

40 Hour Practicum Journal

Preceptor: Hallie Miller

Mercy Medical Center

Kent State University

College of Nursing

Fall 2011

By

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## 40 Hour Journal

*Part One: Integration of Leadership and Management*

**Staffing.** When I discussed staffing with my preceptor, she told me that on 7 Main at Mercy Medical Center, staffing is not done based on the acuity of the patients but actually on the population number. She gave me the example that if there are twenty-five patients then five nurses will be staffed. Most units at Mercy will be based on acuity. She told me that in the ICU or CCU, nurses may only have two or three patients due to the need to constantly be watching their patients. 7 Main works on the nurses having six to seven patients and that is it.

According to Kelly (Patricia, 2012), the American Nurses Association (ANA) supports taking into consideration the following variables when determining staffing: patient characteristics, intensity of nursing care, context of the unit, and staff expertise. A patient classification system is a measurement tool used to articulate the nursing workload for a specific patient or group of patients over a specific period of time (Patricia, 2012). Classification data can be used to predict the amount of nursing time need based on a patient's acuity (Patricia, 2012). As a patient becomes sicker the acuity level rises, meaning the patient requires more nursing care. As a patient acuity decreases, the patient requires less nursing care (Patricia, 2012). Historically, patient census was used to determine staffing needs. This method of patient census staffing was proved to be highly inaccurate because of the variability of patient care needs (Patricia, 2012).

The bill Ohio HB 346 requires hospitals to establish staffing plans, with meaningful input from direct patient care nurses, which are consistent with the principles of safe staffing developed by the American Nurses Association and other nationally recognized organizations. Evidence-based nurse staffing level recommendations will be used to guide all staffing decisions. This is not a one-size fits all approach to staffing. Instead, it provides hospitals with the flexibility of tailoring nurse staffing to the

specific needs of patients, taking into account critical factors that should guide the highest level staffing decisions. According to a journal from [www.ohnurses.org](http://www.ohnurses.org) this bill according to Bianca Miller, “took nursing a step in the right direction with the bedside nurses have a voice in staffing decisions”. Ms. Miller powerfully stated, “In order to feel respected and valued an organization needs to include the nurses in everyday operations. A committee with bedside nurses, hospital administration, and nursing management needs to be established.” A copy of the bill can be found here <http://nursing2015.files.wordpress.com/2008/10/sdoc1418.pdf>.

**Change/Power/Conflict.** I think the things that could be changed on 7 Main would have to be the help that the nurse assistants get. I’ve seen one nurse assistant break down and cry because she was constantly putting patients on and off bed pans and bedside commodes and getting them up to go to the bathroom and she wasn’t getting any help because another nursing assistant was not schedule on that floor at that time. The only way I could really initiate that change would be to try and help the nurse assistants out as much as possible with the little things that I can help with. If a patient needs on a bedpan and I’m in the room there is no need to go out and find a nurse assistant. I would definitely utilize my own skills and any down time I had. Helping the nurse assistants would decrease the amount of frustration they have with possibly feeling like they are getting everything pushed on them.

According to Kelly (Patricia, 2012), there are seven different types of power. Expert, legitimate, referent, reward, coercive, connection and information are all types of power. Expert power is power derived from the knowledge and skills nurses possess. The more proficiency the nurse has, the more the nurse is received as an expert (Patricia, 2012). Legitimate power is power derived from an academic degree, licensure, certification, experience in the role, and job title in the organization (Patricia, 2012). Referent power is power based on trust and respect that people feel for an individual, group,

organization with which one is associated (Patricia, 2012). Reward power is power that comes from the ability to reward others to influence them to change their behavior (Patricia, 2012). Coercive power is power that comes from the ability to punish others or take disciplinary actions against others to influence them to change their behavior (Patricia, 2012). Connection power is power that comes from personal and professional relationships that enhances one's resources and the capacity for learning and information sharing (Patricia, 2012). Information power is power based on information that someone can provide to the group (Patricia, 2012). I'd have to say that I have come into contact with or observed many of the nurses on the floor displaying many of these types of power. Every single person on the floor demonstrates legitimate power just by having their badge say RN in red under their name. And most of the nurses I observed expert power just by their knowledge of the medications they are passing and diseases and disorders. I'd say that most of the nurses on the floor demonstrate connection power just by being able to share with one another and have a good working relationship. When it comes to referent, reward and coercive power I don't really think I have seen those just yet, that or I just don't notice the reward or punishment of the nurses on the floor.

I haven't observed conflict on the unit I am on as much as I have observed the nurse assistants being stretched so thin to cover so many patients that have high acuities. Two nurse assistants are usually staffed on 7 main. On September 9, 2011 7 main was supposed to receive a float nurse assistant from 2 main but the float nurse never came so the one nurse assistant was left to help all the nurses on the floor. After the first 8 hours were so stressful she learned that they were not receiving another nurse assistant and she began to cry because she was so worn down and stressed. Issues of power and conflict are not new in health care environments (Eagar, Cowin, Gregory, & Firtko, 2010). Woelfle and McCaffrey's (2007) study of New Zealand new graduate nurses revealed one-third of respondents ( $n = 551$ ) had experienced comments that were 'rude, abusive, humiliating or involved unjust criticism' (Eagar, Cowin, Gregory, & Firtko, 2010).

