120 Hour Journal

Precept at Aultman 4 East

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Nursing 40045 – Integration of Leadership and Management in Nursing

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Part I: Integration of Leadership and Management

Quality Improvement (Mandatory Topic)

- **Give examples of quality improvement areas your unit is involved in.**

The quality improvements in 4 East that my preceptor and I discussed were the Acuity staffing ratio, culture of team medicine, and in my opinion an unofficial quality improvement of team work.

The acuity ratio is an idea that I was always interested in and actually wished that they would implement on the rehab unit that I work. At this point in my career I have only been exposed to a patient to staff ratio, which could mean you have a row of all high acuity patients and another nurse would have a group of patients that were all much lower acuity or easier patients. The system on 4 East an acuity based system with a number system of 2-5, with 2 being a most stable and 4 being not very stable or move involved patient. There is also a level 5 which is a charge nurse discretion that will cover areas not foreseen in the first 4 levels. Level two involves a patient that is A/O, independent with care, up with no assistance and with stable vital signs. Level three patients, need assistance getting up with the help of one, isolation, call light use, multiple IV medications, possible trach, difficult family members and confusion. The last level with criteria is level four, patients in this level are the least stable and require the most attention and are high risk patients. Patients in this level require at least the assistance of two people for getting up out of bed or tuning in the bed, patient may be incontinent, excessive call light use, confusion, terminally ill, feed, unstable, and restraints may be in

use. The charge nurse responsible for the staffing and assigning the patients based on the acuity criteria as a guide. Many of the patients don't fit exactly into one level or another so some critical thinking and knowledge of the patients is required to use this staffing system (West & Shere, 2009).

The purpose of the team culture of medicine was to create an interdisciplinary rounding process to improve communication between the patients, nurses, and physicians. In the team more communication has been started and topics are brought up that may have been overlooked in other cases of not collaborating thinking. The reason for this quality improvement was because there was no real verbal communication between the nurses and physicians on the floor. Another reason for this improvement is the nurse may have 5 patients and 5 different doctors a communication method was needed. A team consists of a physician, clinical coordinator, staff nurse, case manager, pharmacist, and therapy services. Per the chart on the wall on the unit about this quality improvement, this has improved satisfaction per a survey from 4.5 to 9.5 after the team concept began (Morrow & Dougan).

The team work issue is just something that I have noticed that is not always seen on other floors. It could be this particular staff but they are very into helping each other out and getting the job done. I rarely saw someone having to stay late due to not getting charting done or not having work done. On the other hand this was the nightshift too, so I am not sure if it is different during the day and afternoon or not. This would also help the overtime cost if everyone is getting out on time on the unit.

- **How do they obtain data related to these areas?**

The data obtain for the acuity based Quality Improvement was through a survey that was completed by the nursing staff asking if they felt the implementation of an acuity based scale has improved care and fairness of patient assignments.

The team concept was also done by surveys completed by the nurses and physicians about the how nurse feel they have adequate knowledge from the physician to provide safe and effective care. The physicians were asked if they valued the nurses input in developing the patient plan of care.

- **How do they evaluate the data?**

The data was evaluated by the returned surveys taken by the staff nurses and the physicians and was placed into bars graphs to show the improvement in each quality improvement. The acuity bar graphed showed that over 86 % of the nurse agreed with the acuity staffing and the fairness of patients (Michaels & Hendricks). The team concept showed improvement in a bar graph form of increasing in the physician valuing plan of care from nurse and adequate knowledge to take care of the patient from 4.5 to 9-9.5 out of 10 per the bar graph (Morrow & Dougan).

- **Who is responsible for providing evaluation data to your nursing unit?**

The floor educator and nurse manager/ supervisor are responsible for evaluating the data and getting the new information out to the floor nurses.

- **Is your preceptor aware of the quality improvement areas being looked at on her/his unit? Is she involved in data collection?**

My preceptor was aware of the areas previously mention and directed me to the charts and presentation of the quality improvements areas on the walls on the unit for more information.

