



How to **be** a nurse.
Don't just do it....be it.



Introduction.



The Big Red Button.

One moment he is asking you for some iced water, the next, he makes a funny noise mid sentence and slumps back into the bed. His eyes roll upward and his prognosis rolls downward.

In an instant your adrenal glands dump a zillion exclamation marks into your bloodstream. Your sphincter goes slack and your oro-pharynx is obstructed by your heart as it tries to leap out your mouth to escape the drainage.

But even before your brain *begins* to fathom which particular medical calamity has befallen your patient, your hand is reaching for it. **The Big Red Button.**

Hit it, and the usual noise of the ED is replaced by a loud demanding klaxon. The Big Red Button will bring a formidable scramble of expertise to your assistance.

For a brief moment in time it unifies us all, no matter the religion, rank or rating, to work together for greater good. It brings us all in close. It makes us listen. And it demonstrates to us that the important things in life are not things. The Big Red Button shows us that the sum of us is far far greater than the one of us.

The world needs more Big Red Buttons.

www.impactnurse.com

Ian Miller 2007

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Chapter 2.



Vertical Nursing.

1. *Out of clutter, find simplicity.*
 2. *From discord, find harmony.*
 3. *In the middle of difficulty lies opportunity.*
- Albert Einstein, *Three Rules of Work*

I think there are two aspects to the *art* of Nursing. The first is a horizontal one. It includes all the activities and interactions we perform on autopilot. The mundane day to day work that we skim along not really thinking about. It usually is rushed and stressed and shallow.

The second aspect is a vertical one. It often opens up in those special moments when you have some deep interaction with a patient. Perhaps it is when you are 'in the zone' during an emergency. It is vivid and spacious and rewarding.

However, the stress and high workload that now flavors a typical shift makes it difficult to slow down and to sink into any verticality. I usually begin each shift feeling fresh and relaxed... but somewhere around 14 seconds into a busy shift

everything goes horizontal. I feel flummoxed, and my mind is speeding 3 tasks ahead of my hands.

It is important that this vertical dimension should be recognized and cultivated, as it provides a nourishment, satisfaction and integrity in our work.

“Integrity” comes from the Latin root, integer, meaning “entire or whole”. This wholeness serves us not by changing the work itself but by changing the way we experience our work.

Here are a few exercises that might slow you down, shake off some stress and open you up to some deep nursing:

- From time to time during the shift, try to be aware of your breath. Feel the sensations in your diaphragm as you breath in and out. Are your breaths short and shallow? Do they feel rushed? Don't make any effort to control your breathing ...just follow it. Be attentive to it.
- Attempt to maintain mindfulness during your activities.
- Mindfulness is a way of learning to relate directly to unfolding experience.
- It has been described as a calm, purposeful and reflective presence which can be applied to all aspects of medical practice. Our work during the shift oftentimes becomes fragmented as we load more tasks onto our to-do-list and spread ourselves thinner. Try to prioritize your tasks to the best of your ability and then just be present with each task as it unfolds.
- Being mindful during your activities is not difficult, but remembering to be mindful is.


“Someone once told me that time was a predator that stalked us all our lives, but I'd rather believe time is a companion that goes with us in a journey that minds us to cherish every moment because they'll never come again. What we leave behind us is not as important as how we've lived. After all number one, we're only mortal.”

- Establish an anchor activity that brings you back to this open state. For me it is washing my hands, something that happens very frequently. When you wash your hands, no matter how busy and hectic it is, take a few moments to let everything drop away. Slow down. Feel the warmth of the water as it runs over your hands. Be mindful of the sensations as your hands wash each other. Notice any tension in your body. If your shoulders are tight roll them forward a few times and then back. Find your breath. Center, and reconnect with your bodily sensations. Other rituals that give you an opportunity to trigger a relaxation response are any repetitive tasks such as setting up for an IV or drawing up medication or picking up a ringing phone.

- Listen. Really listen as patients are speaking. Give them some time and listen to their words. Watch their body language. Don't interrupt with your own agenda. Try to connect with your gut feelings about them as you are listening, but don't pollute those feelings with a judgmental attitude.
- Be gentle with yourself and your colleagues. Most of us are lucky enough to have two hands and two legs... but you can only carry so many bedpans at a time.
- If you have made a mistake or you feel things are overwhelming you don't beat yourself up. After all number one, we're only mortal. Any nurse that tells you that they have not made at least one distressing error during their career is either a liar or haven't been nursing very long. I've made some crackers.
- Ask for help often. Ask questions often. Eat chocolate often.

