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# A Student's Perspective of Learning on a Dedicated Education Unit

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Running head: LEARNING ON A DEDICATED EDUCATION UNIT

A Student's Perspective of Learning on a Dedicated Education Unit

Senior Honors Project

Fall 2011-Spring 2012

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Rhode Island College School of Nursing

*Abstract*

*It is the intent of this honors project to give a student's perspective of learning in the Dedicated Education Unit (DEU) on Bridge 7 at Rhode Island Hospital. Bridge 7 is a 38-bed unit specializing in general medical surgical patient care services. A student's perspective is illustrated by journal entries written from each clinical experience over the course of one semester, during the course Adult Health II. In addition to a student's perspective, it is the intention to compare the learning experience on the DEU, to the traditional model of clinical learning. This project will include current nursing research that focuses on different areas of dedicated education unit learning. Findings from these nursing research articles will be compared and contrasted to a student's perspective of the same outcomes. Prior to each clinical day, students set personal goals. These personal goals will be addressed, with a focus on how learning on a DEU enhanced goal attainment. Lastly, well-known nursing theorist Pat Benner's conceptual model of how nurses evolve from novice to expert will be utilized and directly incorporated into the student's perspective.*

The intent of this project is to illustrate a student's perspective of learning on a Dedicated Education Unit (DEU) for Adult Health II clinical component. With the increased demand for undergraduate nursing graduates to address the nursing shortage, limited faculty to provide instruction and lead clinical course components, nurse educators and leaders around the country, and around the world, have sought out and turned to alternative learning methods. The development of DEUs has been one successful way to address the shortage of nurses, and nurse educators. The concept of DEUs is a fairly new concept and an equally new way of clinical instruction, thus, literature and nursing research regarding this model is limited. According to Moscato, S. R., Miller, J., Logsdon, K., Weinberg, S., & Chorpenning, L., (2007), a dedicated education unit is "a client unit that is developed into an optimal teaching/learning environment through the collaborative efforts of nurses, management, and faculty. It is designed to provide students with a positive clinical learning environment that maximizes the achievement of student learning outcomes, uses proven teaching/learning strategies, and capitalizes on the expertise of both clinicians and faculty." (Moscato et al., 2007) In 2010, Rhode Island College School of Nursing (RICSON) was the first school in the state of Rhode Island to collaborate with a hospital to create a unit of the hospital dedicated solely to the education of students from one school of nursing.

Learning on a DEU differs from the traditional model of clinical education in a multitude of ways. First and foremost, the traditional RICSON clinical education model consists of approximately eight students per one clinical nursing professor, attending one facility, in which other clinical groups from other educational institutions may be present on differing days. Each clinical day, a student is assigned to one client to provide nursing care, and clinical instructor time must be divided amongst the students to ensure skilled hands-on practice is adequate for

each student. This traditional model requires that faculty divide their time so student learning is most optimal for each student. Sometimes this means students are unable to practice critical clinical skills, such as administering medications, every clinical day, unless the assigned staff nurse was willing to guide the student. According to Dr. Jane Williams, Dean of the School of Nursing at Rhode Island College, “A rotating roster of students from different educational programs reporting to the same locale on different days of the week has caused confusion for members of the nursing staff, who have a hard time interacting with them.”

As stated previously, nursing research on the concept of DEUs as the newest model of clinical learning is limited but growing. A literature review was completed and research findings from previous studies used in analyzing a student’s perspective. The first DEU model was developed at the Flinder’s University of South Australian School of Nursing in 1997.

(Edgecombe, K., Wotton, K., Gonda, J., & Mason, P. 1999) It was developed with the intent to create the most optimal hands on learning environment for nursing students, while enhancing collaborative relationships between clinicians and academics. The two-part study from Flinder’s University of South Australian School of Nursing will be utilized in this project to compare and contrast the findings with a student’s perspective of RIC’s DEU on Bridge 7 at RIH.

(Edgecombe et al., 1997) Part 1 discusses perceived limitations with the traditional nursing clinical education model and rationales for the development of the DEU. As mentioned earlier, one of the main issues with the traditional model is that there is, on average, a student to instructor ratio of 8:1. This poses a challenge when trying to ensure that each student is able to perform critical clinical nursing skills each clinical day. To add to this challenge, nursing students from different schools may be present on different days, on the same unit, from varying levels of education, adding to the already present issues of patient care management and

confusion. Staff nurses are affected because this can cause confusion. They are confronted with the issues of handling their patient assignments, in addition to recognizing which students from what school are present for the day, which educational level they are at, and what the learning expectations are. A third perceived issue with the traditional model is that staff nurses find it difficult to work with nursing students because they are unaware of the student's clinical skills, are unfamiliar of the nursing curriculum that the student is guided by, and their expected learning outcomes. Traditional models generally do not support continuity in student learning.

Implementation of a DEU as an educational model enhances continuity in the duration of clinical practice and ample opportunity for learning through repetition and continuity. Students on the DEU are assigned to work with 1-2 staff nurses for the duration of the semester. Staff nurses are given the title Clinical Instructor (CI). This enhances continuity for students and the staff nurses. This consistent pairing of student to CI also allows for student learning on a greater personal and professional level, and students no longer have to reprove their skills and competencies every clinical day, as compared to the traditional model. Students get to know their CIs on a more personal level and are given the opportunity to develop clinical competencies on a much higher level as a result. Part 1 of the study done by Edgecombe et al. (1997), proposed that DEUs enhanced adequate time for clinical practice and ample opportunity for learning due to increased opportunities for repetition of skills. Ample opportunities for learning through repetition occurred on a daily basis during my experience on the DEU, as illustrated in weekly clinical journals (Appendix A). As the semester progressed, I was able to expand on critical nursing skills such medication administration, IV therapy, patient assessments, follow-up assessments, documentation, etc. As the semester progressed, I began to look at the entire patient clinical picture, rather than focusing on individual patient care tasks. Each clinical day, I shared my

personal and professional goals with my CI, and my CI was able to share goals they had for me, and we worked together to meet these mutual goals. In the traditional setting, perhaps it was related to inexperience, but I would focus on the same task every clinical day: completing or assisting in patient activities of daily living, and physical assessment. Whether or not my professor was busy with other students determined if I was going to give medications on any given day. If I was able to give meds every two weeks, that was satisfactory. Prior to this DEU experience, I was lacking knowledge regarding IV therapy. I was not familiar with programming IV pumps, setting them up, changing primary bags, and reconstituting and hanging medications. Edgecombe et al., (2007) also suggests that DEU models allow for the development of clinical competency to a higher level. As noted by daily feedback and evaluation from my CI's, there was a significant improvement in my clinical skills, my knowledge, and my critical thinking from the first to last day of my clinical practicum on the DEU. The benefit of working with consistent CI's was that they were able to learn more about me, my strengths, and areas observed that could be improved on. This allowed me to develop a higher level of clinical competency. Part 2 addresses two main questions: What are the strengths and weaknesses of the DEU? What are the similarities and differences between students' and clinicians' perceptions of DEUs? During analysis of this study, six dominant themes were identified: preferred placement model, student/clinician learning, peer teaching/learning, clinical facilitation, workload, and relationships. Both students and clinicians predominately believed the DEU to be the preferred placement model. Students stated they were able to reflect on their work, identify goals achieved and set new objectives. Students also indicated they were exposed to a greater learning opportunities. In my experience on the DEU, I found this to be a fact. Working consistently with the same CIs, we were able to develop a working relationship. Every clinical day, I shared my

pre-set goals with them and they could help me to achieve them. They were able to identify strengths and areas that could use improvement in the clinical setting because of the continuity, and monitor my progress in achieving the course outcomes in addition to my personal objectives. Throughout the semester, we worked together to achieve these goals. Due to the continuity of the working relationship, and the CI student ratio of 1:1, this afforded much greater learning opportunities for me. Every clinical day I was able to work with my CI in providing care to the entire patient assignment for the day rather than only one patient. Being exposed to caring for an entire patient assignment allowed for exposure to a variety of patients with complex acute and chronic clinical conditions. The second dominant theme from this study involved student/clinician learning. Students believed the DEU to have provided more opportunities for repetition of clinical skill practice, increased exposure to a variety of experiences, time to develop and synthesize knowledge, time for reflection, and that learning on the DEU assisted the application of theory to practice. I found each of these findings to be true in my DEU experience. Learning on the DEU fostered mastery of fundamental clinical skills, through repetitive practice. Skills including spiking and priming new and already existing IV tubing, reconstituting medications, subcutaneous injections, drawing up and administering insulin, and focused and generalized patient assessments, just to name a few. The repetitive nature of the DEU fostered mastery of skills and tasks, and in turn increased my level of confidence. Being able work one on one with consistent CIs allowed for time to develop and synthesize knowledge, and allowed for times of mutual reflection and evaluation. During my clinical learning experience with traditional models, one on one learning time with professors is sometimes limited due to the student to professor ratio of 8:1. In turn, professors are required to divide their time to ensure fair time distribution for each student. This hindered students from asking questions while learning



new concepts and skills. During my DEU experience, I never encountered a time where I was hesitant to ask a question. I believe this to be due to a few factors including the working relationships my CIs and I had developed, and greater time to interact and gain knowledge they had to share with me. As illustrated in my journal entries, at the end of every shift, I would share my perception of the day, and in turn, my CI would share their constructive perspectives and state some goals for the following week. For example, during my experience, my CI believed that I was ready to take on a three patient assignment the following week after seeing my progression from one to two patients. At the end of every clinical day, my CI would give me thorough feedback as to what I did well, what I improved on, and areas for improvement for the next clinical day. CIs also complete a weekly evaluation to gauge strengths, areas for improvement, and progress made during clinical time. This performance evaluation tool reflects the student's mastery of critical course outcomes for adult health II. The rating scale is numerical and ranges from 5 (excellent) to 1 (poor). Every day I would send a goal to my professor, and after the day was over, I would state whether the goals were met and how or why they were or weren't met. I was able to self-evaluate, and I was able to set goals for myself and my CI's were able to set additional objectives for me by introducing new skills and experiences, etc. Lastly, learning on the DEU certainly fostered the correlation of learning from theoretical knowledge to clinical practice. RICSON's DEU program provides specialized work shops for the participating staff nurses to attend to become CIs, to familiarize them with what their students will be learning in the course, and to familiarize them with the school's curriculum. They are also guided by college faculty in fostering their role as a CI in the clinical setting. With the CIs being familiar with what students are learning, or have already learned, in theory, they are able to help the student transition this knowledge to practice. In the traditional model, staff nurses were unaware

of what types of content the students were currently learning, or had already learned, and in turn, it made working with students difficult for them. The DEU learning model is a solution to this issue.

