80 Hour Practicum Journal

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Part One: Integration of Leadership and Management

Delegation

"The American Nurses Association (ANA) defines delegation as the transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome" (Marthaler & Kelly, 2012, p.369). When discussing delegation with my preceptor, Hallie Miller, her thoughts were that it is really important to know exactly what the person is able to do under the law. She said, "If you are not sure just do it yourself." Delegation on 7 main is performed appropriately. The nurse's aides usually do the vitals, change the sheets, do the baths, help patients to the bathroom and are able to place telemetry on the patients. The LPNs are assigned patients however an RN is also assigned to cover that patient as well. The RN does all IV requirements except if the LPN is certified. LPNs are not allowed to touch PICCs, central lines, hang anything with potassium, blood or give any IV pushes. The LPNs are also not allowed to take orders from the doctors or complete admissions. The AACN (2008) suggests, "Assessment of five factors that must occur before deciding to delegate":

1. *Potential for Harm*: determine if there is a risk for the patient in the activity delegated.
2. *Complexity of the Task*: delegate simple tasks. These tasks often require psychomotor skills with little assessment or judgment proficiency.
3. *Amount of Problem Solving and Innovation Required*: Do not delegate simple tasks that require a creative approach, adaptation, or special attention to complete.
4. *Unpredictability of Outcome*: Avoid delegating tasks in which the outcome is not clear, causing volatility for the patient.

5. *Level of Patient Interaction*: Value time spent with the patient and the patient's family to develop trust. (p.374)

"Each state nurse practice act and its related rules or regulations, augmented by professional nursing organizations' adopted standards, define the legal parameters of nursing practice, including delegation" (Davis-Alldritt, 2009, pg.180). There are certain tasks that RNs cannot delegate to LPNs or NAs. Davis-Alldritt suggests that: "As a guide to delegation decision making, the nurse should consider the five rights of delegation; Right Task, Right Circumstances, Right Person, Right Direct/Communication, and Right Supervision" (National Council of State Boards of Nursing, 1995).

As a student I do not feel comfortable delegating tasks to LPNs or NAs. I have delegated an aide to help get a patient off the bedside commode and back to bed. I try to do as much as I can for my patients so that I can get a better idea of having to manage total care of several patients if an aide is not available. I personally have not seen any inappropriate delegation of nursing tasks on my unit. I was told by Hallie about a situation that had occurred once when a nurse had asked an aide to obtain vitals on a patient. The patient was not doing well and even though the vitals were reported back to the nurse and action was taken quick enough the patient still ended up coding and not making it. She said, "When there is a change in the status of a patient the nurse should be taking primary care of that patient. Others can help with the patient but the nurse needs to know exactly what is going on and happening with the patient." Appropriate delegation to nurse's aides are things such as, "assisting with ADLs, bathing, toileting, ambulation, transport, feeding, measuring intake and output and documenting the care that they give" (Marthaler & Kelly, 2012).

Time Management and Prioritization

Stepping onto 7 Main in the morning thoughts about patient care and how the day will be organized run through my head long before patient assigns are even given. My preceptor and I prioritize our care based on patient acuity. Patient acuity is defined as, "The measure of nursing workload that is generated for each patient" (Bernat, Fisher & Vottero, 2012). Situations that take first priority are, "Life-threatening or potentially life-threatening conditions" (Maloney, 2012). Second priorities are, "Activities essential to safety" (Maloney, 2012). The third set of priorities is, "Comfort, healing and teaching" (Maloney, 2012). After rating our patients acuities, with one being low need and five being high need, we decide our routine for our patients. "Routine brings about a sense of predictability, sense of time control and familiarity, and is relevant to time management" (Waterworth, 2003). Hallie has said that, "Throughout the day patient's statuses may change, thus acuity level will change and therefor the routine may change." An example of this was Tuesday October 11th, a male patient had an acuity of 3 due to circulatory issues. He had +3 to +4 edema in his lower extremities, scrotum and upper extremities. His blood pressure at the beginning of my shirt was 78/62. When taking his noon telemetry vitals his blood pressure was 74/62. I brought the decrease to my preceptor's attention, she began to handle the issue at hand and the patient was eventually transferred to 10 Main for an IV drip. His blood pressure dropping raised his acuity level to the highest priority. By the time the patient was settled in his room on the tenth floor his bilateral lower extremities from his knees to his ankles were cold and blue.

