

Amie D. Smith
Donald D. Kautz

A Day with Blake: Hope on a Medical-Surgical Unit

All nurses care for patients who change their lives forever. Blake was one of those patients. Blake's story and the interventions his nurse (Amie) instituted illustrate a hope-promoting framework that medical-surgical nurses can use every day in practice.

Amie D. Smith, BSN, RN, is a Staff Nurse, Acute Medical and Trauma Unit, Wake Forest University Baptist Medical Center, Winston Salem, NC.

Donald D. Kautz, PhD, RN, CNRN, CRRN-A, is an Assistant Professor of Nursing, University of North Carolina at Greensboro, Greensboro, NC.

Blake, a man in his late 20s, with pancreatic cancer, was admitted to Room 15. His last hospital course had been long and arduous, including intraperitoneal hyperthermic chemotherapy (often referred to as “shake and bake” because of the alternating side effects of shivering and fever), insertion of several PICC lines and subsequent removal due to infection, a whipple procedure, and numerous procedures involving drain insertions. I heard that he was extremely needy and more than persistent with his call bell when it was time for his pain medication; also, his mother was hovering and worrisome.

In the first 90 minutes of my shift, every time I looked down the hall, every call light was ringing except the one for Room 15. The lab was calling with critical lab values, and two different residents were asking for help and telling me the orders they needed entered into the computer. Periodically, a woman would wander out into the hallway from 15, look at me, and then walk back through the doorway. After 30 minutes, I was concerned that I was late with Blake's medicine and he had yet to call me, so I asked the nursing assistant working with me to check on him. The paperwork and notes were piling up on my medication cart, and I dreaded entering his room because his medicine time was getting later and later. At 8:40, I gathered his pain medicine and walked into his room. I took a deep breath, waiting for my first meeting with this man and his family; I dreaded the encounter so much that my cheeks were red and I had broken into a slight sweat. I found a man in tremendous pain and an extremely worried mother.

It seemed incredibly hot in this room (which I attributed to my nervousness), and I noticed that Blake barely fit in the hospital bed. His large feet were hanging over the end, he was sweating profusely, his eyes were clenched shut, and he looked pasty. A turtle balloon that someone had brought in from the gift shop was dancing around near the window. I apologized to them both for the delay in bringing his medication while frantically trying to remember his vital signs that morning. Blake muttered a curt response to my apology and my questions as I completed his morning assessment. I gave him his scheduled medicine, asked him how well the analgesics had been working for his pain, and ascertained that they probably were not going to be enough. I took another deep breath and told him I would get his pain medication, and I was going to call the resident to see if I could get an order for some additional analgesic. For the first time, he opened his eyes to look at me. “What?” I told him again what I was planning to do, and asked him if that was OK.

“Why?” he asked. I said he was in so much pain because his PRN pain medications had not done much for him. I explained that my tardiness in administering his medications had caused him to have a pain of 9 out of 10, and I felt obligated to remedy the situation.

"You must be freaking kidding me," Blake responded. I was confused, but sure that at this moment I would feel his wrath. I told him to think about it, and said they could discuss it while I was getting his PRN analgesic. I walked down the hall to the drug dispensing system, got his medicine, and returned to his room. As I gave him his Dilaudid®, he watched me with one eye open. I asked him again what he wanted me to do about calling the doctor. "Is it going to do any good?" he asked. I explained that I did not know, but I had several encounters with the senior attending resident (SAR) on duty for the service, and he was generally pretty quick to respond to pain issues.

"Are you going to call him now?" I asked him if he would rather I waited until next Thursday, and he started to chuckle. He said he was sure everyone was tired of hearing about his pain. I explained to him that I would not call if he did not want me to do so, but I would not know if anything would change unless I called. His mother then broke in and said they did not want to cause any trouble for me. She had watched me scamper up and down the hall all morning, the doctors asking me a million questions, and she had heard my phone ring over and over again. Her son had been hurting all morning, but they did not want to hit their call bell because they knew how busy I was and they did not want to make it any worse for me.