- **The "Right" Nurse Staffing Model**

This article talks about a staffing by acuity staffing ratio, much like the one being used at Aultman, which optimizes the nurses on the floor. The article uses a cancer center as the center for its acuity setting. In the article it has a 6 level system that is based toward cancer patients getting Chemo medications, cancer related symptoms and treatment along with standard areas used such as tube feeding, trach as examples (West & Shere, 2009).

- **Team-Based Learning in an Undergraduate Nursing Course**

The article reflects what is being done at Aultman with the team concept of physicians, nurses, case worker, and other disciplines. The team concept is in the article deals with nursing student divided into groups that collaborate on a topic and come up with more approaches than an individual on their own. This works the same in the hospital with the multiple disciplinary teams all working on one patient for the best outcome for the patient possible (Clark, Nguyen, Levine, & Bray, 2008).

Evidence-Based Practice (Mandatory Topic)

- **Discuss evidence based practice with your preceptor**

When I discussed this with my preceptor she explained it to me as it is an idea that is backed up by evidence that may change a policy or way new way doing a

procedure that was being done another way in the past. Two examples she gave me were the every two hour turning on patients and the Shoosh program.

- **How does your unit utilize EBP?**

The shoosh program started to help patients get sleep at night. I have heard numerous patients in clinical and as an LPN that say that there is a lot of noise in the halls at night when they are trying to sleep. This could range from a vent alarming, call light going off, to a confused patient yelling out into the hall. When this happens patients can be tired in the daytime or become very confused from lack of sleep and not act like themselves. The plan that is in place at this point is to lower the lights at night to help keep some of the light out of the rooms and if the patient is not a high fall risk close the door to the room. The other new idea was to give the patients ear plugs to block some of the normal sounds that occur on the floor. The next step from what my preceptor told me is that soon they are going to receive eye covers for patient to help with the lights. The hospital also has a channel that is just calming music and beautiful scenery that may help keep a confused patient calm (Lee, Low, & Twinn, 2007). The article I choose dealt with the elderly patients of men that experience a difficult time sleeping from all the noises in the halls of the hospital. It ranged from noises from alarms having to go to the bathroom to nurses checking on the patient and getting vitals. The patients understood that all of this needs to be in place but still didn't like the noise. The biggest complaint was that when they got woke up it was hard to fall back to sleep (Lee, Low, & Twinn, 2007).

Every two hour turning is the idea of turning the patient to preventing bed sores, and to not have the patient on their back all the time. This prevents skin break down and from becoming necrotic from not getting oxygen supply if constantly laying on a

particular part of their back or bottom. This also allows you to see if the patient was incontinent and needs cleaned during the turning of the patient. The turning of patients has shown to decrease bed sores and is backed up by the article about preventing pressure sores. This is also a big deal since Medicare is no longer paying for hospital acquired bed sores that are a result of being in the hospital (Blaney, 2010).

- **What examples can you give from your unit that demonstrates evidenced based practice?**

The two examples given are the ones previously mention above that deal with every two hour turning, and the shoosh program. Also I thinking rounding on the patient would be another example, along with asking for patients to receive the flu shot to help prevent a flu outbreak in the hospital.

- **What are they doing in practice that is or is not supported by research?**

The turning every two hours, shoosh program, and the flu shot are all supported by research. The every two-hour turning has been proven to decrease the chance of bed sores on a patient (Blaney, 2010). The shoosh program was put in place due to the findings that patients are not getting sleep in the hospital setting due to noises inside and outside the patient's room (Lee, Low, & Twinn, 2007). Finally the flu shot has been shown to decrease the chance of acquiring the flu during flu season. This is a good idea for the patients but also for the staff too. Some institutions have issued mandatory vaccines to the staff and others strongly encourage getting it to protect yourself and the patient you are caring for (Sachs & Prince, 2010).

- **What examples have you observed that may not be supported by research?**

To my knowledge I did not see anything that was out of the ordinary that I would call not evidence base practice. The only issue that I am not sure of is that in isolation rooms the use of an antimicrobial soap. I never saw a separate soap in the rooms that was used to scrub with after going into an isolation room. I am not sure what type of soap is in the dispensers it could already be an antimicrobial soap, I am not sure.