Most the doctors and nurses that I admire are vertical practitioners. Many just exude it freely and naturally. They have been blessed with the genes or the nurturing or the karma to integrate their work and their life into a seamless whole. Still waters running deep. For the rest of us it is a challenge to overcome our vertigo and navigate safe passage amongst the rapids.

Chapter 3.



**“Oh, me?
I’m just* a nurse.”**

* patient advocate	grief councillor
lifesaver	systems analyst
troubleshooter	teacher
quality controller	dirty job doer
social worker	detective
UN ambassador	agony aunt
director	care giver
strategist	hero

Swiss Army Nursing.

It is very true what they say; knowledge is power. Over the years I’ve seen doctors and nurses swinging their intellect around the department with the sensitivity of a medieval broad sword. Their brainpower is vast and voluminous, yet it seems like the top heavy mass of their knowledge causes them to unbalance, and stagger around *bumping* into patients rather than making any meaningful contact.

Sure they gain a certain respect from the staff. The same sort of respect that any person wielding a weapon gets.

Wisdom, on the other hand, comes from the heart. Much closer to the center of gravity, it allows a smooth application of power with clear direction.

Yup, knowledge may be the broadsword, but wisdom is the swiss army knife.

packing some wisdom:

- always make the effort to remember your patients names.
 - stop calling them sweetie or darlin' or honey when you do forget them.
 - focus less on producing nurse practitioners and more on empowering nurse mentors.
 - slow down, loosen up, engage in plenty of intercourse and raise your voice.
 - become an advocate for improving our profession. Be focused. Be credible. Be tactical.
 - stop seeing patients as problems and start respecting them as complex beings with their own values, needs and priorities.
-
- recognize that there are plenty of nurses out there who just want to come to work, do the shift and collect the payslip. Respect that attitude.
 - work towards changing that attitude.
 - learn one new thing at work every day and lock it in.
 - never forget the importance of the nurse delivering patient care. And to recognize the direct relationship between the quality of the nurse and the quality of the patient outcome.
 - stop wasting time trying to force more respect for our profession, and simply respect our selves.
 - don't just bitch in the tearoom...lead on the floor.
 - always apply a little more lubricant than you think necessary.
 - just because we are all over here, doesn't mean the answer isn't way over there.
 - do not kill your patients.
 - make sure that "the system" does not kill your patients.

And finally: know when its time to go home.

Chapter 4.



The Search for Confluence.

bedpans, bandages, and bollocks.

Turning up day after day to the stressful environs of the ED, constantly having to deal with an endless exposure to OPP (other peoples problems) can quickly sap your resilience, stifle your spirit and leave you open to that nastiest of medical infections; necrotizing cynicism.

Your perception of the nursing profession quickly narrows to an endless cascade of repetitious, menial activities. Passing out bedpans, inserting cannulas, dressing wounds, hanging fluids. The patients before you resolve into a set of medical caricature's. The bowel obstruction in bed 4. The Geriatric in bed 8.

Work is shallow and stagnant. In order to get the fluids flowing again it may be necessary to push off into deeper waters. Lets have a look at some deeper nursing at the confluence of three streams of nursing practice:

- Engaged practice.
- Reflective practice.
- Contemplative practice.

Or you could think of them as **doing, thinking** and **being**.

Attention to these three areas will allow you to cultivate a significantly enriched and rewarding nursing experience for you and a higher quality of care for your patients .

engaged practice.

There are two ways to wash the dishes. The first is to wash the dishes in order to have clean dishes and the second is to wash the dishes to wash the dishes.

I was watching a TV show the other day about an expedition to climb Mt Everest. During the ascent to base camp one of the climbers stuck his crampon into his leg, sustaining a laceration to his shin. The expedition doctor attended to the distressed climber and I was mesmerized by the way he ministered his craft.

You would have thought this was the most important procedure he had ever performed. He was totally absorbed as he interacted with the patient, engaging with the climber in hushed reassuring tones whilst gently probing as to whether the lapse in concentration that led to this injury might not in fact be the pro-drome of a more serious altitude related problem. His actions whilst performing the apparently simple task of cleaning and dressing the cut had an observably calming effect on his patient. There was a lot more going on here than the disinfecting of a wound.

The psychologist [Mihaly Csikszentmihalyi](#) coined the term Flow to describe this state of engaged activity. Total immersion in the present moment produces an energized focus in which the doer of the action and the action itself merge. Time may condense or expand, tasks are accompanied by feelings of calm or joy, complex activities seem effortless. The cannula simply inserts itself. The entire shift is over in a happy flash (*ahem...advanced practitioners only*).

reflective practice.

Do what you love. Know your own bone; gnaw at it, bury it, unearth it, and gnaw it still.

Reflective practice is the process of applying a structured inquiry to the actions and experiences of your work.

