

Section 1: Summary of a GNP of choice and self-reflection

The Monash Health Graduate Program is a comprehensive program aimed at helping a nursing student transition smoothly to the role of a registered nurse. It provides a highly supportive environment for applying theoretical knowledge to practical scenarios so that students can get a clear idea of healthcare practices. Monash Health is a pioneer in the field of public health services that provides healthcare to people belonging to any age group. This can give the student a lot of experience in taking care of different types of patients with different age-related conditions. Monash Health also has a wide network of healthcare facilities where students can get a lot of exposure in catering to different populations.

My dedication to my work and love for experiential learning has always made me stand out at my workplace. I feel that I have the necessary attributes to support my education in the Monash Health Graduate Program, and I can readily develop the qualities required to complete the program successfully.

Here, I have used the ERA (Experience, Reflection, Action) framework to consider my suitability for the Monash Health Graduate Program.

Experience: Since my first year as a nursing student, I have taken the initiative to visit every department of the healthcare facility where I was assigned for internships. I have worked in more than 10 departments and with at least 4 vulnerable populations.

Reflection: Working in a variety of different settings has helped me acquire a broad overview of the needs of patients suffering from different conditions. I have been able to learn a lot practically and this knowledge has helped me act sensibly in emergency situations.

Action: I plan on gaining more exposure and acquiring in-depth knowledge and skills in different departments so that I can be prepared to handle different types of patients. I will seek out healthcare professionals in different healthcare facilities and learn from their experiences so that my knowledge can be applicable rather than just theoretical.

Section 2: Clinical Question

Depending on the type of seizures, the person may exhibit different symptoms and have different levels of consciousness. Hence, the first step would be to identify if the patient is having a seizure or is just unconscious. The patient's eyes should be checked to see if they are open or shut because if people lose consciousness as a result of an epileptic seizure, their eyes are usually open. If the patient's eyes are open, it should be assessed if the patient is able to perform simple movements or is exhibiting any orienting responses. This will help determine the person's level of consciousness and the seriousness of the situation (Blumenfeld, 2012).

If the person is having a seizure, it is important to start timing the seizure to determine its severity. The patient should be reassured and should be kept calm and safe until the seizure stops. Most seizures last a few seconds to a few minutes. However, if the seizure continues for more than 5 minutes

and the person shows a complete loss of consciousness, then emergency help should be called immediately (Shafer, 2020).

During the duration of the seizure, it should be ensured that there are no sharp or dangerous objects in the vicinity of the patient which can cause harm to the patient. The patient's clothes should be loosened if necessary and he should be turned on his side with his mouth towards the ground. This will help the patient breathe more easily by preventing his saliva from blocking his airways. Care should be taken to not restrain the patient while he is having a seizure as he may respond agitatedly or aggressively. If the patient exhibits breathing difficulties or appears as if he is choking, emergency help should be called immediately. If the first seizure does not stop within 5 minutes or if the patient has a recurrent seizure, emergency help should be enlisted. The patient should not be left alone during the duration of the seizure and should be kept safe and comfortable at all times (Shafer, 2020).

Once the seizure is over, the patient should be spoken to calmly and reassuringly. Time should be given to the patient to recover from the episode and the patient should be allowed to move around in a safe and enclosed space. Once the patient has returned back to normal, he may be referred for electroencephalography (EEG) or magnetic resonance imaging (MRI) to understand the nature and type of seizure that he just had. EEG records brain waves that can help identify abnormal electrical discharges in the brain and classify the seizure as generalized or localized. This classification can help determine the further course of treatment using antiepileptic drugs or rescue medicines. Based on the severity of the patient's conditions and frequency of seizures, he may need to take medications daily or only when he experiences seizures (Aragon and Burneo, 2007).

Section 3: Prioritization

One of the most important duties of a nurse is to understand the individual needs of every patient and prioritize their care. This often involves careful and in-depth analyses, consideration of all factors involved, and logical reasoning of the situation. Based on these factors, the nurse needs to address the individual requirements of each patient such that every patient is given appropriate care and consideration.

Given the case scenario, the first thing that the nurse needs to do is switch off the infusion pump alarm, temporarily stop the IV therapy, and reassure Mr. Young that his pain will be taken care of shortly. Continuous sounding of the infusion pump alarm can disturb other patients around leading to emotional disturbances and anxiety. It can also desensitize the staff to alarms from different medical devices leading to alarm fatigue and lower responses to alarms (Glover et al., 2018).