At that moment, I realized I liked this man and his mother a great deal. I also realized that even though Blake was in extraordinary pain, he and his mother were more concerned about my well-being than his. I tried to wipe the astounded look off my face, closed my now gaping jaw, muttered something, and quickly left the room. I have no idea what I said, or whether formed words even came out of my mouth; all I knew was that I had to get out of the room before I began to cry. I paged the resident and prepared myself to ask, beg, or fight — whatever it would take — to get an order to give this man more pain medica-

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tion. Fortunately, the SAR responded as I had hoped, and I was given orders for several different types of analgesia if the first dose was not effective.

The rest of the day, the parade of residents continued and the call bells kept ringing, but Blake's scheduled pain meds were right on time and I assessed his pain level every time I walked in the door. As I gathered my papers to give report, I decided to peek in one last time before I left the unit. When I walked in the room, he was sitting up in the bed watching television and typing on his laptop. He had on small round glasses, and his legs were crossed. He had stopped sweating several hours earlier, but he still looked as if he had been through the ringer. He looked up at me, glanced at the clock, and asked, "Hey, it's about time for you to go home, isn't it?" I told him I was doing one last check before I headed out. He assured me that he was feeling pretty good, and his pain was much better; he would be waiting for me in the morning when I returned, and not to be alarmed when I walked in because his brother was staying with him that night instead of his mother.

I cried the entire way home. I was exhausted. I was hungry. But most of all, I was sad. All I could think was that even though I had just experienced a grueling 12 hours, I was leaving. Blake could not leave. He was going to spend another night in the hospital, relying on nursing and medical personnel to meet his needs.

Hope on a Medical-Surgical Unit

All nurses have taken care of patients they never forget. Sometimes, these patients change their lives forever. Blake was one of those patients. Blake changed Amie forever. Blake's story and the interventions Amie instituted illustrate a

hope-promoting framework that any nurse on a medical-surgical unit can use daily in practice. By adopting a life-promoting, hope-inspiring framework for nursing care and looking at mundane tasks in a new way, nurses can help patients maintain hope and also maintain their own sense of purpose.

A medical-surgical unit is an appropriate place for many patients who are not going to improve. However, prioritizing care is key to avoiding burnout in this setting. It is hard to do grueling work day after day and maintain hope in spite of the despair in the patients. Miller's (2000) framework for nursing interventions can help nurses inspire hope, focus on strategies to enhance patients' control, and remind nurses why they entered the profession.

Hope is a "state of being, characterized by an anticipation of a continued good state, an improved state or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future that is good and is based upon mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, as well as sense of the possible" (Miller, 2000, p. 253).

This definition includes three key points. First, hope need not be based on verifiable evidence; nurses, patients, and families all may have differing beliefs about patients' ability to get better. Second, nurses can have a tremendous impact on patients' "sense of the possible" (Miller, 2000, p. 253) by focusing on relationships with others and increasing patients' personal competence, coping ability, and psychological well-being. Finally, by increasing patients' awareness of what is possible, nurses will come away with a renewed sense of purpose.

Miller's (2000) framework also includes numerous categories of interventions. Seven are described in this article: enhancing control, maintaining dignity, sustaining relationships, viewing the opportunity to care for patients as a privilege, controlling pain, meeting spiritual needs, using humor, and promoting hope for the moment.

Enhancing Control

Miller (2000) indicated that nurses can enhance a patient's sense of control in two ways: by returning control over some facets of their daily routine, and by assuring them that their lack of control is temporary. Amie gave Blake control over his pain by asking him about calling the doctor for pain medicine. Amie also ensured that Blake got his pain medicines on time, further enhancing his control. Nurses may be able to give patients choices about when they take their medications, whether they take a bath or shower, or when they want treatments. Even when the nurse cannot give the patient choices, a simple reminder that things will not always be this way and that the patient and family will again have control when the patient leaves the hospital may reduce the perception of unrelenting powerlessness.

Maintaining Dignity

The patient's dignity is often ignored in health care. From the moment a patient is admitted to the hospital, a transformation begins. Before becoming a patient, a person is a human being with preferences, choices, and history. Upon admission, the person becomes a physical manifestation of a disease process. John Doe is no longer the son of Jack and Mary, employee of a local restaurant, an active member of his church and/or community, owner of two dogs, and an honors student at a local university. He has now become Mr. Room 326, age 22, status/post-intramedullary nailing of the right femur, Foley catheter to straight drain, allergic to penicillin, last pain medication given at 5:45 a.m.

