

Practicum Journal Three

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**Part One: Integration of Leadership and Management****Change, Power, Conflict**

The MICU seems put together well, at least to me, from the amount of time I have spent there. Although I did notice some individuals that could possibly work on changing their attitude before arriving to work. It seems like these types of people are never going to go away in any workplace. I understand if someone has had a bad day, but coming to work and not wanting to interact or help others is another story. For example, Cathy and I really needed help with a patient, who was experiencing chest pain and shortness of breath. He was in distress and was getting out of hand because he was so anxious. The residents hadn't arrived to the room yet, but we thought we were going to receive help from two other nurses who stopped by. Cathy and I thought they were coming to help us, and then they said, "Hey, could you watch our patients because we are going to go get some breakfast real quick." I was shocked and I could tell Cathy was annoyed. Cathy didn't even answer them back, and then they just walked away to go get breakfast.

First off, I thought that the nurses were very rude and selfish for not offering a hand. They could noticeably see how we were stressed and needed help. Secondly, they wanted us to watch all four of their patients, when we hadn't even had time to check on our other patient for over an hour. This was, thirdly, unsafe because we had a hard enough time with both of our patients and so there certainly wasn't going to be any time that we could spend watching their patients. Thankfully, the charge nurse stepped in and took over to help us and was able to watch the other nurses' patients. This incident was really discouraging because Cathy and I are always

helping others, willingly, not because we have to. Every nurse should be able to be utilize their judgment effectively, provide safe patient care, and willing to be a team player.

It's not comforting to see nurses' show up to work with a bad attitude or only do what is least expected of them. Cathy and I talked about if we were going to initiate this change we could first start off by approaching the nurses ourselves to talk to them about how we felt. If that doesn't dissolve the situation, then we could inform the unit director on the floor. She said that if you have a complaint about a specific employee you work with it, and couldn't solve it with that person yourself, then you could go to the charge nurse or unit director. She stated that, from her experience, going to the unit director about a certain individual would stay more private and anonymous, as opposed to going to the charge nurse. She said that depending on who the charge nurse is, depends on how professional or pro-active they are because she has noticed that some of them might gossip and cause more unnecessary drama than others. If this is true, it should also be changed!

If there are other areas on the unit that would benefit through change, you could first inform the patient care specialist, or charge nurse. Then you would move up the chain of command to the unit director, the vice president of the division, and then even the chief nursing officer if your problem still has not been solved. There is always room for improvements to be made, especially when it deals with maintaining quality care for the patients.

I have observed several conflicting events on the unit, such as the one described earlier. "Interpersonal skills are a key component of effective leaders and include the ability to listen actively, provide authentic expression of understanding, and communicate effectively in negotiation of disputes or the provision of discipline" (Radovich, Palaganas, Kiemeney, Strother, Bruneau, & Hamilton, 2011). All conflicts that I have witnessed have been resolved through

discussion, either between two nurses, or between a nurse and the charge nurse. Cathy explained that sitting down and discussing the conflict is the first and best method to diffuse a situation. Then individuals who are involved in the predicament have the opportunity to say their piece and listen to the other person's side of the story. Hopefully, through communication, everyone would be able to understand each other and come to an agreement on the conflicting topic.

Many of the nurses on the MICU have demonstrated different sources of power. All the nurses on the unit demonstrate legitimate power considering they all wear the symbols on their badge that display their licensure and professional standing in the health care field (Miller, Maloney, & Maloney, 2012). I have seen Cathy, along with the other nurses I have interacted with, use expert power and information power multiple times on the unit. Cathy always communicates accurate knowledge of patient care skills and human processes, based off of evidence-based-practice and nursing education, which is useful to other nurses or residents on the unit when discussing patient interventions or patient concerns (Miller, Maloney, & Maloney, 2012). I have also witnessed Cathy and other nurses use referent power and connection power. This is when respectful, trusting, good working relationships are formed and therefore, they should be able to work together on solving problems and sharing information with each other (Miller, Maloney, & Maloney, 2012). The charge nurse has demonstrated reward power or, according to Miller, Maloney, and Maloney, providing appropriate positive feedback to nurses on the unit about their competent skills or patient care. Cathy has even demonstrated this type of power when she has given me feedback on my skills and improvements. I was not able to observe coercive power on the unit. I feel that sources of power are very important to the nurse as a leader, an individual, and a licensed healthcare professional.

