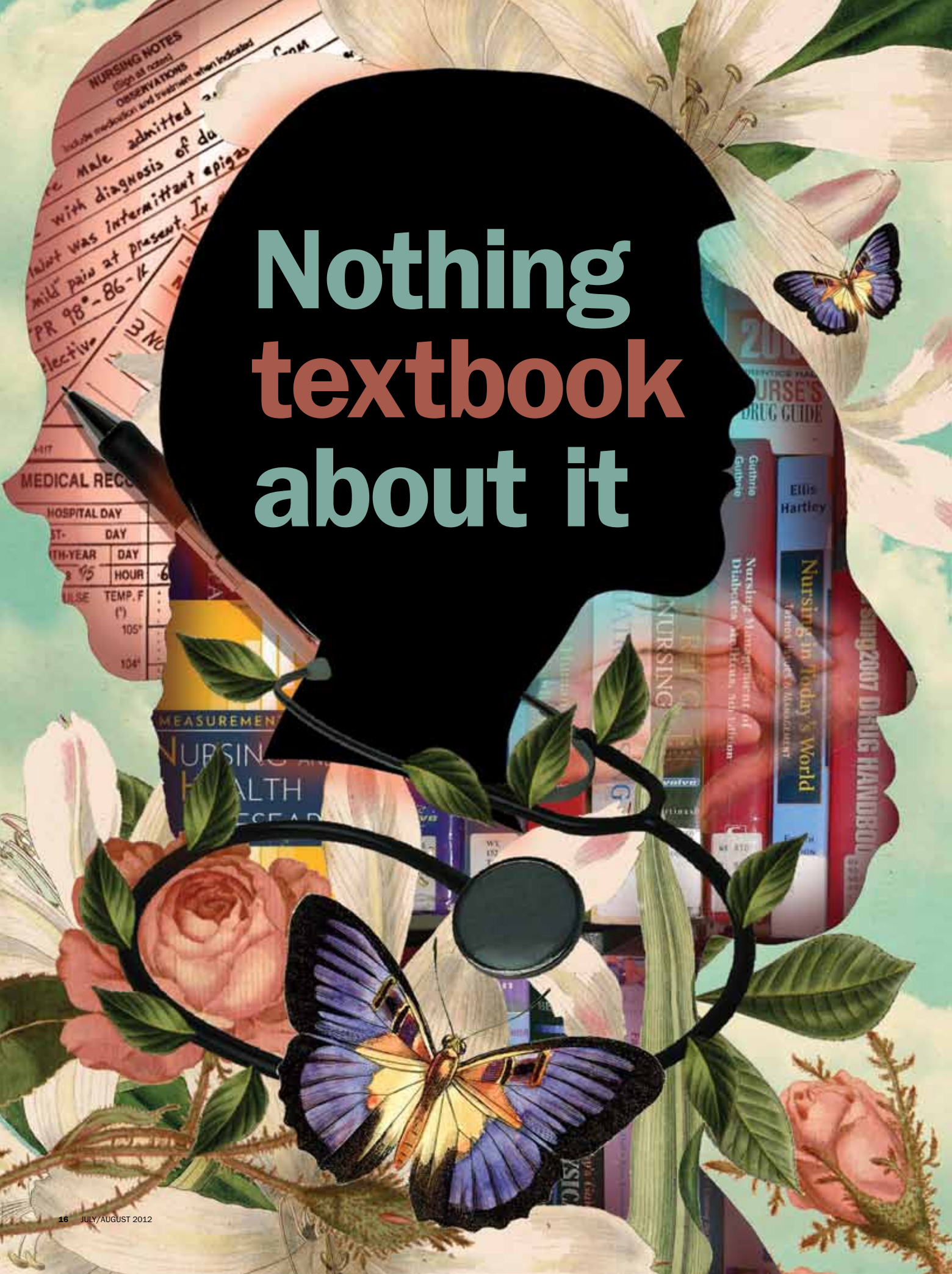

Nothing textbook about it

Each summer, our July/August issue of *RNJ* features your stories. This year, we asked you to write about some of the lessons you have taken away from daily nursing practice that you could not have picked up in a textbook or learned in nursing school. Your stories offer touching, humourous, and thought-provoking reflections about your day-to-day nursing practice. We're confident these stories will resonate with you, whether you are a new or recent grad, or a veteran RN with a couple of decades of experience behind you. Your encounters with patients and colleagues provide meaning and context for your work. Thanks to all of you who shared a piece of your own personal history with us...

ILLUSTRATIONS BY JOHN WEBSTER / i2iART.COM
EDITED BY KIMBERLEY KEARSEY

Textbooks and tutorials didn't teach me…

How to hold the hand of a dying woman

Fatima-Angela M. Caluag, Kitchener, Ontario

During a semester-long placement on the medicine and palliative care unit at Stratford General Hospital earlier this year, I met patients whose stays were much longer than the typical acute care patient on another unit. Some showed progress, while others did not. Some would become palliative and die within a week. Others would suffer for much longer. I met Mrs. G during one of my first shifts. She was admitted for end-stage, cancer-related pain control. Mrs. G was a middle-aged woman, bedridden due to weakness, not a single hair left on her head. Her family was at her bedside each day and, eventually, a cot was set up in her room to allow members of her support system to remain like sentries while she slept.

One night shift, her call bell rang. For reasons unknown to me, her family was not there that particular night. Due to her health history, Mrs. G was under contact isolation. When I arrived at her doorway, I called to her that I was coming, and pulled on the requisite yellow gown and blue hospital gloves to protect against infectious disease. She told me her mouth was dry and sore, which I assumed was due to a decreased oral intake and her medication regime; a common issue with palliative patients.

