The example should include a description of the situation, alternatives that you considered, and rationale for your decision.

One moment that stands out to me is when I was caring for an elderly Russian pt who only spoke Russian. She was in her early 80s and had had no health problems until she presented with chest pain. She had been in the hospital for 2 days and we were finishing up her tests the day I cared

for her. She was very self sufficient and cooperative and we tried to understand each other as best as we could and when things got too bad she would call her daughter and her daughter would tell me what her mom wanted.

The pt really wanted to go home and the family was anxious to have her come home too. The Dr. was waiting for the test results and I could do nothing until I had orders from the Dr. I assured her that as soon as I heard anything I would let her know. After lunch I went into her room to see how she was doing. She had just hung up the phone and she had tears in her eyes. I knew that she was homesick. There was nothing I could do except give her a hug.

She could not understand my words but I hope that the hug communicated comfort and assurance to her. As I write this, I realize that I should have called her Dr to find out about discharge plans. I am still trying figure out the protocol about when to contact the Dr. I find that I do not want to bother them. I need to get over that feeling.

14. What evidence did you draw upon for the care of your patient? During the semester, you must answer this question at least 3 times with a short review of a journal article that incorporates research relevant to your practice area. Cite/reference any journal articles.

I cared for a man with peripheral vascular disease (PVD) or more accurately lower extremity arterial disease (LEAD) (Calianno & Holton, 2007). Both legs were affected but the left far more than the right. His lower leg and foot was covered with ulcers that had become infected. It was extremely painful and terrible to look at. The vascular surgeon was called for a consult to figure out what could be done for this man. The first problem I had to address was adequate pain control. His MAR listed only one oral pain med q 6h. I got a doctor to order him some morphine but since the pt was new to the floor and did not have an assigned doctor, this dr ordered the minimal amount of morphine. When the vascular dr came, I told him about the pain problem and he was able to write an order for an adequate amount that would cover the pain. Diane and I also made a way for the pt to hang his leg down off the bed since that relieved the pain by getting blood to the lower extremity.

When I got home that night, I found that the cover article in Nursing 2007 was on lower extremity ulcers (Calianno & Holton, 2007). It describes the 3 types of LE ulcers—venous, arterial, and neuropathic and discusses prevention, care and treatment for all three. Venous ulcers are a result of chronic venous insufficiency c/b incompetent venous valves. The blood cannot return to the heart and pools in the LE, leading to hemosiderosis (dark discoloration of the tissues), edema, dermatitis, dry flaking skin and aching or throbbing pain. Venous ulcers usually form on the medial aspect of the lower leg near the ankle, are irregularly shaped and are partial to full thickness wounds. They have moderate to large amounts of drainage.

Arterial ulcers are caused by abnormal arterial flow to the lower extremities. Atherosclerotic plaque narrows the lumen and restricts blood flow. A person with LEAD usually has thin, pale, hairless legs with taut and shiny skin. They may also have intermittent pain in their calf when walking (moderate disease) or cramps at night or when their legs are elevated (advanced disease). Ulcers c/b LEAD occur usually on the tips of toes and the lateral aspect of the lower legs (the most distal points of arterial perfusion) and are usually dry and covered with eschar. There is usually very little signs of inflammation because of the lack of blood supply. They usually start with some sort of trauma—a bump or scratch or other minor injury.

An Ankle Brachial Index (ABI) is done to assess arterial flow in the lower extremities. To determine the ABI (Calianno & Holton, 2007):

Take blood pressures on both arms and both legs

Use a doppler to take the dorsalis pedis (DP) and posterior tibial (PT) pressures

Determine the ABI for each leg by using the PT or DP pressures, whichever is highest, and the higher of the two brachial readings. The ankle systolic reading is then divided by the brachial systolic reading.

1.=healthy person

0.8=arterial vascular disease

0.6=advanced peripheral vascular disease

0.5 or less=severe ischemic disease

(My patient's ABI could not be determined because his arteries were so hardened by the plaque build up that they could not be compressed. Diane told me that the doctors were thinking that he would probably need an above the knee amputation.)

