120 Hour Precepting Journal

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Part I: Integration of Leadership and Management

Teamwork

"A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable" (Polifko-Harris & Anunciado, p. 268, 2012). In other words, a team is composed of people who have a similar mission and want to achieve the same thing. Teamwork is an important part of almost every profession and it has many advantages but also disadvantages too. One of the most evident reasons teamwork is needed in the healthcare setting is for effective collaboration between the different professionals (Kalisch, Lee, & Rochman, 2010). Without teamwork and without collaboration, no organization would be able to function.

Teamwork is extremely essential because it is not only beneficial to the employees, but also to the patients for which we care. Having effective teamwork and team building on one's unit where they work is crucial and favorable to the employees and patients (D. D. Tomlinson, personal communication, November 12, 2011). Research has found that teamwork is directly associated with employee job satisfaction. Studies have established that nursing staff who reported more teamwork were more likely to be satisfied with their work (Kalisch, Lee, & Rochman, 2010). It is very important for any employee to be pleased with their job and where they work.

As previously mentioned, the patients are also a part of the benefit provided by teamwork. Teamwork between the healthcare professionals provides safer care to our patients. Furthermore, increased teamwork has also been found to lead to higher quality of care for the clients and their families. These results clearly show the importance of continuing and

improving nursing teamwork (Kalisch, Lee, & Rochman, 2010). Memorial 4 East demonstrates teamwork in a variety of ways.

Teamwork is used each and every day on Memorial 4 East. An obvious and reoccurring example is how the nurses help each throughout their day on the floor. If it is something simple such as helping out to move a patient or turn them over, a nurse is always willing to help out. I think this occurs quite frequently on the unit due to the busy atmosphere. I even noticed how the nurses were willing to help whenever they were not asked. For example, if a nurse was passing a patient's room and the patient's IV was beeping, the nurse would enter the room and help out as if the patient were their own. Teamwork occurs most often during patient care.

"Teamwork equalizes power through shared governance" (Polifko-Harris & Anunciado, p. 268, 2012). The different committees are an example of team building. There are three different shared governance committees made up of bedside nurses. The three committees are known as practice and education committee, recognition and advancement, and quality and research (D. D. Tomlinson, personal communication, November 12, 2011). Teamwork does not seem to be an issue on the unit; therefore I don't know how it may be enhanced. To promote more teamwork and team building one should approach anyone on the unit that they feel is a good leader. For example, personally, I would consider speaking to Denise because she is a great leader but also a listener.

Evidence-Based Practice

Since Aultman has achieved magnet status, evidence based practice is an ongoing and important part of not only this unit, but the whole hospital. Of course our unit utilizes evidence-based practice. Nurses used evidence-based practice every day when providing care to patients; in fact it is necessary for nursing. An example from Memorial 4 East step-down unit that is

supported by research and demonstrates evidence-based practice is the fall prevention project. The unit used research and evidence-based practice from other hospitals to see if implementing a convenient high risk falls kit would help decrease fall incidences and increase staff self awareness of the high risk falls patients. A survey was then provided for 47 employees on Memorial 4 East including nurses, nursing assistants, and unit secretaries. Out of 39 employees who returned survey results, 35 of them stated, “YES” to the convenience of the falls kits (D. D. Tomlinson, personal communication, November 12, 2011).

An example observed that may not necessarily be supported by research deals with the sequential compression devices (SCD). Sometimes, when patients have the devices on and they need to get out of bed, instead of removing them off the patient the tubes are disconnected (where they usually attach) and tucked in the wrap. In other words, the SCDs are not completely removed, they are rather disconnected. Evidence-based practice is one of the most important things to patients and professional nursing. It should be used as a basis for care in every organization although many people have perceived barriers to evidence-based practice (Christie-McAuliffe, O’Malley, Alexander, Androwich, & Kelly, 2012).