To step back and explore the *how's* and *why's* of the interactions and relationships that are occurring. To drop the pre-conceived and the pre-known and replace them with an open curiosity. And then to make course corrections or practice changes based on lessons learned from these explorations.

Utilizing reflective practice to foster an atmosphere of continuous learning has been called a defining characteristic of professional practice ([Donald Schön \(1983\)](#)).

Reflective practice can occur as reflection *in* action (whilst doing) or reflection *on* action (after doing).

You place a Hudson Mask delivering oxygen at 6 liters a minute on a lady experiencing chest pain. *Why do we do this?*

Once the oxygen is commenced the lady becomes anxious and restless. *What is this all about?*

Tools to assist this process include:

- **Mentorship:** Perhaps the most useful tool is finding a mentor to both guide and listen during the reflective process.
- **Journaling:** Some find it useful to keep a journal or written narrative of their experiences. The very act of structuring and arranging your thoughts, and funnelling them through your left hemispheres onto paper may be very illuminating.
- **Blogging:** opens a great potential for reflective practice that has been underestimated and largely ignored by our profession. It provides ample opportunity for interaction, extrospection and cross-referenced reflection.

contemplative practice.

Do not fear death so much, but rather the inadequate life.

Developing a contemplative practice is perhaps the most difficult discipline. It requires a deep and often uncomfortable examination of *you* as well as the places where you and your profession touch. The reward for looking into these nooks and crannies is the possibility of making profound changes in your relationship with your work (and your life) and greatly enhancing both your engaged and reflective practices.

Contemplation comes from the Latin root *templum* (from Greek *temnein*: to cut or divide), and means to separate something from its environment. Which is pretty accurate 'cause contemplative practice isn't all quiet incense, pan pipes and swimming with the dolphins. It is about cutting and peeling open. It is fleshy and raw and will get no doubt get yourself covered in bitter-sweet juices.

And what is it that you must attempt to tease out from this warp and woof of your life? Well that is for you to unveil. This is a path of *self*-discovery. Developing a contemplative practice will add verticality to your work. You will learn to trust your intuition and develop a solid foundation on which to build your knowledge, skills and values.

Tools for developing contemplative practice might include:

- **Find a teacher.** Most of the contemplative traditions say something along the lines of; when the pupil is ready, the teacher will appear. If you take some time to listen, you will probably hear the pull towards the necessary path. That may mean reuniting with your religious roots, perhaps exploring for some affinity with other religions or contemplative traditions.
Perhaps a more comfortable fit for you will involve perusing scientific enquiry as to where your place is in the universe, by simply asking, why is it so?
Whichever path you choose finding someone who has explored the territory a little further ahead will be invaluable.
But remember life is short, so get up off your arse.
- **Bodywork:** such as yoga, or just improving your level of fitness.
- **Meditation or prayer:** taking some time for undisturbed stillness.

So here I have offered as a quick overview some methods you might wish to explore further to deepen your doing, thinking and being. Take pause from splashing about in the shallows and consider the mystery of deeper waters.

to be a **great** nurse



you must **understand**



both these hearts.

Chapter 5.



In the Zone.

There are times when a resuscitation goes bad. Every possible combination and permutation of failures and difficulties will conspire to shape the situation into a large overripe pear. Staff will get frazzled, patience will evaporate, leadership will diverge and tempers will flare.

Every piece of equipment will either fall apart in your hands or simply disappear into the ether at the vital moment it is needed most. Batteries will go flat, patients veins will go flat, ECG tracings will go flat.

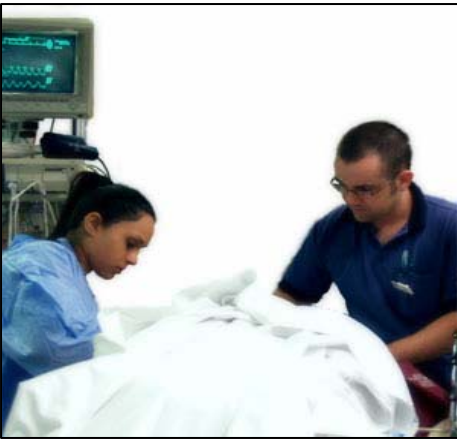
At times like these you need a few tricks to get yourself back into the zone:

