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Chimdera Nzelu

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Cardiology Student Nurse Internship

Chimdera Nzelu

University of Arkansas

NURS 498VH Honors Education Thesis/Project

Abstract

This past summer and into my final semester in the Eleanor Mann School of Nursing, I became a student nurse intern at Washington Regional Medical Center in the Cardiology department. Heart disease and other heart-related morbidities are on the rise within our population, especially as the baby-boomer generation continues to age – and healthcare must follow suit. The Cardiology department combined with the Walker Heart Institute of Washington Regional is a champion within Northwest Arkansas for the best care related to the heart, and I had the incredible opportunity to serve and learn from their talented healthcare team. Through my internship, I have learned about several different cardiovascular procedures, what it means to cater care to the individual, how to advocate for patients, and the vital importance of holding on to hope in adversity.

Cardiology Student Nurse Internship

"The workings of the human heart are the profoundest mystery of the universe. One moment they make us despair of our kind, and the next we see them in the reflection of the divine image." Charles W. Chestnutt, an African-American storyteller, meant this quote to discuss the plight of African-Americans in his novel entitled *The Portable Charles W. Chestnutt*. Ironically enough, the pathophysiology of the heart follows the very same notion of this quote in the literal sense. Every single day, the heart beats an average of 115,200 times per day, equating to approximately 3.5 billion beats in the average lifetime of 80 years. With each beat, approximately ⅓ cup of whole blood is projected through the body, providing fresh oxygen, plasma, and other components to every capillary and vital organ with each pump (Hoffman, 2017). This past summer, I devoted my time to studying what happens when this system fails us. When our hearts, as they pump, when we sleep and when we wake, make the miniscule mistakes that lead to the most tragic of outcomes – not only for the patients, but for their families, and all those who are impacted by them.

This summer I worked as a student nurse intern at Washington Regional Medical Center in Fayetteville, Arkansas. Washington Regional Medical Center, in combination with the Walker Heart Institute, is a leader in Northwest Arkansas in Cardiology, boasting over 10 board-certified cardiologists, 4 cardiovascular surgeons, and over 300 heart health professionals. The unit currently holds 60 beds and is undergoing expansion in 2020 to support a 20-bed acute care setting for those transitioning from the coronary intensive care unit into a more stable, less intensive setting for discharge. The Walker Heart Institute also houses the only electrophysiology program in the entirety of Northwest Arkansas, which gives them the ability to

offer procedures such as the Watchman (left atrial appendage closure), cardiac ablations, and the new Micra Transcatheter pacemaker. We also offer the Impella heart pump, Transcatheter Aortic Valve Replacement (TAVR), and comprehensive cardiac rehabilitation and pulmonary rehabilitation services. To add to their resume, in a study done by *U.S. News and World Report*, Washington Regional placed number one in the region for support and care for patients with chronic heart failure. This was based on objective calculations such as readmission rates, risk-adjusted survival, volume on units, quality of nursing, and patient safety (Washington Regional, 2019). Washington Regional is making huge waves in our community with innovative technology and personable health care providers, equipping patients to make the most educated and sound decisions for their bodies. I was honored to serve and learn from them and be a pivotal part of the Cardiology team. Here, I shadowed both board-registered nurses, case managers, and certified nursing aides alike as they navigated care for patients recovering from various cardiovascular procedures.

Throughout my internship I saw quite a variety of patients. Some patients as young as thirty years of age, and as old as ninety-two, some Caucasian, some African-American, some Marshallese, men and women alike. The only commonality they all shared was that their hearts failed them. At some point, whether in recent history or undetected over the course of their entire lives, their heart started to ache, they became unconscious, started having difficulty breathing, etc. So, I asked myself, when did we begin to fail *our* hearts? Studies clearly show that obesity, heavy workload, increasing age, smoking, and diabetes increases our risk for heart disease and cardiology-related comorbidities (American Heart Association, 2019). However, some were just dealt a bad hand, and were born with atrial fibrillation or other cardiac dysrhythmias.

What I saw most in the former was older Caucasian men, typically accompanied by curious wives or children who seemed more invested in their healthcare than they did. They would often recount stories similar to: *I was just out working in the yard and I fainted, and they [family] brought me to the emergency room. I found out I have some really bad blockages in my heart.* They were often eager to leave, as it was evident that they disliked being a burden and wanted to return to being their normal, productive lives. They were often restless and openly discontent in their rooms. I could feel the disappointment they had in themselves, wishing they had the liberty to walk out and get themselves a cup of coffee, brush their teeth, or relieve themselves without bringing the entire world to a halt. In the latter, I would typically see women with atrial fibrillation, chronic hypertension, heart failure, and other things of the like. They were often older, sweet and polite, compliant with their care, refusing any help or denying their need for anything. In both of these groups, some would not say a word to me except smile and extend their arm, ready for me to take their blood pressure as I did every four hours, on the hour. Others would start extensive conversations with me about nursing school, about their childhood best friends, or about their deepest fears and insecurities. One patient, I remember in particular, went as far as telling me I had a particular "spirit" about me, and politely asked me to pray for him. If I learned one thing through this, it is that every patient is unique and has different needs – and if it is within our scope of practice and boundaries, it is our job as personnel to do our best to meet those needs the best that we can.