How can the best possible care be provided to patients if the care has not been proven to be effective? This is precisely why the care we give to our patients must be based on evidence. When the unit reviewed evidence-based literature for falls prevention they were benchmarking data. Data collected for quality improvement is a good way of utilizing evidence because evidence-based care should be viewed as the highest level of care (Jadlos & Kelman, 2012). It has been found that “decisions that are based on scientific clinical research are considered to increase effectiveness, to minimize the possibility of error and to standardize practice” (Mantzoukas, p. 3, 2007). This is a great reason why evidence-based care is so important.

Evidence-based nursing practice alone is not sufficient and successful for the patient without inclusion of the patient's plan and other health care professionals involved in the patient's care. The role of the nurse is to collaborate between using an evidence-based plan of care along with the patient and other team members involved (Jadlos & Kelman, 2012). Without the use of the patient(s), families, and members of the health care team in collaboration with the evidence-based care plan, the evidence-based practice alone is useless for the patient. We must involve the appropriate individuals which will help to personalize the plan of care for the client in order to provide them with the best kind of care possible. Implementing evidence-based nursing practice is correlated with doing the right thing, avoiding harmful interventions, and providing the best care possible (Mantzoukas, 2007).

Part II: Goals

120 Hour Goals

During the last forty hours completed, some goals were accomplished while others were not. Two of the goals were also "partially" met. To further explain, one of these partially met goals included recognizing the patients' different types of irregular heart rhythms. During my shifts, I was able to distinguish *some* of the heart rhythms. Due to not having been through the critical care course yet, this was a challenge for me to understand. To help practice and understand the different heart rhythms, my preceptor printed me different heart monitor strips to take home and look at. The easiest ones for me to identify were sinus rhythm, sinus tachycardia and sinus bradycardia. The heart rhythms were reported to other nurses during shift change, and were also documented in the charts. Meeting this goal means to have mastered all of the different kinds of rhythms. Although I did not master all of the irregular heart rhythms, I learned some of them which is a great start and provides a little advantage for next semester.

Demonstrating proper insertion of a foley catheter with proper sterile techniques was one of the goals accomplished. The opportunity arose when a patient needed to be catheterized during one of my shifts. Previously, I had inserted catheters in female patients but this was the first male I accomplished. Of course I was a little nervous at first but I was confident in my skills and did a good job. Another goal I met throughout my clinical shifts was being able to be more assertive in communication with my patients and families. During the start of my precepting experience I wasted much of my time when patients were constantly requesting things or trying to “argue” with me. Being new and intimidated, I was beyond generous to my patients which did not help manage my time wisely. For example, several months ago a patient requested that I give him a bath when he was perfectly capable of performing it himself. Even his family in the room was rude and demanded that I give him the bath. Although I was in a hurry I quickly got the bath done because I didn’t want to argue with the patient and his family.

Currently, I no longer let the patient and families take advantage of me during my shifts. When things have to be done, I simply use more assertive communication when it is needed. In the past I always found it hard to say no but I’ve learned that it is okay to do this at times. To provide an example of a way in which this goal was met I will refer to a patient and family scenario that will also be discussed later. The patient and his family were rude to me and demanded many things that were beyond my control. They required a lot of my attention and at times tried to argue with me about the type of antibiotic the client was receiving, for example. I demonstrated more assertiveness by simply stating to them that the type of antibiotic that the client was receiving was prescribed by the physician. The family continued to argue with me and was asking me why the physician prescribed this type of antibiotic. I was assertive in my

communication and informed them that this information is something to discuss with the doctor because it was not under my control.

Part III: Professional Reflection

The completion of my one hundred and twenty hours consisted of four different shifts. The first shift started off with four patients between the ages of fifty-seven and ninety-one. I wasn't surprised of their ages because the patients I have always had are around this age group. This shift was one of the best I've had because it wasn't overwhelmingly busy, like it usually is. One of the patients had a history of cerebral palsy which meant he was a complete feed because he couldn't do anything for himself. I was a little nervous when I heard about him in report before I started my shift because I never took care of a patient with cerebral palsy or knew of anyone personally with this disorder. I know it doesn't sound like a big deal but the disorder was a little new to me because I didn't know exactly what to expect from him. I knew that there were different types of cerebral palsy but didn't know the details of the patient. The client was on a puréed diet and thick liquids and presented with tremors, abnormal movements, speech problems, tight joints, drooling, and urinary incontinence.