- **Palpate the midline:** when it all turns to shit, its pretty easy to have a mental brown-out. Your mind goes off all over the place trying to sort out all the problems simultaneously whilst trying to keep up on top of what is happening and listen to all the carry on. So, the first thing to do is palpate your midline.
Take a moment to bring your mind back into your brain where it is needed most.
Pay note to your breathing which is probably all up in your chest and re-center it back down into your diaphragm. Stand up straight and feel your feet on the floor. Takes a couple of moments to do....remembering to do it is the hard part.
- **One thing:** now the trick is to just do one thing at a time and bring all your attention to it. Forget multitasking which is for unit managers and circus plate spinners. Find the very next task that needs to be attended to and give it your full package.
- **Slow speed:** Somewhere between rushing around like a headless chook and dropping into 'frozen in the headlights' inertia, is a zone of slow speed where tasks are performed with an easy fluidity. Once you have centered yourself and focused your breathing for a moment it is pretty easy to drop into this niche. And with some *slow speed* applied to the *one thing*, you will begin to accomplish a lot quickly.
- **Make good ripples:** if one member of the resuscitation team is flustered or getting steamed up, these emotions will quickly spread though the entire team. Thats the bad news. The good news is you can change this dynamic with your own actions.
- **Follow the leader:** there is only one team leader. You know who it is. Follow their directions and don't be distracted by all the other cooks making soup.
- **Attend to the trinity:** Air goes in and out. Blood goes round and round. Oxygen is good. This was taught to me by Dr Hollis who is much much smarter than I am and leads me to...

- **Know shit:** no point getting into the zone unless you've got something to do in there. Watch the difference between a doctor or nurse who knows their stuff when things go bad, and one who does not. Now let me assure you I am not even in the same ball-park as an uber-nurse, but let me tell you that when things are happening and you understand *why* they are happening and you know how to manage the happenings and it all fits together, well that's a powerfully beautiful thing to experience. So open a book and ask lots of questions. Here endeth the lesson.
Oh, maybe just one more....
- **Remember it could always be worse:** it could be you on the bed.

Now this all probably sounds pretty *out there* right now, but just give it a try next time you are helping during a difficult intubation and you drop the laryngoscope and trip up in the ECG cables as you try and catch it, and collect the IV tubing on your way down and drag the whole resuscitation scenario down onto the floor with you.

Chapter 6.



Burn-out.

A recent issue of the Australian Emergency Nursing Journal (AENJ) includes a literature review conducted by Caroline Potter from the Emergency Department at Royal Darwin Hospital. She conducted a critical review of the literature describing burnout amongst nurses and physicians working in emergency departments.

12 papers were included in the in-depth analysis, which underscored the urgency for further exploration of this subject.

ED nurses were found to experience significantly higher levels of emotional exhaustion and work under statistically higher work pressure than other wards of the hospital (including intensive care units).

definition.

[Wikipedia](#) defines burnout as: *a psychological term for the experience of long-term exhaustion and diminished interest ("depersonalisation" or "cynicism"), usually in the work context. Noting that, Health care workers are often prone to burnout. Cordes and Doherty (1993), in their study of employees within this industry, found that workers who have frequent intense or emotionally charged interactions with others are more susceptible to burnout.*

Causes:

The ANEJ study found that high levels of stressors were found to be piled on ED staff by:

- Work load.
- Short staffing.
- Uncontrollable environment.
- Violence.
- Trauma.
- Difficult situations.
- Access block.

access block.

Perhaps the biggest single contributing stressor is the effect of access block on the ED and its resultant overcrowding, waiting time blow-outs, and adverse outcomes for patients. A [recent study](#) in the Medical Journal of Australia found thirteen *preventable* deaths a year statistically linked to overcrowding of our own emergency department.

But working in the ED from shift to shift the staff don't see statistics, the staff see people. And despite the effects constant immersion in this environment must imprint, Caroline's paper highlights the lack of hard data on this topic with most of the evidence remaining anecdotal.

violence.

It is well acknowledged that [violence](#) is an ongoing and a major problem in emergency departments. Interestingly, Caroline's review found that nursing staff were at a greater risk form patient violence than medical staff. Probably due to the more professionally intimate patient contact that nurses have with their patients.

And of course long term exposure to this environment leads to the pernicious cycle of low morale, negative work attitudes, increased horizontal violence between staff, increased illness and high staff turnover.

In our own unit, times of increased stress levels and a pervasive feeling of impotence over controlling our environment (i.e. we cant stop the arrivals and there is no-where to send all the admissions), often leads to us taking it out on each other. We eat our own.

staff sickness.

A study was cited that found significantly lower levels of salivary bio-markers in stressed ED nurses reflecting a suppressed immune system and susceptibility to illness. We see this at the beginning of each shift when our allocation book has staff *crossed off* due to illness. They are replaced by staff recalled to work an extra shift, or staff from the wards with little ED experience. Either way, tired or inexperienced staff increase the stress levels within the unit and around we go.

loss of experienced staff

The impact that burn-out has on both the effective operation of the ED and the patients it serves is enormous. The skill set and experience that a *hardened* ED nurse possesses is much undervalued and under nurtured.

