Emergency Department Practicum

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Nursing 40045- Integration of Leadership and Management in Nursing

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60 Hour Journal

Emergency Department Practicum

Integration of Leadership and Management

Quality Improvement

The Intensive Care Unit (ICU) at Aultman Hospital is involved with continuous quality improvement. The data for quality improvement is obtained from audits. For example, the daily Braden Score and the Morse Score are attained for quality improvement. Skin breakdown prevalence is charted every week on Tuesdays. Nurses are involved with quality improvement on a daily basis because of Braden Scoring and Morse Score. This is why accurate and adequate charting is needed. Team consultants are also consulted with which barrier cream would be best for the patient's skin breakdown. This data is evaluated by looking at the charting, audits and the National Database of Nursing Quality Indicators (DNDQI). The unit director is responsible for providing evaluation data to the nursing unit. Areas of ICU that may benefit from quality improvement include bereavement. For instance, ICU is providing bereavement baskets to patient's families. This was an idea that needed to be approved by the Board of Directors that shows nurses in an empathetic light. These baskets provide blankets and a locket of hair of the loved ones.

Quality improvement is a continuous process that is constantly looking at trends so that patient outcomes can improve. One of the main parts to quality improvement is standardizing care. Flores, Hickenlooper, and Saxton (2013) stated "We believe that incorporating the QI process into a nursing research course and providing "real life", "real time" QI learning experiences is a viable strategy to ensure that new graduates are prepared to participate in the QI process" (p. 10). Educating nursing students before they become nurses can help with the transition of applying quality improvement to their nursing discipline. Standardizing care can

help reduce the risks related to medical errors because there is a set of steps healthcare providers follow. There are two methodologies implemented to improve the quality in hospitals. This includes the Plan Do Study Act Cycle (PDSA) and FOCUS method. Benchmarks are used to monitor quality and allow hospitals to compare the level of quality in various hospitals and the national average. The main thing with quality improvement is that decisions should be driven by the data (Kelly, 2012).

Evidence-Based Practice

The ICU utilizes evidence-based practice. There are protocols to follow that are based upon research studies. For example, spontaneous breathing trails are initiated daily for qualifying ventilator patients. This is to help wean patients off a ventilator. Research has shown that this reduces the length of mechanical ventilation support as well as reduces the ICU length of stay (Symrnios, 2002; Vitacca et al., 2001). Another protocol I reviewed was related to glycemic control. Research has shown that effects of hyperglycemia are detrimental and can result in inflammatory response. This can contribute to a higher mortality in ICU patients. In addition, glucose should be maintained between 80- 110 mg/dl (Holzinger, Feldbacher & Bachlechner, 2008; Spuhler & Veale, 2007). The sedation protocol is also based on research. Nurses are to hold the sedation drips from ventilator patients to see how patient handle it. This is because research has shown that daily interruption of sedative drug infusions decreases the duration of mechanical ventilation and length of stay in the ICU (Sessler & Varney, 2008). My nurse said there have been instances where nurses have given more sedation medication through intravenous route than what is prescribed. This can contribute to unsafe patient outcomes. Nurses need to contact the healthcare providers if they feel the medication dosage is not enough to sedate the patient. I have also seen nurses pull out more medication than what is ordered and do

not waste the rest. They leave the medication in a syringe in the locked cabinet in the room and when the medication is prescribed to be given again, they use the medication already drawn up. This is to save medication and costs for the hospital, but may not be worth the risk. For instance, fentanyl may be ordered as 0.25 mL but nurses will pull out the full 1 mL from the vial and use it the next time they are in the room. This can create unsafe practices where narcotics can be easily stolen.

Many benefits are seen with applying evidence into the healthcare. An organization may see improved recruitment of nurses, improved retention of nurses, improved employee satisfaction, and higher percentages of nurses pursuing or attaining advanced degrees in nursing. Patients can also benefits from the integration of evidenced based practice into the healthcare. These include shorter hospital stays, reduced readmissions, reduced mortality and morbidity, and improved patient satisfaction (Kelly, 2012).