The patient with cerebral palsy was only fifty-seven years old and after I met him I was overcome with emotions. I felt so sorry for him because it must be devastating to have such a disorder. He was a very sweet patient but due to his speech problems, I had a really hard time understanding him. At times, I felt embarrassed because I repeatedly had to ask him to repeat himself when he was speaking to me. When I first assessed him, I came across a little problem. As soon as I entered his room, the patient was telling me something but I could not understand him. I closed the door to better understand him by eliminating noises from the hall. Finally, I made out what the client was saying—he was telling me that he needed catheterized. I asked

him again several times to double check that I heard him correctly. Once again I started feeling embarrassed because he did not have an indwelling catheter or any orders for one. I went to my preceptor to ask her if she knew anything about it. I felt very “lost” because I had no idea why the patient would say that. Usually, something like this would have been told in report before my shift started.

My preceptor went to talk to the patient and she told me that she also didn’t know why he was saying this. There were no orders in the computer for a catheter. Later during the day we found out that the patient gets straight catheterized whenever he is in the hospital but no one got this memo when he came to our unit from the emergency department. As soon as we found out, I catheterized him and emptied his bladder. This experience could have been handled in a better way if we looked into it right away. If I talked to someone about it right away the patient’s bladder wouldn’t have been so full and made him feel uncomfortable. Although I did tell my preceptor right away, there was nothing we could do since we were clueless about the situation. I think the initial problem was that the emergency department failed to inform us about the catheterization.

During the same shift, I was also taking care of a sixty-six year old male who was in with neutropenic fever and sepsis. He seemed pleasant but didn’t say much. His wife was also in the room with him when I entered to assess him. The wife seen a sign on his door which showed gloves and a mask since neutropenic precautions were in place. She asked me if she needed to wear those things too or if only the nurses needed to because no one informed her or the family. Educating her that everyone who comes into the patient’s room has to wear a mask and gloves felt very satisfying. Teaching her that we were trying to protect the patient from our germs

somehow made me feel good and useful. I like having answers for people. It was a good experience.

During another shift, I encountered two patients whose families were very needy and difficult, to say the least. One of the patients was there with a history of gastric cancer for vomiting and weakness. His heart rhythm was also irregular in Atrial Fibrillation. The patient had at least three family members in his room at all times throughout my shift. One of the patient's sisters was a physician in Toledo. Whoever was in the room with the patient always had a notebook and took notes on everything that was done with the patient including medications, assessment findings, all vital signs, etc. The patient's family had Zofran sublingual for him that they had from home but refused to send it to the pharmacy. Most of the patient's family treated me very rudely and sometimes made me seem responsible for things which were beyond my control. For example, the patient was receiving antibiotics by mouth and the family was upset with me that he was not getting IV antibiotics instead. Later on during the day they were upset with the certain kind of antibiotic he was receiving. I calmly explained to her that she can discuss that with the physician because I didn't know why he was getting that certain kind. The patient's sister, who is a physician herself, should have known this but decided to give me a hard time anyway.

This situation with the patient's family put me in a very bad mood. It seemed like the patient and family were not happy with anything that was being done for him/them. At one point, the family asked me to up his dose of his IV pain medication since he would be transferred to a different unit shortly. I informed them that I could only administer the ordered 1 milligram. The sister wanted us to call the physician to get it changed so we did. Every time I went into his room to do something everyone was questioning everything. This made me angry in a way

because no one was doing anything wrong. I find it sad that some patients and families choose to act this way towards people who take care of their loved ones in an appropriate way. I have learned that although patients and families are at times very difficult, we as healthcare professionals must somehow overlook this because it will never end no matter what.