After using a water-soaked oral sponge for a few minutes, I asked her if the water helped. She nodded. I asked if she would like me to apply more water. She shook her head, and her eyelids fluttered closed as if the effort from parting her lips had drained what little strength she had left. I turned away to dispose of the sponge, and when I turned back, I saw her hand raised, trembling ever so slightly.

"Can I get you something?" I asked as her fingers settled around my hand. When she did not immediately answer, I instinctively turned my hand over so I could reciprocate by grasping her fingers. I prompted, "Mrs. G?"Her eyes opened partially. Her voice was hoarse and barely above a whisper. "I just want you to hold my hand."

Those eight words conveyed the importance of touch with a depth and richness of humanity that a textbook never could. Nothing I studied in nursing school could have prepared me for the burning threat of tears that I blinked back, or my desperation that I could not, at that pivotal moment, take my glove off to hold her hand properly. Instead, I ran my rubber thumb back and forth over her knuckles to give some semblance of physical comfort. I still regret being unable to provide at least one brief reprieve with true touch and human warmth.

A few days later, Mrs. G died.

Textbooks and tutorials didn't teach me…

That advocacy is at the core of everything we do as nurses

Ildiko Nanai, Lindsay, Ontario

My graduating class at Seneca College was one of the last to complete the three-year diploma program before a four-year degree became mandatory in 2005. At first, I felt cheated and disappointed, but soon realized it didn't matter how many years I was in a nursing program; even four years would not have prepared me for all the other things I would learn outside of school.

What they didn't tell me during my three years of study was how crucial advocacy is, not only for patients but for nurses. This realization hit me when I became a correctional nurse. Correctional nursing is the fusion of the health-care system (nursing) with the legal system (corrections). Generally, nurses are expected to maintain professionalism at all times, provide care within their scope of practice, and advocate for patients without bias. This is a challenge in a regular health-care setting. In corrections, it's even harder.