It becomes easy to forget a

human being's basic need for and right to respect and dignity. No matter how many times nurses were reminded as students to respect a patient's privacy and dignity, as practitioners they often are overwhelmed by a heavy patient assignment, countless medications due at 8 a.m., phone calls from the lab, and order after order from physicians. These events and many others allow nurses to forget that the patient in Room 326 might not appreciate

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the bright lights turned on and covers removed as a wake up call at 7:00 a.m. His dignity is further ignored if a nurse rolls her eyes when he asks for pain medicine, walks in without knocking, talks about her personal problems while doing a lengthy dressing change, or tells the next nurse in report that he is needy, whiny, irritating, or otherwise unpleasant. These interactions not only dehumanize the patient, but negate nurses' humanity as well. It is difficult to imagine how it would feel to be confined to bed, unable to eat without assistance, in a foreign environment, and completely dependent on strangers for everything. It is common for nurses to help a patient on and off a bedpan, but simple strategies to preserve patients' privacy and dignity show that nurses believe it is a privilege to care for them.

Amie told another story of a patient who returned to her unit 9 months after hospitalization for a small bowel obstruction. The patient saw Amie, came up to her crying, and said, "You washed my hair." Through this simple, often ignored task, Amie made an impression that the patient remembered for months. When Don was in nursing school in the 1970s, instructors drilled him on the importance of keeping the basic bedside table clean and ensuring that basic hygiene needs were met. Unfortunately, in changing the

focus to the more complex and technologic aspects of care, nurses have let performance of some basic tasks be neglected. Amie noted that nursing staff can assist in maintaining personal dignity by ensuring patients have five things: clean hair, a small cup of hand gel available on the bedside table for hand hygiene, a clean room (especially the bedside table), regular oral care, and an up-to-date dry erase board in the patient's room that identifies the nurse and nursing assistant assigned to that patient. Changing sheets every day and bringing fresh water twice a shift are other ways to impact patients' experience of being in an unfamiliar place, constantly having their privacy invaded by a myriad of strangers, and experiencing frightening clinical manifestations of illness.

Sustaining Relationships

Most nurses were taught to maintain some professional distance from patients to avoid burnout. The most common way nurses maintain distance is to focus on tasks rather than on the patients' experience. While maintaining professional distance helps nurses accomplish the tasks at hand, this distance also may prevent them from getting to know their patients as individuals, with life stories of their own. Patients are more than just their diseases; a growing body of evidence indicates that patients do better and improve sooner when those who provide care actually get close to them — not only know their disease, but know them and their families as persons (Cioffi, 2000; Whittemore, 2000; Wilkin, 2002).

Nurses also are less likely to make errors when they know their patients (Beyea, 2006). Nursing staff can detect subtle differences in patient condition each day, individualize their care, and ensure that they have the best possible outcomes (Rasin & Kautz, 2007). Just as it is essential to report to the next nurse how well patients ate, their IV fluids, vital signs, and other aspects of their care, nurses also can relay a few key points about patients' personal history so

they are transformed into real persons. Jackson (2005) found that knowing the patient was key to new RNs seeing themselves as having had a good day, and made it easier to prioritize and complete their work.

Viewing the Opportunity to Care for Patients as a Privilege

It may be difficult for a nurse to see beyond a patient's symptoms, especially if the patient has open wounds, is incontinent, or has infections with foul-smelling discharge. It is hard to see the privilege in providing care in these circumstances. However, seeing beyond symptoms to the privilege is essential if nurses are to promote hope for patients and themselves. For example, a patient was admitted with extensive care needs. During the shift-to-shift report, nurses tended to focus on her difficult behavior and the complex care she required. However, this patient had been a well-known performer, and Amie used the computer in the report room to show the nurses pictures from the patient's career. The entire conference room fell silent. What a privilege it was for these nurses to care for such an accomplished person!

Controlling Pain

Most hospitalized patients experience pain, and unrelieved pain can lead to despair. While pain management has improved tremendously in recent decades, most pain in hospitalized patients still is undertreated (O'Malley, 2005). In addition to pain from a disease process, patients routinely undergo painful procedures. A landmark study by the American Association of Critical-Care Nurses (Puntillo, 2003) revealed that the procedure patients considered most uncomfortable and which nurses were the least likely to treat with pain medication was being turned in bed. Being transferred from bed to chair, or from bed to stretcher to go for a test or procedure, also is painful. However, nurses do not medicate patients routinely prior to turning or transferring them. The Institute for Clinical Systems Improvement (2006) evidence-based guideline on acute pain and

the American Pain Society (2007) guidelines and resources are very helpful for nurses interested in learning more about managing pain.