The second to last shift was one of the best shifts so far because the day went great for me! Absolutely everything was done on time and flowed very smoothly and I even had five patients. Looking back, it makes me feel proud that I could handle five patients on this unit. One of the patients was a sweet little lady that I took care of previously in the month. She was first admitted with a GI bleed and now she also had supraventricular tachycardia (SVT). It was a good feeling taking care of someone familiar who remembers you, although I was disappointed to see her back on our unit so soon. Her heart rate was no more than ninety-six beats per minute during my shift which left me a little surprised because I was expecting it to be in the one-hundreds. At one point her blood pressure had dropped so we notified her physician and he told us to stop her normal saline when the bag was done to see if her blood pressure improves. I was questioning why the physician didn't decrease her dose of Lasix because she was a little lady getting sixty milligrams and was urinating a lot. This could have been related to her blood pressure change since she was losing a lot of fluid.

W.M. was a patient who had the highest acuity due to several factors. He was in isolation for a history of *Clostridium difficile* and had generalized edema almost everywhere. The patient had an unstageable wound on his sacrum that was the biggest and worst thing I had ever seen. It was about was about the size of a textbook and as deep as a pillow. I couldn't believe my eyes when I seen it. It was pretty much a huge hole on his sacrum and I think I even seen some bare bone. W.M. also had another unstageable wound on his left hip, although it was not as large as

the one on his sacrum. The wound also had a wound vacuum. The client was incontinent of stool and seemed very confused at times. He required a lot of attention and was at times difficult to handle because of his noncompliance.

My last shift at Aultman on Memorial 4 East was at the desk with the charge nurse. To begin, we received report about all of the patients admitted on the unit. The Unit Director also sat in for this and I didn't even realize who she was. There were a total of twenty-seven patients on the unit that day. Next, we went to sign the crash cart and also check the temperature of the mini fridge in the medication room. I considered it sort of unusual because I hadn't thought it would be a responsibility of the charge nurse. Another responsibility of the charge nurse was going through the charts and double checking the new orders. We verified the new hand written orders with the ones entered in the computer. There was much going on at the desk and the charge nurse was very busy. A large variety of tasks needed to be done; however, I enjoyed experiencing the role of the charge nurse rather than just reading about it.

Professional Issue

Situation

C. W. is an eighty-five year old white male who was admitted to Memorial 4 East with vomiting and weakness. He had a history of gastric cancer and his heart rhythm was irregular in atrial fibrillation. He was alert and oriented although he was sleeping most of the day. His code status was Do-Not-Resuscitate Comfort Care-Arrest (DNRCC-Arrest). The patient presented with nausea and pain throughout my clinical shift. This client always had at least three family members present in his room throughout my whole shift. The patient's rooms are already very limited in space so it was extremely difficult to do my work whenever I entered his room

because I could only stand in one place. Most of the time the family members were rude and didn't bother to shift around the room or walk out when I had work to be done.

The client's family made sure to write down everything once a healthcare professional walked into the room. They kept a notebook with the patient's medications, assessment findings, all vital signs, etc. This is not something that is improper to do, rather it is very smart to keep track of our family's health and care which they are receiving; however, this family handled the situation in an improper way. They were not polite when they needed to know certain information and they always thought that we were wrong they were right. This sort of troubled me. I think the reason they felt this way was because of the client's sisters was a physician herself in Toledo, Ohio. The situation with this patient and his family challenged my knowledge and values in the following ways.

The client and family included were not happy with any of the care that C.W. was receiving because they felt there was always something wrong with what was done. Many of the times the family challenged me about issues that were beyond my control. For example, the patient was receiving antibiotics by mouth and the family was upset with me because he was not getting IV antibiotics instead. Later on during the day they were upset with the certain kind of antibiotic he was receiving because they felt it was not appropriate. Another issue was that the family had the medication Zofran sublingual from home and refused to send it to the pharmacy as they should have. They were using it to their discretion which shouldn't have been done. Near the end of my shift the client's sister ordered me to administer C.W.'s Dilaudid because he was in pain. I asked the patient if he was indeed in pain and to rate his pain. He admitted that he was in pain and rated it a three out of ten. The client's sister, who is herself a physician, ordered

that we need to increase his dose of Dilaudid because his current dose has not really helped. She continued to be demanding and impatient.

