Professional Progress Summary

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During my time at Old Dominion University's School of Nursing, I have certainly grown into a more competent nursing student. I have advanced from basic skills and rudimentary levels of planning to higher understanding. The School of Nursing assesses students in eight categories, known as the "Great Eights", which include critical thinking, nursing practice, communication, teaching, research, leadership, professionalism, and culture. Throughout my two years in this program, I have progressed from a novice to competent in these eight areas. I still have much to learn moving forward, but through a review of my clinical logs, I have seen how far I have come just in these twenty-one months.

Critical Thinking

My thought process has become more concrete and faster during my nursing school career. I have added use of the steps of the nursing process, at first only being confident in assessment, then slowly becoming comfortable up to evaluation. I have become more comfortable in making my own judgements regarding interventions. My care has also changed from bridging the gap of patient self care deficits to manipulating the environment to help provide to the patient moreso.

At the beginning of my junior year, I had a patient with scrotal swelling due to congestive heart failure, and my knowledge was based more on assessment, so my intervention was regular assessment of the skin for breakdown. The use of critical thinking related to vital signs and assessment continued in my psych clinical, this time in reference to blood pressures of patients detoxing. Due to the uncertainty related to detoxing from drugs or alcohol, the patients were regularly being assessed, up to every two to four hours, with sitting and standing pressures. Like

the previous semester, much of my critical thinking was in understanding rationale for interventions already in place and how they related to my patient's condition. In my adult health clinicals, my critical thinking expanded to rationale for interventions, and helping to plan the care. When caring for a patient, the other student and I observed a lesion not previously noted by our nurse, so we applied a topical gel and bandage, and notified the nurse once we were done.

During senior year, I returned to my adult health clinical site, and began to evaluate the plan and interventions I used in care. My interventions have begun to look beyond the primary diagnosis. A patient recovering from a knee replacement had a history of cerebral palsy, with weakness to the opposite side. During the day, her ankle looked to be dropping, so I placed a sheet behind her foot to prevent foot drop while I looked for a boot, notified the nurse, and mentioned it in report to the next nurse when a boot could not be located. This patient also had an increase in their medication, and reported feeling a type of euphoria. This is not the typical response to pain medication, so we assessed her frequently while lowering her dosage back down. In this way, we evaluated the data and questioned the physician to lower the dosage to a safer amount given patient response.

During my role transition, I have become more confident in my critical thinking process. With the greater consistency with patients, I was able to evaluate the interventions. Over the course of a couple weeks, I witnessed a patient decrease the demand for supplemental oxygen. This was due to chest physiotherapy, suctioning, and placement in the bed. I helped to suction the patient, and evaluated her oxygen demand after each round. Toward the beginning of the oxygen process, she had a mask on, which kept sliding and causing pressure on her eye, so I placed a washcloth underneath it to help keep the placement and protect the eye if it did slide. I

evaluated this action later, with the mask still in place and no more pressure to the ocular area. I have also begun to prioritize patients due to caring for more. One day I assessed a patient that was going to transfer off the unit soon, then a patient that had a medication due at shift change, then a patient that had been stable for days, and who I had worked with before, so I understood his care.

I have become confident in the nursing process and have progressed to critically thinking at all levels of the process. At first I was only able to understand my assessment findings, but as I have progressed, I have been able to question the plan or implementation. I still have a lot to learn, and I look forward to this as I begin my nursing career. I feel competent in this, but I am still aware of my extent of knowledge, and have become more comfortable with asking for help when needed.

Nursing Practice

My nursing practice has grown throughout my months in this program. During my first clinical, I had an encounter with sloughing feet that ended in me hunched over a trash can wondering if I could be a nurse. Luckily I continued, and in just the next semester, I was face to face with a gangrenous foot during wound care. My knowledge of practice has expanded with every clinical.