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15. Describe an example of leadership that you observed or demonstrated during the week. The example should include a description of the situation, application of a leadership theory to analyze and critique the interaction(s), and what you learned from the situation that would be helpful to you in the future. Journal 3

16. What barriers did you experience and what facilitated your learning during clinical this week?

I do not understand what this question is asking. Can you explain it for me?

17. Describe a situation where you worked with family and/or involved community systems. Journal 2, 3

18. Describe an ethical conflict you experienced.

I learned that my initials are important. I asked the nurse that I worked with for one day when Diane was sick to sign my hours form. I wanted her to sign for a couple of times that I had worked with Diane so that I would not have to make a special trip back to the hospital because I would not see Diane again until after the sheet was due at school. The nurse graciously but firmly refused. "I'd rather not." I was embarrassed that I had asked. However, I really appreciate that the nurse refused. I hope that I too will hold my signature or initials to such high standards. They are not to be used lightly or dishonestly.

19. Other comments, feelings, frustrations, and/or emotions about the week. Journal 3

20. How is your patient care linked to Healthy People 2010? Journal 3

21. Read Benner (2001) on your own during the term. In observing the nurses in your clinical area, reflect on their practice and relate it to Benner's Novice-to-Expert continuum. Give specific examples of both practice and Benner's framework. As an alternative, describe how you view your developing practice in relation to Benner's continuum.

Benner (2001, pg 48) says, "...expert human decision makers bring a deep background understanding to the situation, so that they can grasp the whole and attend to the most salient aspects." As an older student I am very aware of my novice level as a nurse because I have chosen to give up my expert position in one field and move to a field I know very little about. The thing that I miss most is that "deep background understanding". I am so very aware that I do not have that in nursing and am also very aware that Diane does. In my first clinicals, way back in Med/Surg I, I used to ask myself, "How can I make my pts day better because I am their nurse?" Now I find myself thinking that I am sorry that the pts have me for their nurse. I am so much more aware of what I don't know.

This is probably growth on my part, but I am so impatient to move beyond novice.

#### References

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*.

Upper Saddle River, NJ: Prentice-Hall, Inc.

Calianno, C. & Holton, S. (2007). Fighting the triple threat of lower extremity ulcers. *Nursing* 2007, 37 (3), 57-64.

Lucretia Shafer  
April 17, 2007

#### N499 CLINICAL JOURNAL

#### 3. Description of new learning (for example, new skills, new ways of doing things that you have done before, new information, a new role, an awesome moment).

On Saturday I discharged two pts. The last pt that I had discharged I felt that I had not done a good job (see Journal 4, question 2). However, this time it went well. When I got the discharge order, I wilted inside, thinking that I was going to mess it up again. The circumstances were kind of the same, in that it was an early morning discharge and I had not seen the pt's med list yet. This time, though, his med list was more manageable and I had an idea about the paperwork that needed to be filled out. I went through his chart and pulled out anything that looked like it related to discharge and got it filled out. I taught the pt and his wife about home care and what to expect. They were quite nice and very gracious about my nervousness. As soon as they walked out the door, the doctor told me that my other pt was being dc'ed. It was good to be able to go through the same procedure again so quickly. I will be much more confident for my next pt discharge!

22. Describe the most challenging moment or event you experienced during the week. What specific actions (based on literature) are you taking to improve the outcome in future situations or to prevent recurrence of the situation?

This is kind of a small thing but it points to a large issue that I have not had to deal with very much yet. I was drawing up some insulin for a pt and Diane put in a call to a Dr about one of her pts. I also had a question for him about a problem that my pt was having. When she was finished with him she very impatiently got me to the phone to talk with him. I explained the problem to him and he rattled off a medication order. Since I was unfamiliar with the meds he had to repeat it to me three times. After I read it back to him and finally got it right he hung up. Diane and I reviewed the order and she showed me how to enter it into the proper section of the chart. She then told me that some Drs hang up if the nurse does not get to the phone immediately. That was why she was so short with me about getting to the phone quickly. At the time all I could think about was what to do with the insulin that I was working on—I did not want to leave it lying around!