That is until they walk.

Or fall.

solutions

So enough of the problems, what about some solutions? In the next chapter, I will give you some strategies to recognise the onset of burnout and some tools to recharge, and re-animate your professional and personal life.

Chapter 7.



Burn-in.

This morning I nearly burnt the house down with some over toasted crumpets I was preparing for breakfast. Why did they burn? Because I wasn't paying attention to the *process*, and was distracted by thinking the newspaper comics were more important.

The process of burnout is a gradual one. Recognising the symptoms and applying some simple antidotes may head off a catastrophe and rekindle your workplace passion. What I like to call... **Burn-in.**

warning flags:

Here are some warning flags for impending burnout:

Sleep disturbances: Insomnia (trouble sleeping) or hypersomnia (excessive sleeping).

Low energy level or chronic tiredness can make simply getting out of bed in the morning a big ask.

Difficulty turning on the zeds may be a normal response to short-term excitement or worry, or shift work, but prolonged restless and disturbed sleep patterns may be flagging a more chronic problem.

Unique physical symptoms. Most people have their own unique built in physical stressor alarm. For me, its clenching of my jaw. During particularly stressful times I can wake up with an aching jaw and painful teeth from the nocturnal workout they are getting. For others the warning zones might be the muscles of the neck or shoulders. Persistent headaches or digestive problems are also common.

Escalating vulnerability.

Feelings of inadequacy, loss of self-esteem, or self-depreciation are common symptoms of over-stress or burnout, and as a defence against the rawness of this vulnerability you may begin erecting some nasty fortifications.

Increasing cynicism or disrespect towards patients and staff is one such barrier. Like all down hill paths, cynicism is an easy option to walk down, and it quickly feels pretty comfortable. But take this path and you are definitely going to miss the view.

Feelings of Impotence: feelings of lack of power to change events surrounding you. Strong feelings of anger towards people you hold responsible for this situation; and feelings of depression and isolation.

Persistent negative internal dialogue. Constant negative mental chatter will quickly drag you into a deep hole.

Loss of sense of humour. Better to lose a leg.

Increased use of recreational drugs: including alcohol and smoking. Sadly, alcohol or drug abuse during periods of excessive stress is a common activity. The symptoms of burnout may produce a desire for the temporary escape provided by licit and illicit drugs. Both, stimulants (such as cocaine and amphetamines) and depressants (such as tranquilizers, opiates, barbiturates, and marijuana), serve as escape mechanisms and have a high potential for addiction and abuse.

Avoiding burnout.

Remember, it is much easier to develop some prophylactic burn-in strategies than to try and change your lifestyle once you are burnt out and mentally exhausted.

Take your breaks:

Meal breaks: its very important to get some time-out during the shift. We get a 30-minute meal break, which, by the time you get your food from the cafeteria, doesn't leave much down time, so consider packing your own meals (see nutrition). And experiment with eating outside the ED environs. A bit of fresh air and vitamin D will do wonders for the energy levels. You might also consider packing your MP3 player and listen to a bit of music during your break. Death Metal is probably not appropriate.

Holidays: do not hoard your holidays. Make sure you take at least one extended break a year. Factor into this, that it will take 4 or 5 days just to transition into holiday mode.

Nutrition: We are what we eat; so choose high-octane fruits, vegetables, whole grains, and low-fat proteins. Include a daily intake of omega-3 fatty acids (Fish oil capsules). As well as being good for your heart, studies have found omega-3 may lead to a significant improvement in the symptoms of depression. Oh, and do not underestimate the theraputic effects of chocolate taken in sensible dosages.

Cultivate a positive mental dialogue: Watch what you think as much as you watch what you say. Continuous negative mental chatter will quickly pull you into a hole. Catch yourself when your internal dialogue is *nay saying* and replace the thought with a stronger positive one.

Sounds corny and forced? True. But trust me, I'm a nurse. What initially feels forced will, with practice, develop into a habit and over time it will become a trait.

Avoid the burnt bits: Burnout can be highly contagious. Try not to get infected by the cynicism, irritability or negative attitudes of colleagues. Surround yourself with a supportive environment.

Can't see one? Rest assured, there are probably plenty of people intimidated by the burnt bits in the department, just waiting for permission to emerge.

Regroup: Lather up your creative juices by involving yourself in a project. Form a working party and initiate a de-cluttering of the ED or work on your departments disaster response plan, or start a journal club. Sounds boring? That's because it hasn't been lubricated by those juices yet.

You can *never* have enough lubrication.

Retreat: Sometimes the best way forwards is to retreat. Perhaps you need a break from the ED for a while. Have a hard think about this and if the negatives are diluting the positives so much that the flavour has gone, perhaps its time for a change.

