5-2020

Honors Internship Evaluation

Lauren Nolan
University of Arkansas, Fayetteville

Lauren Nolan, Honors Internship Evaluation

Lauren Nolan

University of Arkansas

Honors Thesis/Project

NURS498VH

Cara Osborne

January 28, 2020

This paper will address the internship completed at Washington Regional Medical Center's Cardiology unit. This internship allowed me to experience shifts on a specialized unit as an aide and a nurse through orientation and work experience. After orientations were completed, I began to work independently on the unit as a student nurse intern which is equivalent to the job of a certified nurse assistant. However, opportunities arose when nurses allowed me to listen to assessments of the cardiovascular and respiratory systems when they noted abnormalities that would be beneficial for me to hear. This internship allowed me to improve my organization, time management, and therapeutic communication, and prioritization skills. This internship also presented an opportunity for learning and improvement. This topic will be discussed later in the paper as an individual patient case.

Student Nurse Intern versus Certified Nursing Assistant

Although my position as a student nurse intern (SNI) was very similar to that of a certified nursing assistant (CNA), there were some aspects of the internship that made these roles different. My main job was to act as a CAN on the floor. However, I had more access to nursing knowledge than CNAs did. This is first made evident by my orientation with a nurse. Although I could not perform nursing interventions, I was paired with a nurse and followed her in her role. This included observing patient assessments, patient teaching, medication administration, the admission process, and charting. In this role, I was able to ask more questions about the nursing role and learn more about patient conditions. Although I could not perform assessments on my own, I was able to listen to or observe what the nurse did. This extended beyond orientation with my assigned nurse. There were times when a nurse would assess their patient and pull me in to auscultate abnormal heart sounds, such as mitral regurgitation. On one specific occasion, a nurse allowed me to auscultate the patient's lungs after he had and asked me to identify the sound. I

was also allowed to view the patient's chest x-ray that was completed at the bedside. Since I had been safety sitting with this patient all day, the nurse asked what could cause the assessment findings. This was especially different than what CNAs could do since the nurse sat with me and discussed the patient's medications and how their fluids, medical history, and current diagnosis had led to fluid overload. I think that I was able to have this experience because the nurses n my unit were very receptive to me and so were the CNAs. It is also important to note that several of the nurses I worked with were clinical instructors. I think this also made a difference in how I was received and treated on the unit.

Organization

I began this internship with an orientation as a nurse aide. This would eventually be my job, so I took this orientation very seriously. During my three-week orientation with my preceptor, I learned many strategies and techniques that I applied when I began working alone on the floor. The aide taught me how she got vitals done more efficiently and how she structured her day. This really helped develop my organization at work and will greatly contribute to my nursing practice. Our regular day was structured as follows; breakfast at 0730, vitals at 0800, vitals at 1200, lunch at 1230, vitals at 1600, and dinner at 1730. My days revolved around these tasks and the charting of meals and vitals. I found that clustering care was very effective when taking vitals. Instead of doing one thing at a time, for example taking temperature and then blood pressure, I found it was most effective to get the patient attached to the machine, start the blood pressure, then start the temperature at the same time. This allowed me to also watch the patient's respirations and, by using this strategy, I was able to get all vital signs from a patient in about a minute and a half. I would also cluster care by attending to anything in the room, such as a urinal that needed emptying or a patient's request, if I did not have more time-sensitive things to attend.

However, I learned that this could turn into many tasks and, if I was behind on vitals or needed to prepare a patient for surgery, I needed to gently excuse myself and explain that I would return as soon as possible to take care of their needs if they were not urgent. Working in this position allowed me to improve my organizational skills by learning how to best prioritize patient needs. This internship also allowed me to improve on my time management skills.

