60 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

Time Management and Prioritization

- **How do you and your preceptor prioritize your nursing care?**

When I go into a new situation or area that I am going to do a clinical or precept for the first time that day involves observing the routine of the nurses on the floor and how the nurses organizes their papers and time for the shift. After the shift I typically come up with some type of flow sheet that I make in Excel to keep myself organized. It helps me feel less stressful and I could see what I have done and what still is needed to be done in the shift.

At Aultman I usually get there about 30 minutes before the shift starts to get my papers ready for the shift. Although about half the time the paper with staffing is not done till about 10-15minutes before the shift start. When we get our assignment I look up all the medications that are scheduled to be given on our shift. The orders are reviewed for code status, diet, daily weight, diagnosis, and tests performed or to be performed the following day. The labs are reviewed and telemetry strips are gathered and studied for a base line for the shift. By the time these tasks are accomplished it is time to get report from the previous shift nurse. Report is taken and any issues or questions are answered and talked about that may have rose up during the previous shift.

After receiving report and any information about important about our patients we come up with a plan of what and where to start for the shift. The first decision is which patient to see first depending on severity and stability of the patients we have in our team. Another factor is when medication are scheduled for specific patients and if a medication

is due at midnight compared to 3am I might see the patient that has a medication due at midnight first to make sure the medication is given on time. The first round of assessments, medications and charting are to be done by 0300. This gives us time to correct any charting that is not correct or could be put a different way to improve the charting. Then around 0400 the focused assessments are started along with other tasks that are to be done in the morning. Medications are usually one of the last tasks done due to most medications are due at 0600.

Aultman uses a system to keep the nurse on course and give a suggested path for completing tasks on each patient. It is called a task list and even though it is not always correct and should be used only as a guide it is a useful tool to use. I do like the task list but I also use my excel flow sheet I make as my main guide. Although you are always on the move it does seem like you are always crutched for time and have to keep on moving. It would be nice to able to have more time with the patients when they are awake and really get an understanding of their whole situation. It is just hard sometimes with 4-5 step down telemetry patients that all need their medications and have tasks that are due every hour. In the article *Factors contributing to nursing task incompletion as perceived by nurses working in Kuwait general hospitals* it states the most common nursing task that was not completed or not to the nurses wanted was communication and comfort talk with the patients (Al-Kandari & Thomas, 2009). This can affect the patient to nurse relationship and in the end possibly the way the patient perceives the health care team.

- **Discuss ways you have reprioritized your care through the day?**

I may have planned my patients out in and order to see them in one way at the beginning of the shift and it may change within an hour if a patient goes or has gone

south. There was a patient that was on my list as one of my first to see that I knew was going to a challenging patient for me. The main issue is that she had dressings that were needed to be changed along with a huge seeping wound on her bottom. This was right after shift report and everyone else was not don't getting report yet and I knew I was going to need more than my preceptor and I to turn this women and replace the sheets and pads due to being wet from seepage and her being a rather large women. Although I wanted to get started with this due to other issues and need for more personal I had to back this patient down my list until others were able to help.

Another issue was an older lady that was at the beginning of the shift stable and then ended up having a change in status. She was one of my lower priority patients that night and then went to the top of the list when this incident happened. Had to call rapid and it looked like stroke symptoms from the way she was acting. The team came up and assessed her and stat CT was ordered for the patient. These events made me have to completely revamp my priority list and go in another direction than I had at the beginning of the shift planned to go.

- **Reflect on your time management during your first 60 hours and how it has changed in your second or third 60 hours.**

I have only completed my 60 hours to this point but I will compare my first 30 hour to my second 30 hours along with time management I did as an LPN compared to now in my first 60 hours precepting as a student RN. I came into doing my precpting with a better understanding than most students due to my background in healthcare as an LPN. I have a way that I prioritize my team and it works for me sometimes just like in any nursing related job that is not always how it ends up at the end of the shift. I was

used to having my team of 5-7 patients in which I only had an RN as a resource as needed or if I had anything to do with IV related issues. So I was well aware of what I needed and expected of me to do on my shift for my patients. Doing the assessment it more based differently than what I am used to as an LPN on my floor. The patients I routinely dealt with were considered stable and these patients that I am taking care of now are in some cases nowhere near stable. I had to grasp my brain around this and allow for extra time in doing things such as an assessment or trach care. An issue I really did not have to worry about in my previous clinical or job.