I feel that I have appropriate time management skills because I feel I am prepared when medications are due and that I do not need to be told to do many things. I write down important times when patients need their blood sugar levels checked, IV bags will be close to empty and pass important medications. I feel I am still working out a system that covers everything and that

in my last 40 hours I should be able to effectively prioritize my care and reflect good time management by completing skills in appropriate timing. The one strategy that I have learned that has helped me a lot was writing out a timeline. I start with 9AM and write each following hour down in a line. When a medication is due I write, $794^{1\,(3)}$, 794 being the room number, 1 being bed number 1 and 3 is for how many medications are due to be passed. This has been very helpful to me. I also write down the times telemetry vitals and glucose levels are due. I make a check mark next to the tasks I have completed so I can make a running list of things that need done and things that have been completed. In Waterworth's study:

> The focus is on two time management strategies that, on the surface at least, present as an acceptable face of time management. The evidence suggest that one of these, prioritizing, is an expected time management strategy and that other actions such as delegation are given professional approval and considered important skills for effective management of patient care. (p.438)

My understanding as a nursing student is that to be a good nurse I have to have excellent time management skills and be able to delegate properly. I feel that I am still working on my time management skills and working towards being able to delegate properly.

Part Two: Goals

Reflecting on my goals from my first and second set of 40 hours I would have to say that I have accomplished all but a few of my goals. Going back to my first set of forty hours my goals were that I would like to demonstrate the ability to perform 5 IV insertions and maintenance of infusions using proper technique within my first 40 hours. I did not complete this goal in my first 40 hours but I have complete three successful IV starts as of October 15, 2011. My second goal was that I wanted to demonstrate good time management skills and prioritizing

of patient(s) treatments and medication administration for at least three patients. Using the word "good" was a problem because there is no way to measure that. But I feel that I accurately and promptly demonstrated care for at least three patients in my total 80 hours. My third goal was that I would be able to verbalize the indications, dosages, physiological responses, and adverse/side effects for the top 20 most commonly encountered medications with the patients on 7 main at Mercy throughout my entire practicum experience. I feel that I have been able to complete this goal every day that I am on 7 Main. My last goal was to be able to demonstrate effective therapeutic communication skills between patients and their families as needed on 7 main throughout my entire practicum experience. I feel that I have been able to communicate therapeutically with patients and their families every day I am on 7 Main. I could sit and just talk to some patients all day and hear how they are doing and what is going on with them.

My goals that I set for my second set of 40 hours were that I would 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. I feel that I have accomplished this goal because other members of the team can approach me and ask about my patients and can ask for help if I am available. I always put my patients first but I am always listening for skills that I could benefit from doing. 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. Again I used the word "good" and I will say that my time management skills and prioritization skills did improve and I did not feel as overwhelmed as I did in the first 40 hours. My third 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. I did not accomplish this goal due to not being able to ask my preceptor to explain what to look for. I do plan on making a copy of the charts in our break room and applying that information to patient's telemetry strips. My fourth 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. I was not able to accomplish this goal either seeing as how patients I was in charge of were not discharged. I did listen in on a discharge during my first set of 40 hours and I plan on accomplishing this goal before my practicum is over.

For my last set of 40 hours I plan on keeping all the goals listed above and also adding a couple new ones. My first new goal is that I want to demonstrate time management skills and prioritization of patient(s) treatments and medication administration on four to five patients by charting in a timely manner. Today at practicum I felt very proud of my time management and prioritizing skills by having all my tasks completed and charted well before the deadline my preceptor had given me. My second goal is to be able to verbalize appropriate and inappropriate skills that are delegated to the LPNs, aides and other RNs to my preceptor to show understanding. I feel delegation skills are something I should learn and have practice with during my time as a nursing student. My third goal is I would still like to demonstrate understanding of the telemetry strips as by telling my preceptor what I believe the patient is experiencing. This is a skill that I feel would make me a better nurse if I would like a position on a floor like 7 Main. And lastly I would like to demonstrate proper placement of IVs, foleys and be able to hang antibiotics and IV bags without verbal assistance from my preceptor. I still do need practice with a lot of my skills and I have not gotten the opportunity to do many on 7 Main. I have had to date three successful IV starts, one foley attempt, one foley removal and emptying a surgical drain. I feel confident in my nursing skills and any practice is welcomed.