Time Management

My time management skills were especially improved upon when I was the only aide assigned to as twenty-bed unit. There were some days that we were short staffed or required aides to safety sit on the unit. This would often leave a twenty-bed unit with one aide in charge of their vital signs, charting their meals, and ensuring that all activities of daily living were met. This could be especially grueling if there were total care patients or patients that required more attention. As stated above, vital signs occurred every four hours beginning at eight o'clock. To better manage this many patients and to ensure the nurses had their vitals on time for medications, I would start vitals fifteen or thirty minutes early. This is something the preceptor I oriented would do and, after ensuring this was appropriate with the nurses, I did this whenever I could when in charge of more than ten patients, the normal assignment when two aides are on the unit. This practice allowed me to start vitals early enough that I was not late getting vital signs entered for the nurses. Although this helped, there were days when starting vital signs early was not possible. On these days, I would try to cluster care and take the vitals machine into a room when a patient hit their call bell around time for vital signs. This allowed me to take care of their needs while also accomplishing a scheduled task. Learning to chart also assisted in the development of my time management skills.

Nurses must chart many things; medications, verbal orders, and patient assessments to name a few. Because of this, I found it very important to learn to chart thoroughly and within a timely manner. Although the mobile charting units were helpful, I did not always have one available, so I made sure I carried a pen and a small notebook. When removing trays from patients' rooms, I had to write down how much they ate and drank. This is important for any patient to maintain a good intake and output, but it was especially important for patients who had fluid and sodium restrictions. I would write down the percentage the patient ate of their meal as well as how many milliliters they drank. After lunch, I would take a moment to sit and chart these numbers. I kept myself organized by crossing out the meal as I charted, in case a patient called for assistance and I had to return to the computer later. This is also a technique I applied to vital signs when our Care Mobiles were not working or were not charged. I took great care when I wrote vital signs by writing the time and charting them as soon as possible. A special kind of vital signs, which we call frequents, were often applied after surgical procedures such as a heart catheterization or abdominal femoral runoff. Sometimes, patients would need to be on continuous frequent vital signs if they demonstrated fluctuating vital signs or, as I saw in one case, dependent on a BiPAP. These patients would not have regular vitals taken, instead, they were recorded and charted later. I tried to manage this by picking up the printed vital sign from out telemetry room right after the patient was removed from the frequents machine. This would allow me to have the vital signs on hand so that I could chart them if I had a moment of down time. All day frequents, though convenient at some points, presented a different issue. I tried my best to chart these halfway through the day then at the end of the day. I did this so I would not have to stay and chart later than necessary. There were times that all these strategies did not work, and I got a little behind or had to stay later. However, these experiences have helped me

develop strategies to manage my time more efficiently and will be helpful to me as I begin my role as a nurse.

Patient Case, The Effects of Bias

Now, I would like to discuss a couple of patients that left a lasting impression during this internship. I will not use any names but will discuss medical conditions and management pertinent to their cases. The first patient I would like to discuss is a patient some might have, and did, call “difficult”. This patient was on the unit for diuresis related to heart failure. The patient was on the unit for more than a month, so I got to take care of them many times. When receiving report on this patient I was constantly informed that the patient and family member were “grumpy”, “particular”, had refused vitals, and had even fired a nurse, aide, and lab technician. Basically, this patient had been written off as difficult, but I did not want to let the opinions of others change the level of care I gave by creating bias. Instead of entering the room with apprehension, I made sure to smile and be as welcoming and warm as possible. The first day the patient and family were quiet, but my mood eventually allowed them to become more open and friendly with me. I was happy whenever I could make them laugh or smile, considering the reputation they had with some of my coworkers. I further improved the relationship by modifying my care to fit their needs. The best example I can think of is when this patient received potassium and was having to use the restroom frequently. This patient was on high doses of Lasix and was having to take potassium orally to replace lost electrolytes. Sometimes, I would enter the room and the patient would be drinking potassium or about to go to the bedside commode. I quickly learned that she did not want to be bothered during this time and wanted the commode to be emptied frequently. I adapted my care by moving on to another room’s vital signs if the patient was taking potassium or going to the restroom. I would return at the end of

my round of vital signs or whenever they called me back and made sure to empty the commode whenever I entered the room. These minor changes made a major difference in the patient and family member's attitude towards me. Whenever I was at work, they were happy to see me and did not refuse any tasks I needed to complete. I think that this experience highlighted the fact that you cannot let another person's opinion of a patient or family lead to bias. Just by having my normal happy attitude instead of dreading entering the room, I was able to make an amazing connection with this patient and family member.