The first 30 hours were more of learning curve that needed done in order to start feeling comfortable on the floor. The first 16 hours was mainly was more of observing and taking care of 1-2 patients on my own and asking many questions. The next 16 hours dealt with me taking the whole team and learning the full weight of step down telemetry patients. I had no real issue with having my work done in the shift just minor things that I may have had to clean up during the end of the shift. The last 30 hours I kept taking the whole team and improved on time management skills and was finishing around the time the other nurses were done with their assignments. I look to further my learning and time skills in the last 60 hours and even have time to help out others toward the end.

- **What strategies have you learned to enhance your time management?**

The main issue I had was with the computer charting system and how it worked and finding everything I needed and where to chart it. After learning and the preceptor answering any questions I had it went more smoothly for me in the charting area. I got used to seeing all the patients quick and prioritizing the patients from least critical to most and looking for life threating conditions first then setting into doing my assessment

and completing the tasks on my shift (Maloney, 2012). Another area in my opinion is teamwork, their teamwork on this for is amazing and this helps everyone in the end get done on time and may also allow that other nurse to do another task and prevent them from getting behind. A strategy that may preceptor told me was not to trust everything on the task list. Their on task that may not be on there and to go off my own paper and now what needed to be charted so I don't forget to chart it when it is due. For example I know that two assessments are to be done on the shift. One ongoing assessment and one focused assessment on the main areas patient may need checked. The ongoing or focused may not be on the task list and needs to be added this forces me to learn what needed to be charted when and not rely on the task list and just use it as a guide and not as the final word.

Change/Power/Conflict

- **Give examples of what could be changed on your nursing unit. How would you initiate this change? Who would you utilize in the change process?**

There are two issues that have made an impression on me that I do not share or indorse in my opinion. The first is that many of the nurses eat or leaves drinks in plain view at nurse station. I think it don't look to professional or tidy to leave a drink out on the nurse station. Part of my issue could be because we are not allowed at my current job but in reality I don't think I would have a drink at the station even if we were allowed personally I think it wrong and it don't look good. In order to start the process of change I would want to see what their policy in place is first. It may be an issue that is just ignored and needs to be enforced which I am assuming it is. I would then go up the chain of command to find or get the answer I want to make it as per policy.

The second change I would make is rounding report. I really did not like this when we started this at my current job but now I have completely changed my mind. We as nurses go from room to room introducing the oncoming nurses and do report in the room so the patient is involved. This has enhanced my report giving in my opinion because if something is different than what I tell the nurse the patient in most cases can correct the nurse and add anything that may be vital to the report. It also let the patient know who the new nurse is before coming in to do the assessment and makes sure that the patient you are getting is as they are telling you in report. It also improves safety by checking on the patient or rounding during shift report (Laws & Amato, 2010). As of now during my clinical the report is done at the computers or at nurse station and not per room. Again I would review the policy first and see what is actually supposed to be done. I then if not already a policy bring it up to nursing manager and suggest the idea.

- **Who have you interacted/observed that demonstrated the difference types of power discussed in Kelly (chapter 12).**

The preceptor I am currently with would be an example of expert power in my opinion. She has been on the floor for a while and has trained a lot of the newer nurses on the floor. Many of the nurses still come to her for advice and for her opinion on a certain issue. Another example would have to be the charge nurse as a legitimate type of power. Since that nurse is charge they are having the final say in a decision that may be made dealing with a certain issue. Also the legitimate type could be used as any RN on the floor to as the power given to them through their degree in nursing (Miller, Maloney & Maloney, 2012).

Delegation

- **Discuss delegation with your preceptor. What are your preceptor's ideas/thoughts on delegation?**

The role of delegating to an aide is a vital role in the nursing process that allows you to delegate a job that the aide is able and legally do per law (Ohio Board of Nursing (2011). It is nice to have an aide on the floor to help you out with getting vitals, daily weights, help turn patients, and giving baths. I also found out that the nurse aides can do EKG's on the floor for the nurses. This is something different than I was aware that they could do I am assuming Aultman is training the aides to do this on the floor. It is nice to have an extra hand when going into the room to turn or clean up a patient instead of having to wait for another nurse to help you. An important issue to remember is that you as the nurse are still responsible for what that aide does that is delegated to them. The nurse should still follow up and make sure the task was completed to the nurses level (Marthaler & Kelly, 2012).