Research findings from Ryan, C., Shabo, B., & Tatum, K. (2011) study also proved to be similar in my DEU experience. (Ryan et al., 2011) One of the questions this study aimed to answer was if students participating in DEUs meet the clinical course outcome requirements as successfully as students learning on traditional models. Throughout my DEU experience, in my weekly journals, I documented critical course outcomes for Adult Health II as I met them. According to Ryan et al. (2011), “students were able to meet and practice all course objectives in a timely manner and students were more pleased with rotation when compared to traditional settings.” I was able to meet all the course outcomes by mid-semester which allowed for further expansion and practice of each outcome, rather than meet it once, check it off, and shift focus to the next, which is essentially what is done with traditional clinical models. As illustrated in my journal entries, I was very pleased with this clinical rotation compared to traditional setting rotations. Another finding from Ryan et al. (2011), revealed that students felt and experienced, “Increased opportunities to participate in clinical procedures, increased engagement in culture of the unit. Participating on the DEU provided a unique opportunity to acquire a real understanding of what it is to be a nurse and improved self-confidence in knowledge of patient care.” Again, my journal entries illustrate these findings as well. I had increased opportunities in procedures like IV care, medication administration, retrieving MD orders, implementing new and existing orders, evaluating changes in patient status, responding to a code, etc. Aside from responding to a code, I practiced all of these listed clinical experiences on a daily basis with the careful guidance from my CIs. Prior to this DEU experience, I had experience approximately three times

with IV medications, and I feel that was the highlight of my experiences on traditional settings. Not only did I gain a real understanding of what it is to be a nurse, working alongside RN's and providing all RN patient care, but also I came to actually feel like a nurse and feel like I was a professional and part of the health care team on the unit. Similarities in my experience to concepts expressed by students in this study included a feeling of acceptance. Students reported, "being accepted as part of the unit team and being intertwined within the culture of the unit." (Ryan et al., 2011) Every clinical day I was made to feel welcome and treated as an equal, and as a team member. When there were on-unit functions, such as birthday celebrations, or the unit was getting take-out for lunch, I was also invited and encouraged to participate. The secretary, who usually coordinated these, would go out of her way to find me and invite me. As almost all student nurses are aware, there is not much worse than having a clinical day on a unit where you are made to feel unwelcome or your presence unwanted. This was often the case on my non-DEU experiences. And as Dean Williams stated, with the constantly changing schools of nursing present, and different levels of students, its hard for staff nurses to work with student nurses. In past experiences, I certainly had my share of welcoming nurses, but I equally had my share of nurses who just weren't interested in teaching a student, or unsure of what we were and were not able to do as students. Sometimes, its not that they don't want us there, its that they don't know their role, or unsure if they will be administering the patient's meds, or if the student and their professor will be. One can easily see the confusion and mishap that can occur with situations like these. On DEUs, the DEU nurses want to be DEU nurses. They want to take on students and mentor them, and share their highly valuable knowledge and skill set. In addition, they are recommended by clinical managers for participation based on their clinical experience, and desire and willingness to work with students. In my last journal entry, I compare my relationship

with the DEU nurse that I worked with most, to a bird carrying me under her wing, and on the last day, setting me free. That is what it felt like to me. We had a working relationship and got to know each other after spending countless 12-hour shifts together. To expand on this thought, students were only required to complete 8-hour shifts. With the CI that I spent most clinical days with, I stayed the entire 12-hour shift with her, and she was happy to have me stay. While working with my second CI on alternating weekends, I was able to stay 12-hour shifts with him, but I usually stayed only the required 8 hours.

The third study used to compare a student's perspective is authored by Moscato et al. (2007). Findings from this study that I was able to confirm as true during my DEU learning experience include, "DEU students were more likely to report: nurses modeled professional behavior and values, nurses were my teachers, staff understood my learning needs, nurses helped develop my clinical learning skills, I was a member of the nursing unit responsible to nursing staff and health team, and I was in charge of my own learning during clinical." (Moscato et al., 2007) My CI's did model professional behavior and values that I admired and aspire to model myself as a student nurse. They were my teachers, my mentors, and my colleagues. I worked along side my CI's who taught me new concepts, reviewed previously learned concepts with me to refresh my memory, and when I had a question or concern about something, it was the nurses, my CI's, that I would turn to, to learn. They understood my learning needs. I didn't feel incompetent or embarrassed when I told my CIs I didn't know how to hang new IV fluids and prime new tubing. They allowed me every opportunity to practice this simple, yet essential, skill. One day, with one of my CIs, we had some down time. He said to me, "Well, what do you want to learn? What can I teach you?" I replied, "Well, I have been asking questions right along as they have come up. But I am wondering, have you used every supply in the clean utility room?"

The clean utility room was a very large, organized room. It had multiple shelves on each of the four walls that went from the ceiling to the floor. Each shelf was lined with bins, organized with clinical supplies. He took me into the room, and we actually went over every supply, what its used for, and how to use it. This illustrates the dedication of the DEU nurses in regards to student learning. I don't believe I would have had this experience off the DEU. Staff, in addition to my CI's, were aware and sensitive to my learning needs. Every morning, the secretary would ask me which rooms I needed rounds reports on, CNAs would ask which patients I was working with that day and would share relevant patient information with me as well as the assigned RN (my CI), other nurses would approach my CI and myself when they had something interesting to share or allow me to experience, like a patient with a wound drain, a rare diagnosis, or complex morbidities. A critical element to support optimal clinical learning for nursing students is based on the fact that clinical instructors are able to work with the students on a personal level, and recognize strengths, as well as areas for improvement. As this study stated, "On the DEU, students don't have to reprove themselves every clinical day. On the traditional clinical unit, students are never able to develop a working relationship with the nurse." (Moscato et al., 2007) While learning on the DEU, because there was consistency in the nurses I worked with, I did not have to reprove my knowledge base and skills every clinical day. This saved a lot of time and allowed the nurses to get to know me over time and know what my skill level was, and my areas needing improvement. This enhanced the quality and safe patient care I performed every day. I was able to develop a working relationship with my nurses and the other staff on the unit. I felt like part of the team everyday. This unique characteristic of consistency with the DEU is a characteristic that the traditional model of clinical does not allow for. As a result, students are assigned to a single patient, and the staff nurse a student might work with one week, will be

different the next. Staff nurses aren't sure of the student's abilities and skill competencies, and hence, find it easier to just allow the student's professor to supervise skills. Students are allowed to practice supervised clinical skills given there is ample time, and a fair distribution of equal instructor time must be prioritized. This study continued on the idea of continuity. "Having continuity in CI was huge. They're always available, they knew my strengths and limitations, and were able to challenge me to the next step." (Moscato et al, 2007) Not only did I certainly experience this during my time on the DEU, but also, it is one of the goals of having a DEU. When compared to the traditional setting, there is a student instructor ratio of 8:1. The instructors are required to divide their time fairly amongst the eight students. This prevents students from administering medications every clinical day, along with other crucial nursing skills due to lack of 1:1. The DEU provides the important 1:1 attention that the nursing education experiences necessitates for optimal student learning and transitioning from student to novice nurse, as I will discuss as another aspect of learning on the DEU. My CI was always available to assist me, to guide and mentor me, and to coach me. They got to know me and were able to set challenges for me based on intensifying patient acuity and patient assignment numbers. I always provided nursing care, with my CI, for the entire patient assignment that we were assigned to. In addition to working with all my CIs patients, I would get assigned one, then two, and eventually three patient assignments by myself, with intensifying acuity levels. This was accomplished because of the continuity in CIs I was able to work with. They were able to identify appropriate learning and competency levels, and foster appropriate learning experiences based on student learning progression.

The following DEU experience comparison is based on a study by Mulready-Shick, J., Kafel, K., Banister, G., & Mylott, L. (2009). This study utilized focus groups with DEU nursing

students. Themes that arose included, teamwork and collaboration, safety, informatics, patient centered care, evidenced based practice and quality improvement. Teamwork and collaboration were the foundation for my success in learning on the DEU. My CI's and I worked together as a team and collaborated our thoughts and skills with interdisciplinary teams to provide optimal patient care. We were able to discuss the details of patients' health and care plans and corresponding rationales. We addressed the concept of safety in terms of medication administration, and other patient safety measure implementation like being aware of implementing fall/seizure precautions, etc. I learned about informatics by accessing daily, electronic resources available related to patient information, H&P, laboratory data, assessment findings, admission data, test results, physician orders, etc., from computers. I also learned how to communicate with patient primary care providers and other interdisciplinary team members via computers. Patient centered care was another theme identified. This study found that students' witnessed positive role modeling behavior while interacting with patients and families. I was able to gain more experience with patient focused care being on the DEU because I was able to observe CI modeled behavior and model it myself. Observing how my CIs interacted with patient and patient families during difficult conversations was something I had no exposure to prior to my DEU experience. In addition to exposure to difficult conversations, non-verbal body language was evident and I was able to model. Also, being more involved with patient care with multiple patients allowed me to be able to practice and expand my skills in providing patient centered care.