Meeting Spiritual Needs

Many patients and families undergo spiritual distress during hospitalization as they face an incurable chronic illness, a new disability, or the acute phase of a terminal illness. Patients may believe God has deserted them, or believe they are being punished through their disease (Vitek, Rosenzweig, & Stollings, 2007). Spiritual distress may contribute to already high levels of pain and aggravate other physical symptoms as well. The simplest intervention is to acknowledge the distress and initiate a referral to the pastoral care department. However, Hughes, Whitmer, and Hurst (2007) identified a need to integrate the chaplain into every day care on their unit. Smith (2006) and Delgado (2007) outlined spiritual care interventions nurses can implement, and Gaskamp, Sutter, Meraviglia, Adams, and Titler (2006) wrote an evidence-based guideline for promoting spirituality in the older adult. Hobus (2000) recommended nurses encourage patients to read literature, write poems and journals, and receive empowerment through readings from the Bible or words and music of hymns to satisfy the need for love, hope, and self-worth.

Using Humor to Promote Hope

The old saying, "if I don't laugh, I'll cry," could be rewritten as, "if I don't laugh, I'll lose hope." Laughter, and the ability to see the lighter side of any situation, promotes hope of endurance and survival. During stressful times, nurses may use humor to help themselves cope and remain hopeful. Nurses also may choose humor as an intervention with their patients. More and more

nurses recommend instilling humor into interactions with patients (Chinery, 2007; Christie & Moore, 2005). However, nurses may worry that they will not be funny, or that they might even offend a patient.

Kevin Lee Smith, a nurse practitioner who writes a monthly column about humor for *Nurse Practitioner World News*, recommends that the nurse use a routine humorous expression the first time he or she interacts with a patient. If the patient responds in kind, the nurse may continue to use humor. If the patient does not respond, or appears to be put off, move on. Smith (2003) believes that sharing a laugh shortens the distance between people. By establishing a relationship through humor, nurses can lessen the anxiety and fear that may accompany admission to an acute care setting. Humor also is effective in distracting a patient from pain. At times, however, humor is inappropriate. In a crisis or medical emergency, or if the patient is unable to grasp the meaning of the joke, humor can become cruel.

Evidence suggests that humor may be the only choice a person has when life becomes unbearable. Freeman (2002) wrote about the use of humor among survivors of Auschwitz concentration camp during World War II. After collected, residents rode for days on a train in a car meant for cattle; stripped, shaved, showered, and completely humiliated, the jokes among the prisoners began. Humor was one of the ways survivors endured the cruelty of the camp. An acute care unit is certainly not a concentration camp, but patients are poked and prodded, sliced and radiated, have tubes in every orifice, and endure a great deal as part of their treatment. Nurses care for all the tubes, often measuring the amount of drainage and reinserting the tubes if they become dislodged. Having all the tubes or car-

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ing for all the tubes seems ridiculous. Laughter between the nurse and the patient means that they are not defined by the circumstances, that despite any indignities, they retain a sense of humor. In the moment of shared humor, they also share a belief that there is hope.

Promoting Hope for the Moment

The most important aspect of inspiring hope is promoting hope for the moment. It has been said that if all there was to nursing was caring, anyone could be a nurse. That is not true; nurses must learn to care. As a nursing instructor, Don frequently assigns students to patients with the most tubes and the most treatments, or patients who are completely dependent on the nurse for their care. After a particularly grueling day with a comatose patient, one beginning student said, "Tomorrow, let someone else have this learning experience." A normal response is to avoid having to care for a patient who is so sick.

Only through experience does a nurse learn to care for a patient without wanting to run away, while enhancing the patient's control, maintaining the patient's dignity, and viewing it all as a privilege. In the moments that nurses spend with their patients, they are saying, "You are worth my time, right here, right now."

Epilogue

Amie had several more demanding and rewarding days caring for Blake, but the first day set the groundwork for all their encounters. Weeks later, Blake finally went home. Two weeks after being discharged, he came back to the clinic for a follow-up appointment and was even joking with the doctors. He died that night in his sleep. ■

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