In the beginning of junior year, my practice consisted of assessment, safety, and patient comfort. I was helping ambulate patients, and nervously performing assessments. In one of my first logs, I mentioned being nervous and referring to the assessment sheet frequently. The next semester I was allowed to do more interventions, so my practice shifted to trying to get as much experience with as many interventions I could. I would be pulled into rooms to observe or help

with interventions, and the amount of time with patient care diminished. Most of my comfort care was done during assessments rather than throughout the shift. In the rehab clinical I was able to perform some interventions, but the main focus was to work with the patient we were assigned, so I helped with physical needs such as suctioning and feedings, but I had time to listen to them and hear their needs, including emotional and social needs. Listening to them helped me remember the need for attention to holistic care. I also witnessed acupuncture during this clinical, which helped with the pain a patient experienced. Weekly acupuncture allowed them the independence to work and live a life with decreased reliance on medications. I continued to remember the need for holistic care as I moved into my senior year.

In the second part of adult health, I tried to give my patients time in between all of the interventions. I was able to give them more time and listen to more patient care, but I was still working on the balance. One of my patients started talking to the nurse and I toward the end of shift, most likely from loneliness, but we were only able to sit and talk with him for so long before we had to go and care for other patients. I was still trying to understand the balance between listening to the patient and the ability to care for the others.

During role transition, I cared for at most four patients, which were the nurse to patient ratios in place for the unit. I was providing most of the care for them, with the nurse coming with me as I was practicing under their license. I was still learning new skills, especially surrounding tracheostomy care, but since I have had practice with most, I was able to understand rationale for performing an intervention, plan, explain it to the family, and implement it. During one of these shifts, a nonverbal child with severe granulation around her gastric tube stoma seemed to be in pain. We planned care to have pain medication ordered for her. Once it was ordered and

administered, she was able to sleep and appeared to be more comfortable. We needed to look at her mental state, which was blinded by pain, which helped to remind us the importance of holistic care for patients.

My nursing practice has improved, and I provide competent care by looking at the patients holistically and using my knowledge of their health issues to plan their care. I have interacted with the interdisciplinary team, such as with physicians to administer medications, in the best interests of the patients.

Communication

At the beginning of my clinical experiences, I was very nervous, and barely felt comfortable talking to the nurse, but by the end of role transition I felt comfortable communicating with residents and nurse managers in a professional manner. I have had to adapt my communication techniques for some of the patients.

During my Fundamental clinical course, my idea of therapeutic adjustment to communication included speaking louder to hard of hearing patients. I experienced one nonverbal patient, but my communication with them was focused on the pain levels. During my psych clinicals, much of the care students provided was centered around communication and listening to the patients. I certainly had more experience listening to the patients, and experienced language barriers. One of the patients used an interpreter, but the other patient without an interpreter had difficulty with finding words to say, but could understand well. With this knowledge, I went to adult health, and continued to provide therapeutic care. One patient had had a change in his cognitive function between the weeks I saw him, so I continued to provide some of the care he had previously liked, and made sure to focus on nonverbal therapeutic

communication, such as holding his hand, and letting him squeeze it when he was in pain. As part of the clinical, our group created a resource for the hospital to use, so we created a pamphlet about salt and diet in regards to congestive heart failure. This helped to educate patients on how to adjust their diets after being diagnosed with heart failure.

During my senior year, my methods of communication have improved, best seen during my role transition. I was on a pediatric unit, and many of the patients had special needs, including developmental delays and sometimes being nonverbal. Many of the patients were nonverbal due to cerebral palsy, so with them I made sure to include nonverbal communication and hold their hand to let them know someone was with them. I also helped teach a family CPR as part of their discharge teaching. The family first watched a video, then they were given a mannequin to demonstrate proper technique. Once they accomplished this, it was clear they would be able to perform it at home if necessary. Another family had communication difficulty with the staff. The mother of an infant spoke Spanish, with slight understanding of short English words. When the physician communicated with them, he used a tablet that was able to interpret for him. Safe nursing practice suggests an interpreter is present when there is a language barrier, but it can be difficult to obtain an employee sometimes, so the tablet helps to ensure both parties are understanding.