Correctional nursing often goes unrecognized as a specialty by its governing body and the legal system. There is a general lack of awareness of its uniqueness. Judges, prosecutors, lawyers, and ombudsmen seem largely unaware of how health care happens within the correctional setting, and what the nurse's role entails. This lack of awareness and recognition means insufficient resources and support, which in turn poses a great challenge for the nurse who is expected to carry out her or his role effectively.

Security and health care: it's a delicate co-existence where safety and security always comes first, nursing second. In corrections, providing unbiased care is the easy part. Providing the right care requires creativity. We have seen an increase in the client population in corrections over the last 15 years. Educational in-services and support systems are vital. We need mental health nurses and psychologists, without whom we cannot advocate on our clients' behalf. How can a correctional nurse advocate for a client with mental illness in a system that focuses primarily on safety and security? How can a correctional nurse properly care for acutely medically ill clients without adequate staffing and resources? Advocacy is the key.

However, before we can advocate for our clients in corrections, we must first advocate for necessary changes for ourselves. We must be recognized and supported so that we can live up to our role to the full extent. It is our right. It is our duty. And it is what nursing is about.

"Those eight words conveyed the importance of touch with a depth and richness of humanity that a textbook never could." —Fatima-Angela M. Caluag

Textbooks and tutorials didn't teach me…

The power of hindsight, and the danger of naiveté

Renee Lehnen, Oakville, Ontario

I would have made a great midwife. However, the admissions office at Ryerson University informed me in a tersely worded letter in 1999 that it didn't share my opinion. Dreams crushed, I turned to Plan B and began the diploma nursing program at George Brown College the following year. I consoled myself with reminders that nursing would be portable, in demand, and reasonably well paid. Thirty-three years old, with two children, a bachelor's degree in environmental studies, and an overseas teaching career behind me, I had a shockingly adolescent, cardboard cut-out view of nursing. I figured my mom is a nurse; how hard can it be? The surprises began in my first week of nursing school, and they've been mocking my naivety ever since.

Surprise #1: The diploma nursing courses were more difficult than the courses I had taken for my bachelor's degree. Our instructors actually expected us to prepare for class and clinical because the information was important.

Surprise #2: A seemingly simple task such as dispensing medication while the call bell rings, and a worried family member tugs at your sleeve, requires the mental discipline of a Buddhist master.

Surprise #3: Caring for someone who is dealing with a health crisis, or facing death, is every bit as rewarding as helping a woman give birth. I am humbled that I ever thought otherwise.

Surprise #4: The sheer breadth of opportunity in this profession is staggering. Since graduating in 2002, I have worked in medical/surgical, home care and primary care. There is no excuse for boredom in nursing. Change is simply a professional development course and resume update away.

Surprise #5: The camaraderie among nurses. Working a night shift, particularly when Murphy's Law asserts itself and trouble finds the team, is like combat. I imagine soldiers feeling the same admiration and kinship for each other that I feel for my co-workers.

Surprise #6: If a catheter bag is not locked off properly, and urine pools on the floor, the resulting mess is surprisingly sticky.

I would never have learned these things if not for front-line nursing.

Textbooks and tutorials didn't teach me…

The true value of family centred care and the support RNs offer in the NICU

Monica Jacela-Dhaliwal, Toronto, Ontario

After four years of nursing school, I gained the fundamental knowledge and understood the clinical guidelines that would direct my practice, including the principles of family centred care. However, six years of clinical experience in both the pediatric and neonatal settings has enriched my practice with valuable life lessons. I now understand that therapeutic relationships with families cannot be taught; they can only be nurtured through experience. And it is through my experiences that I am now able to truly understand the complexities of providing family centred care.