I failed to meet these needs for a particular patient one day, on a rare busy Saturday. I came into work only to discover that I would have 17 patients to take care of that day. My usual was 10, as I had just come off of my orientation and shadowing portion of my internship two

weeks prior. I had a patient that was struggling to maintain an adequate blood pressure. I took his blood pressure in the morning when I arrived, before breakfast trays, as usual, but was lost in a whirlwind of busyness all throughout lunch, so, somehow, I missed his afternoon vital signs. It would not be until two weeks later that my clinical coordinator would send me a message, asking me to come to her office to explain the occurrence. What I did not know was that no vital signs were charted for that patient between 8 o'clock in the morning and 4 o'clock in the afternoon that day. The patient ended up transferring to the intensive care unit that night, as his blood pressure continued to worsen, and ended up passing away only two days later. The weight of my mistake, or rather, timidity in asking for help, could have cost the hospital a hefty lawsuit. In that moment, I did not know it was okay to ask for help. I had never considered the weight of my actions. Since then, I have changed my mindset to think about these patients as my family members. If my own mother was in the hospital, how would I feel if neglect was projected onto her because the hospital was understaffed? When I was frustrated that a certain room seemed to turn on their call light every 3 minutes, I remembered that this could be my grandmother, my mom, my sister, or even *me* in that same room – and I would be more than appreciative if that same level of care was extended to both them and me.

My grandmother suffered from a stroke when I was four years old. I never knew her, but only of her via stories my father would tell me as I grew up. What I do remember vividly, is sitting at the kitchen table writing a small poem to be placed at the back of her eulogy, and celebrating at her wake as we danced with enlarged pictures of her in our arms until the sun rose the next morning. When my mother was pregnant with me, she has recounted stories of how she suffered from toxemia, severe gestational hypertension, and other pregnancy complications that

ultimately made her deliver me a whopping 3 months early – a not-so-pleasant surprise for *all* parties involved. She often tells me that the 10 weeks I spent in the NICU were the most heartbreaking, difficult, but joyous times in her life, because she knew she had a resilient baby girl that would make it through to the other side and fight her way back home. Nonetheless, I say all of this to say, the celebration seems to triumph, suppress, or shadow the hurt. Similar to the way everything seemed to fade away when my mother held me for the first time in her arms and rejoiced in the gift instead of the pain she endured just moments prior, the moments when those cardiac patients are able to return to their families and revel in their bodies recovering from the unthinkable, makes it all worthwhile. It is what pushes the post-operative coronary artery bypass graft patient to make another lap around the unit when oxygen feels scarce and tachycardia is imminent. It is what makes the heart failure patient take their Lasix every day at the same time with an unsettling, yet astounding punctuality, even though getting up to urinate every hour for them is equivalent in exertion to running – not walking – a 5K. The celebration matters. Hope is the tether to which we can tie the mountaintops and the valleys of our lives to.

This all became real to me with my first coronary artery bypass graft patient. He was relatively young, in his early 60s. It was not his biographical age that made him young, but rather, the way he cared so deeply for his wife. In the few days pre-operatively I took care of him, I would often walk in to take a set of vitals or deliver a meal tray only to find him, snuggly fit into the squeaky twin-size hospital bed, laying peacefully alongside his wife as they watched whatever rerun was streaming on cable television that day. In our conversations, it was evident that he was determined to get well – whether it was for his wife, for himself, or for a combination of the two or beyond that I will never know. It was almost as if he chose to

blissfully ignore all of the elements that could possibly go wrong with a procedure of this caliber. Or, if he was anxious, not even the tiniest expression of it manifested itself on his face or in his demeanor. Nonetheless, a combination of his wishful thinking, will to get better, and the talented Cardiology team at Washington Regional got him successfully discharged post-procedurally within record time.

To my amazement, it was not but two months later that I walked into a different room on the unit only to see him, this time, alone, with an audible heparin bolus whirring in the background and reruns of *Friends* playing on the television. "Well, hello!" I said, not hiding the elements of confusion and surprise in my voice. He looked up at me, smiling, recalling who I was. "I have to admit, I'm really not happy to see you here," I said, jokingly. He replied, "me, neither," and we laughed. He explained to me, the best that he could, intermittently pausing for shallow breaths, that all of a sudden he woke up the previous night having trouble breathing. He had developed a pulmonary embolism and was receiving high-doses of heparin in an effort to break up the clot. What I remember thinking about on my drive home that day was not how sad I was to see this patient back in the hospital, but the hope I heard in his voice. Even in this nearly fatal setback, whatever disappointment that was present in his voice was quickly overcome by positive thoughts and a joyful disposition. That, though immeasurable and intangible, was the difference that allowed him to go home to watch another rerun with his wife and see another day. Whether he knows it or not, I learned more about healthcare through him than I ever thought I would. We, as healthcare professionals, are legally and ethically bound to do anything and everything possible for our patients, within limits, that will promote healing, health, and wellbeing. However, if the patient fails to believe in themselves – if there is no hope to tether

onto, these efforts may be squandered. It is our job to remind patients of this and equip them to make the best, most medically sound decisions for themselves.

During my time in this internship, I truly became aware of the power of the heart. It sincerely is the most profound mystery of the universe in that, at any moment, it has the power to determine the course of the rest of our lives. It has a mind of its own, working as we sleep or as we run a marathon. It is consistent and steadfast until it is not. Until, at some point, we find ourselves pushing epinephrine intravenously and crushing rib bones to compensate for its lack with each compression. In all its glory, the power of the heart is unparalleled. Even in all our knowing, we might never come to understand it – and that, is the truest reflection of the divine image.

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