Teaching

As a student, I sometimes feel unqualified to teach a patient or their family. This concept is something I have had to work on during my time in clinical. In the beginning, I could identify patient education needs, but would have an excuse as to why they were not ready to receive education. I’ve come to understand many education topics may need to be covered multiple

times, and through different sources. While it is important to assess a patient's readiness to learn, I have become more ready to educate patients and families.

In the beginning of my clinicals, I identified education the patient should receive based on their diagnosis. I studied their chart, and from that I went in with an idea of what education materials they would need, such as drug cessation or information on congestive heart failure. I also felt that in order to educate a patient, I had to have a pamphlet or packet of information with me to give them. As I went into adult health, I realized education can be informal, so I would give education on their medications before administering them. Still, at this point when a patient asked me questions I would refer to the nurse.

In my senior year, I began to answer questions patients asked me, such as their diet needs or how they would ambulate once home from their joint surgery. I also began to provide discharge teaching. At first, I would review it with the nurse, then rehearse it in my head a few times before going into the patient's room. As I became more familiar with the discharge planning, I would just rehearse in my head and look over the materials on my own. During my community health clinical, we attended the Art of Aging Expo, an event for older adults to understand the services available to them. During this, I helped with a keynote on fraud. The keynoter had a presentation with them, then asked the audience for personal stories, which fueled a conversation and helped the group know they were not alone. Once the keynote was done, I was able to hear the participants talk about it amongst themselves, they seemed to understand the ways to avoid being scammed, so the teaching seemed to be recepted well.

I also helped with much of the teaching in my role transition. I was still trying to learn some of the tasks, such as tracheostomy care, but the ones I did know, such as safe sleep, I

shared with families regularly. I also led discharge for a few patients. Throughout the experience, I feel I have become confident and competent in performing education to patients and the community.

Research

I began nursing clinicals being able to get the information regarding a patient, then going home and understanding what information I was looking at, including researching findings I may not be familiar with. My research in the first semester was more behavior based, and wondering about unanswered questions, including from one of my logs, the impact an odor can have on the healing process. I then changed to researching more about a disease process and common interventions for such disease during the second half of my first year. During the summer, I was introduced to specialty journals, and began looking through specific journals rather than a general search. The ability to use specialty journals, such as AWHONN, helped to narrow down the search results and ensure validity.

During my senior year, my research focus shifted again. I now will use a computer to do a quick search if I am unsure of something, like I did when I had a patient with possible trisomy 18, but my research is typically more intervention based. I am looking for information regarding the efficacy of research, and prefer to review nursing research rather than evidence based practice. I continue to use the databases through the school, in order to find scholarly journals, often peer-reviewed.

Leadership

I have grown in my leadership role over the past twenty one months. When I first started clinicals, I was a follower, and maintained the role of a care partner with the addition of

assessments. I have now become a more confident leader and have become comfortable delegating to others and assuming a leadership role.

As stated, I did much of the same role as a care partner in my first few clinicals. Then, when I had the ability to do more interventions, I began to follow the nurse and do as they asked. It was not until community health in the summer that I began to assume a leadership role in the health care setting. My small group and I formed a plan to provide care to a community of older adults. We had our ideas approved by a staff member, then created the handouts and planned the days we would be meeting them.

The next semester, the staff member stopped communicating with us, but we took the self-direction to reach out to other organizations and began to work with them. This leadership role helped me also gain confidence in the hospital, and I began to delegate tasks to the care partners. I would then make sure the task had been accomplished, which they typically were. Finally, in role transition, I became comfortable with the staff I worked with, and felt able to reach out to ask for help and delegate. I wrote in a log that I asked my nurse to feed a baby while I assessed another patient and documented. I trust the staff I worked with during my role transition, so I felt comfortable delegating tasks to them, not just the care partner, but my nurse or the charge, depending on the situation. I also would ask for help when I wanted to perform a task, such as suctioning, but wanted to ensure I had a witness. My ability to direct care of a patient and delegate tasks makes me believe I am competent in leadership, and look forward to stepping into such a role in the near future.