When I first started my practice on the neonatal intensive care unit at The Hospital for Sick Children in 2010, I was very focused on providing acute clinical care. At times, I questioned parental motives in continuing care versus withdrawing life-sustaining medical therapy when a baby's prognosis was poor. These ethical dilemmas made me question my own beliefs and values as a professional. When do health-care professionals intervene and advocate for the decision to withdraw or continue life-sustaining medical therapy if limitation of intensive intervention is in the best interest of the baby, but against parental wishes? For the first year of my practice, I did not understand how the interdisciplinary team came to these important decisions. I saw the baby separate from the family. I witnessed the baby struggling to survive, undergoing countless invasive procedures, and, at times, did not feel I was able to provide family centred care because I felt unable to empower the child, or support the baby in a way that would respect the baby's well-being and quality of life.

I've since learned that the epitome of neonatal nursing is family centred care. I am finally able to take a step back and understand family coping mechanisms, and the integral role the interdisciplinary team has in fostering family understanding and peace.

I realize there are situations that call for the health-care team to provide a family *time* to cope and come to terms with the acute situation. In return, families feel empowered to utilize positive coping skills. At the end of the day, it is the family that must cope with the loss of their child; or alternatively, the prospect of having a child with chronic illness or disability.

It was not school, but my clinical experience that taught me family centred care is about facilitating resiliency within the family to deal with the hardships of life. Nurses have the opportunity to be a pillar of support when people face the death of their baby, or the prospect of their child developing chronic illness or disability. Nurses empower families so they are able to cope with other situations; navigate the health-care system; and create a network of supports within their community. That is the true influence of nurses in providing family centred care in the NICU.

"Six years of clinical experience in both the pediatric and neonatal settings has enriched my practice with valuable life lessons." —Monica Jacela-Dhaliwal

Textbooks and tutorials didn't teach me…

That I have as much to learn from patients as they have to learn from me

Bev Chambers, Kingston, Ontario

In 1981, with four years of nursing experience under my belt, I applied to study midwifery in Scotland, a post-RN program that was not available in Ontario. In order to practise as a registered nurse in the UK, I had to work two months as a student on the surgical floor at Victoria Hospital in Kirkcaldy. I was not looking forward to this as I had already worked as an RN in Canada, but I did it because I was determined to go to midwifery school.

Scotland's health-care system was very different from what I was used to in Canada. In particular, Victoria Hospital's procedures were outdated; students were not allowed to read patient charts, and the head nurse (or Sister) would delegate tasks during the day. Although the nursing practices were unusual to me, I learned about the value of community among patients.

One day, I was assigned to care for eight older men in one room. They conversed with each other, and were a friendly lot. I could not always understand their Fife accent, and they teased me about my Canadian twang. I had to give one of the gentlemen a suppository. There was one large bathroom on the whole unit for all to share. It was quite a distance away, so I decided to put a commode by the bed and pull the curtains. The appropriate interval of time passed, and I returned. "Mr. D," I said. "Did the suppository work?" Another voice called out from the other side of the room. "Och aye," Mr. D's roommate shouted. "It's been heavy gunning over there, like the Battle of Waterloo!" Everyone doubled over with laughter, including Mr. D.

Each ward at Victoria Hospital had a small dining room, and patients who were ambulatory would walk to it, sit at its tables, eat together and have a grand chat. Often, the most mobile patients would sit with bedridden patients to keep them company, and sometimes help set up the tray.

After witnessing the degree to which patients were socializing, I realized the importance of laughter and a sense of community among patients. At school, I learned about therapeutic conversations with my patients, and how most of those conversations should have a serious purpose. Humour was not something I was encouraged to use. My experience in Scotland challenged that premise. We now know that laughter is beneficial, releases endorphins and helps reduce stress.

I never learned to encourage patients to mingle. Infection control was always foremost in my mind. But these patients demonstrated the value of peer support long before it was popular. The people of Scotland humbled me with their generosity and warmth. And they made me realize patients have far more to teach us than we can teach them.