The trouble with evidence-based practice is applying the new research into practice. Sherwill-Navarro, Kennedy, and Allen (2014) state that they are creating a list of a selection of nursing journals that will help with finding the most recent evidenced-based practice. Many barriers create a gap between new research and implementing this new research into practice. Peterson et al. (2014) states, “To help close that gap, the American Association of Critical-Care Nurses has developed many resources for clinicians, including practice alerts and a hierarchal rating system for levels of evidence” (p. 58). By using these levels, nurse can identify the strength of a research study and help to evaluate the evidence for future implementation. A list of resources where evidenced-based practice can be found may also be helpful.

Magnet Status

Magnet hospitals are recognized as top hospitals to the public. This is because there are

certain standards hospitals must meet in order to receive a Magnet status. American Nurses Credentialing Center (ANCC) awards the Magnet status to hospitals. This is a branch of the American Nurses Association (ANA). In order for a hospital to achieve a Magnet status, they must follow through the magnet appraisal process. This process consists of four parts including the application, evaluation, site visit, and award decision. A database needs to be established to collect data on nursing sensitive indicators. By joining the NDNQI, hospitals can accomplish the data-collection requirement. During the second step, ANCC does the evaluation. A site visit can be arranged if enough points are earned related to the written documentation. The last step is to award a decision, which involves members agreeing the hospital reflects (Kelly, 2012).

> Aultman Hospital is designated as a Magnet hospital by the American Nurses Credentialing Center (ANCC) for nursing excellence, an honor shared by less than 7 percent of hospitals in the nation. Aultman first achieved Magnet recognition in 2006 and earned the designation again in 2010. Aultman is the only Magnet hospital in Stark County. (Aultman Health Foundation, 2010, para. 8)

Magnet recognition is relevant to nursing because it is a sign that the hospital has taken the steps to providing quality care by seeking leaders of the highest excellence, expanding its services to the community, and valuing evidence-based practice. Many benefits are seen with working in a facility with Magnet recognition. This includes improved patient outcomes, enhanced organizational culture, increased nurse recruitment and retention, enhanced safety outcomes, and enhanced competitive advantage (Kelly, 2012). Stimpfel, Rosen, and McHugh (2014) conducted a study that supports these findings. They discovered that magnet hospitals promote an environment that is supportive of nursing which can contribute to the better nurse-reported quality of care.

Goals

My goals for the first 60 hours of practicum were:

- I will be able to take on ½ of the nurse's patient load by the end of the first 60 hours.
- Delegate one task to an AP within their scope by the end of the first 60 hours.
- I will respond to a client's concern using therapeutic communication by the end of the first 60 hours.
- I will teach a client the pathophysiology of their disorder within the first 60 hours.
- I will use the six rights every time I am administering medication during the first 60 hours.

I accomplished my first goal. By the end of the first 60 hours, I was able to care for three patients, while maximum patient load is four for an emergency department nurse at Mercy Medical Center. This goal was not as hard to achieve as I thought and this is mainly due to the environment and the type of patients coming in. Many of the patients who come in are discharged as just as fast. The environment in the emergency department is set up to treat the patients with the minor acute disorders and discharge them, but admit the patients with the major acute and debilitating chronic disorders onto a hospital floor. This is quite different than any rotation I have had to the hospital, but it is a change that I find enjoyable and interesting.

My second goal was not met. While there are many emergency department technicians on the floor, these technicians understand their duties so well that when orders for something like labs come in, they are already in the room drawing labs. Although they do other things as well, I have not had the opportunity to delegate a task to one of these technicians. I will try to complete this goal during my second 60 hours if I see an opportunity to delegate to a technician.

My third goal was met. I was able to incorporate therapeutic communication techniques, like active listening and restating, into my commination. I was able to mostly communicate with patients using therapeutic communication, but sometimes I would use non-therapeutic techniques, which I hope to work on during my second 60 hours. Also, there were some patients that unruly, who tried to take up all of the nurse's time, which made it difficult to communicate with them therapeutically. I have not had a problem like this with any of my patients yet, but I have seen it happen on the floor. If this does occur during my 60 hours, I hope that will be able use therapeutic communication and learn from the experience.