Professionalism

At the beginning of nursing school, I was relied on general standards of practice, but as I continued through the program, I began to differentiate between the different standards of practice and take ownership of the care I provided. During my first clinicals, I was providing standard safety precautions, which are within the scope of practice of all nurses, and I was ambulating. Due to the hospital I was in for this set of clinicals, I was able to remove a Foley catheter, but at the hospital of my next clinical, insertion and removal had to be done by a registered nurse. The standards of practice and limitations to the practice of students was seen most in the specialty settings.

In the pediatric rotation, hospital policy states intravenous medications are only to be administered by a registered nurse. Luckily, this was not the same policy for during my clinical rotation for role transition. I was able to perform assessments and give all medications except for IV push medications, due to the high possibility of error. I gained more independence throughout my clinical rotations, as first shadowing a nurse about one patient, then taking care of one, to taking responsibility for all aspects of care for multiple patients, as I did in role transition. I was responsible for all of the care I provided the patients, so when something was forgotten, such as moving a pulse oximeter, it was my responsibility to remember and fix the error. During this, I also had to take account for the care I delegated. One of the days, I had asked the charge nurse to feed a child, but when I saw the child’s bottle still on the counter, I went in to feed them myself. Through this I feel I have become competent in professionalism and am ready to continue to follow my standards of care and accepting the responsibility of caring for others.

Culture

At first I looked at the visible aspects of culture, but as time has progressed, I have seen how culture is multifaceted. I also have now seen how different socioeconomic statuses and social determinants of health play into the access to care someone can receive.

Many of my patients have had difficulty with access to care. In my first clinical, a patient did not have insurance, so he wanted the least amount of care possible. I was unsure how to adapt for this, so I did not change anything. In clinical fall semester of my senior year, I had a patient that was underinsured, so my nurse and I conferred with case management in order for him to be able to afford his medication upon discharge. In the Hampton Roads area, most people are close enough to go to a hospital during emergencies, but during the spring semester of this year, I went to a rural town in Donegal, Ireland. The town's nearest hospital is an hour away, so despite having universal healthcare in the country, they are still unable to use this in the case of emergency typically.

I also have witnessed how culture can affect care. Throughout the beginning of the first semester, our professors kept telling us culture plays a large role in care. At first I did not understand, because I had been oblivious to it in the past. I was in psych clinical the day after the Marjory Stoneman Douglas shooting had occurred, and one of the patients was on the phone with their child, explaining how this shooting, and the mental health of the shooter, was going to impact the unit she was on. This incident opened my eyes to how important culture is to care. The country suddenly turned to this idea of the mentally ill, an idea that could harm many to come.

During my role transition, one of my patients died, and although she was young, her family had been adapting to different definitions of health. The child had multiple chronic

diseases, and during the hospitalization she continued to decline to the point the family decided to withdraw care. The family was religious, and as such, asked for their child to be baptised and have a prayer said for her when she passed. When she died, as the family requested, the chaplain baptised her and said a final prayer. This was a way for the family to continue to have cultural ties, even in death.

Through the difficult experiences I have been through patients with, I have become more culturally aware. I have assessed my bias, and I continue to do so, which is just one of the factors of being a culturally competent nurse. I assess and recognize my bias, then I have to put it aside and do what is best for the patient at all times.

Conclusion

I thought some of the interventions would come more naturally to me than they did. I had a tendency to step back and let others try, instead of taking more charge of my learning. I wish I had been a bit more willing to do interventions I had never tried before, but have my nurse walk me through it instead of stand on the sidelines and observe. Going forward, this is something I must continue to work on. I will not be able to do a skill perfectly on the first try, so I have to accept there will be room for improvement. I feel much more confident in my skill to work as a nurse. I am still nervous and not sure what the future will bring, but this next chapter in my life will be a wonderful challenge. I still have to work on my time management skills, especially with a higher patient load, but it is something I have to learn on the job and try different methods until something clicks.