Lastly, according to Ranse, K., & Grealish, L. (2006), three major themes were identified by DEU participating students. These dominant themes were based on student perceptions and included acceptance, learning & reciprocity, and accountability. I can easily identify with these

three major themes from my learning experience on the DEU. These were three fundamental building blocks that occurred on an ongoing basis during every clinical day. Acceptance occurred day one, which is very important, although it may seem like such a small thing! There is nothing worse, as explained earlier, than going into clinical and feeling as though you're not welcome, or feeling more like a shadow and in the way. It isn't always done directly, or purposely I am sure, but it does happen, and it significantly impacts the learning experience in a negative way. It becomes a barrier to success. Everyday I was greeted by the secretaries and other nursing staff, and included in unit activities. The little things that allowed me to feel accepted, which allowed me to focus on giving the best patient care I could while striving to learn as much as I could. If I didn't feel accepted, I wouldn't be able to fully concentrate on the day's work. I would be trying to concentrate on patient care in addition to not stepping on anyone's toes or getting in the way. Learning and reciprocity was another theme identified in this study. Again, I can easily confirm this in my experience too. I was finally able to apply theory to clinical experiences fully. For example, granted I did have patients during traditional clinical settings that were matched to current theory topics, I wasn't able to fully see the "big picture". On the DEU, we had access to computers and patient charts, and sole attention of a CI. So if a question arose about a particular piece of patient data, we would have to ask other students, or wait for the professor to finish with other students. Depending on if you had a receptive nurse that assumed primary accountability for your assigned patient, determined whether or not a student would feel comfortable enough to approach and ask a question. This reinforces the particular aspects of DEUs being accepting, and the importance of working one on one with a CI caring for patients. I was able to practice skills on a daily basis to ensure competency and mastery. Accountability, the third and final theme identified in this study, is another aspect I experienced on the DEU. When I initially proposed to



do this senior project, I had to perform a literature review and find existing research that I would be comparing my perspective to, and I couldn't quite grasp how I was going to find accountability on the DEU. I initially thought of the word in a negative sense as in, being held accountable for not doing something right. By the end of my clinical rotation on the DEU, I was able to see accountability as a positive thing too. I was proud of my patient care and my learning, as well as my CI's. Being held accountable for optimal patient care is a positive component of accountability. I provided competent and appropriate care with my CIs, and in turn, was pleased to be held accountable at the end of the day when I would receive positive feedback. I was assigned responsibilities that were appropriate for my knowledge base, yet I was challenged every day. My CIs held me accountable for my learning. They were able to provide feedback, but ultimately, it was up to me to take the provided feedback, and turn it into something I could use in my growth as a student nurse.

The next part of this projects aims to illustrate the daily personal goals that were set for each clinical day, and how learning on the DEU fostered their attainment. With the first clinical day being orientation, my only goal was to become oriented to the unit. I was oriented on day 1, and continued the next few weeks. My first real clinical goal was to practice and enhance my SBAR shift hand-off reports. In turn, my CI allowed me to provide this to the oncoming nurse, and would only add pieces of information I may have missed. My next goal was to be able to care solely for a 2-patient assignment, with only supervision and minimal assistance from my CI. I hadn't even shared this goal with my CI yet this day, and they suggested it, stating they believed I was ready. That boosted my confidence, and assisted in goal attainment. My next personal goal related to recognizing patient medications that had corresponding labs/parameters that needed to be checked prior to administration. I was not sure of all medications that needed

special attention prior to administration. I knew of insulin and glucose checking, digoxin and apical heart rate, blood pressure medications and blood pressures, etc. One of our patients for the day was on the antibiotic vancomycin. I did not know this medication had peak and trough levels that were monitored, and required confirmation prior to administration. We checked the level, and it was above what was considered therapeutic range for this patient. We notified the physician who looked at the BUN and creatinine levels, which were within normal limits, and ordered its continued administration. I learned vancomycin has potential nephrotoxic effects, hence why the blood levels, and BUN/creatinine levels need to be monitored. Another goal I had was to enhance my patient prioritization skills. I wanted to learn how my CIs were able to prioritize care every morning and through out the day for patients. Prioritization criteria shared included looking at which patients are at most risk for becoming unstable. Have any patients had any vital signs that have been out of normal range? Are any labs emergent or reaching critical levels? Is anyone going for procedures or tests today? My CI shared rationales for why patients were being seen in the order they were. I was then allowed to practice and provide newly learned rationales on subsequent days. Another goal was to acquire a better system of recording information received in report. I noticed my CIs each had a different way of recording and organizing information. My report sheets consistently had random information recorded on an unorganized sheet of paper. This was the only goal I had not significantly improved on during the semester. I concluded it is just something that comes with practice. My personal goal for the last clinical day was to be as self sufficient as possible in caring for a 2-3 patient assignment. I did care for a 3 patient assignment, with minimal assistance from my CI because of the consistent feedback throughout the semester and continuous personal and clinical growth.

Well-known nursing theorist Patricia Benner, introduced her theory of how nurses evolve from novice to expert practitioners in 1982 in her book titled, "From Novice to Expert. Excellence and Power in Clinical Nursing Practice." Her theory proposes that the process of transitioning from novice nurse to expert nurse occurs through the progression of 5 stages of proficiency: Novice, Advanced Beginner, Competent, Proficient, and Expert. The process of transitioning through these five identified stages involves mastery of each stage prior to progression to the next. Each stage has a foundation based on expanding clinical experiences with patient care to foster progression to subsequent stages. Her theory suggests that nurses' advance through stages of practice proficiency through expanding clinical experience and knowledge and skill acquisition in the clinical setting, rather than through classroom based education and theory lecturing. She stated, "...situational, experience based premises of the Dreyfus model (the model from which Benner created hers) which distinguishes between the level of skilled performance that can be achieved through principles and theory learned in a classroom and the context-dependent judgments and skill that can be acquired only in real situations." (Benner, 1982, p. 21) In my experience on the DEU, I can provide examples of clinical situations in which model each stage of Benner's model.

Patricia Benner's model of nursing proficiency can be directly applied to student learning on DEUs. She describes stage one of proficiency, novice, as beginners that "have no experience of the situations in which they are expected to perform." (Benner et al., 1982) She further explains that access to these situations is vital and it allows students to gain the experience essential for skill development. During this stage, students are educated about nursing and patient situations in terms of objective attributes, like weight, intake and output measurements, blood pressure, etc. These features of patient care can be acknowledged without situational, or

clinical, experience. This stage is characterized by exhibiting “rule governed behavior,” in which rules exclusively guide performance. Student characteristics of proficiency are generally comparable to these noted in Benner’s stage one, novice. During my clinical experience on the DEU, I exhibited beginner characteristics. I was able to understand basic patient clinical information such as vital sign results, laboratory results, etc. It was my CIs who answered questions for me, and explained the clinical situations to me that allowed to me have a better idea of the “big picture.” Towards the end of the semester, I found myself advancing away from this natural mindset, and progressing closer towards a professional novice nurse, as illustrated in the next stage. Advanced beginners, proficiency stage 2, “demonstrate marginally acceptable performance. They have coped with enough situations to note the recurring meaningful situational components termed “aspects” of the situation.” (Benner et al., 1982) When faced with the challenge of prioritizing care or nursing tasks, Benner describes the advanced beginner as “a mule between two piles of hay.” (Benner et al., 1982) meaning they have difficulty choosing. Towards the end of my DEU clinical experience, I was able to begin to correlate clinical information about patients and put them together using critical thinking skills. For example, one of our patients was admitted with end stage renal disease, and was requiring dialysis to sustain life. Having consistent analytical clinical experiences, before looking at the patient record, I had a solid idea of what to expect. I expected low urinary output, lab values, specifically potassium, BUN, creatinine, and RBCs, to be out of normal range. All of these pertinent clinical information assumptions proved to be true. I was wondering what his home diet was like. I assumed he had either uncontrolled hypertension or diabetes mellitus that caused the renal disease, which ended up proving to be true. During this stage of nursing proficiency, many hospitals provide preceptors to assist advanced beginners organize pertinent data, prioritize care, and assure that

“aspects” of real situations can be made aware of. While learning on the DEU, compared to the traditional clinical model, students are paired consistently with the same nurse(s) to provide continuity in learning, and to allow students to excel to their full potential. While consistently working with the same registered nurse, students avoid having to “reprove their skills and competencies” each clinical day because they are partnered with a different nurse, like the traditional clinical model. This teaching and learning strategy unique to a DEU allows for clinical instructors (registered staff nurses) to get to know the student, their strengths, and areas for growth, and are able to tailor learning based on students’ individualized needs. In this way, as Benner describes, “aspects” of real situations can be pointed out to students, hence enhancing the transition to the next level of nursing proficiency. My clinical experiences as illustrated in my journals, mirror this stage of Benner’s proficiency model.

An advantage of learning on a DEU, consistently paired with the same nurse(s), is that it fosters a “real nursing” experience for students. Compared to traditional clinical learning models where students have one patient, whom they may or may not be able to actually perform all nursing functions, like medication administration, learning on the DEU allows for students to really experience clinical situations. This repeated exposure allows for effective skill and nursing function mastery, which increases student nurse competency level further preparing the novice for progression to the next stage of “Advanced Beginner.” “...With experience and mastery the skill is transformed. And this change brings about improvement in performance.” (Benner et al., 1982) After reading through the weekly DEU clinical journal entries, it is easy to see the transition made in terms of experience, competency, and confidence in my role as a student nurse. Had I not been able to participate in Rhode Island College’s DEU program for adult health

II, the transition and proficiency that was in fact attained, may not have been so through other modes of learning.

In conclusion, it is easy for one to see that nursing schools using DEUs as alternative clinical experiences in place of the traditional model, fosters independence, increases confidence, and proficiency in nursing students. This has been illustrated through journal entries kept for each clinical experience. Findings from five nursing research journals were compared to a student's perspective. Positive research findings were confirmed true and similar in a student's perspective. The weekly journals kept proved to be a key piece in thoroughly and successfully evaluating the effectiveness of DEU learning models for nursing student learning. Weekly clinical goals were set and shared with CIs at each clinical day. The second portion of this project discussed each goal and its attainment, or lack of, with rationales. The third portion of this project aimed to compare nursing theorist Patricia Benner's Model of Nursing Proficiency to student transition from stage one and two of her five stages of transition to expert nurse. Again, clinical journals enforce these findings. In conclusion, Rhode Island College's use of a DEU as an alternative clinical learning model to the traditional clinical model, proved to be remarkable, efficient and most rewarding to nursing students.

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Nurs-372-Clinical Day #1: 9/2011 7am-7pm with CI: M.M, RN.