- **How is delegation performed on your unit?**

Some of the time there is an aide on the floor you are able to delegate tasks too. The aides on this floor know what is expected of them and do not need much delegation except on specific task that a nurse may need help with. Most of the time I have been on the floor there is not an aide on the floor so the nurse is responsible for all the care of their patients.

- **Discuss examples of appropriate and/or inappropriate delegation decisions you have observed on your unit.**

An example of appropriate delegation would be asking an aide to help the nurse turn and clean up a patient that has soiled the bed and needs a bed change and cleaned up.

An inappropriate example would be having an aide do a job or task that the aide is not legal allowed to do. This could be giving medications to a patient that is not allowed by and aide is reserved for a nurse to do (Marthaler & Kelly, 2012).

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.*

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

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.*

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 what a good and bad level is but nothing beyond that for this goal. It will be hard to educate family members with me doing midnight clinical and the fact the family members are not there at night to often.

60-120-hour goal: *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.*

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.*

This goal was met and performed every time I went into the room. I picked up anything that was out of place to clean the room to prevent falls for the staff and the patient. If I used dressing I would clean up the wrappers and never leave them in the room and if 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: *Demonstrate when dealing with a ventilator patient the importance of mouth, trach care, and suction for a patient to keep the patient safe.*

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.*

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 one that I did try but of it was the patient's veins were small and rolled which I have not had much experience with until now.

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.

Part III. Professional Reflection Using Gibbs' Reflective Cycle

The first 56 hours of my prectorship was and experience in more ways than one. The first day I went in to the unit and everyone looks at you because they don't know who you are or what you are doing here. It is just a natural response people have and at this point I have been exposed to it enough that it doesn't bother me to much anymore. I to the unit about 30 minutes before the shift had started but the staff don't usually come out or get to the floor until 10 minutes till it is time to take report. This was a change for me since I like to be ready to go 5 minutes before it is time for report. My preceptor got there on the floor and she introduced me to some of the staff and what the routine is before the shift starts. She showed me the computer system since I had not used it in over 2 years and it was only for a semester. After looking up our medications, orders, and tasks we needed to do for the shift we went and go report from the previous outgoing nurse (Gibbs, 1988).

The first day I observed the nurse for the first half of the shift and learned and picked up what I could from watching the preceptor. I learned best by demonstration and observing others and their routine so this was the best way for me to what I was capable of doing later on in the hours and future days. The last half of the shift I took 2 patients and did their focused assessment and other task the patient had did all the charting and report to the oncoming nurse

for my two patients. It was a good way to ease into the precepting and I was glad I got the opportunity to start off this way (Gibbs, 1988).

Throughout the 56 hours after the first day I took mainly the whole team and did very well having my medications and tasks completed on time. After the second day I was pretty much on my own and was doing everything without the preceptor over my back. She didn't want to be on looking over my shoulder all the time and it was very pleasant feeling to be on my own at a clinical. I don't like people watching me but I have gotten used to it with families in the room when you are assessing a patient or giving medications or completely other tasks. In my opinion it is easier to do with family in the room rather than a peer or in this case a preceptor in the room with me (Gibbs, 1988).

Many of the patients I had were mainly some type of repository, heart, and kidney related issue such as pneumonia, COPD, CHF, and acute renal failure. I had three ventilator patients to date so far and would not mind more of these patients. I know most of these patients are a lot of work but I want the experience with these patients now while I am precepting. I want the experience now before I get out on my own so I know how to handle that situation if I run into it on my own in my nursing career. I am normally a calm person even in code and rapid response situations but it helps to know what you are doing so you can stay calm in a critical situation (Gibbs, 1988).

Some of the experiences that I have gained a better understanding of are ventilators and there settings and the importance of watching theses patients close due to their critical state. I never got a chance to draw blood from a PICC, central line before until now and it was a new skill that was gained that will be very useful in the future. I also was not very strong with using their IV pumps and hanging piggyback due to never really getting to hang too many of them on

other clinical sites. I was involved in a rapid response of one of my patients and it wasn't my first rapid response but it was the first one I have been involved in that the patient was one I was taking care of and was the actual nurse. It was just a different perspective thank what I was used too (Gibbs, 1988).