I am very nervous about interacting with the drs mostly because of what I have heard. Even though we (the nursing profession) claim to work alongside doctors rather than as their handmaidens, I wonder if we really believe it. I would think that by now there would be mutual respect between nurses and doctors (which does have to be earned but it should go both ways!) and that all involved would know that neither one's time is more valuable than the other's. I also find it appalling that doctors are allowed to eat nursing's young. Do we consider it a right of passage or something that we need to learn to deal with?

However, I digress. I want to put in my vote for computerized physician order entry. In this day and age of computers, high speed internet and blue tooth phones, etc, there is no reason to delay. There is abundant research that shows typed physician orders save time and lives and probably tempers. It would not ease my unease with doctors but it would certainly make my job easier and keep my pts safer.

23. Describe an example of critical thinking that you did this week. The example should include a description of the situation, alternatives that you considered, and rationale for your decision.

I took care of a pt in endstage liver disease. She was as yellow as a tennis ball, had anasarca and bleeding issues. There were two things about her case that sent up red flags for me when I received report. First, she was a full code. Second, her diet was low sodium, high protein. I don't think that a person in endstage liver disease c/b alcohol abuse not on the transplant list should be

a full code. I decided that I would talk to her about her decision to try and understand her choice. When I asked her about it, it became obvious that she had not yet come to grips with her condition and at the time was not interested in discussing it. I gave her a bit of information about what a code situation involves and then went on to give her the best care I could for the day without broaching the subject again. When I gave report to the next shift I told them about our conversation and asked them to look for opportunities to continue the discussion.

The high protein diet was a puzzle to me because in end-stage liver disease, protein breaks down into ammonia, which is toxic to the brain. I would think that her diet would be LOW protein. I did look at her labs and found that her albumin level was low and she was very edematous. I think the idea was to increase the protein in her blood to help with the third spacing. She was not showing any signs of hepatic encephalopathy (confusion, change in mentation, irritability, etc) that I could see. I was planning on asking the doctor why she ordered a high protein diet but I did not see her.

24. **What evidence did you draw upon for the care of your patient? During the semester, you must answer this question at least 3 times with a short review of a journal article that incorporates research relevant to your practice area. Cite/reference any journal articles.**

When I first started at SFH, I was kind of taken aback by the condition of the pt's IVs. They were usually anchored by the transparent dressing only and sometimes the catheter was coming out (or had never been pushed all the way into the vein?). Often, there was blood or serosanguineous drainage at the site. The policy on the floor is that every pt must have a patent IV but few are actually receiving fluids on a continual basis. They are used to administer IV push drugs or for emergency situations. We flush them once a shift if they are not in use, checking for patency and other problems that may develop. I have noticed that often the most pain pts have to experience is having an IV put in. Additionally, our population is usually quite elderly or very sick and tend to be "hard sticks".

I found an article in Nursing 2006 that reviews the results of seven studies comparing catheters secured by tape, sutures and a catheter securement device (StatLock by Venetec). Three of the seven studies involved 429 adults with short peripheral catheters secured either by tape and transparent dressing or with the securement device. For pts with the securement device:

- Overall complications were reduced by 69%
- Catheter dislodgements were reduced by 95%

- Catheter dwell times were prolonged by 61%

These results meant that pts with the securement device needed fewer IV restarts. According to the article more research on catheter securement needs to be done but it currently appears to be a simple and safe way to improve pt care, reduce complications, and save time. There was no discussion about cost effectiveness. (Frey, A. M. & Schears, G. J. (2006, September). What's the best way to secure a catheter?. *Nursing 2006*, 36(9), 30-31.)

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25. Describe an example of leadership that you observed or demonstrated during the week. The example should include a description of the situation, application of a leadership theory to analyze and critique the interaction(s), and what you learned from the situation that would be helpful to you in the future.