My first clinical day on the dedicated education unit turned out to be better than I had imagined. I did not anticipate it being a negative experience, but I also didn't expect it to be as outstanding as it was! I arrived just prior to 6:30am and was able to get rounds reports on my CI's and my patients for the day. My CI arrived prior to 7am and we met for the first time. She repeatedly told me to ask any questions at all that I might have, and not to feel embarrassed or afraid to ask. My initial feelings of fear and intimidation, from previous traditional clinical experiences, quickly dissipated. During report, which was the first activity of the day, she offered me a seat, which I refused politely, and she explained how she organizes her report information from the end shift nurse. I found this to be very helpful in expanding my organizational skills. I learned that you listen to report, ask questions to verify or clarify information from the end shift nurse, and also that you don't learn everything, especially pertinent information from just rounds reports and change of shift report. After report, we reviewed other patient information on the computer for all of our patients including admission reports, progress notes, and other pertinent chart information. Using this organizational system that my CI used, I had a good mental picture of these patients we were about to care for the day before we even entered any rooms. At this point, another RN on the floor had pulled a chair over for me. This really made me feel welcome! We reviewed morning vital signs and lab reports for each patient and she would ask me certain questions regarding them, requiring me to use my beginner critical thinking skills. For example patient X had a low K+ level, and orders included PO and IV K+. It was concluded, and confirmed, this patient had been suffering from severe diarrhea. She also went through all the normal lab orders and asked me how each electrolyte (decrease and increase) would affect a patient. I only knew a few, which motivated me to go home and figure the rest out. After all, it is

important to know electrolyte balance/imbalance physiological effects. While I was a little embarrassed about not knowing all of them, my CI made me feel better by showing me resources that she uses when she comes across something she's unfamiliar with. Instead of caring for my own selected patient for the day, and assisting my CI in providing care for the rest of her patients, I provided care of all of our patients under direct guidance from my CI. I learned how to properly draw up heparin, using a 22 gauge needle, and inject using a 25 gauge. A skill I previously practiced only once before, but the nurse I was working with drew up the heparin and just handed it to me to inject. I gave all the patients all of their ordered medications, and my CI would ask what the medication was I was about to administer and why the patient was getting it. I found this very helpful. She would also ask questions, for example, Beta blocker meds, what needs to be assessed before giving a med like this? And I would assess pulse and blood pressure just prior to administering. Any medication I was not familiar with, she showed me how to look up indications up, special considerations, important patient teaching, etc. My CI and I had lunch together with the other nurses and everyone was so welcoming! During lunch, my CI asked to see my goal/skill list to see what I have yet to do skill wise. She knew of a patient, that was not ours, that had an abdominal wound drain, and she asked that patient's nurse if I would be able to look at it with that him. He gladly allowed me to go with him to assess the drain. One of the last nursing skills I practiced for day #1 was pin care for a client with a fractured fibia tibia and lateral maleolus. She showed me how to prepare for this skill, and performed the first pin care, and watched me do the rest. The autonomy and confidence she helped me to gain through out the day was tremendous. I was scheduled to work with my CI from 7am-3pm. She was actually working a 12-hour-shift, and offered me the option to stay the entire shift with her! I stayed the entire shift and continued to share patient care with her. I really felt not only welcome, but I felt

a sense of belonging, partnership, and I felt like a professional nursing student. She gave me a few tips on skill improvements when it was just her and I around, which made me feel competent and respected. Before we left for the night, she gave me her personal phone number in the event that I needed anything from her, a question, etc.

My personal goal for the day was to learn to do general body system assessments, in addition to a focused assessment based on client admitting diagnosis(es). I did not meet this goal fully. I believe it to be because it was our first day working together and I did not have a client assigned to me. I will keep this as my goal in addition to another goal for clinical day #2.

Nurs-372-Clinical Day #2: 9/2011 7am-7pm with CI: M. M., RN.

My 2<sup>nd</sup> clinical day with my CI M. M., was even more fulfilling than the first day. She assigned me to provide 1:1 care with a very challenging patient, in addition to assisting her with the other 3 patients that were on our patient load for the day. My 1:1 patient was an elderly quadriplegic (from progressive MS) man that was completely dependent on others for every aspect of his care. She asked me if I were intimidated to care for a patient this dependent, and because of the trust and comfort we established the first day, I was not afraid to tell her I was in fact a little intimidated. I had been asked before during another rotation if I was intimidated to care for a particular patient, and out of fear of saying yes, I said no. I felt okay to be intimidated for once. She told me we would get through the day and she had complete confidence in me and that she was always going to be around if I needed her for anything. I immediately felt much more relaxed. If I only had half the knowledge and critical thinking skills she has, I could probably care for anyone! While reviewing labs together for this patient, he had a critically low K<sup>+</sup> level of 2.9. After reviewing his meds and ordered tx's, she asked me from all this information, what did I think could be the cause of this low K<sup>+</sup> level. She gave me a hint right off the bat as to his daily frequent use of suppositories and enemas to evacuate his bowels (as he is unable to voluntarily control bm's). Following his suppository and enema, stool was very watery, loose, and I knew here was one source of K<sup>+</sup> loss. This patient also presented with right hand edema and was prescribed lasix. I knew this was another source of K<sup>+</sup> loss. Lastly, his admitting dx was FTT. His dietary intake was less than optimal already, and now with being sick and admitted to the hospital, along with the diarrhea and Lasix, he had some electrolyte imbalances. She congratulated me on my critical thinking skills and told me we needed to hold the treatments until we talked to the PCP, because we know low K<sup>+</sup> can lead to cardiac issues.

PCP ordered continuation with tx's and ordered a K+Cl- supplement. I would normally have felt so incompetent and scared, that even if I did know answers to questions nurse would ask, I would fumble with my words and have difficulty gathering my thoughts. Being some comfortable with M. M., allowed me to really use my knowledge, and most importantly to not be ashamed of not knowing something! I shared my goals with her for the day, which were to continue working on last week's goal of body assessments, and a new goal of learning to better prioritize patient care. She said okay, lets work on prioritization right now. We heard report and gathered our necessary information to provide client care for the day. She then told me how she prioritizes care and why. Her high priority markers are those patients with unstable vital signs, or deteriorating vital signs. None of our patient's matched this description. Her next priority is recent treatments, like blood transfusions, post op, pre-op, etc. From there she looks at the diabetic patients, unstable labs, etc. I felt I had a better idea on how to prioritize patient care at the beginning of a shift. In addition to caring for my assigned patient, I assisted M. M., with the other 3 patients we were assigned to. I was able to administer all meds and do RN treatments. I did ask her how often she gets patients where the med, like an antibiotic needs to be constituted and further diluted. She said sometimes she gets them, but there was a patient on the floor whose antibiotic needed to be reconstituted. She asked that patient's nurse if she would allow her and I to mix and administer that 12noon med. We did, and she helped me every step including the math! Which was what I wanted most experience with. I found it very nice that she took time out of her own busy day, also she was charge nurse again today, to care for another patient just to give me the experience of something new. One of the last important events that was important today was M. M., sending me into my quadriplegic patient's room to d/c his IV before discharge that evening. I remembered he was on coumadin after she reminded me, and I went in there

alone. I explained the procedure to the patient and successfully d/c'ed his IV. Within 25 seconds of holding the folded 2x2 gauze in place, it was completely saturated. My immediate thought was that I had done something wrong. That I had pulled the catheter out at the wrong angle and torn something, or just something had gone wrong. Panicked, but not letting the patient or family know I was panicked, I hit the call light for M. M., to assist me. She immediately came in. She has gauze in her pocket ready to go, as if she anticipated this. She handed me the gauze and said just hold some extra pressure on it, smiled, and walked out. When it was over, and I left the room, red as could be, we laughed about it! She said, "I told you it be would ok! See? You did it just fine!" I smiled and laughed when she asked me if I thought I messed up or something. Today I was given more patient care to provide alone. M. M., sent me in another patient's room to prime new tubing and hang a new primary bag. She said I did excellent and there were no air bubbles. I feel she is trusting me and my abilities more and is not only giving me tips on how to improve some skills, but complementing me on what I do very well. One of the patient's told her I was going to make an excellent nurse and she replied that she agreed 100%. At the end of the shift, (she let me stay the entire 12-hours again!) she made sure I got to my car alright too, which is going beyond her role as my CI.

Nurs-372-Clinical Day #3: 09/2011 7am-3pm with CI: M. M, RN.

As I have begun to examine my progress of learning on the DEU and comparing my clinical experiences to the course outcomes for Adult Health II, I have realized that I have already met multiple course outcomes, and I have only completed day #3. My patient of main focus today was an elderly Cambodian man in chronic renal failure admitted for critical hyperkalemia. After reviewing the patient's chart and progress/admission notes with my CI, I realized that the client was in a hyperkalemic state secondary to his primary dx of renal failure. The PCP also had a note that read "use of NSAIDs is discouraged in the patient". M. M., asked me why this was. I knew and answered that NSAIDs are excreted in the kidneys, and that this would be a clear contraindication for this patient to take NSAIDS given his failing state. This is course outcome I B and C. IB: Demonstrate knowledge of health problems and other fields to assess and manage clients' problems. IC: Utilize knowledge from nursing and other fields to assess and manage clients' problems. While I was preparing to give meds to this patient, one of the medications ordered was "metropolol" for hypertension. I knew that prior to giving this medication, a careful assessment of the patient's blood pressure and pulse was essential. The client's blood pressure that I took manually was reading 48/32mmHg. I retook the BP again and got a reading of 46/34mmHg. M. M., took the BP and got the same readings. I knew that warranted a non-administration of the drug, and also an immediate further evaluation of the client and a PCP phone call. The client, whom was Cambodian speaking only, had his son spend the nights with him and was there at the time. The son served as a translator to allow for effective communication. The client stated he was not dizzy and that he felt fine. Pulse was 88bpm, temp of 99.9, pulse ox 97% on RA, and respirations 20/min. The PCP ordered NS @ 90mL/hr to raise the BP. I frequently re-evaluated the patient's vital signs and reported them appropriately. His

BP rised to 82/44mmHg, and was still asymptomatic. I was able to meet more course outcomes including IV A: Accurately document/report client information and outcomes of care. C: Demonstrate communication skills essential for effective role performance. And also course outcome VII D: Make appropriate decisions regarding the needs of clients based on current knowledge, assessment data and professional ethics.

I was planning on completing a 12-hour shift with my CI M. M., again this clinical day, as I have been doing the last 2 clinical days. But I ended up becoming suddenly ill about 2 hours before it was my scheduled time to leave (at 3pm). I wanted to stay the entire shift, until 7pm, but I was sick, and my CI could see that I was even before I mentioned it to her. I apologized for leaving at my scheduled time and she reassured me it was okay to leave and that by staying, I wasn't doing myself any good. She even offered to call someone for me to pick me up, and gave me the phone number to the floor because she wanted me to call as soon as I made it home safe and let her know I was okay. That really made me feel good knowing she was so understanding and courteous to my needs and safety. My goal for the day, which was to give a really good SBAR to the 7pm shift nurse, was not met because I left earlier than I planned to stay. Before I left though, she did go over my documentation and said it was excellent and gave me a few tips for improvement. For example, I had documented assessment pieces, but forgot to also document a plan of action for every assessment.