**Staffing**

According to Cho, June, Kim, Cho, Yoo, Yun, & Sung (2009), it is important to have a nurse to patient ratio of 1:2 in the ICU because they, “require higher levels of nurse staffing to closely monitor severely ill patients and provide quality and safe nursing interventions without delay” (p. 1730). When discussing staffing with Cathy she explained that on the MICU staffing is census driven, based on patient ratio, and is evaluated in four hour increments among other critical care units as well. Each nurse is assigned to two patients at one time. For example, if there are five patients total then there will be three nurses and one charge nurse working. If there are twelve patients total, then there will be six nurses and one charge nurse working. There are some instances when a nurse will be assigned to only one patient because they are very critically ill and need monitored constantly. For example these types of patients could be those who have had a stroke, are on continuous dialysis, or have many vasopressors running intravenously through several different lines. Sometimes a nurse can be given three patients. This is only in situations where the patients are stable and waiting to be transferred or just waiting on another nurse to come in onto the unit because they were called in. Cathy said that a nurse will never have more than three patients because it is not safe for the patients that are in critical condition and need constant monitoring.

Staffing on the MICU is mandated by intensivists. Apparently, if there are more than fourteen patients on the unit then there needs to be two charge nurses working. Cathy told me that, realistically, this never happens on the unit. She said that census is always changing based on admissions, discharges, or codes and they rarely ever have more than one charge nurse working at a time. The charge nurse is mainly the one who assigns patients to the nurses. Deciding which nurse will be responsible for which assignment depends on their skill and acuity

levels. New or less experienced nurses can take longer to accomplish some tasks than more advanced nurses, therefore it is more appropriate to place an experienced nurse with a heavier workload than a beginner nurse (Bernat Fisher, & Vottero 2012).

The Ohio Nurses Association explains that there are lower costs, less complications, better care plans, and fewer mortality rates when there are a higher number of nurses staffed on the units. Hospitals are required to organize staffing plans with, “meaningful input from direct patient care nurses, which are consistent with the principles of safe staffing” (HB 346). This bill also mentions that nurses should be staffed based off of patient ratios, such as used in the MICU, and standards that include assigning patients to nurses based off of their acuity and skill level (Ohio Nurses Association). I have seen multiple times when nurses have been called in at three or four o’clock in the morning, due to admissions, to maintain the 2:1 patient to nurse ratio. I feel that the Aultman MICU does very well with maintaining two patients to every one nurse in order to maintain quality, competent, and safe care to the patients.

### **Part Two: Goals**

#### **120 Hour Goals**

1. Demonstrate proper prioritization skills while maintaining effective management of time for two full patient assignments for a complete twelve hour shift.

I was successfully able to care for two patients during a whole twelve hour shift, with the exception of having Cathy there to scan medications and clear orders on the computer charting because since I’m a student the computer system would not allow me to. I would check the patient’s labs, perform all assessments, and administer meds for two patients on time for a whole shift. I would communicate patient concerns, first to Cathy, and then to the doctors and residents by myself. I received orders from the residents, would put them into the computer and paper

charting, and would also sign them off once they were completed. I was also able to stay organized and improved on my prioritization skills.

2. Introduce myself to the unit manager to possibly discuss future employment possibilities in the MICU before the end of my 120 hours.

I did get to meet the unit director, Kim, once. I had just met her for a second and introduced myself when I was getting off of my second shift. On my third shift one of the charge nurses, Casey, told me to wait for her on my last day and that we would both go in and talk to Kim about working there or keeping a position open in the future for me. When I came in on my last day Casey told me that Kim would not be in on Wednesday morning and so instantly I was bummed I wouldn't get to talk to her at all. Then Casey told me that she had a meeting with Kim the day before and said really good things about me. She said that other nurses in the meeting also said nice things about me and that Kim wanted me to leave my resume in her inbox. I was so thankful and so appreciative for everyone who said positive things about me. I did leave my resume in her mailbox and hopefully I get to speak with her in the future about possible employment! It is my dream to start off my career at Aultman and I hope I can do so. I would work in any position at Aultman, but if I could get a position working in the ICU it would be an incredible added bonus. I absolutely loved my experience in the ICU.

3. Demonstrate effective communication to the oncoming nurse by discussing a full, extensive, complete report of two patient assignments before leaving each shift.

Along with taking care of two full patients on my own for a whole shift, I was also able to report off to the oncoming nurses at the end of my shift. Cathy and I had been working on this during my eighty hour rotation too. At the end of my 120 hour rotation I was able to report off to the oncoming nurse all on my own. Cathy would chime in every now and then on accident,

because she is so used to doing it, but then she would stop herself and have me finish the report. I feel accomplished that I am now more comfortable with talking to other nurses, residents, and healthcare members on the unit.

4. Verbalize to my preceptor an understanding of the physiological disadvantages of severe liver cirrhosis and how it affects the human body.