I had mainly positive experiences in learning new skills with the IV pumps and drawing blood from the central line and the computer charting system at Aultman. The experiences I had that I did not like that more frustrated me was when I would not chart something the way it was supposed to be charted and the preceptor had to show me to chart it this way or when I didn't read the strip right and when I thought it was a certain rhythm it was in fact a different one. I understand that this is just part of learning and no one is perfect just don't like to not have the answer or be wrong if I can help it. Overall I feel I did quite well in my first 56 hours and I know that I still have some areas to work on in my charting especially in their wound, and in-depth parts of charting that I may not have had to use yet and read strips (Gibbs, 1988).

If I came across the same issues had in the beginning of the 56 hours compared to know that they are over of course I would be better off now. I do not think the patient that I had to rapid that had the stroke like symptoms outcome would have really been changed by anything that I did. I think the alter status the patient went in to would have happened regardless of anything we did with the patient. It ended up not being a bleed as we had suspected since she was on heparin drip. So this clot could have been brewing for a while and just then clotted off enough to have theses symptoms. We did what we could and call the rapid and got the patient off the floor and doctors, and family members called. Literally she was fine 30 minutes before this happened making jokes and watching TV. My preceptor and others nurses had including myself had been in that room the whole shift and never saw anything out of the ordinary until

that moment. It just proves that a patient can go south that quick. Even though she was having this change in status she was still with it and really had no real deficits to one side or another just the speech was slow and some words not coming out write. I am really not sure there really could have been on any alternative plans she was on a heparin drip to prevent any clotting and it still happened. I just wish it didn't happen but it did and there is no way to turn back time (Gibbs, 1988).

Professional Issue

Situation:

The patient is a 70-year-old African American that is on the unit with repository issues and distress. She has a history of COPD, cancer that has metastasized over much the body including lungs and breast. The patient's entire body was flaccid and the patient could only open their eyes to stimuli and touch. The patient was currently on a vent and was trached with a peg tube. The wounds on this patient were the worst I have ever seen. I have seen my fair share of what I thought was a bad wound but I felt so bad for this woman when I saw what wounds she had and what she was going through. Her breast was an open wound that was actively bleeding that had cancer in it and was just eating away at the breast. It was actively seeping from the breast with right red blood. I t was covered with abd's and 4x4's that had to changed twice on my shift around. This was not getting addressed by the doctors at this time due to per the stay doctors were hospitalist. The next wound is the worst I have ever seen in my life, the women is a big women over 300 pounds and her entire but was one big open wound. It started above her coccyx and down both sides to the beginning of the thighs. It was red and meaty, with a foul

order and you could even see part of the spine on the patient. This wound was left open and we were just changing the pads under the patient.

The patient also had a tube feeding that was on hold per the doctor and I went to pull back residual and stopped pulling at 240cc and patient also had a temperature of 101.6. The doctor was called and made aware of the high temp and didn't want to do anything about it at this point in time. The tube feeding was on hold and left off and per order the patient was put to suction through the peg tube. This was about halfway through the shift at this point and within for hours the patient had 1000cc in the canister from suction. The patient's doctor was hospitalist and did not think the patient deserved to be a full code at this point and were basically not doing anything for the patient. This is per what the staff had been saying who had the patient previously. The family was never there and did not come in at all and if a decision needed to be made it was done on the phone per the staff. This was not even the worst part it was said per the staff that the patient's social security checks were going to her son at this point. It was rumored that the family may be keeping her alive for the checks. I cannot confirm or deny this rumor but it was true it really makes me sick. The pervious nurse also told us that the doctor did not want the patient to be coded or rapid responded because they were not going to transfer to the unit because they felt her code status should be changed due to her critical condition. The hospital was also tying to get guardianship of the patient due to the family issues of the family not ever being there and not making decisions and not answering the phone on calls. It was just an all around bad situation that should have never went this far and it really hit home just how mean some people could be.

Action:

The nurses and I kept the patient as comfortable as we could during our shift. I changed the dressing on the breast that was seeping twice during my shift due to it being soaked. We also changed the pads under the patient every time we turned the patient every two hours. Suctioned the patient very often to make sure airway was clear and also called the doctor about the high temperature, and large residual amounts from the peg tube. Everyone did the best they could with this patient and everyone felt sorry for this patient. Some of the staff didn't even feel comfortable taking care of the patient because the doctors didn't even want the patient to be coded or rapid response. My preceptor did end up going to her manager about this issue.