I have not yet observed this but I am planning how to interact with my NAC. I need to become a part of the healthcare team and as a student, I feel that I am viewed as an outsider who will be gone tomorrow. Either that or the NACs do not know how to treat me and so they go to Diane. However, if I am to be able to adequately care for 3-4 pts on my own I need to be able to work with my aid in order to give great pt care during my shift. So I am going to do so problem solving!

**Define the problem:** Lack of teamwork between the NAC and me.

**Gather information:** I talked to Diane about the perceived problem and she suggested that at the beginning of next shift I go over my pt list with the NAC and discuss each pt's needs and find out how I can help the NAC with her/his day. The NAC needs to know the Diet and Activity of each pt.

**Analyze the Information:** That sounded like a good idea to me.

**Develop solutions:** I could also explain my situation of being a student to the NAC and offer her the opportunity to train me to become a nurse who is understanding and compassionate toward not just the pts but also the NACs! I want this to be a win-win solution for both of us. I also need to find out how to find my NAC during the day.

**Make a decision:** OK, I have! I am going to be proactive in interacting with my NAC.

**Implement the decision:** I will keep you posted!

It is now three working days later and I have worked with three different NACs. Each time it has gone really well. Teamwork is happening and I think we are all happier and more comfortable with each other.

**Evaluate the decision:** It was a very good decision. It is nice that I am getting organized enough to look around and see ways that I can improve on things rather than always feeling like I am on the edge of control. I really like working as a team and I feel that the NACs appreciate the chance to train me. I am finding their input invaluable. Also, it is fun to interact with them and overall, the patients are getting better care because of our ability to work together.

This problem solving process is elaborated on in *Effective Leadership and Management in Nursing* (Sullivan and Decker, 2005, Upper Saddle River, New Jersey: Pearson Education Inc. pg 113-116).

26. What barriers did you experience and what facilitated your learning during clinical this week?

One of the biggest barriers that I feel during my clinical days is my inability to access Pyxis when I need to. Time management and prioritization is hard enough without that added frustration. Diane gets me in and then usually walks away, as she is comfortable with my med skills. She knows that if I have a question I will seek her out. I wish I could keep track of how much time I spend looking for Diane or better yet, how long the pts have to wait because I do not have my own sign on for Pyxis.

27. Describe a situation where you worked with family and/or involved community systems.

28. Describe an ethical conflict you experienced.

29. Other comments, feelings, frustrations, and/or emotions about the week.

30. How is your patient care linked to Healthy People 2010?

Objective 5-1. Increase the proportion of persons with diabetes who receive formal diabetes education. Target: 60 percent. Baseline: 45 percent of persons with diabetes received formal diabetes education in 1998 (age adjusted to the year 2000 standard population) (Retrieved April 13, 2007 from Healthy People 2010 website:

<http://www.healthypeople.gov/document/html/objectives/14-29.htm>).

It is not unusual on any given day, for over half of my pts to have diabetes--usually insulin dependent type II. They are in the hospital either because of a complication caused by their

diabetes or the diabetes exacerbates or complicates their return to health. We try to teach on a wide variety of topics—anything that the pt needs to learn about. I try to talk with my pts about their diabetes and how they control it (or ignore it), emphasizing how destructive it can be to their health if it is not controlled. Any pt with a new DM diagnosis we teach how to monitor their blood sugar and give themselves insulin. Additionally, we talk about what good nutrition looks like. Since we cannot give them all that they need to know and it is overwhelming in the beginning, they also receive follow up information for additional teaching in an out-patient setting.

31. Read Benner (2001) on your own during the term. In observing the nurses in your clinical area, reflect on their practice and relate it to Benner's Novice-to-Expert continuum. Give specific examples of both practice and Benner's framework. As an alternative, describe how you view your developing practice in relation to Benner's continuum.

#### N499 CLINICAL JOURNAL

1. Description of new learning (for example, new skills, new ways of doing things that you have done before, new information, a new role, an awesome moment).