Nurs-372-Clinical Day #4: 10/2011 7am-3pm with CI: F., RN.

I arrived a little early to clinical today hoping to get a head start on looking up our client load information on the computer. It was almost 7am and M. M., my CI I was scheduled to work with, had yet to arrive. Once the assignment board was updated and all the nurses were assigned their patient load for the day, M. M.'s name was not on the assignment board. So of course, I became anxious and nervous about what would happen. Turns out she called in for a sick day. I approached to charge nurse and explained my new-found dilemma. She looked around and asked a nurse, F. if she would mind having a student today because M. M. called out. I could feel my face red and warm and some feelings of anxiousness coming about. F. looked at me and said, "Of course I don't mind" and she introduced herself to me and told me a little about what the day would entail working with her. Immediately, my feeling of anxiety settled. Feelings of uncertainty became apparent, I believe, in part to past clinical experiences on traditional clinical sites where many nurses were reluctant to work with students. For me, there is not many things, involving clinical, worse than being at clinical and having to work with someone where the feelings of excitement aren't mutual. I wasn't sure what to expect working with F. because for the past 3 weeks, I had been working solely with M. M. and had become very familiar with expectations of myself and what my day would be like. In addition to being familiar with M. M.'s nursing and leadership style, I had become very comfortable working with her and felt as though she viewed me as a professional developing novice, and she respected me. Although F.'s teaching and leadership style was different from M. M.'s, I was not, for lack of a better word, short-changed today. Instead of taking on F.'s entire patient assignment with her and focusing on a client of my own, like I always did with M. M., I focused on one client assigned to me by F., and also helped her with her other patients when my work with my patient for the day was

completed. I was able to practice skills not yet practiced outside the nursing lab in school and received positive feedback at the end of the day from her. My assigned patient for the day was admitted for post D&I buttock abscess with cellulitis, and newly dx MRSA and S. Aureus after the wound culture results came back. This patient was on two antibiotics, vanco and zosyn and was sharing a room with another patient. Once I learned of the MRSA lab results, I asked F. if we would now have to move this patient to a private room and initiate contact precautions. She said yes and it felt good, although it was more common sense to me at this point than critical thinking, that I knew something. I am not sure I would have automatically thought newly positive MRSA result and the need for a room change and appropriate precaution implementation had I been at an earlier nursing course. I was able to perform a wet to dry packing change on my patient with guidance from F., and we even decided to call the prescribing doctor for something a little stronger than percocet for these very painful 2XD dressing/packing changes. Hence, I was able to IV push morphine for the first time also. F. showed me how she prefers to administer medications like this and that involved running the primary NS bag at a flush rate, administering half the syringe, flushing again, and then administering the rest of the medication. I had never administered medication like that before. Something else I learned from F. that I will never forget is the manner in which she gives medications. In the past, after all the meds were scanned in and the patient was correctly identified, the meds were all opened and put into one cup for the patient to take. The issues F. pointed out with that method is that, 1.) What if the patient decides they don't want a certain med that day, and now you have multiple pills in the same cup? And 2.) It is important for patient's to know every medication they are receiving incase they refuse it, or want to know what it is. So to avoid potential complications from arising, she tells the patient one med at a time what it is and what it is for, and then opens it to put into

the cup, all right at the bedside. I noticed patient's feel more involved in their care this way and even would ask the dosage they were receiving to detect any variation from home doses of their usual meds. I liked this method of administering PO meds and will continue to use this method from now on. Everything about it made perfect sense! Something else I learned today involved the antibiotic vancomycin and frequent blood draws to monitor therapeutic levels and deviations from the norm. My assigned patient was receiving vanco and zosyn for cellulitis, MRSA and S. Aureus infected area. The lab called to report a critical level that was slightly above therapeutic range. F. and I reviewed the results, gathered the necessary information including a recent increase the dose, and called the Dr before giving the vanco. The Dr. wanted to continue the medication at the prescribed dose and frequency because the potential issue with increased vanco levels is the risk for nephrotoxicity. This client's creatinine level was WNL, and warranted no issue at this time. I didn't know vanco levels needed to be monitored, and I didn't know a result involved potential nephrotoxicity. If I ever see a situation like this, I will know that prior to calling the prescriber, I will have looked at the corresponding lab values associated. A similar issue came about at a past clinical experience I had where the nurse was working with 2 students and the other student's patient had a critical med related lab value. But the student wasn't able to be involved with the process as I was today because of time issues I presume. The student was just told that med was going to be held, and it was left at that. A great learning opportunity missed. After I finished my assessment and patient care for the morning and afternoon hours, F. had a patient who had an EKG ordered. As silly as I thought it sounded, I had never actually done that before, and couldn't remember exactly where all 10 leads were to be placed. I was a little embarrassed to tell F. that but she said it was fine and that she would teach me! And she did. I learned to do a proper EKG. Yet another great learning opportunity I was able to have

thanks to the dedicated education unit nurse I was working with. F. complimented on my documentation skills and I thanked her again before I left for working with me on such short notice. She assured me it was no trouble and she enjoyed working with me! She wished me well and assured me my next clinical day, with my new CI M. R., would be another great learning day for me!

Nurs-372-Clinical Day #5: 10/2011 7am-3pm with CI: M. R., RN.

I thought my first clinical day with CI M. R. was off to a rocky start initially. I have a somewhat overwhelming fear of “messaging” up in clinical, or being considered a “burden” to the nurse I would be working with for the day. 7am was approaching, and the assignment board was yet to be updated because a nurse called out last minute, so there was some difficulty fairly and evenly distributing the remaining patient load amongst the other nurses for the day. My CI M. R. was assigned a challenging patient load, was serving as charge nurse for the day, and had a student. I could hear him voicing his concern to the night charge nurse and she wasn't willing to accommodate his needs. I was standing at the front counter not really sure what to say or do and immediately felt uncomfortable and was afraid this would be a bad day. I must have looked nervous because he walked over to me and said this has nothing to do with you, we are going to have a good day regardless. I immediately felt better and the fact that he showed concern for me and reassured me was something I wasn't exactly expecting. I just didn't want to be considered a burden in the clinical setting. Learning on the DEU has once again proven to be a student friendly environment. I recently attended to Sigma Theta Tau dinner meeting and the guest speaker said some important words that stuck with me. “If we (“we” meaning nurse educators) scare our students or make them feel so intimidated, they will go into patient rooms and have tunnel vision. They will focus on one problem, and not even realize the Foley bag is practically overflowing, the primary bag is empty, the call light is on the floor, etc. and then feel incompetent when these basic things they missed are pointed out.” From being in the same scenario as spoken about, I can vouch it is true. In general, people function at optimal levels when they feel comfortable, and competent. I learn better and can carry out the clinical day successfully when I feel wanted as a student and am treated at a competent student nurse.

Working on the DEU has allowed me the opportunity at each clinical day to provide confident and competent care to patients, and I can leave everyday thinking, “wow that was the best day of my nursing student career thus far”.

Working with CI M. R. was certainly a different experience than working with CI M. M. or F. While all CI experiences have been positive, each is different because of different leadership and teaching styles. Something M. R. did that I really appreciated was explaining everything he did, all day. From explaining what and why he was looking up on the computerized patient charts, to different chart findings, M. R. explained everything and gave a rationale. Through out the day he would give me tips and advice on different aspects of patient care, and share thoughts are things he wished someone taught or told him while he was in nursing school. Something so silly and simple that I had yet to experience and practice was actually performing all the necessary touch screen steps after the RN would sign onto the pexus machine. My previous CI's would sign on and complete on the steps touching the screen, and I would just pull the meds from the drawers and following blinking lights. M. R. explained why all the buttons were being pushed and how to look to up what meds are to be given now, later, etc, something I consider an important clinical skill that I was able to practice today. One of our patient's had a new NPO order, so even the medications had to be changed to IV administration while awaiting the PEG tube to be inserted on Monday. This was a new experience for me and I was able to administer some medications that I never even knew or thought was made IV. A concern I voiced to M. R. was how he or myself would know which meds are compatible and which are to be administered IV push and which ones had to be further diluted and hung, etc. He showed me the IV drug guidebook we would be using, and about ½ the meds were ok IV push, and the other ½, IV push was forbid. There was even a med, Levythyroxine, that was to be given

IV that M. R. said he was unsure about because he had never given this med IV. He said, “Some of your most valuable resources while practicing as a professional nurse, are your colleagues.”

After looking in the IV book, M. R. was still unsure about the dilution and administration of the thyroid med and he asked another nurse about it who had done this before, who helped us figure it out. He also told me to never be afraid to call the PCP or ask another nurse something, no matter how silly or basic the answer may be, because you never know until you ask and you are doing a disservice to yourself and your patients who rely on you. I will never forget that.

While I did not complete any new skills on my skills checklist this week, I was certainly able to practice and expand my knowledge base. I did however meet a course outcome that I have been unsure of how to go about meeting it all semester. I guess it just happens. This course outcome was “demonstrating accountability for own actions”. Last week with CI F., I wrote about how I really liked her method of med administration of by opening meds one at a time and explaining them to the patient. This week I did not do that because M. R. did not use this method. He helped me open and scan all the meds and one of the meds was metropolol, so I knew I had to assess BP and P before administering. After assessing the BP, it was below the minimum parameter the MD had set, so the drug was to be withheld. But the meds were already opened and sitting in the cup waiting for 2 pt identifiers and administration. The metropolol med was cut in half, per the order, and another pill came in half. Both were white and the same size. There was no way of safely depicting which med was which, and it never even crossed my mind to attempt it. I notified M. R. of the dilemma and he just took both white half pills and appropriately discarded, and “wasted” so the pt would not be charged for the error, and he pulled the other identically appearing drug and brought it in the room for me. I was a little embarrassed it happened but he pointed out how important it was that I knew what happened and responded

appropriately and competently. I will however, continue to use F.'s method in the future and explain the rationale to my CI. Had I used F.'s method, I would have never opened the metropolol yet, and wouldn't be confused about which med needed to be returned, never mind wasted. Overall, M. R. said it was a successful clinical day for me and that I did very well.