Teamwork and Team Building

- **Discuss teamwork and team building with your preceptor**

When my preceptor and I talked about teamwork we thought the definition was pretty self-explanatory. Basically what we came up is when you are helping out each other for the good of the patients and the unit to achieve a common goal.

- **Discuss examples of how is teamwork is demonstrated on your unit**

As I stated earlier in the paper teamwork is very common and definitely a part of this floors agenda. Some examples that are also pretty common on others floors is the covering of patients when one nurse goes to lunch. Another example is the RN's always seem to be in other nurse's rooms answering call lights, resetting IV pumps if they are beeping or helping a patient in any way possible. I have worked on other floors at Mercy when I get floated where the nurses do not help each other and it is a bad experience. I really did not see this on this floor, even though it felt like I was getting floated to another floor the first few times I went to the floor. Each time I went I was welcomed by the nurses and they helped me whenever I needed it. Also teamwork allows everyone to get their work done, get out on time, and helps to eliminate incidental overtime that results from not working together. This is especially important in code and rapid response

situations that require the attention of a majority of the staff and resources on the floor (Herbert, 2012) (Michaels & Hendricks).

- **What are your ideas about how teamwork could be enhance on your unit**

  The only way I can think of to enhance it even more is if the charge nurse would answer some of the call lights more often. I know they have their own agendas and list of things that need to get done but possibly on midnight this could be done. I cannot think of a more team oriented unit I have worked or did a clinical on. It just makes me wonder why their turnover rate for nurses is so high unless it is not like this on other shifts.

- **Who would you talk to with to promote teamwork and team building**

  The person to talk to would be the supervisor or charge nurse to try to promote teamwork even more but at least on midnights it is very well a team oriented unit already.

Part II: Goals

60 Hour Goals:

Time management goal: *Student will demonstrate time management skills by passing medications on assigned patients within half an hour of scheduled time of administration and identify the correct dose and use of the drug to the preceptor before administration.*

Results: I was able to achieve this goal by the second night with my assigned patients but I only had two patients that night so I do not really count this as when the goal was actually completed. By the third night I had 4 patients and was able to pass all my medication on time within half an hour of scheduled time.

60-120 hour goal:

Time management goal: *Student will demonstrate time management skills by having medications, assessments, and other tasks completed by 0300 with focused assessments, medications and remaining tasks completed by 0600.*

Results: I was able to do this most of the time during the last part of my precepting. There was one night where we were very busy and was behind the whole night but I was able to catch up and get out on time.

Psychosocial aspect of the clinical: *The student will explain and demonstrate to the patient and family member's importance of checking blood sugars before each meal and at bedtime to ensure blood sugar is at a level of 80-120 mg/dl.*

Results: I was not able to complete this goal like I wanted too. I was able to educate a patient about the specific blood sugar range of what a good and bad level is but nothing beyond that for this goal. It was hard to educate family members during midnight clinical because the family members are not there at night to often.

60-120-hour goal:

Psychosocial aspect of the clinical: *The student educates and explains the use of a certain medication to a patient that is either new to the patient or if the patient has a question about how a certain medication works.*

Results: I explained a new medication to a patient that was placed in isolation for C-Diff. The medication was oral Vancomycn that is common to give patients have C-Diff. The oral version seems to work best for C-Diff over the IV version per what my preceptor told me.

Pathophysiological goal specific to the unit/patient population you are assigned: *Demonstrate professionalism and cleanness by keeping room tidy and free of clutter to prevent falls and injury.*

Results: This goal was met and performed every time I went into the room. I picked up anything that was out of place to prevent falls for the staff and the patient. If I used dressing supplies I would clean up the wrappers and never leave them in the room. When I was helping someone with a dressing a lot of the time I was cleaning up for them as they were finishing up with their patient.