Today (4/19/07) I cared for four pts! Granted I definitely needed Diane to help me but at the end of the day I gave report on all four. They were not easy pts either. One was in for pneumonia and newly diagnosed diabetes. Diane spent time teaching her how to check her blood sugars and give herself insulin but I reinforced the teaching and did her assessments and charting. One was a very complex pt getting ready to be discharged but developed a new bout of chest pain. She needed nitro x 3, an ECG and cardiac enzymes drawn. The third was in for diverticulitis and cardiomyopathy. He had severe pain with moderate anxiety. At the end of my shift he was upgraded to PCU status. The fourth was an elderly, very confused gentleman with a sitter (because the family did not want him restrained). He was in for pneumonia and a severe case of shingles. Half way through his Acyclovir his IV infiltrated. I interacted with the pts, the NAC (not very well because I was in over my head just trying to do my job) the family of one of the pts, the sitter, and the doctors for two of the pts. To top it off, we even got to eat lunch (one hour before our shift ended...) It felt good!

I have taken care of 4 patients two more times now and each day it gets better. I am also able to help the NACs a lot more also. The last 2 days that I worked they both thanked me for my

help at the end of the shift. I think now that they know that I want to learn from them and help them out whenever I can we are able to work together and accomplish what needs to get done.

2. Describe the most challenging moment or event you experienced during the week. What specific actions (based on literature) are you taking to improve the outcome in future situations or to prevent recurrence of the situation?

This question is hard for me to answer because everything is hard but on the other hand everything is doable. The skills are coming just fine.

- I stuck another IV last week but I am no where near able to do it alone or with confidence.
- I faced an angry doctor but I think she was having a more stressful day than me and it is nice to be able to say that a doctor yelled at me and I survived.
- I cared for a very dissatisfied patient and her husband. There was nothing we could do that would make them happy. In the end they left with threats of calling in a “three star general” to go over the hospital with a fine tooth comb and 2 newspapers to alert the public to the “worse than third world” conditions in our hospital. I was gracious to both of them and used my best practice skills when I cared for her wound.
- I spent time with a dying woman, talking with her daughter and brand new 2-week old granddaughter who were sitting with her. We talked about life and death, moms, and hope. I gently brushed the mom’s hair out of her eyes because she did not speak English.
- I think the hardest times for me are when the patients cry because they just want to go home. I still don’t know what to do when that happens.

3. Describe an example of critical thinking that you did this week. The example should include a description of the situation, alternatives that you considered, and rationale for your decision.

This is actually critical thinking that stretched over 2 weeks. I was kind of mystified by the pt who was in for diverticulitis and cardiomyopathy and had been upgraded to PCU status at the end of my shift. I talked to Diane about him the next day when we found out that he had been transferred to the ICU. It sounded like a bed swap rather than something really serious with him but I was bothered by the fact that I did not know that he was so sick when I cared for him. He was morbidly obese and the day I cared for him he refused to eat or take his meds until the dr saw him. The only thing he wanted was his pain meds, like clockwork. He was very diaphoretic and pale but his vitals were fine. His pain was bad but he was able to get out of bed to go to the bathroom and even joke a little.

I forgot about him until this past Friday when I saw him back on our floor. It turns out that he had a ruptured intestine and had undergone surgery, which involved the removal of some of his intestines and a colostomy. He looked a lot better the day I visited him compared to the day I

cared for him. I told his story to a nurse friend who has 35 years of nursing under her belt. She immediately knew what was wrong with him when I told her his symptoms. We talked about his pallor, abdominal pain and diaphoresis and how the body shunts blood away from the skin to get it to the core vital organs and how the body compensates and so the vital signs hold steady. I am sure that the dr knew what was going on but I sure did not. However, the next time I will pay a lot more attention to pale skin, diaphoresis and pain, even if the pt can still walk and talk.

4. What evidence did you draw upon for the care of your patient? During the semester, you must answer this question at least 3 times with a short review of a journal article that incorporates research relevant to your practice area. Cite/reference any journal articles.