Aside from expanding knowledge and learning knew concepts today, something I felt worthy of a few sentences happened at lunchtime. M. R. sent me to have lunch while he continued his charge duties. As I just sat down to eat, a nurse came into the room and said she wasn't sure if anyone told me but they were having a surprise party for a secretary that was moving to another floor, and a CNA's birthday, and that there was going to be a ton a food, and I was more than welcome to the party food! I gratefully accepted the invitation and offered to help set up all the hot and cold crock-pots and dishes. I helped set everything up and was there for the big "surprise" when the secretary and nurse assistant came into the room thinking it was a party for the other. ☺



Nurs-372-Clinical Day #6: 10/2011 7am-7:30pm with CI: M. M, RN.

Today with CI M. M, I felt I learned more about non-hands on skills that are essential for efficient quality nursing care. I was able to continue perfecting my already learned clinical skills including IV care, medication administration, dressing changes, etc. I also was able to learn about the discharge and admission process of patients, as we had one of each today. I learned the importance of performing the admission assessment directly with the patient and not just from referring to patient history/progress notes. Prior to today I never had any experience with admitting a new patient or discharging a patient ready to leave the facility. The patient newly admitted was a victim of a single vehicle MVA from an early morning crash. While a little unsure about what kind of care this patient would require, I was excited for a new experience. This would be my second patient admitted for MVA involvement. Within ½ hour of this patient's arrival to the floor, the dressing applied to his face was saturated with blood. M. M. showed me how to apply a new "pressure" dressing using special "pressure" adhesive. After discussing more in depth about this patient's medical history, I was able to pull out the critical information that this patient was currently taking plavix, and needed to be considered with the bleeding that was still occurring on the face. M. M. changed the first dressing, and I was able to do it the second time it was to be replaced using the pressure tape. For some reason, I left the unfolded ends facing upward towards the eyes. M. M. addressed it and explained the rationale for having the smooth non-paged edges below the eyes for optimal vision reasons. It made perfect sense but for some reason, I initially did not think of this. I was a little embarrassed but it was ok. I am a student and am still attempting to perfect my novice skills. Another patient had an admitting dx of hypertensive crisis r/t non-med compliance 2/2 patient reports of htn meds causing constipation. When I took a manual BP reading, it was at a dangerous level of

200/100mmHg. I immediately reported my findings to M. M. and we administered prn IV push hydralazine and notified the PCP. This patient had consistent hypertensive readings, despite the medications we were administering. We believed the fact the patient was on 100ml/hr of NS running was a contributing factor and this was also addressed with the PCP. As a result of these two patients alone, I was able to meet clinical objectives 1C-Utilize knowledge from nursing and other fields to assess and manage clients' problems, IVC-Demonstrate communication skills essential for effective role performance, and VIID-Make appropriate decisions regarding the needs of clients based on current knowledge, assessment data and professional ethics.

Although I provide care for all patients assigned to my CI for the day, I do have one patient assigned solely to me at my CIs discretion each clinical day with her. M. M. specifically assigned me to a particular patient whom was very quiet, and refused to participate in her own plan of care, and refused to communicate, if there were more than one HCP in the room. I provided compassionate care to my patient and by the end of the shift she was telling me about her family and her children and other information. While performing the shift physical assessment, I went to auscultate the heart and the patient stated, "I have no heart, you won't hear anything," and she looked sad and stared out of the window. I placed my hand on her shoulder and asked her if there was something she would like discuss because she seemed so sad. She refused my communication offer at the time and I let her know that should she like to talk, I will be here to listen. By the end of the shift, she was communicating her life concerns regarding her illness and children, etc. After conferring with M. M., we ordered a social work consult for her. I was able to expand upon clinical objective VIIA-Provide nursing care in a non-judgmental and sensitive manner.

Another interesting client I was able to work with today was an elderly person with dementia and sun downing syndrome. This client enjoyed sitting in her chair in her doorway. As the evening approached, this patient became increasingly confused and disoriented. She constantly mistook me for her daughter and I would attempt to reorient her. She repeatedly asked “Oh over there, is that my daughter? She is coming to see me. She is coming to get me. I am a sick girl. Someone made a mistake, I am supposed to be in the hospital down the road there.” When I would tell her her daughter was just here a little while ago, as the other nurses were doing, she replied “Oh ok, I will just sit right here and wait then. Thank you for letting me know she is on her way.” She became increasingly tearful. I had a few minutes of down time so I sat with her and held her hand and listened to her repeat herself. She pulled my hand closer to her and told me I was a sweet girl and a great nurse. I felt moved by this patient and my heart hurt for her seeing her sad and confused.

At the end of the shift, M. M. told me she could see a difference in my skills since the first day. That was nice to hear because I have been trying to learn to most I can and get the most out of every opportunity. She recognized this and told me that she could see my dedication every day she worked with me through wanting to stay longer than my “required” time, always up for a new task or skill she assigned to me, and always eager to learn. It felt really good to hear her and recognizing my hard work! She did however tell me something I did know, and wasn’t sure if anyone else could see it. But she knew. She said I lack the confidence that I should have. Which is true, although I am learning a tremendous amount on the DEU, and am enjoying every minute of it, I have a feel of uncertainty in the back of my mind. The feelings of “hurting someone” I can’t seem to shake. I shared my feelings with her and she told me I was a great student and was certainly going to make a great nurse. She said she could see it everyday she works with me and

sees how I interact with our patients. She gave me some words of advice I will never forget.

“You can’t constantly worry about hurting someone because that’s when you’re most likely to hurt someone. Always ask questions about anything your unsure about, and never be afraid to ask for help. Whether a student or a RN, never be afraid to ask questions or ask for help.”

Nurs-372-Clinical Day #7: 10/2011 7am-3pm with CI: M. R., RN.

Today with CI M. R., I had a rough start just due to the fact that we were both sick! I had been trying to recover from a cold for a few days, and this morning I felt just fine to go to clinical. However when I arrived, my body was sending mixed signals about how I felt. M. R. could see it. He commented on my pale complexion and “sickly” look. We initially agreed I would do a half-day because I did not want to go home! But by 9am, I felt fine again and I was able to complete the entire day. I didn’t not take his offer and go home because I was afraid of someone thinking I might just be “trying to get out of clinical”, I wanted to be there! I felt that by leaving and trying to fight through, I was doing myself a disadvantage! Who knows when I will have a chance again to work with such knowledgeable and dedicated nurses!

The day progressed and we had a few interesting patient’s with admitting diagnoses that I had only learned in nursing courses prior to clinical today. And also, had I had not been on the DEU, who knows if I would have gotten the new experiences and the unique care necessary for each. One patient was admitted for a recent (within 2 months) dx of Chron’s Disease that was not responding to PO medications. This patient was very particular about things, hence why M. R. assigned her care to me for the day. She had a sign posted on the door that read “I do not want ice and water. Please do not disturb.” She had another sign below that that read, “Do not take my blood pressure before 7am”. She just didn’t want HCP’s or people in her room prior to 7am for any reason, and she didn’t want to be checked on every hour with fresh ice and water because she only liked bottled water. She questioned every move M. R. or myself made, so it was a good experience for me to not only work with, for lack of a better word, demanding, patient, but to be asked “Why” for everything that was done. She was very involved in her health care, which impressed me to an extent. She apologized for “being a pain” as she stated. I replied, “I do not

mind at all! Its your health, you have every right to ask any question you like and I will answer anything I can to my best ability, and should there be something I am not sure of I will do my best to find the answer for you.” She was very peculiar about her PICC line. She didn’t want anyone to touch it because she was so fearful of infection with it. M. R. shared a few statistics with me regarding infection and PICC and I shared them with this patient and provided education to her pertaining to interventions nurses use to prevention infection and contamination (ex: scrubbing the hub with etoh, etc) I felt like a real nurse, answering patient questions all by myself, with no one else in the room except me and the patient. This patient was on day 8/10 IV abx including Cipro and Flagyl. I noticed there were two separate piggy back tubing and bags for each abx. So I asked M. R. about it and he explained it to me. He also showed me how to use a computer resource to look up medication interactions in the event he was going to give IV medications, that he was not sure were compatible with the same tubing.

Another new patient experience for me was caring for a young client admitted with etoh withdrawal seizures. I remember learning about particular care tailored for these clients in psych nursing. So care he needed throughout the day, I was familiar with textbook wise. I was able to perform CIWA assessment, administer prn ativan almost every hour for the tremors, and I was also able to mix a “banana bag” That was a new term for me. M. R. explained it is called that because the multi-vitamin turns the solution yellow in color. This patient actually disconnected his IV to use the bathroom. When I went to check on him and saw his IV pump was off and disconnected, I informed M. R. and I went back in the room to teach the client how to unplug the pump from the wall and wheel it to the rest room with him, although we encouraged him to use the urinal b/c of his risk for injury status. I was able to reconnect the IV and set the pump back to where it would be. It was a small calculation we learned about it school before (correcting a med.

Infusion time based in fluid remaining, etc.) that I was able to figure out. It feels like all the little things are starting to come together.

Aside from the 2 new patient dx experiences I had today, it was a relatively slow day on the floor. I asked M. R. if he would mind if I helped out the CNA's with anything they might need. He said he did not mind at all. I helped the CNAs complete afternoon vitals, bath and dress dependent patients, and even helped another nurse with a patient who needed bathroom and food prep assistance. It felt good to feel like a part of the team and family on the DEU. The other nurse thanked me multiple times. This nurse's patient that needed food prep assistance soiled the gown a little with the tomato soup she had eaten, and although my shift was over and M. R. had said I was able to leave, I stayed like I promised the client I would, to help her into a clean gown when she was finished eating and get her situated and comfortable. The client, an elderly woman, was so thankful to me and thanked me so many times. I just thought to myself, for what? Getting you a clean gown? I certainly would want a clean gown if I spilled food on mine! I try to treat every patient, whether they are part of my CI and my assignment or not, as if they were a loved one, or even myself. The small things like that really can make a difference to a patient. I asked her if there was anything else I could do or get for her before I left and she replied, "just a smile when you walk by the room. That's all I want." I smiled and said "of course."