Vent your spleen. The best way to decant the pent up frustration and angst is to talk it out. Discuss the problems that are pushing your buttons with some trusted friends. Try not to let yourself withdraw from your social contacts.

Treating burnout.

Consider professional help: It is important to recognise that all these responses are perfectly normal. However they can begin to interfere with your safe work practice even before you are totally burnt-out. Consideration should be given to some professional counseling, and many hospitals offer a confidential counselling service for free.

Chapter 8.



Deep Questions.

Once again the shift is sliding slowly into a pit of poo.

Along with the other staff, I find myself zigzagging about the overflowing department, trying to prioritize an unraveling list of tasks and responsibilities. Immersed in my own stress soup, I sometimes lose my perspective... and a patient who wants (or needs) to talk, can on occasion become an almost bothersome interruption to my work. I find myself taking a 'hit and split' approach with my interactions and assessments, using a rapid succession of closed and leading questions in order to get the information 'I' want so I can move on to the more 'important' tasks at hand.

This shallow communication with my patients not only provides a poor quality of care, but will, in the long run, often be counterproductive, resulting in an even greater workload. The word communication comes from the root word “common”. And it is for you to discover that you have far more in common with your patients than you would care to admit.

When a patient presents to the emergency department and enters your care, it is usually a meeting of complete strangers. In order to develop and prioritize a management plan for this person, a field of mutual trust must be cultivated. And this field must be ploughed with sensitivity, competence and acumen.

“You can tell whether a man is clever by his answers. You can tell whether a man is wise by his questions.”

The patient will most likely present with pre-formed expectations of the emergency department (which may or may not be realistic). They may also present carrying a large suitcase packed with emotions and inhibitions including; anxiety, anger, fear, shame and embarrassment, regarding what may be simple ailments or complex personal problems.

It is important to make this person feel genuinely welcomed at first contact.

Introduce yourself and explain the association you will have with them.

“Hi, my name is Ian. I am one of the nurses that will be helping to care for you this afternoon.”

It is surprising how many people have no idea if the person they are talking to is a doctor, nurse, clerical staff or radiographer. (...besides, you want to make sure they know who to send the chocolates to, no?)

The difficult part for us as ‘busy doing 15 things at once nurses’, is to remain present (fully attentive), and engaged (not emotionally detached) with this person both whilst talking and listening to them. The ability to interlace deep listening and effective questioning is indeed a precious skill.

Make it evident to the patient with good eye-contact and a relaxed body posture that you are fully present with them.

Try not to rush through the conversation... they must be given time in which to express themselves and speak freely.

Acknowledge your understanding (“I see...go on.”) as well as seeking

clarification or explanation when necessary. When you do understand, nod your head in agreement or acknowledgment. This will show the patient that you are, in fact, paying them attention.

Mirroring or reflecting may also be used to signal your understanding. This is achieved by repeating back important emotional statements, desires or objectives that the patient may talk about. It probably feels less contrived to do this by repeating what you have understood in your own words (paraphrasing).

I'm all ears.

Any verbal interaction between you and a patient will carry a symphony of verbal and non-verbal information. Even a short phrase or sentence may contain a rich layering of needs and desires.

In order for effective communication to occur, both parties must correctly interpret and understand the others *intended* meanings. Some of the counterpoint running through a dialogue may include:

- conveying a fact (information).
- saying something about the patient (self-revelation).
- expressing the patient's feelings on how you are relating to one another (relationship).
- and it may be seeking some form of influence (appeal).

For example, a lady presents commenting, "this is the second time I've been here with this stomach pain in the last week", may simply be stating a fact, or revealing that she is anxious that it might be something serious (self-revelation), or showing her unhappiness with the treatment she received on her last visit (relationship), or attempting to be seen with more urgency (appeal).

And to further complicate things, each of these subtexts may be explicit (expressed directly) or implicit (expressed indirectly).

For example, "can you tell me how much longer before my son can see the doctor?" maybe a simple enquiry as to the waiting time, or it might implicitly infer feelings such as: 'My son is in pain', 'I think you have forgotten us', 'I'm getting pissed off with waiting for so long' or perhaps, 'I don't think you have properly assessed how unwell my son is'

In order to correctly perceive the marrow of the intended message it may help to answer these questions:

- What is the factual content?
- What is this telling me about the patient?
- What does this person feel about our relationship?
- What do they want to achieve?
- Is there any implicit information here?

“It was impossible to get a conversation going, everybody was talking too much.”

Remember that a very high proportion of messages contain implicit information so look for congruence between verbal and non-verbal cues such as body language, gesticulations, and character of voice.

Listen not only to what is said but what is not said.