Over the past two weeks I am finding myself becoming more confident in my interactions with the other nurses, with the NACs, the HUCs, and the tele monitors. I am getting much better at charting and finding my flow for the morning as long as my pts don't have a long list of meds that I don't know. Because I am becoming more familiar with the floor and the people I work with am finding that I have more time to spend with my pts. I read an article last semester about pt's perceptions of time that their nurses spent with them and it was reported that if the nurse sat down with a pt for just 3 minutes, the pts reported that their nurses spent a lot more personal time with them. I have been trying to actually sit down in each of my pts rooms at some point during my shift and talk with them about anything that they want to talk about. I don't know if they appreciate it but it makes me feel like a better nurse.

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5. Describe an example of leadership that you observed or demonstrated during the week. The example should include a description of the situation, application of a leadership theory to analyze and critique the interaction(s), and what you learned from the situation that would be helpful to you in the future.
6. What barriers did you experience and what facilitated your learning during clinical this week?

I still say that not having Pyxis access is by far the biggest barrier that I have to face day in and day out. I am seeing how my position as a preceptee acts as a barrier because everyone there "knows" that I will be leaving sometime soon (students come and go all the time around here) and so I have had very few formal introductions. I have never really met the doctors, the social workers, the respiratory therapists or the dietitians but I am now collaborating with them in patient care. One of the doctors got kind of miffed with me because she thought that I had paged her in error. Actually our HUC was given the wrong information and so I had to go right back to

the dr to find out who my patient's doctor was so I could get my question answered. She was still miffed but the next day I greeted her by name and that seemed to go well.

7. Describe a situation where you worked with family and/or involved community systems.
8. Describe an ethical conflict you experienced.
9. Other comments, feelings, frustrations, and/or emotions about the week.
10. How is your patient care linked to Healthy People 2010?
11. Read Benner (2001) on your own during the term. In observing the nurses in your clinical area, reflect on their practice and relate it to Benner's Novice-to-Expert continuum. Give specific examples of both practice and Benner's framework. As an alternative, describe how you view your developing practice in relation to Benner's continuum.

I was reading chapter 14 in Benner, Excellence and Power in Clinical Nursing Practice and discovered what it is that I am missing and desperately desire in my nursing. Benner describes six qualities of power associated with the caring provided by the nurses who participated in her study: transformative, integrative, advocacy, healing, participative/affirmative and problem solving. They highlighted for me how far I have to go. I hope that I will go back to these occasionally in the next few years and reflect on my growth and realign my sites. I do not want to get lost in the day to day grind and lose sight of the big goal.

**Transformative power** is a nurse's ability to change the patient's view of their world—in essence to offer hope when the patient wants to give up.

**Integrative power** reconnects the patient back into their own social world. The nurse uses this power when she helps patients maximize their ability to continue with meaningful life activities despite their limitations.

**Advocacy** is when the nurse runs defense for her patients. It is the nurse's ability to remove any obstacles and to stand along side and enable the patient.

**Healing power** is the relationship that nurses have with their patients which creates a healing climate. It uses the patient's internal and external resources and empowers the patient by bringing hope, confidence, and trust. It is the interpersonal and social side of healing verses science and technology.

**Participative/Affirmative Power** is the positive energy derived from emotionally draining situations that enable the nurse to gain strength and affirmation rather than end in burnout. The

work of caring exposes the nurse to seemingly immeasurable depths of pain but her ability to walk through it with the patient rather than to detach or avoid earns her affirmative power.

**Problem solving** requires a caring, involved, creative attitude. “This is because the most difficult problems to solve require perceptual ability as well as conceptual reasoning, and perception requires engagement and attentiveness.”

It is this last form of nursing power that I covet. I am a very creative person and I value “thinking out of the box”. I want to be able to read my patients faces, to recognize minute nuances, tiny imperceivable clues that allow me to better take care of them. I will do whatever it takes to gain excellence and power in clinical nursing for the benefit of those for whom I will care.

Nursing without caring is powerful and devastating. Nurses can have enormous power over how a patient will spend the first or last hours on earth. Although nurses have done much to ensure that the first moments of life are spent with loving parents, the last hours are all too often spent in restraints or resisting a retention catheter that has been put in place for the health care personnel’s convenience (Benner, 1984, pg 216)

This made me cry....