Outcome:

In the end when we left our shift the patient was as comfortable as we could have made her. I heard over the weekend my preceptor and I did not work from a nurse that was their that the patient ended up getting transferred to the unit after her pressure dropped to 70/something and she ended up pass on shortly after that per the nurse we talked too. I have felt patient's pain before in my career but never did it hurt as bad as it did with this patient. It was a relief for me to hear the patient had passed on it felt like something had be lifted off my shoulders and my preceptors and other nurses felt the same way.

Reflection:

Basically the discussions were all around the family not ever being there and no one caring family wise for this patient. The rumor that the family kept her code status on full for the social security checks that the son was currently receiving in the mail. Another issue that the preceptor and I was discussing was the lack of care the patient was getting we felt from the physicians that were covering this patient. Due to the lack of action from the doctor regarding the temperature and tube feeding situations we didn't have much faith in the medical staff at this

point. The guardianship issue was currently going through the works of the committees to get approved and this was also an issue that was discussed that made the social security check rumor and that's why code status was still full code look even more realistic. Another issue that was brought up and discussed by my preceptor to her charge nurse was the fact about supposedly the doctors not wanting the nurses to call a code or rapid on this patient. My preceptor told the charge nurse she felt uncomfortable taking this patient because of the issue with not being able to call a code. Although they must of at some point to get her down to the unit when we were not there I am assuming unless the doctor just transferred the patient to the unit. I know my preceptor did have a conversation with her nursing manager about this issue so the manger may have done something too.

Before I ever was an LPN my thoughts were always to preserve life it was just the way I felt it was to be done. Then I went through school and practiced as an LPN for over two years and you learn that preserving life is a good idea but with some issues. You are taught to persevere life as a health professional but also as nurses to provide the patient with as much dignity and respect as can be achieved that the current situation will allow. I had started in my career as an LPN and even in the news about issues where sometimes the family interests are above the patients. I believe this was the case in with this patient and it made me sick to think that the family may have been keeping her alive and on full code for their own gain. Although I cannot support this but do know the family never came to see the patient and everything was done over the phone if the nurses could even get a hold of anyone in the family. The other fact that the hospital was trying to get guardianship of the patient puts into question what was really going on with the patient and the family too and lastly the lack of action taken by the medical staff for this patient really put into doubt the finals weeks and months that a patient faces too me.

I know how I would be in this situation and it's not what I would have wanted. That wound on the patients back side had too hurt and she was getting morphine every four hours scheduled but you got to wander if that medication was even touching that pain she was having. From what I could tell she was comfortable not breathing to hard and heart rate not really high but other than those signs she could not tell me what was going on with her. My issue is that sometimes the family may not be thinking of what the patient would have wanted and are just doing what any person would do without medical or health rated background get the person alive. I just think the policy on near end of life situations needs to be more clear and brought to the attention of the family or patient making the decision and not beat around the bush just tell it like it will be if you decided to do this then this will happen. Give them time to make the decision but no false hopes and leading the family down the wrong path. Or in this case make sure the family understands this is what is going on with your; loved one and maybe in this case show the family the wounds and see how ill the family member really is not just over the phone. In the end it has changed me for the better and as far as end of life decision-making and care I will remember this monument for the rest of my life and it will empower me to make sure no one has to go through what this patient did. It will serve as a reminder for me to always try hard and get everything you can for the patient within what the circumstance will allow.

The article I choose to use to try to explain this sad patient case is *the Legal aspect of end of life care* by Claire M. McGowan, RN, MS, JD, CCRN. The article talks about end of life decisions and how sometimes the family may have different views than what the patient would have wanted. The issue then would go to a bioethics committee and to court to gain a type of guardianship in some cases or to rule in one favor or another. Basically there are always two sides in an issue and it is the courts job to decide what is bioethicaly correct and best course of

treatment or end of life treatment for the patient. This article focused on different milestone cases throughout the years but the main topic to get out of the article is the fact that courts sometimes need to step in and make decisions when the family may be wrong or emotionally compromised or in my patients case never there to make decisions on her behalf. This is why in the hospitals mind guardianship was the best choice for the patient. It may not be liked by the family but in the end the patient didn't need to be treated like this and kept alive for someone else's gain (McGowan,2011).

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