60-120 hour goal:

Pathophysiological goal specific to the unit/patient population you are assigned: Demonstrate *when dealing with a ventilator patient the importance of mouth, trach care, and suction for a patient to keep the patient safe.*

Results: In my 60-120 hours of precepting I amazingly did not have a ventilated patient on my team, although, the importance of mouth care is to prevent infection and ventilator associated phenomena. Suction is to keep secretions from blocking the airway which could hinder the patients breathing.

Other goals: *Insert an IV safely and correctly per policy in a patient and maintain that IV line throughout the shift. Second goal of attempting to learn the names of the staff within the first 24 hours worked on the unit with preceptor.*

Results: I was able to insert an IV in a patient with some difficulty but I did get it done and secured right and did maintain the line throughout the shift. I also was not able to get a stick that I did try but, the patient's veins were small and rolled which I have not had much experience with until now.

Results: I did not complete the goal of learning all of the staff's names at this time. I am at about 50% at this point and hope to learn by the end of my 120 hours.

60-120 hour goals: I want to continue the two other goals and work on inserting more IV's and learn the entire staffs names the midnight staff by the end of the 120 hours.

Results: I was able to insert three move IV's and do feel more confident with the procedure. I was still not able to learn the whole staff's names but manage to recall about 75%, basically the people I talked to the most and worked with the most.

Part III. Professional Reflection Using Gibbs' Reflective Cycle

During the last 60 hours I was really surprised that nothing really too exciting happened. I had no vent, or trach patients that were assigned to us during our shift, and there were hardly any vent or trach patients on the floor for the last 60 hours which is not unusual per the staff. In a way this worked to my advantage, because I did get to see chest tubes that I did not get to see in the first 60 hours. I have not been exposed to chest tubes too much, and they went over it briefly in critical care and in clinical, but it was nice to actually get to the hands on experience. I had quite a few patients that were in restraints for being confused, pulling at lines, and trying to take out nasal cannula or BiPap. There were a lot of confused patients on the floor and the staff and I were constantly going into rooms for alarming BiPaps and pulse ox's. I got to start numerous IV's this time and do feel more comfortable with the procedure and insertion. The hardest part for me that will just take practice is attaching the interlock tubing to the cannula of the catheter. I get nervous when I am doing this part because I don't want to have the IV come out when I am attaching the tubing with the interlock. I routinely had four patients were I did complete care of the patients with the preceptor's supervision. There were two or three days that

we did have to pick up another patient at 3:00am or started out with five patients from the beginning of the shift. The first time I had five patients it did take me the entire shift to get everything done and came down to the wire, although, I was able to still get out on time. The other times when I had five patients I was able to time manage and get all of my tasks completed in time (Gibbs, 1988) .

In the last 60 hours I felt confident in knowing what I needed to accomplish during the shift and in my skills to complete the tasks. I knew the routine and got everything done with time to spare 95% of the time. I did feel a little pressure and rushed the first time with five patients on that floor but, the second time it was no big deal. When I had a 5 patient team my preceptor helped out the floor by answering call lights and helped the other nurses. Toward the end some nurses were taking advantage of this and my preceptor and I felt that wasn't right. One of the nurses told my preceptor that since she wasn't doing anything she needed to do things for her. I thought that was really wrong of that nurse to say that to my preceptor and it made my preceptor a little angry. In reality she has to check my charting to agree with it and is already helping out the floor by answering call lights. My preceptor said her main concern is me and our patients. She just felt like she was getting taken advantage of on a few occasions by the other nurses and didn't care for it at all. Overall I feel that my assessment skills have improved especially in my opinion listening to and identifying different lung sounds and hearing irregular beats. Previously I had been exposed to diminished and wheezing lungs sounds but never had a patient that I would identify as having ronchorus lung sounds. With all the respiratory issues on this floor I was able to pick up on this quite easily after hearing it a few times. The irregular heart beat I referred to was atrial fibrillation or A-fib. I had heard it before in other clinical's but I was always told the patient was in A-fib and never had to identify it myself. I have since

learned to just listen apically for an irregular rhythm and then I can look at my papers to see if the patients has had episodes of A-fib before or is presently in A-fib (Gibbs, 1988) .