In terms of meeting course objectives, I have been able to not only meet every course objective timely, but I have been able to meet them with an initiating experience, and build upon them with successive experiences throughout the weeks on the DEU. Where as during my MedSurg 1 course, yes, I met all the objectives, but I could think of one specific experience that it happened, rather than many, like I am now. For example, yes I met this course objective on

this day, but the next time, I was able to expand upon it, perfect it. Kind of like a self feedback/evaluation.



Nurs-372-Clinical Day #8: 11/2011 7am-8pm with CI: M. M., RN.

Today, I must say, just may have been the most inspiring, successful, and best clinical day of my student nurse career yet! I stay for 12-hour shifts when I have clinical with M. M., but today I asked her if it would be okay if I left at 3pm because I wanted to get an extra 4-5 hours of studying for an upcoming exam on Monday. She said it was absolutely fine. (Of course, I ended up staying for the remainder of her shift, and happy I did.) After starting to feel a little down from last week because other students were saying they were finally caring to 2 patients independently, M. M. told me I was going to provide complete care for 2 patients today! Not only were my sole assignment 2 patients, but also one was complete care, and one mostly complete care. I have wanted an experience with a PEG tube since Fundamentals nursing. Until today, I had never even seen one, never mind provide care for, feed through (continuous 7pm-7am, with two 240ml bolus at 12-noon and 4pm), and administer medication through. M. M. walked me through every step, and of course, provided rationales for every step. I found this very helpful on the DEU. They really are dedicated to providing students with optimal learning experiences. It takes time to explain everything to a student, but on the DEU its second nature and I really feel like no question is too stupid to ask. Another new experience today was changing a central line dressing. M. M. and I both remained sterile in the event I needed assistance, which was nice to know she was right there with sterile hands to intervene should I need it. (Which I did not.) My skills check list has so many new entries and is starting not to look so bare! Again, today I was able to expand my experiences on the course outcomes. I have so much more confidence with IV care since learning on the DEU and actually being able to work with one every day I am at the hospital. Compared to med surg 1 in a traditional setting, I think I worked with an IV once, maybe twice. I am able to switch primary bags, and prime piggybacks

without any direct supervision. I am starting to really feel like a nurse. I was having such a good day, I told M. M. I didn't want to leave if she didn't mind, and that I would just get up extra early the next day to study. So I stayed.

A new order came in for a blood draw from a mid-line IV. M. M. was gathering supplies with me and teaching me what equipment is required for this type of blood draw, when a code came across the intercom on our floor. M. M. looked at me and said we were going to respond. I put all the supplies in my pockets and we hurried down the hall to the room where the code was called. There was a doctor, the patient's nurse, another nurse, and now M. M. and I. The patient was going to respiratory arrest and had a decreased LOC. Within a minute, a CRNA, and respiratory therapist arrived. I have to admit, I was scared. Very eager to see what was happening, as this was the first emergency experience in any clinical setting for me. There was enough nursing help in the room so M. M. left to administer meds to the other nurse's patients so this nurse could respond to her patient's code status. I was standing in the corner trying to see what was happening but trying to stay completely out of the way. One of the 2 nurses said "Come over here where you can have a better view." And she placed me right at the foot of the bed. The CRNA was talking to me and explaining every thing she was doing to me, from what meds she was drawing up, why she was giving them, and what they are going to do for the patient. (The patient, was retaining too much CO<sub>2</sub> and subsequently experienced a decreased LOC.) Within minutes, the patient was intubated and we were preparing her for transport to the RICU. They needed someone to quickly gather the pt's belongings so she could be transported and I volunteered myself! As I was gathering the pt's things, the RICU nurses wanted a Foley inserted before transport. I helped the nurse hold the patient's legs in position for the Foley insertion, and I helped tie wrist restraints to prevent traumatic extubation in the event the meds

wore off and the pt woke up. Even though my tasks and minute contributions were on a small scale, I felt like I was part of the team! The nurses and the CRNA provided optimal emergency care for the patient and ensured a learning experience for me as well. The CRNA told me to read up on hypercarbia, as this is what was happening with this patient. She also encouraged me to become a CRNA one day. What a role-model she is and the nurses!! After everything had settled down they made sure I was ok, and asked if I had any questions about what happened. Someday, I hope to be able to be an unforgettable mentor, as they were to me. Had I not been on the DEU, I most likely would not have been able to experience this tonight, never mind be so included as I was.

Revision:

In addition to this eventful day, at the end of the shift, M. M. told me she had really noticed a difference in my confidence level since the first day. I was happy to hear her tell this to me because I really had felt much more confident in the clinical area since day one. She said she has noticed a greater degree of independency, a greater level of confidence, and she noted that I did a fantastic job caring for two dependent patients by myself.

Nurs-372-Clinical Day #9: 11/2011 7am-3pm with CI: M. R., RN.

Today was my last day working with M. R. Today I was able to get quite a bit of experience with patients that have more of a psychiatric admitting diagnosis. One patient we had was a homeless person, whom was being discharged today. This person was interesting and I felt sad for him. We weren't able to d/c until later in the afternoon because the shelter this person would be going to did not open until the evening. Another interesting patient was admitted with confusion, and was found wondering the streets inappropriately dressed and disoriented to time and place. Even when M. R. and I would be providing care for this patient, they would be confused about where they were, and who we were. I was able to practice therapeutic communication skills more thoroughly in a med surg setting today. Had I not been on the DEU, this most likely would not have happened. It is an important experience because there is a growing psychiatric population in med surg settings which can, as in these patients' cases, potentiates the health and psychosocial problems already present. Especially when there is no family or support structure available for these people. It is important for students to have some experience with this type of patient population and to be aware of patient's particular needs.

I was able to gain more experience with PEG tubes today and the care they require. I was assigned to one patient today with M. R. to assess, but I was able to provide care with him to the other patient's, as we do every clinical day we work together. The patient I provided sole care for was in end-stage Alzheimer's disease, and there was a family member present 24/7. We received report from the night nurse that the family can be demanding at times. Another good experience for me because in reality, all patient's and families are not the same. And I like to think the "demanding" patients and families just need a little more reassurance and a few extra minutes of a listening ear. This proved true in this situation. The patient's family was just concerned and

wanted to best care possible for their loved one, although they often come across as “over-bearing/demanding”. I spent a little extra time in this patient’s room just listening to the family member talk. They had been providing sole care up until now and had been feeling worn out but not ready to give up. M. R. told me I did a great job. It was nice to hear. He reminded me that you always have to see for yourself and dig a little deeper with families. Most of the time they are just concerned. Aside from my day of expanding my psychosocial skills, I was able to expand my med surg skills and documentation. My patient had yet to void all shift and had to have a straight cath the day prior to remove the urine. In the early afternoon, despite no distention, the patient had yet to void. After lunch, there was still no void, and some beginning distention upon palpation. M. R. decided it was time to use the bladder scanner. This was the first time I had used a bladder scanner! After a few minutes of trying to get the right picture, the scanner revealed almost 600mL of urine. We notified the PCP who ordered a foley cath and a culture to be taken. With this same patient I was able to provide wound care for a stage III pressure ulcer and was able to assess and document too. I was also able to administer my 1<sup>st</sup> IM injection today.

We did have some down time where there wasn’t much to do. Patients were all caught up with care. Earlier in the day, when M. R. and I were in the supply room, I asked him if he had actually used every piece of equipment in this room. I told him how intimidating it was to me seeing all these supplies so organized and so many different things. We ended up going in there for about 30 minutes and he just showed me every piece of equipment and explained its use. Equipment such as incentive spirometers, Texas catheters, and even every wound dressing available. I thanked him for taking the time to go through all the equipment with me! That was really helpful to me. He asked me if there was anything else I wanted to learn about. My

experience on the DEU has been so positive. The CI's are there to provide optimal patient care, and ensure that student's get a lot of experience and learning. I have met all course objectives by the end of the semester, which has allowed me to use the rest of the time to enhance these skills and objectives. Rather than on the traditional setting where I feel like once I've met an objective once, its time to move onto the next. At the end of the shift, M. R. complemented me on the growth in the DEU and said my clinical skills are on key and that he was impressed with my initiative to learn and always wanting to me involved. He also sad I asked great questions and he was happy I asked a question whenever I had one. He told me again today, as he has before, to never be afraid to ask a question about something. I thanked him for all his help this semester and told him I had learned an incredible amount of information in such a small time frame.

Nurs-372-Clinical Day #10: 11/2011 7am-7pm with CI: M. M., RN.

Today was my last clinical day with M. M., and my last day on the DEU for adult health II. After receiving report on our 4 patient assignment, M. M. looked at me and said, “Do you think you are ready for 3 patients? I think you are!” I was a little nervous about my abilities to care for 75% of our patient assignment but I knew if I had any issues, she would be there to guide me. Of my own 3 patient assignment, one patient was completely dependent. This patient was an end-stage brain cancer patient, admitted with pneumonia, and a DNR/DNI status. He was the most complex patient of our assignment. This patient was unable to communicate, and physical condition is comparable to that of a quadriplegic person. During my physical assessment, I came across an issue that had gone un-noticed prior to my assessment. This patient had a deep, irritated, crater-like hole on the hard palate, with a thick, black, partially detached scab. Concerned about infection in an already compromised patient, I immediately got M. M. to come evaluate. She gave me a pat on the back for a good find and excellent assessment skills, and the MD was called to further evaluate. I really felt like a Nurse today and M. M. and the MD discussed with me ideas of what caused this. At the end of the shift, M. M. told me what a great job I did today with the 3 patient challenge, and how much she enjoyed working with me all semester. I was sad to say good-bye, but happy I am leaving with confidence and skill that I learned from M. M. and M. R. on the DEU.

In my proposal for this honors project, I discussed several nursing research articles that I had planned to use to compare my findings to. They are listed below.

\*\*Ryan, C., Shabo, B., & Tatum, K. (2011). Using experienced clinicians to facilitate clinical education. *Nurse Educator*, 36, 165-170.

Findings from this study that I was able to confirm as true during my DEU learning experience include:

-“Being accepted as part of the unit team and being intertwined within the culture of the unit.”

Every clinical day I was made to feel welcome and treated as an equal, and as a team member.

When there were in-facilities functions, like birthday celebrations, or the unit was getting take-out for lunch, I was also invited and encouraged to participate.