Textbooks and tutorials didn't teach me…

That there is no place for self doubt in nursing

Olivia Boodram, Pickering, Ontario

I was doing my diploma in nursing at a college in Toronto in 1981. During an obstetrics/gynecology rotation for clinical practice, I was caring for post-partum moms at a large, urban hospital. We were expected to teach our patients about using a heat lamp to heal their episiotomy incision. However, I refused to do this and gave my rationale to my instructor at the time. In my view, the approach was potentially dangerous for someone to do without supervision. I also felt it was highly unlikely that a new mom would have a heat lamp at home to use after discharge. I felt the more effective way to promote healing of the incision was to keep the area clean, and to air the episiotomy at least three times throughout the day. My instructor did not share my opinion, and told me I would never be a good obstetrical nurse. I never understood the comment, or why she felt the need to say this to me, but I knew as soon as she said it that I would be an exceptional nurse who would provide the right care for my patients.

I did end up working in obstetrics, and have stayed true to myself and my beliefs. I started out in the nursery, and then moved to post-partum care. I have worked in a high-risk pregnancy setting and have developed and launched a new unit that monitors high risk clients as out-patients. I have been providing optimal care to each and every one of my patients for more than two decades.

This goes to show that you can never let someone's opinion get in the way of what you truly want to do and have a passion for. It also proves that students do have a voice and the ability to articulate well-thought-out and rational approaches to caring for patients.

If I ever cross paths with that instructor again, I'll have to thank her for making me realize that I have so much to offer the health-care system.

Textbooks and tutorials didn't teach me…

That there are boundaries in practice, just as there are between countries

Nancy Sinclair, Cambridge, Ontario

It's been more than three decades since I was a new grad, but I've told this story to my nursing students several times. I graduated at a time when nursing jobs were scarce in Canada, so many of us packed up and moved to Florida to practise. The transition (most of us were young women) was huge. New independence. A new country. A new health-care system. A new practice. Back in school, we didn't talk about the change from student to grad, or the transition shock that has now been researched so well. I worked in maternity, and on my unit, the clients were either public (socially assisted clients of the midwives), or private (paying clients of the doctors). The public clients were in the four-bed wards, while the private clients were in the semi-private or private rooms across the hall from each other. One evening, a young mom in her teens, a client of one of the midwives, and a mom with whom I had established a good nurse-client relationship, told me she was craving chocolate. As a fellow chocoholic, I completely understood the craving and said I would get her a chocolate bar while I was on break. The charge nurse found out I had done this and I was chastised for treating a public client better than a private client. The lessons were profound: about expectations in a two-tier health-care system; about treating clients with respect and dignity regardless of their ability to pay; and about my personal values and beliefs about client centred care.

Textbooks and tutorials didn't teach me…

The importance of being open to new experiences

Marie Salovaara, Powassan, Ontario

I graduated from nursing school as an RN in 1995. I had been an RPN for 10 years prior to that, so I knew a thing or two my classmates did not. I remember being in class and the other students wanting a day off from lessons to attend the school's winter carnival. How upset they were when we were told to be in class as usual that day; no time off would be allowed.

One of the first things you learn in nursing is that it is a 24/7 proposition. You better get used to missing out on things, including birthdays, Christmas, holidays and special events in the lives of your family and friends. This was a reality that surprised me when I first became a nurse. In fact, it came as a bit of a shock to be at work at 2:00 a.m., 3:00 a.m., and 4:00 a.m. instead of home in bed with the rest of the world. I don't remember that point ever really coming up in class. It's something I learned after a bit of time in the real world.

Early in my RN career, I also learned that sometimes you have to bend the rules. Not all scenarios fit into a neat little category. Allowing family to stay after visiting hours, having more people at the bedside than policy dictates, allowing special foods or treats that are not on the diet plan, and turning a blind eye now and again; these are all things you learn to expect as you go along and gain experience.

I have also learned when to speak up and to be vocal on behalf of my clients and when to keep my mouth shut. Nursing has been a wonderful ride for me. It's taken me places I never thought I would go, and I learn new things every day about my clients, co-workers and most of all myself. The key is to be open to new experiences, and never stop learning. **RN**