The last issue I had with regards to feelings was to help another nurse with a patient that had passed away. The nurse needed help to put the patient on the stretcher to leave for the morgue. I have seen, cleaned up, and dealt with patients that have passed before and it did not affect me too much. What I did not like and almost felt embarrassed myself was what was done to the patient in transferring the patient. The patient was a really large man that was easily over 350 pounds. The transporters from the service that was picking up the body brought this little stretcher that was not made for a bariatric patient. We got the patient over to the stretcher to only find out the straps were not long enough to buckle across the patient. The transporter I think also felt embarrassed when he had to leave the room to go back to the vehicle to get extensions for the straps so that they would fit over the patient. So in the meantime another nurse, son in law, another transporter and I are waiting on the other guy to return with the extension straps for the patient. It is just kind of strange waiting there in silence for the other transporter to return, because what do you say in this situation. I think some better communication should have been used to tell the transporters ahead of time that a bariatric stretcher was needed. If they had known it would have decreased the embarrassment of everyone(Gibbs, 1988). I think we handled the situation the best we could with the equipment available but that the situation could have been avoided with better critical thinking.

My action plan for the last 60 hours really would focus on what I did when I had five patients. The first time I had five patients' it was more of a learning curve that needed to be met and learned. I was able to barely tread water at first with the five patients but caught myself up

at the end and did end up getting done on time. The second time I had five patients I was able to apply what I learned and used it to have a more relaxed and easy flowing shift (Gibbs, 1988).

Professional Issue

Situation: I decided to focus on the flow of this paper and continue with the awesome teamwork that takes place on this floor in a code or rapid response situation and focus on one patient as an example. There quite a few rapid responses on the floor throughout my 120 hours of precepting that required teamwork and communication to get the job done and achieve the best outcome for the patient. The one that sticks out to me probably since it was my patient was the patient that ended up having a stroke. It happened so fast, I was literally in the room talking to the patient maybe 30 minutes before it happened and she was taking and making jokes like she had been the whole shift. I was with another patient when another nurse answered her call light and noticed she was talking different. He came to me and my preceptor and told us about how she was acting now noting it was not the way she was acting before. Then we called a rapid response.

Action: The rapid response was called and in the meantime blood pressure and vitals were obtained along with a quick assessment of the patient concentrating on left vs right neurologic symptoms and answering cognitive questions. Her arms and legs were strong with a very slight right side weakness when holding arms straight out could be noted. Then the left side of her face started to drop slightly and her speech signaled that something was wrong. At first she was able to talk to us but very slow. Then she started to mess up a few words and slur some words at times. When the rapid response team arrived the other floor nurses left to help answer call lights on the floor and tend to the other patients. I really liked that the nurse that comes up for the rapid

response stays with the patient during tests if needed. So it gave my preceptor and me a chance to see other patients and check on them while the patient went down for a CT scan. I believe this happened on either my first or second night on the unit.

Outcome: We later found out from the results that the patient did end up having a stroke but not the kind I had suspected. My preceptor and I thought it was a hemorrhagic stroke due to the patient being on weight based heparin. It ended up that the patient was diagnosed with an ischemic stroke. That was shocking to me because she was on heparin. The patient was transported to the stroke floor, four north I believe. I think the patient had the best outcome possible due to teamwork on the unit. The nurses were willing to answer the units call lights not just the call lights on their team of patients.

Reflection: I have seen and dealt with stroke patients on numerous occasions at Mercy's rehab. It is one of our biggest patient populations on the floor because we are a stroke specialty unit. However I see the patients after they are stable and are recovering from the stroke. We are working with them on their deficits following the stroke. I have never seen a stroke take place before my eyes and see it evolve. It was just nice to have other staff willing to help and use teamwork for the best outcome for the patient. Especially in the emergent situation everyone stayed calm and did what asked of them like a well-oiled machine. The article I choose to use was about a patient having an allergic reaction with a nursing student who was with the patient and the nurse student noticed that something was not right with the patient. An experienced nurse then call rapid and was with the patient the whole time staying calm and delegating task to others and uses teamwork to get the job done and achieve the best outcome for the patient possible (Herbert, 2012).

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