Patient Case, Significance of Debriefing

The second patient I would like to discuss passed away during my shift. This was my first code, as well as my first death. I had had this patient for two of the three days I worked and knew they were very ill. The patient was mid-40s and had many health complications affecting his renal and cardiovascular systems. Due to complications, this patient was sent to surgery for amputation of all their toes. I worked with the patient pre- and post-operatively and noticed a large difference in behavior. Previously, this patient had been quite and very rarely called for help or asked for anything. Post-operatively, this patient was placed on frequent vital signs where the blood pressure is taken every fifteen minutes and peripheral oxygenation and cardiac rhythm are constantly monitored. After the surgery, the patient called out frequently complaining of pain and requesting the prescribed pain medication. As a student nurse intern, this fell out of my scope and I had to repeatedly inform the patient that I would let the nurse know and that she would be in shortly. I always double checked that there was nothing else the patient needed to increase comfort but was often shooed away or yelled at again for pain medication. The day went on like this and, although I was present at every call light, felt unable to help this patient with reducing their pain. After lunch, I was speaking briefly with the patient's nurse, just about

random things, and was about to move on with my other tasks when another nurse answered an incoming phone call. It was then that we were informed that the patient was in sustained ventricular tachycardia. I had never seen anything like the flurry of action that ensued. The nurse ran to the room and I was instructed to bring the crash cart. As I did, more individuals began to appear and assist with the code that had been called. I was sent to retrieve suction equipment then told to resume my duties on the floor. I did as I was instructed but I was eventually called back to this patient's room to assist with chest compressions. This was my first-time performing CPR on a patient, so I was very nervous and looked to my colleagues to ensure I was performing adequate compressions. A nurse gave me encouragement and asked if I felt able to perform compressions until the next pulse check in one minute. I replied affirmatively then proceeded to check for a pulse when time was called. I remember vividly my hope to feel a pulse, but I did not and neither did another nurse or physician. It was then determined that the rhythm on the defibrillator was pulseless electrical activity and the patient was pronounced dead by a physician in the room. All individuals who participated in the code were called to the break room for a debriefing, but I was told to return to the floor. This being my first death, many people checked on me and, although I said I was fine and continued with my tasks, I found out later how badly I needed that debriefing.

According to Harder, Lemoine, and Hardwood, debriefing sessions are highly beneficial to the emotional wellbeing of healthcare providers who experience a patient death (Harder, Lemoine, & Hardwood, 2020). These individuals used a literature review in order to determine mental and emotional outcomes of debriefings following expected and unexpected patient deaths. Their findings included that debriefing could result in relief of feeling of anxiety and that there was emotional support for individuals who participated in a debriefing (Harder et al., 2020,

p. 333). This is important to note and resonated with me because I did not get to debrief and therefore did not get much emotional support other than individuals checking in on me occasionally. This was very different compared to a clinical experience I had in which a patient passed and the chaplain sat with myself and the nurse for a little while to talk about the day and offered her time should either of us need it. Had I had this type of experience with this patient, I believe I would have been able to manage the stress, anxiety, and sadness I felt that day much better than I did. This leads to another finding of the study that demonstrated that debriefing allows for an easier grieving process for healthcare providers who experienced a patient death. The authors state that the debriefing sessions allowed for providers to "manage grief and [learn] more about coping strategies," (Harder et al., 2020, p. 340). Because I was unable to attend the debriefing, I kept any feelings I had to myself in order to complete tasks given to me. This did not allow me to express the shock and guilt I felt about my patient's unexpected passing. I remember sitting in my car after work and breaking down because all I could think was "what did I do wrong?" Even though I knew there may have been no way for me to prevent the patient's sudden cardiac arrest, I still thought maybe I could've gone in the room more often or checked his monitor at the central station to identify odd rhythms sooner.