My fourth goal was met. There were a few patients who came to the emergency department and did not know about the disorder that they had been diagnosed. I was able to teach these patients what the disorder was, the pathophysiology of the disorder, and what the prescribed medications did regarding the disorder.

My fifth goal was met. This goal was one that I thought would be very easy to complete as I assumed the emergency department used barcode-assisted medication administration with electronic medication administration record (BCMA-eMAR) , which would make checking the six rights relatively easy. But when I first got on the floor and saw medication administration, I saw that they did not incorporate BCMA-eMAR. The nurses on the floor would print out the medication order and check the patient it was given to, the medication that was ordered, route of the medication, the dose, and the time it was to be given. After all that was complete, the nurse would documented that the order was complete. Most of the medications that were ordered were given right when they were ordered. The issue I had was that the software used on the emergency department would not let me complete any orders, so I could not administer medications until I knew my preceptor had some time to document that the medication was given.

I view these first 60 hours as a success. I have been able to bolster my confidence and improve my communication skills during these first 60 hours of practicum. I have also been able to gain some knowledge form the preceptor about what kind of things to look for and ask when doing a focused assessment on emergency department patient. I also know that there are a few things that I need to work on and improve. Even though I have been able to take care of 3 patients, I still want to improve my time management and I need to cluster my care better. I also do forget to ask some important things when I'm doing an assessment on a patient and so I have to sometimes go back to ask.

My goals for the second 60 hours are:

- I will be able to take the nurse's full patient load by the end of the second 60 hours
- Delegate one task to an AP within their scope by the end of the second 60 hours.
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- I will research the pathophysiology behind two medical conditions I do not understand and explain the pathophysiology to the patient by the end of the second 60 hours.

Professional Reflection

Description

In my first 60 hours of my practicum, I have been exposed to many different situations and have seen patients with many different disorders. I have exposed to patients with disorders, such as drug overdoses, chest pain, myocardial infarction, gastrointestinal pain, and bronchitis. I was able to practice my assessment skills and medication administration. I have also been more exposed to health care environment and the relationship between the members of the health care team. I have been able to incorporate my care with other members of the health care team. I have also been able to improve my skills in inserting IVs and starting IV therapy.

Feelings

Through my first 60 hours of my practicum, I have been able to become more comfortable in the care that I provide to patients. I have been given on many occasions the opportunity to start IVs. Although I still need my preceptor to help me at times, I have become more comfortable in looking for veins and inserting the IV. I have found that the whole medication administration process is easier to go through. I find it easy to get medications and administer them to patient that I did during my previous experiences. I have also been able to hone in my assessment skills and become more comfortable in doing focused assessments. I have also become more comfortable in communicating with the patients and the healthcare team. Before this practicum, it was always a struggle for me to really communicate with other people that I did not know really well. Although this problem may manifest at times, it is not as bad as it used to be. I am able to go into rooms and have no problem communicating with patients. I am also able to communicate with physicians on important pieces of information that I may have seen or that they have requested. I believe that I need to work on a few things though. I can at times forget to ask patients about important information on their charts and I also sometimes forget to do things while I am in the room with my patients, which I have to go back and do.

Evaluation

Looking at the beginning of my practicum to now, I can definitely see that I have improved much. My preceptor and I agree that I have made much progress during my first 60 hours. I have gotten much better at my assessment skills. Before this practicum, I have only had the opportunity to do full assessments. When I started off doing focused assessments, there were things that I would miss. I have now gotten better at critically thinking through my assessment and honing my assessment towards the issues and problems the patient is facing. I have also

gotten better at documenting what I have found in my assessment. I did have an issue adjusting to not having the BCMA-eMAR around. There are many medications that are compatible and not compatible and not having an external software prompting warnings when certain medications made me rely on my preceptor, until I could research the compatibility myself. I was able to ensure the six rights of medications were maintained throughout these 60 hours. I have found that my communication skill have improved greatly. I can easily converse with patients and their families about medical and non-medical matters. I have also found that communicating with the health care team is much easier. This in part might be due to being exposed to them very often though. Overall, I think that I have improved greatly since the beginning of the practicum, but I hope to improve some more.