Throughout my last forty hours we did not have any patients with cirrhosis as we did at the beginning of my practicum. I do understand the effects this disease has on the body from looking it up on my own after my eighty hour rotation was completed. Most of our patients all had major GI bleeds and other diagnoses in my last rotation. Therefore, I did not get to verbalize to Cathy about the understanding of cirrhosis and how it affects the body because none of our patients had this diagnosis and so we did not discuss it at all.

### **Part Three: Professional Reflection**

#### **Description**

On my first shift of this rotation, we cared for two male patients. Our first patient was a fifty-two year old male who was admitted the day before with respiratory failure, hypercapnia, sepsis, and COPD. He had a central line, foley catheter, and was vented. This patient was stable and stayed asleep throughout the night. Our second patient was an eighty year old male who was admitted earlier that day with a lower GI bleed and was anemic. He also smoked a pack of cigarettes every day and drank at least a pint of whiskey every night. This was also a peritoneal dialysis patient. He was not vented and did not have a foley catheter. He did not void the entire night, but did have about ten or eleven large, bloody, bright red, clotted, tapeworm-like stools. I had never seen this kind of stool appearance in my life. He was also receiving several units of packed red blood cells and fresh frozen plasma throughout the night. He was stable at the

beginning of the night, but later became short of breath, complained of chest pain, became majorly hypotensive, and his oxygen saturation was decreasing. We informed the residents and then they decided to insert a central line, so he could receive vasopressors to bring his pressure back up. It was my first time seeing a central line inserted. I was excited I was able to experience that procedure. Once the central line was in and he was receiving levophed his pressure was brought back up and he became stable again.

During my second shift of this rotation, we cared for an eighty-one year old female who was admitted with atrial fibrillation, tachycardia, and slurred speech. In her chart, it said that she was being looked at to rule out a cerebral vascular accident, which I would think they would have been able to figure out after she had been there for two days. She was vented, had a foley catheter, and was on isolation because she had a history of *Clostridium difficile*, or C.diff. One stool was tested and came back negative, but they needed two negative stools in order to discontinue the isolation protocol. She also had a central line with many different medications running including: levophed, heparin, esmolol, insulin, milirinone, potassium chloride, D5 sodium bicarbonate, 3% normal saline, and 0.9% normal saline. She had an oralgastric tube she was getting tube fed from. It was very important to monitor her IV medications and titrate them when necessary. During this shift we also cared for a sixty-one year old male who was admitted three hours before our shift because he was found at home lying face down in his couch. The family had not talked to him since three days prior to when he was found. Apparently he was a very heavy drinker and the family said that recently he had been drinking all day long because he had lost his job. He was diagnosed with rhabdomyolysis from his muscles breaking down over such a long period of time, and was also diagnosed with sepsis, hypotension, and hyponatremia. His two great toes and second toes on each foot were necrotic. He had abrasions along both

arms, elbows, knees, and shins. He also had some facial bruising and scabbing. He was vented, had a foley catheter, and a central line inserted. Both patients were stable for most of the night, other than constantly needing suctioned and their IV medications titrated. We were very busy between both patients, but no major critical events occurred.

On my third shift of this rotation I cared for a seventy year old male who was admitted with acute respiratory failure. He also had myasthenia gravis and Guillain-Barré syndrome. This patient was vented and had a foley catheter. He refused to use the bed pan even though he made it clear through nodding yes that he had to make a bowel movement. He seemed very urgent that he had to go but would refuse to go on the bed pan. He was very anxious throughout the night and began shaking the bed rails. Cathy decided to calm him down by giving him some versed and fentanyl. That didn't seem to work very well, so the residents starting him on a propofol drip. The propofol worked just fine for this patient and he remained stable throughout the night. He also relaxed well enough to relieve his bowels and had several bowel movements. I did not care for any other patients that night. There were three different times we were supposed to get admissions and then they ended up getting transferred somewhere else and never even came to the unit. I was excited I had some time to talk to Cathy and some of the other nurses about possible employment in the ICU during our downtime.

On my fourth and final shift of my 120 hours I was able to care for two full patient assignments all on my own. I have been practicing throughout my entire 120 hours, and in this last forty hour rotation I felt competent and confident at doing it on my own. I cared for a seventy-six year old male who was admitted with pneumonia and a left sided possible lung mass. He was getting a bronchoscopy the next day. He was vented and had a foley catheter. This patient was very calm and also slept throughout most of the night. When he was awake he was

very alert and cooperative. I also cared for a seventy year old female who was admitted with a GI bleed and bright red rectal bleeding. When I cared for her she did not have any bleeding in her bowel movements and she had many bowel movements throughout the night. She was not vented and did have a foley catheter. She was receiving several units of packed red blood cells and fresh frozen plasma. Otherwise, she remained stable and slept most of the night.