Note your own behavior during interactions... do you tend to interrupt or cut the patient short?

Have you ‘preemptively packaged’ this patient’s problem with your own subjective values. E.g. Just the flu. Probably a psych patient.

Constipated....wasting our time.

Remember, the initial presenting problem may only be a ‘ticket in’ to seek help with deeper issues.

Many of the communication problems that we encounter are the result of a poor questioning technique. As questioning is one of our most important diagnostic instruments we are very good at focusing on *our* objectives whilst neglecting those of the patient.

A good question is one that:

- Is easily understood by that particular person.
- Is posed at the right time.
- Encourages an answer.
- Increases the depth of the dialogue.
- Encourages further communication.
- Is empathetic.

Two commonly discussed forms of questions are open and closed.

Closed questions can usually only be answered with a yes or no (or a very brief, limited) reply. E.g. “do you have any chest pain right now?”

They may be useful to keep the conversation focused and illicit specific information but will hamper a deepening discussion, and when used too often produce a dry, mechanical, superficial ambience. (However they are very useful

in an emergency situation where rapid, concise information must be gathered in a very short time.)

Open questions encourage the patient to tell their story in their own words. E.g. “tell me what brings you in to see us tonight?” They offer the opportunity for self disclosure and even a ‘warming’ or opening that may result in some insight on the part of the patient.

Sounding questions are used to obtain specific information without being closed. E.g. “How has your baby been feeding?”

Catalogue questions give the patient a choice of a series of key words or descriptions. E.g. “is the pain sharp, stabbing, burning or cramping?”

Try to avoid **leading questions** . E.g. “does this pain get worse when you lean forward?” or “has the nausea eased after that injection?” These questions tend to limit the conversation or even place subconscious pressure on the patient to answer the way *you* want them to.

We spend about 70% of our waking hours communicating through speaking, listening, watching and reading.

It has been said that we typically hear only about 20% of the information communicated to us and that we forget about 80% of that within 24 hours. Therefore..we must communicate clearly, briefly and repeat important information often or else most people will only get about 4% of the information we want them to have.

Also avoid double, **triple-barreled questions** . E.g. “did you sleep well last night... and have you had any rectal bleeding?” This becomes confusing and you will probably only have to repeat one of the questions anyway.

Judgmental questions are a big no-no. E.g. “if you have had this pain for a week...why-o- why have you decided to come to the emergency department tonight?” Like many big no-no’s it might make you feel all smug and pious for a moment, but all they do is put the patient on the defensive and close down communication.

In Conclusion.

Always conclude any interaction by giving the patient an opportunity to seek clarification or ask their own questions. OK. this all looks... most easy peasy....but drop me onto the triage desk on a Saturday night, and this list of skills tends to get stuffed away at the bottom of that growing pile of untriaged patient sheets. And perhaps in some cases long conversations are not appropriate in an emergent situation.

However, by taking a little extra time to have a deeper conversation with my patients I might just be able to deliver a more effective and efficient level of care,... and they might just feel more satisfied that someone has taken the time to *really* listen to them.....and they might just remember who to send those chocolates to.

Chapter 8.



10 Commandments.

What do you think are the 10 most important guidelines for a nurse working in the ED?

Here is one set of commandments I found on the mountaintop. There are plenty more for you to discover yourself.....so get climbing.

ONE: always document the care you deliver.

Legal Requirements

Your documentation must reflect the patient's care status (condition/treatment) and include nursing interventions and outcomes of care.

Documentation must demonstrate accountability of practice.

Remember: The Clinical Record provides proof of the quality of care given to a patient and is admissible in court as a legal document. If it isn't documented it didn't happen.

The Process

Clinical notes must meet the following criteria:

- they must be legible.
- they must be dated, timed and followed by author's signature and designation.
- they must be a clearly identified signature. If your signature looks like spaghetti, print your name in brackets afterwards.
- each page must be labelled correctly,
- you must use only approved abbreviations as per hospital protocols. Here are some examples of acceptable medical abbreviations ...not

Precisely document any information reported to a medical officer that relates specifically to a change in a patient's condition.

Record arrival date, time and mode of arrival. Obtain a thorough history and nursing assessment. Document any pre-existing conditions including allergies and their reactions.

Thorough and appropriate documentation of haemodynamic observations including pain score.

TWO: listen to parents.

While it is true that some parents completely lose the plot over a microscopic splinter in the little toe, most do not. After performing a quick assessment of the child listen closely to the parents story.

THREE: reassess your patient after giving treatment.

Its all part of the nursing process. You can think of it as **A Delicious PIE**.

- **Assessment.**
- **Diagnosis.**
- **Planning.**
- **Implementation.**
- **Evaluation.**

Always reassess to gauge the efficacy of your current treatment.