Action Plan

For my next 60 hours, there are a few things I want to do to hopefully improve my patient care. I want to be able to organize my information better and take more time looking through patients'' charts. If I find anything that I think may relate to patient's symptoms, I will write it down, so I do not forget to ask the patient. I will also write down the tasks that need to be down for my patients, so I can better cluster my care. Another are I need to work on is my knowledge on the compatibility of drugs. This will provide safer patient care, as well as more time effective care.

Professional Issue

Situation

The electronic medication record (eMAR) is a great innovation that has helped health care professionals in improving and providing safer patient care. Off shoots of the technology, like the BCMA-eMAR, have taken the concept of the original and made them better. When I

started completing my hours, I was surprised to find out that the emergency department at Mercy Medical Center did not incorporate BCMA-eMAR into their patient care. To my knowledge, every other department in the hospital incorporates the BCMA-eMAR into their patient care. Without a BCMA-eMAR, the nurse has a bigger opportunity to violate one of the six rights of medications.

Action

In the emergency department, the situation can go form to hectic in a matter of moments. Being caught up on patient care is very important in emergency department. When the nurses get busy, it is not unusual for other nurses to step in and help in providing care for some of the patients. One thing that is usually done to help is providing medication to patients of busy nurses. This opens up a big room for error when it comes to ensuring the six rights of medication. On one occasion, my preceptor and I saw one the nurses had become really busy. We decided to help and complete the medication order for one of her patients. We noted the order on Emergisoft and went and the got the medication. As we were going to the room we saw the other nurse rush into the room and provide the medication we had just gotten. Afterwards, my preceptor informed me that this is why it is very to note orders when you are going to complete them.

Outcome

The patient was not double medicated, but there was a big possibility of it happening. If we had gotten the medication a minute earlier or a minute later and the other nurse did not note the order, there is a big chance that the patient would have been double medicated.

Reflection

Situation like this happen every day and they show the importance of the BCMA-eMAR. Talking to my preceptor about the issue, she said that the biggest focus on medication administration for the emergency department was time. When there is a patient that is quickly spiraling out of control, the last thing the health care professionals want to worry about is getting logged into a hand-held and scanning barcodes to provide medication. I understand this point of view that many of the health care professionals in this emergency department hold, but the incorporation of the BCMA-eMAR has more pros to it than cons.

After two weeks of intubation, the family had to decide if they wanted their mother to have a permanent ventilator or if they would like to extubate and place her on palliative care. When I cared for her, my perception of the situation seemed like the patient was improving. After talking with the preceptor about how she felt with the situation about two weeks after the initial intubation, she explained to me that the sepsis was very serious and knew that the likelihood of the patient recovering would be slim. Having little experience in the ICU setting, my perception was that the family did the right thing to prolong their mother's life as she heals. After talking with my preceptor, my view changed. I understand now that I was not seeing the big picture and there was little room for improvement. In this case, I would have advocated for the patient's wishes to be respected. After caring for this patient, I know that nurses constantly make decisions whether the technology, interventions or the medications are still appropriate for the patient.

Lind, Lorem, Nortvedt, and Hevroy (2012) conducted a qualitative study in the ICU from a relative's perspective of the nurses' involvement in the end-of-life process. The study revealed that nurses were perceived as vague in their communication and this created a situation where

the relatives missed the long-term perspective in the dialogue. The study suggests that relatives therefore felt that the nurses could have been more involved in the process. Research like this supports need for more training in the end-of-life processes. With end-of-life process, families should be made aware of the situation and chances of improvement. Hyde, Kautz, and Jordan (2013) have some ideas that can help to assist critical care nurses to lead discussions among family members who disagree about end-of-life care. For one, nurse can have this discussion early on. They also recommend that training in bereavement may help nurses have an easier discussion related to end-of-life. Providers should also say, "Allow a natural death" instead of things like terminating or withdrawing treatment. Being a part of end-of-life process to a patient is crucial and a scary time for a patient's family. The family needs the support of the healthcare to aide them in a difficult decision about the different options they have.

Preceptor/ Student Evaluation

Log of Clinical Hours

Schedule for Following 60 Hours

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