### **Feelings**

I feel so accomplished after this preceptorship and somewhat in denial because I cannot believe it is actually over. I was really glad that I could take on two patient assignments without falling behind schedule. I felt that I gained more clinical skills and learned more in this preceptorship than I have throughout all my other clinical sites in nursing school combined. I am so appreciative I had a second chance to do my preceptorship where I originally wanted to do it at, which was in the ICU, and not in med surg like I originally signed up for. I wouldn't have traded this experience for any other experience and feel so lucky that I had this opportunity.

### **Evaluation**

When deciding what was good or bad about my experience, I feel like everything happened for a reason and there is nothing bad about any of the experiences I went through. I have learned to view every experience as a positive outcome because I either learned more, or grew from the experience, one way or another. I also have strengthened my critical thinking skills from the negative and positive experiences I have gone through. I was able to see some of behind-the-scenes in nursing, such as the politic situations. Cathy talked about it with me too and some of her experiences she has gone through. At least I have some type of perspective to what I can prepare myself for when I do become a nurse, but I will also make my own judgments once I

am faced with certain people and situations. I would not change anything about this experience and with every positive or negative situation I went through, I was able to grow from.

### **Action Plan**

If I were faced with similar situations I was faced with at the beginning of my practicum, I would definitely be able to handle them better now. I have learned so much more about myself, as a nurse, from reflecting on my strengths and weaknesses throughout all my time in the ICU. I am now able to provide more quality competent care in the future to ensure my patients are comfortable and safe when in my hands. I plan to keep the relationships I have already made throughout this experience and hope that after I pass my boards I can start my career at Aultman Hospital. I absolutely loved my time in the ICU and I could definitely see myself as an ICU nurse in the future!

## **Part B: Professional Issue**

### **Situation**

I was outside the patient's room charting when I heard one of her IV pumps beeping. I walked into the room to see which one was beeping and why it was beeping. The IV pump that was beeping was running esmolol, a beta blocker. It was beeping because it had air in the line. So, I took out the IV tubing from the pump to remove the air, without stopping the IV pump or at least clamping the line.

### **Action**

Cathy was in the room with me and she instantly grabbed the IV line and clamped it off to the patient. Calmly, she said, "So, what did you just do wrong here?" I was kind of caught off guard because I didn't think I had done anything wrong, especially because I have done this with Cathy before to get air out of the pumps when they are beeping. Well, all the other times we had

done this together she had already clamped the line without me seeing, so in the routine of things, I did what I normally did and just opened up the pump to get the air out of it. She immediately showed me that since I did not stop the pump or clamp it off before pulling the tubing out that it was running directly into the patient wide open.

### **Outcome**

We stayed in the room and monitored her heart rate and blood pressure for about ten minutes to make sure they did not decrease from where they had been. She was prescribed the esmolol because she had atrial fibrillation and was tachycardic. This medication helps to control the ventricle rate by decreasing the rate and force of the heart. Luckily, her blood pressure or her heart rate did not change from where it had been and she did not have any issues from this problem throughout the night.

### **Reflection**

Being educated on IV therapy and the IV pumps is essential in order to provide safe and competent patient care (Lavery, 2011). Cathy and I discussed the dangers that this could have caused for the patient. She explained that if this was another medication such as potassium or cardizem, it could have been fatal for the patient. She told me that she was glad she was there with me and that it wasn't as serious as it could have been. According to Lavery (2011), those who rely solely on the IV pump devices, are more at risk for restricting their critical thinking skills when providing safe care. Cathy talked to me about paying more attention to the small things and how to correctly follow through with important skills in order to avoid major, severe events that could occur.

At this point in my practicum I felt very comfortable with the IV pumps and how to correctly use them, so I thought. This incident greatly changed my original perception of this

issue, from when I didn't catch on that I had done anything wrong at all. I about had a heart attack once I realized what I did! I couldn't believe I didn't comprehend that the medication would be running wide open since I didn't clamp it or stop it. I felt really stupid because it's something so simple to rationalize and something I should have known. I just need to stop and think about things sometimes before going into the "routine" of things. The line was only out of the pump and unclamped for a minimum of 5 seconds, but it could have been very serious if Cathy wasn't there. On the brighter side of things, learning from these types of mistakes will improve my skills when providing safe patient care. I am only human, and at least I am able to accept and take responsibility for the mistakes I have made. I'm glad this happened to me during my practicum, and while Cathy was in the room with me, because I will never forget this incident or let it happen ever again.

### **Part C: Preceptor/Student Evaluation**

#### **Evaluation form**

Please see preceptor/student evaluation form attached.

### **Part D: Log of Clinical Hours**

#### **Clinical Hour Log**

Please see log of clinical hours attached.

## References

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