*Part Two: Goals*

My first four goals, two were geared toward the entire 120 hours of clinical time. My two goals that were geared toward my first forty hours, I believe I was able to accomplish my second goal, which was being able to demonstrate good time management skills and prioritizing of patient(s) treatments and medication administration for at least three patients. I believe I was able to focus on the treatments and medications that had the highest priority and properly administer all medications. My first goal I did not accomplish because no IV's needed to be placed. I'm hoping that my next 40 hours I will be able to properly place IV's. My other two goals, I feel like when asked about medications I was able to properly verbalize the indications and actions and severe side effects such as watching blood pressure and heart rate. And also I believe that I demonstrated effective therapeutic communication skills between patients and their families. One example was a female patient of mine, when pressure was applied to her arm by taking her blood pressure or tourniquet. She would be in so much pain, so when I went to take her blood pressure and take her hep-lock out I talked to her about her family. She was so distracted with talking about her family she didn't even notice the pain as much. She didn't wince at all.

My goals for my next forty hours should set the bar higher than what I can accomplish now. I am keeping two goals from the previous ones as they pertain to the entire 120 hours. My first new goal is I will integrate myself in the unit as a member of the staff based on the relationship-based care model. This includes making myself available as a member of the team that can be delegated to as well as delegating tasks to the unit RNs. My second new goal is to demonstrate good time management skills and prioritizing of patient(s) treatments and medication administration and assessments for three to four patients as by charting appropriately on those patients throughout a 8 or 12 hour shift. My 3<sup>rd</sup> new

goal is to become able to understand the telemetry strips as by telling my preceptor what I believe the patient is experiencing in an 8 or 12 hour shift. My 4<sup>th</sup> new goal is to demonstrate proper discharge of a patient with medication information and all questions answered at least once in the next 40 hours.

### *Part Three: Professional Reflection*

What I experienced during my first 40 hours was information and situations that I will come across everyday as a nurse. In my first 3, 12 hour shifts I was able to properly hang IV solution, draw up and administer medications, pass oral medications, obtain blood sugar levels, clear IV pumps, give SUBQ and IM injections, hang antibiotics, and do dressing changes. This is all stuff I had done in the past but doing it on a regular basis gave me the opportunity to have those actions become like a second nature. The first thing I do in the morning when I'm doing my assessment is make sure that there is enough IV fluids hanging and if low go and get a new bag. I also feel more comfortable drawing up medications and administering them. Overall the feelings I was experience were the feelings of this is what I will be doing on my own soon, it made me nervous in a way but I also felt empowered by the fact that I have come this far and can show what I know. I do feel inferior sometimes while up on 7 main and like I'm not going to get the hang of things. I think based on what I have already observed and done that as soon as I can get into the flow of things I will be able to not feel inferior and assume my responsibility as an RN. I feel like I could handle the situations I have already experienced better now looking back on things because I was getting feedback from my preceptor. I feel that I handled situations well the first time around but there is always room for improvement. Overall I was satisfied with this set of hours I am just looking forward to being able to practice more nursing skills such as IVs, foleys, NG tubes, etc.

*Part Four: Professional Issue*

The professional issue that I choose to talk about was a medication error on the end of the pharmacy. It was my very first patient going into the room with Hallie Miller and she began to show me the new medication handhelds. We had scanned a medication and it had said order not found. So Hallie and myself looked at the medication package and the handheld and noticed that the medication the pharmacy had sent up was a medication that was XL and the patient needed the medication that was SR. Hallie explained to me that if that would have been a paper MAR the nurse may have only looked at the first word and the dosage and completely missed the fact that it was the wrong medication. The handhelds are like a safety net that picks up if a medication is not ordered or the dose is wrong. Hallie proceeded to call down to pharmacy and explain that they had sent the wrong medication up and that we needed the right medication STAT. The outcome of the situation was that the patient ended up receiving the right medication, the SR form of the medication. A very simple professional issue I'd say, but something as simple as the wrong release type of a medication has a drastic effect on a patient. This could have been a very big problem but because the handheld cross checked it with the patient's MAR the error was caught and changed.

Afterwards at lunch when my preceptor and I had a chance to further talk about the medication error that morning we were just shocked that people who go to school to go into the business of dispensing medications to units at a hospital could make a simple error such as not reading what type of release the medication is. Had the patient needed the medication to be released rapidly into her system and she received a slow release form she would have never gotten the medication she needed. Despite advancement in technology (the handhelds instead of paper MARs), medication errors continue to cause patients harm and thousands of deaths annually (Prusch, Suess, Paoletti, Olin, & Watts, 2011).

Intelligent infusion devices (IIDs), bar-code-assisted medication administration (BCMA), and an electronic medication administration record (eMAR) have been effectively implemented at our health system, contributing to a decrease in medication errors, a strengthened collaboration between pharmacy and nursing, and a culture of patient safety (Prusch, Suess, Paoletti, Olin, & Watts, 2011). This article did a study and the purpose of this project was to improve medication safety through the integration of these technologies and decrease the potential for error during IV medication administration. Whether it be PO medication or IV medication there should still be multiple checks that are done to make sure the right patient is getting the right medication. Each patient has 5 rights, right patient, right route, right dose, right time and right medication. I have become even more careful when passing medications especially if I have a lot of medications given at one time. I am sure to check the dosage on the computer MAR then check the medication against the MAR when I'm pulling it out of the medication cart, and then also again when I am scanning the medication. The saying goes you can never be too careful and I would rather take an extra minute or two out of my time to make sure that as a nurse I am giving that patient their 5 rights. The incident did change my perception of the original event because now its as if you can trust no one. Even though pharmacy is supposed to check the medication against the MAR they obvious might not read the entire drug name. So seeing as how I'm the middle man between the pharmacy and the patient getting that medication I feel like it is even more of a duty that the nurse check every single medication sent up from pharmacy on their shift.

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