FOUR: never assume a patient who is behaving erratically is drunk.

Oh boy, this can be a tough one. Any patient with an altered state of consciousness needs careful assessment and close monitoring. Period.

FIVE: never ever ignore your gut feelings.

Is it an impending calamity? Or is it last nights vegetable vindaloo? Either way, ignore it and the outcome will be the same.

SIX: never deviate from safe and ethical nursing practice.

The Code of Ethics for nurses in Australia was first developed in 1993. In 2000, a conglomeration of nurses from the Australian Nursing Council, the Royal College of Nursing and the Australian Nursing Federation stayed up late for quite a few nights nutting out the current code which can be found [here](#).

1. Nurses respect individual's needs, values, culture and vulnerability in the provision of nursing care.
2. Nurses accept the rights of individuals to make informed choices in relation to their care.

3. Nurses promote and uphold the provision of quality nursing care for all people.
4. Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
5. Nurses fulfil the accountability and responsibility inherent in their roles.
6. Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well being.

SEVEN: do not accept a doctors orders without question if you have a problem with them.

Doctors are sometimes dumb as stumps. Just like us.

EIGHT: work as a team.

1. There is no "I" in: *emergency department*. There is, however, a "team".
2. There are more than enough "I"s in: *I'm in deep shit again*.

NINE: filter for suspicions of child, spouse or elder abuse.

Our hospital's Health Child Protection Policy requires all its staff to make a mandatory report to Care and Protection Services should they suspect non-accidental injury, sexual abuse, emotional abuse or neglect in the course of their work.

It happens more than you would wish.

TEN: pain is a four letter word.

Get rid of it. I remember in the bad old days we used to leave our patients rolling around in agony until a doctor could get to them under the pretence that if we got rid of the pain, the doctor would not be able to properly assess them. What a load of bollocks.

No patient should be left in pain. Use a visual or numeric analogue scale (VAS) to obtain a subjective rating of the pain from the patient. Try not to be [judgemental of their response](#). Think they are narcotic seeking? Makes no nevermind. Control the patients subjective discomfort and then you can sort out the rest.

(if the patient has known, documented history of repeated narcotic seeking behaviours, they should have a management plan developed in co-operation with drug and alcohol, and pain management specialities.)

There are many different strategies for effective pain management (which I will leave for another post.) and a wide spectrum of interventions that can be implemented.

How much should I give? In cases of severe pain. Many nurses are hesitant to give large accumulated doses of narcotic analgesia in case they kill their patient or get them addicted. Here is a quick guide as to a safe analgesia regime:

1. Observe them closely.
2. Keep giving aliquots of narcotic analgesia as per your hospital protocol until A) the pain score approaches zero OR B) they are too drowsy to give you a pain score.
3. If pain remains uncontrolled consider [patient controlled analgesia](#).(PCA)
4. Ensure you have oxygen, airway adjuncts and [Naloxone](#) available.

Chapter 9.



In a Nutshell.

So, to sum up. If you want to **be** nurse you must put in the hard yards.
To be a nurse is not just 9 to 5, it's a tough gig and it will shake your life.
And once you *are* being a nurse, nobody is going to notice much anyway.

Except your patients.
And your colleagues.
And me.

How to be a nurse (in a nutshell.)

- Try not to sneeze when wearing a protective face shield.
- Never bend down to pick up your pen when the patient is vomiting into a kidney dish.
- Always give the patient a call-bell, even when they have an itchy buzzer finger.
- When returning from a toilet break always always check to make sure you do not have a tail of toilet paper hanging out the back of your pants.
- Wash your hands. Often. And properly.
- Be gentle with your colleagues.
- Always handle a dead body with respect.
- Air goes in and out. Blood goes round and round. All the rest is obfuscation.
- Never underestimate the amount of faeces that can be concealed in a pair of old y-fronts.
- Listen until it hurts.
- Watch for burn-out. Watch for rust-out.
- Best not to fall asleep at the desk and dribble all over your patient notes.
- Remember: Best practice. Remember: Worst case scenario.
- Guard your testicles from static electricity when making a bed on a dry day. (If you don't have testicles, guard the testicles of those around you.)
- The voice of experience sometimes gets drowned out by the din of expedience.
- There is no such thing as this will only take a moment.
- If you tell your patient "Ill be right back", make it so.
- Chocolate is brown. Faeces are brown. It's confusing, I know. But try to pay attention.



This is the most complex and most powerful piece
of diagnostic and therapeutic equipment you will carry.
It should be worn facing outwards.

do not let the batteries run down.

Please send any comments, suggestions or feedback
regarding this eBook to ian@impactednurse.com