-“...Able to meet and practice all course objectives in a timely manner and students were more pleased with rotation when compared to traditional settings.” I was able to meet all the course

objectives by mid-semester which allowed for further expansion and practice of each objective.

Rather than meet it once, check it off, and move to the next. As illustrated in my journal entries, I was very pleased with this clinical rotation compared to traditional setting rotations.

-“Increased opportunities to participate in clinical procedures, increased engagement in culture of the unit Participating on the DEU provided a unique opportunity to acquire a real understanding

of what it is to be a nurse and improved self-confidence in knowledge of patient care.” Again,

my journal entries illustrate these findings as well. I had increased opportunities in procedures like IV care, medication administration, retrieving MD orders, implementing new and existing

orders, evaluating changes in patient status, responding to a code, etc. Prior to this DEU

experience, I had experience 3 times with IV medications, and I feel that was the highlight of my experiences on traditional settings. Not only did I gain a real understanding of what it is to be a

nurse, working alongside RN’s and providing all RN patient care, but also I came to actually feel like a nurse.

\*\*Edgecombe K., Wottom, K., Gonda, J., & Mason, P. (1999). Dedicated education units: 1, A new concept for clinical teaching and learning. *Contemporary Nurse*, 8, 166-171.



Findings from this study that I was able to confirm as true during my DEU learning experience include:

-“Ensured adequate duration of clinical practice and ample opportunity for learning repetition.”

As noted above, clinical practice and ample opportunity for learning repetition occurred on a daily basis on the DEU. Everyday I was able to expand on critical nursing skills like medication administration, including IV's, thorough assessments, and follow-up assessments, etc. I was able to look at a patient and the whole picture. In the traditional setting, perhaps it was r/t inexperience, but I would focus on the same task every clinical day: completing or assisting in ADL's, and physical assessment. Whether or not my clinical instructor was busy with other students determined if I was going to give medications on any given day. If I was able to give meds every 2 weeks, that was satisfactory. Prior to this DEU experience, I was lacking in IV knowledge. I was not familiar with programming them, setting them up, changing primary bags, etc.

-“Develop clinical competency to a higher level.” As noted by daily feedback and evaluation from my CI's, there was a significant improvement in my clinical skills, my knowledge, and my critical thinking from the 1<sup>st</sup> to last day of learning on the DEU. Working with consistent CI's, they were able to learn more about me, my strengths, weaknesses, and areas observed that could be improved on. This allowed for me to develop a higher level of clinical competency.

\*\*Gonad, J., Wotton, K., Edgecombe, K., & Mason, P. (1999). Dedicated education units: 2, An evaluation. *Contemporary Nurse*, 8, 172-176.

Findings from this study that I was able to confirm as true during my DEU learning experience include:

-“Able to reflect on work, identify goals achieved, and new objectives could be set.” At the end of every clinical day, my CI would give me thorough feedback as to what I did well, what I improved on, and types of things that I can improve on. Every day I would send a goal to my professor, and after the day was over, I would state whether the goals were met and how/why they were or weren't met. I was able to self-evaluate, and I was able to set goals for myself and my CI's were able to set additional objectives for me by introducing new skills and experiences, etc.

-“The DEU allows for a gradual increase in the student's patient load, which in turn enables students to perfect their practice at each level. Whereas traditional is more rushed.” This was very true in my experience. From day 1 to the last day, my CI's were able to evaluate the care given each day, and challenge me with a gradual increase in my patient assignment.

-“The DEU provided a greater opportunity for repetition of practice, exposure to a range of different experiences, time to develop and consolidate knowledge, and time for reflection.” As described in my journal entries and above findings, the DEU did allow for repetition of practicing and subsequently mastering skills. I was exposed to a range of different experiences, that more than likely, I would not have been exposed to on the traditional setting. There was time to develop and consolidate knowledge, if I had a question about any aspect of care, I was able to comfortably ask, and there was time for reflection. I was able to reflect on every day that I provided care through my journal entries, evaluating whether my daily goals were met and course outcomes, and also through continuous feedback from CI's.

\*\*Moscato, S. R., Miller, J., Logsdon, K., Weinberg, S., & Chorpenning, L. (2007). Dedicated education unit: An innovative clinical partner education model. *Nursing Outlook*, 55, 31-37.

Findings from this study that I was able to confirm as true during my DEU learning experience include:

-“DEU students were more likely to report: nurses modeled professional behavior and values, nurses were my teachers, staff understood my learning needs, nurses helped developed my clinical learning skills, I was a member of the nursing unit responsible to nursing staff and health team, and I was in charge of my own learning during clinical.” My CI’s did model professional behavior and values that I admired and aspire to model myself as a student nurse. Nurses were my teachers. I worked along side with my CI’s who taught me new concepts, reviewed previously learned concepts with me to refresh my memory, and when I had a question or concern about something, it was the nurses, my CI’s, that I would turn to, to learn. Staff understood my learning learns. Staff, in addition to my CI’s, was aware and sensitive to my learning needs. The secretaries every morning would ask me which rooms I needed rounds reports on, CNA’s would ask which patients I was working with that day and would give relevant patient information to me as well as the assigned RN (my CI), other nurses would approach my CI and myself when they are something interesting to share or allow me to experience, like a patient with a wound drain, or a code.

-“On the DEU, students don’t have to reprove themselves every clinical day. On the traditional clinical unit, students are never able to develop a working relationship with the nurse.” While learning on the DEU, because there was consistency in the nurses I worked with, I did not have to reprove my self and the skills I had every clinical day. This saved a lot of time and allowed the nurses to get to know me over time and know what my skills and limitations were. This ensured quality and safe patient care every day. I was able to develop a working relationship with my nurses and the other staff on the unit. I felt like part of the team everyday.

-“Having continuity in CI was huge. They’re always available, they knew my strengths and limitations, and were able to challenge me to the next step.” Not only did I certainly experience this in my time on the DEU, but also it is one of the purposes having a DEU. When compared to the traditional setting, there is a student instructor ratio of 8:1. The instructors are forced to divide their time fairly amongst the 8 students. This prevents students from administering medications every clinical day, along with other crucial nursing skills due to lack of 1:1. The DEU provides the necessary 1:1 attention that the nursing education experiences necessitates for optimal student learning and transitioning from student to novice as I will discuss as another aspect of learning on the DEU. My CI was always available to assist me, to guide and mentor me, and to coach me. They got to know me and were able to set challenges for me based on intensifying patient acuity and patient assignment numbers. I always provided nursing care for the entire patient assignment that my CI was assigned to, but in addition to that, I would be assigned to one, then two, and then three patient assignments by myself, with intensifying acuity levels.

\*\*Mulready-Shick, J., Kafel, K. W., Banister, G., & Mylott, L. (2009). Enhancing quality and safety competency development at the unit level: An initial evaluation of student learning and clinical teaching on dedicated education units. *Journal of Nursing Education*, 48, 716-719.

-“Common themes that arose from this study’s focus questions: Teamwork and collaboration, safety, informatics, patient centered care, evidenced based practice and quality improvement.” Teamwork and collaboration were the foundation for my success in learning on the DEU. My CI’s and I worked together as a team and collaborated our thoughts and skills with interdisciplinary teams to provide optimal patient care. Safety deals with medication administration, and other patient safety measure implementation like being aware of

implementing fall/seizure precautions, etc. Informatics learning deals with electronic resources available related to patient information, H&P, laboratory data, test results, etc., from computers. I also learned how to communicate with PCP's and other interdisciplinary team members via computer. Patient centered care was another theme identified. This study found that students' witnessed positive role modeling behavior while interacting with patients and families. I was able to gain more experience with patient focused care being on the DEU because I was able to take modeled behavior and model it myself. Also, being more involved with patient care with multiple patients allowed me to be able to practice and expand my skills in providing patient centered care. Evidenced based practice and quality improvement. ? I am unsure.

\*\*Ranse, K., & Grealish, L. (2007). Nursing students' perceptions of learning in the clinical setting of the dedicated education unit. *JAN Original Research*, 171-179.

-“Student's perspectives identified three major themes: acceptance, learning & reciprocity, and accountability.” I can easily identify with these three major themes from my learning experience on the DEU. These were three fundamental building blocks that occurred on an on going basis during every clinical day. Acceptance occurred day one, which is very important, although it may seem like such a small thing! There is nothing worse than going into clinical and a.) Not being welcome somewhere or b.) Feeling more like a shadow and in the way. It isn't always done directly, or purposely I am sure, but it does happen, and it significantly impacts the learning experience in a negative way. It becomes a barrier to success. Everyday I was greeted by the secretaries and other nursing staff. They went out of there way to find me to let me know if they were ordering take out for lunch or to invite me to a surprise party in the break room for someone. Every morning the secretary would ask me which rooms I needed rounds reports for. The little things that allowed to feel accepted, which allowed me to focus on giving the best

patient care I could while striving to learn as much as I could. If I didn't feel accepted, I wouldn't be able to fully concentrated on the days work. I would be trying to concentrate on patient care in addition to not stepping on anyone's toes or getting in the way. Learning and reciprocity was another theme identified in this study that I can very easily confirm in my experience too. I was finally able to apply theory to clinical experiences fully. For example, granted I did have patient's during traditional clinical settings that was matched to current theory topics, I wasn't able to fully see the "big picture". We had access to computers and patient charts and our instructors. So if a question arose about a particular piece of patient data, we would have to ask other students, or compete with 7 other students for our instructor's time. Depending on if you had a receptive nurse that assumed primary accountability for your assigned patient, determined whether or not a student would feel comfortable enough to approach and ask a question. This reinforces the particular aspects of DEUs being accepting, and working 1:1 with a CI with patients. I was able to practice skills on a daily basis to ensure competency and mastery. Accountability, the third and final theme identified in this study, is absolutely another aspect I experienced on the DEU. When I initially proposed to do this senior project, I had to read all of these research articles that I would be comparing my perspective to, and I couldn't quite grasp how I was going to find accountability on the DEU. I initially thought of the word in a negative sense as in, being held accountable for not doing something right. By the end of my clinical rotation on the DEU, I was able to see accountability as a positive thing too. I was proud of my patient care and my learning, as well as my CI's. Being held accountable for optimal patient care is a positive component of accountability. I provided optimal care with my CI's, and was pleased to be held accountable at the end of the day when I would receive positive feedback. I was

assigned responsibilities that were appropriate for my knowledge base, yet I was challenged every day.