I still feel somewhat guilty about this situation and wonder if going to the debriefing would have helped to alleviate some of the guilt and sadness I felt and still feel. By observing the evidence presented in Harder, Lemoine, and Hardwood's work, I think it would have. Even though I was not able to attend the debriefing, I did learn a lot from this experience. I learned how to process my emotions while continuing to care for my other patients and I also learned how important it is to provide respectful post-mortem care for my patients. I believe respectful post-mortem care is the most important lesson I learned from this experience. Since the patient's

family was not present, my colleagues and I were the ones responsible for making sure the room was calm and the patient looked peaceful. Although I still wonder if I could have done something to help my patient, I think that this experience will make me a better nurse because I now understand how to manage my own emotions in the moment to care for others, be that family members or my other patients.

Recommendations for Future Students

It was brought to my attention during presentation of this experience that there are several things that could be done to improve the experience. I was among several students that completed this internship, however, not all the students selected for these positions were University of Arkansas Nursing students. We were placed on different units throughout the hospital which included: medical surgical, cardiology, neurology, and emergency department. I was asked if the other students and I met as a group to discuss our experiences. I met periodically with another student who worked with me on the cardiology unit, but only briefly during our shifts. I do think it would be beneficial to have the honors student meet periodically throughout this experience to discuss their roles and what they had seen and done during their shifts. I believe this could prompt discussions concerning best practice and changes that could be made to improve the quality of care. Although some of the students in this internship may not be honors students, they should also be invited to these meetings. This would be to ensure that there are plenty of individuals to address experiences. I think it could also be beneficial to have students identify practices that they saw or completed on their shifts and search to see if those are practices are evidence based. An example I could use is the procedure of chlorhexidine bathing prior to surgical procedures. This was a procedure I completed on patients who would have heart catheterization, coronary artery bypass grafting, and other invasive procedures. By performing a

search within CINAHL, I was able to find an article that used a meta-analysis to address this procedure and its effects on surgical site infections from 2017. The article described its selection criteria for studies and, in conclusion, found that there was no reduction in infection when using 4% chlorhexidine gluconate (Franco, Cota, Pinto, & Ercole, 2017, p. 347). This raises questions about the effectiveness of this pre-operative procedure that is so integral to preparing patients. I think the ability to search for and locate research related to policies and procedures is an integral part of being a bachelor prepared registered nurse and should be integrated into this internship experience.

Conclusion

Overall, this internship was very beneficial to me as an honors nursing student. It allowed me to grow in skills necessary to the nursing profession and to truly experience what a nursing career could be for me in the future. I believe that this was due in part to the willingness of the nurses and aides to teach me about their own experiences. I would, and have, recommended this internship to other nursing students. I believe that this internship is well tailored to learning experiences as well as giving the student autonomy by allowing them to work independently on the floor.

References

Franco, L. M., Cota, G. F., Pinto, T. S., & Ercole, F. F. (2017, April 1). Preoperative bathing of the surgical site with chlorhexidine for infection prevention: Systematic review with meta-analysis. *American Journal of Infection Control*, *45*(4), 343-349. https://doi.org/https://doi.org/10.1016/j.ajic.2016.12.003

Harder, N., Lemoine, J., & Hardwood, R. (2020, February). Psychological outcomes of debriefing healthcare providers who experience expected and unexpected patient death in clinical or simulation experiences: A scoping review. *Journal of Clinical Nursing*, *29*(3-4), 330-346. https://doi.org/http://dx.doi.org/10.1111/jocn.15085