Part Three: Professional Reflection

During my second set of 40 hours I experienced different situations that I will come across at least once a shift while I'm a nurse. I continued to get experience in properly hanging IV solution, administering medication in a safe and timely manner, monitoring glucose levels and administering insulin if coverage is needed in a timely manner, hanging IV antibiotics, emptying surgical drains, PICC line dressing change and dressing changes. The start of my shift I listen during report and the patients that I am assigned I assign acuity to help prioritize my care. I obtain vitals and an assessment and report any abnormal findings to my preceptor in a timely manner. Throughout the day I plan my care by writing down what time my patients have their medications due to stay on task. I always check to make sure that my patients have everything they will need throughout the day whether it is personal care items, IV fluids if their bag is getting low and anything else the patient may need throughout my shift. When my shift is coming to an end I make sure that the oncoming nurse knows everything important that has happened through my shift and anything she may need to know.

The second set of 40 hours I was feeling more confident in my nursing care and I received a few compliments from patients that I will make a wonderful nurse in the future. When I hear that I'm such a caring and compassionate person it makes me love what I'm doing even more. When I first started nursing school and started in my clinical rounds I always got the impression that patients view nursing students as people who do not know what they are doing. During my practicum, patients have treated me like I am their nurse and even though I may not have all the answers they are looking for I always make the attempt to get in contact with my preceptor who may have the answers that I do not. I am still feeling nervous about certain

aspects like my skills because I have not gotten the opportunity to complete a lot of them. I feel very confident in my medication administration and IV/PICC patency maintenance.

What I enjoyed about this set of 40 hours is that it was different than my first set of hours. It only had a few more skills, such as emptying a surgical drain, but the patient situations were different. In my 80 hours I've had patients with cancer, gastro problems, integumentary problems, surgical patients, cardiac problems and psychiatric illnesses. I've had patients be hospice status, taken to ICU, brought from ICU to our floor, and I've also had cardiac patients. I feel I have had a wide range of different types of patients, diagnoses, and the care that comes along with the patients. I would not say I had any bad experiences during my second set of 40 hours. Any experience is a learning experience and I welcome any experiences because that will just make myself a better nurse and I will be able to deal with situations as they come. I feel that if presented with the same situations that I would be better prepared to handle any of the situations that I encountered. Going into my last set of 40 hours I plan on continuing to complete each shift to the best of my ability and to learn from every situation that I encounter.

Professional Issue

As stated in the study by Kelly, Brandon and Docherty: Documentation of patient care is a fundamental, yet critical, skill used by nurses to communicate the current health status of the patient's individual needs and responses to care (Bjorvell, Wredling & Thorell-Ekstrand, 2003). While working on 7 Main, I experienced a situation where the computer system, MediTech, was down for two shifts. Every health care member was required to chart everything on paper. We were told throughout the day that it would be up at 9:30 AM, when the time came it was not up. We were told several times throughout the day that it would be up and each time we were very

disappointed when it still was not up. Hallie decided it was best for me to just focus on completing skills, passing medication and doing patient care instead of charting.

When discussing potential problems with MediTech being down, the conclusion I came to was that there is less nurse-patient interaction due to more time being spent on charting. Kelley, Brandon, & Docherty's study suggests:

> Similar to paper-based documents, electronic systems contain flow sheets to gather information about an individual patient's needs and plan of care. However, electronic nursing documentation introduces new features such as copy and paste (Siegler & Adelman, 2009), electronic interfaces (Kroth, Belsito, Overage & McDonald, 2001), and structured drop-down menus (Kossman & Scheidenhelm, 2008), not found in paper documents. (pg. 155)

With these features I believe that nurses are able to chart more efficiently and spend more time with patients and on their care then with paper charting. Robles (2009) stated, "These features of electronic nursing documentation are seen as time savers for nurses, they may alter the processes by which nurses assess and critically think about the patient status and care." The article, Electronic Nursing Documentation as a Strategy to Improve Quality of Patient Care helps in the understanding of whether or not paper charting and electronic charting gives a difference in the outcome of patient care. "Given that electronic documentation has both strengths and potential for weaknesses that may lead to errors, investigation the existing literature on the use of electronic nursing documentation for the provision of quality care to hospitalized patients is imperative" (Kelley et al.) The situation's outcome was that the entire staff on 7 main was stressed out because of essentially the "extra work" that had to go into paper charting. I think if the situation would present itself again in this last set of hours that my preceptor would again

chart everything that needed to be charted. I was comfortable telling my preceptor what needed to be charted. I am actually thankful for electronic charting because it allows me to sit at a computer and chart on multiple patients as opposed to having to get multiple charts.

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