Following this, the nurse needs to assist Mrs. Peterson to empty her bowels as she is a high falls risk patient. She had a stroke two weeks ago and requires assistance for mobilization. Many hospitals have classified falls as a 'never event' meaning that patients should never fall due to mismanagement in the hospital at the nursing level. If the nurse does not attend to the patient immediately, Mrs. Peterson may try to leave her bed by herself resulting in possible injuries, functional impairment, pain, and increase in the length of stay in the hospital (King et al., 2018). Additionally, breakfast is about to be

served in another 10 minutes, and the patient requires this much time to empty her bowels and get herself ready for breakfast.

After ensuring that Mrs. Peterson is comfortable after emptying her bowels, the nurse needs to direct her attention back to Mr. Young. The nurse has noticed that his IV flask is almost empty and this needs to be refilled as per his physician's guidelines. Mr. Young has also been complaining of pain which needs to be assessed based on his chief complaint for admission and prescribed medications. Based on indications on his medication chart, painkillers can be administered along with IV to help alleviate the patient's pain (Jin et al., 2015).

Mr. Young is nil by mouth, which means that he will not be eating breakfast. So, by the time the nurse attends to Mr. Young, the other patients would have started with their breakfast. However, Mrs. Walters is about to go to the operation theatre shortly and so, she will not be having food either. Hence, after attending to Mr. Young, the nurse can help the ANUM search for Mrs. Walters' pre-operative checklist and prepare her for her procedure.

Finally, Mr. Stavropoulos needs to take ventolin and prednisolone after his breakfast. Both these medications are for his acute asthma condition and need to be administered on time to prevent occurrence of asthma episodes (FDA, 2010; FDA, 2014).

Section 4: Professional

Miscommunication in the clinical setting is a serious issue and is the most common cause of inefficiency in the workplace. Nurses, in particular, require excellent communication skills because they are responsible for the management and care of several patients on a regular basis. Communication also needs to be clear in the different hierarchical levels such as amongst resident medical officers (RMOs), nurse unit managers, and registered nurses so that there is no discrepancy at any level in providing the best possible care to patients. If there is a lack of clear communication in a healthcare setting, it can lead to mismanagement of patients and reduction in quality of care given to patients (Sibiya, 2018).

In the given case study, it is clear that there has been a miscommunication and misunderstanding between the Associate Nurse Unit Manager (ANUM) and RMO regarding the time of ascitic tap procedure for Mr. Stanley. The nurse on duty was informed that the procedure would take place after lunch when sufficient staff was available for taking care of the other patients while the nurse assisted the RMO with the procedure. However, the RMO has already arrived for the procedure during lunch time when extra staff is not available. Although the nurse is around, there is a hypoglycemic patient who requires continual monitoring and cannot be left alone.

In such a scenario, the nurse needs to approach the RMO and explain the situation. The nurse needs to use the appropriate principles of communication where the objective details of the situation are conveyed without blaming any single person for the predicament. Care needs to be taken that professional standards of communication are maintained that involve respect for all people involved, not hurting the sentiments of any single person, and not pointing fingers on any person. The nurse needs to express her issue of taking care of her hypoglycemic patient clearly so that the RMO

understands all the aspects of the situation and co-operates with the nurse in finding solutions (Kourkouta and Papathanasiou, 2014).

At this stage, the nurse can propose that the RMO give the nurse a few minutes to find another nurse to monitor the hypoglycemic patient while the RMO starts with the basic preparation for the procedure. Professional courtesy entails that this suggestion is made in a manner that ensures the best possible outcome for everyone involved. It also ensures that the nurse is knowledgeable of the rules that govern the workplace and is accountable for her decisions and actions (ARNNL, 2014). Once the RMO agrees, the nurse can get in touch with the ANUM and explain the situation in a manner that, again, does not point fingers or blame any single person. The nurse can request the ANUM to arrange for another nurse to take care of the hypoglycemic patient so that s/he can be available to assist the RMO with the procedure.

Resolution of this scenario is based on effective communication strategies on the part of the nurse with the RMO as well as the ANUM. In both cases, the nurse needs to be professional, objective in stating the facts, and direct in making a request. The nurse needs to understand that this is a critical situation where two patients require immediate attention. This is not the time to analyze what went wrong, where the miscommunication happened, and how it could be avoided in the future (Ghadirian et al., 2014).

Once the ascitic tap procedure on Mr. Stanley is complete and the hypoglycemic patient is in safe hands, the nurse needs to re-visit the incident and perform an extensive analysis so that events like these are not repeated in the future. The nurse may use a reflective framework such as the Gibbs' Reflective Cycle to reflect on the event and its outcomes, and understand what could have been done differently for better results (Wilding, 2008). The nurse also needs to report the incident to the healthcare management to ensure that stricter communication guidelines are enforced and there is a written system of agreement for timings of patient procedures. The system needs to be altered to incorporate at least three lunch shifts of half an hour each, so that a reasonable number of clinical staff is available on rounds for patient emergencies.

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