Action

Since the client and his family liked to document everything that was being done I decided to let them know every single result that I would get when assessing the patient. For example, instead of waiting for them to ask me rudely what his vitals were, I informed the individual(s) the result as soon as it was done. As soon as I finished taking C.W.'s blood pressure, I reported the result and so on. This was also an advantage to me because it omitted the part where I was approached impolitely. When the issue with the patient's antibiotic arose I handled it in a calm and appropriate manner. The family and patient wanted the antibiotic to be IV instead of by mouth so they refused it when the medications were due. I informed them that there is nothing else for me to do since the physician was already informed of this issue. They were not happy when I told them that I had to wait until the pharmacy sends up the new IV antibiotic.

When the client's antibiotic arrived, the sister was not happy with the kind of antibiotic he was ordered. She informed me that she never prescribes Levaquin to her elderly patients because it can cause them heart issues. She was holding me responsible for giving the patient something that she personally doesn't prescribe. Once again I informed her that the *type* of antibiotic he was ordered was beyond my control. I asked the patient and family to clarify if they wanted me to hang the IV antibiotic but they did not refuse.

The last dilemma that occurred was with the patient's pain medication. As previously mentioned, the client and family complained that the 1 milligram of Dilaudid every four hours

did not help. When they requested an increase in the dose of the Dilaudid I informed everyone that this again, was beyond my control but I could try and page the physician to let him know. I educated the patient that since he recently had 1 milligram of Dilaudid and four hours had not passed yet, he could not receive another dose. Afterward, we spoke to the physician and told him the situation and he increased the dose of Dilaudid from 1 milligram to 2 milligrams. Once again, I informed the patient and his family as soon as I found out to let them know that I hadn't forgotten about their request. Later on, I assessed the patient to see if he was still in pain and he was. I administered the requested 2 milligrams of Dilaudid IV and everyone seemed happy. Soon after, the client's sister called out for Denise and me to check the patient because now she was worried that he had *too much* pain medication. We assessed the client and notified them that C.W. was seemed to be doing fine.

Outcome/Reflection

This situation reminded me of several previous ones which also dealt me with similar challenges—caring for difficult patients and families. Dealing with these types of issues causes many problems for both the nurse and the client/family. Research has found that nurses distance themselves from these types of "difficult" patients and families. "The emotional distance causes the nurse to see the patient through a filter" (Michaelsen, p. 6, 2011). Any kind of distance will make one to see someone else through a so-called "filter". Michaelsen said it very well by using the word filter. When we distance ourselves from the patient and family we no longer see the whole picture. I tried not to do this when I was taking care of this particular patient and family.

Looking back, the situation with the client and his family didn't bother me nearly as much as it would have at the beginning of my clinical experience on Memorial 4 East. I used to experience a form of anger inside when I dealt with patients that seemed like they weren't happy

with any of their care they were receiving. Having patients and families that are noncompliant or "difficult" causes nurses to lose interest in them (Michaelsen, 2011). I think I did the best I could not to lose interest in my patient because their family was at times rude, and noncompliant. I did everything the patient and the family requested me too and I never ignored their concerns.

Another consequence for nurses who take care of "difficult" patients is one not pertaining to the nurse personally, or the patient, but to the nurse's own family. Findings in a research article show that nurses who care for difficult patients in return act in an aggressive way to their own families (Michaelsen, 2011). Obviously, nurses become emotionally affected when they deal with these types of patients and families. It is important for nurses to be educated about the crucial effects that can take place when we take care of a client or family member who is giving us a hard time. It might not seem like a big deal initially, but with time it can change the way we care for our patients and even our own families.

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