Nursing 4790 Clinical Immersion: Clinical Reflection (3)

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Introduction

Like my previous two reflections, the situation that I will be referring to throughout this entry occurred in the Cardiovascular Intensive Care Unit (CICU). However, this reflection is different because it spans across the course of three consecutive night shifts and concentrates on the concepts of communication/collaboration, advocacy, leadership/change agent, and safety and quality improvement. After arriving at the hospital on Tuesday evening, October 29th, I noticed that there were several family members in my assigned patient’s room. Realizing that it was not visiting hours, I began questioning my preceptor about the situation. Throughout the process of receiving report, I learned that the family was allowed to come to the patient’s room because he had just returned from surgery and a minister was there to pray because the surgery had not gone as smooth as expected. Once the family was finished praying, my preceptor and I went into the room to introduce ourselves and assess the situation. Understanding the severity of the situation, we allowed the family to remain in the room to help alleviate some of their concerns. Acting as the patient’s primary nurse, I was required to interact with the family directly. Several other health care providers were involved and are as follows: My preceptor, the surgeon, multiple physicians, a respiratory therapist, a Nursing Assistant, a X-Ray Technician, and a Dialysis Nurse.

Problem Statement

The following clinical situation is the focus of this journal entry. The patient was a 62-year old male, post-op day one following an emergency Coronary Artery Bypass Graft involving four vessels. He had a history of Hypertension, Obesity, Type II Diabetes Mellitus, severe Peripheral Vascular Disease, and Chronic Kidney Disease. After presenting to the emergency department with chest pain and shortness of breath, the patient was diagnosed with Respiratory
Failure, Cardiogenic Shock, and Acute on Chronic Renal Failure. He was rushed to the Cath Lab where he coded. After being revived and stabilized he was rushed to surgery. As I assessed the patient in the CICU, I noticed that he had severe edema and fluid overload. He displayed a decreased cardiac output and remained hypoxic despite being on a ventilator. Additionally, his systolic blood pressure was in the 80s and he was in sinus tachycardia. The patient’s weight of 157 kg (345 lbs.) confirmed his obesity. Lab data indicated hypoxemia with a RBC-2.43, Hgb-7.8, Hct-22.1 and kidney failure with a BUN-48 and Creatinine-3.08. Lab data also displayed a blood glucose level-161. The patient had Insulin, Levophed, Dobutamine, Dopamine, and Primacor drips infusing.

**Gaining Knowledge**

Prior experiences in both the clinical and classroom settings allowed me to properly care for the patient. Having previously cared for several patients following heart surgery in the CICU allowed me to understand how the medications work and why they were being used. For example, Milrinone (Primacor) increases contractility of the cardiac muscle through the use of vasodilating properties to relax vascular smooth muscle resulting in decreased preload and afterload. Dobutamine increases contractility of the heart and increases cardiac output without causing a marked increase in heart rate. Levophed on the other hand, is used to help elevate blood pressure by causing vasoconstriction in blood vessels, which causes increased contractility and heart rate. This ultimately improves coronary blood flow and increases cardiac output. Dopamine is the drug that I have had the least experience with, but I recall from class that low doses promote vasodilation of the renal vessels in order to increase kidney perfusion. Although I am not allowed to titrate these drugs as a student, I was able to explain the use of these medications to the family members as my preceptor focused on the titrations.
Class experiences allowed me to know and understand hemodynamic monitoring such as the pulmonary artery pressure, central venous pressure, cardiac output, and cardiac index. Having experience with reading chest tube and Foley catheter output allowed me to accurately monitor these numbers. Knowing the normal parameters allowed me to relay any significant variations to my preceptor so she could adjust the medications appropriately.

Interactions with the interdisciplinary healthcare team involved calling the physician frequently with updates. The respiratory therapist was also called repeatedly, as the ventilator settings regularly needed to be adjusted. Most of my direct interactions occurred with my preceptor and the family members. The family informed me that the patient had recently had a bilateral metatarsal amputation performed and that the procedure was a direct result of the patient’s noncompliance with insulin use. Theory experiences have taught me a great deal about the affects of uncontrolled blood sugar so I planned to focus my teaching on that information.

**Responding**

Based on collaboration with my preceptor and several physicians, strict intake and output measurements were ordered along with accurate hemodynamic monitoring while vasoactive drugs were being administered. According to Ackley and Ladwig (2011), measuring hourly urine output is useful because decreased cardiac output results in decreased perfusion of the kidneys, with a resulting decrease in urine output. Ackley and Ladwig (2011) also explain that titrating inotropic and vasoactive medications within defined parameters to maintain contractility, preload, and afterload is important to maintain systemic perfusion. Following these parameters allows the nurse to ensure balance of the medications that stimulate the heart to increase contractility, while maintaining adequate perfusion of the body. The patient was also scheduled to begin dialysis the following day to help remove the excess fluid that was
accumulating as a result of the kidney failure. Continuous renal replacement therapy (CRRT) is indicated for severe volume overload, refractory heart failure, and renal failure related to heart failure (Ackley & Ludwig, 2011).

**Evaluation of Clinical Situation**

By the end of my third shift working with this patient, he was able to sit up in a chair and hold a conversation with his family, which made both the family and the patient happy. All of the vasoactive drugs were discontinued and the hemodynamic monitoring was no longer needed. The patient was still undergoing dialysis; however, the order was switched to 6 hours of hemodialysis a day instead of CRRT. Although the patient’s lab values remained abnormal, the numbers improved each day. On October 30\(^{\text{th}}\), the lab values were as follows: RBC- 2.91, Hgb- 8.7, Hct- 26.0, BUN 37, and Creatinine- 2.22. On October 31\(^{\text{st}}\), the lab values were as follows: RBC- 2.99, Hgb- 9.0, Hct- 26.9, BUN- 36, and Creatinine- 1.83.

**Self-Reflection**

As I mentioned, this clinical situation was different from my previous experiences in CICU because I was able to care for the same patient over three consecutive shifts. Spending an extensive amount of time with one patient allowed me to get to the know him and build some trust. I was also able to build a professional rapport with the patient’s family. This experience allowed me to work on several professional concepts. During collaboration with the health care team, I was able to act as an advocate for the patient by identifying his needs and concerns to the physicians. My communication skills were improved as I frequently updated the family members to alleviate their concerns. The frequent monitoring of the patient’s care and care outcomes helped me understand the concept of Safety and Quality Improvement. My leadership skills were also tested as I used information, which I gathered from conversations with both the
family and the patient, to help teach the patient and the family members about insulin compliance and obesity.

**Teaching and Learning Experience**

1. Considering the patient’s condition, both the patient and family learning needs were focused on the effects of obesity and uncontrolled diabetes. I explained how obesity can cause Type II DM, and how uncontrolled blood glucose levels can cause chronic damage to all of the vessels in the body.

2. Throughout my time with the patient, I noticed several tattoos on his body. Each one was a picture of a different grandchild. He loved to tell me about his grandchildren. Keeping this in mind I was able to explain that improving his health would allow him to spend more time with his family. Knowing that the whole family had weight issues, I explained that changing his habits would positively affect everyone around him.

3. In order to evaluate my teaching, I had the patient identify different ways to help control his blood sugar while attacking obesity at the same time. Some of these methods included lifestyle modifications such as changes in diet, physical activity, and medication compliance (insulin).
References