NURSEDECK

THE INSIDER'S PERSPECTIVE OF NURSING

Caring.Integrity.Diversity.Excellence

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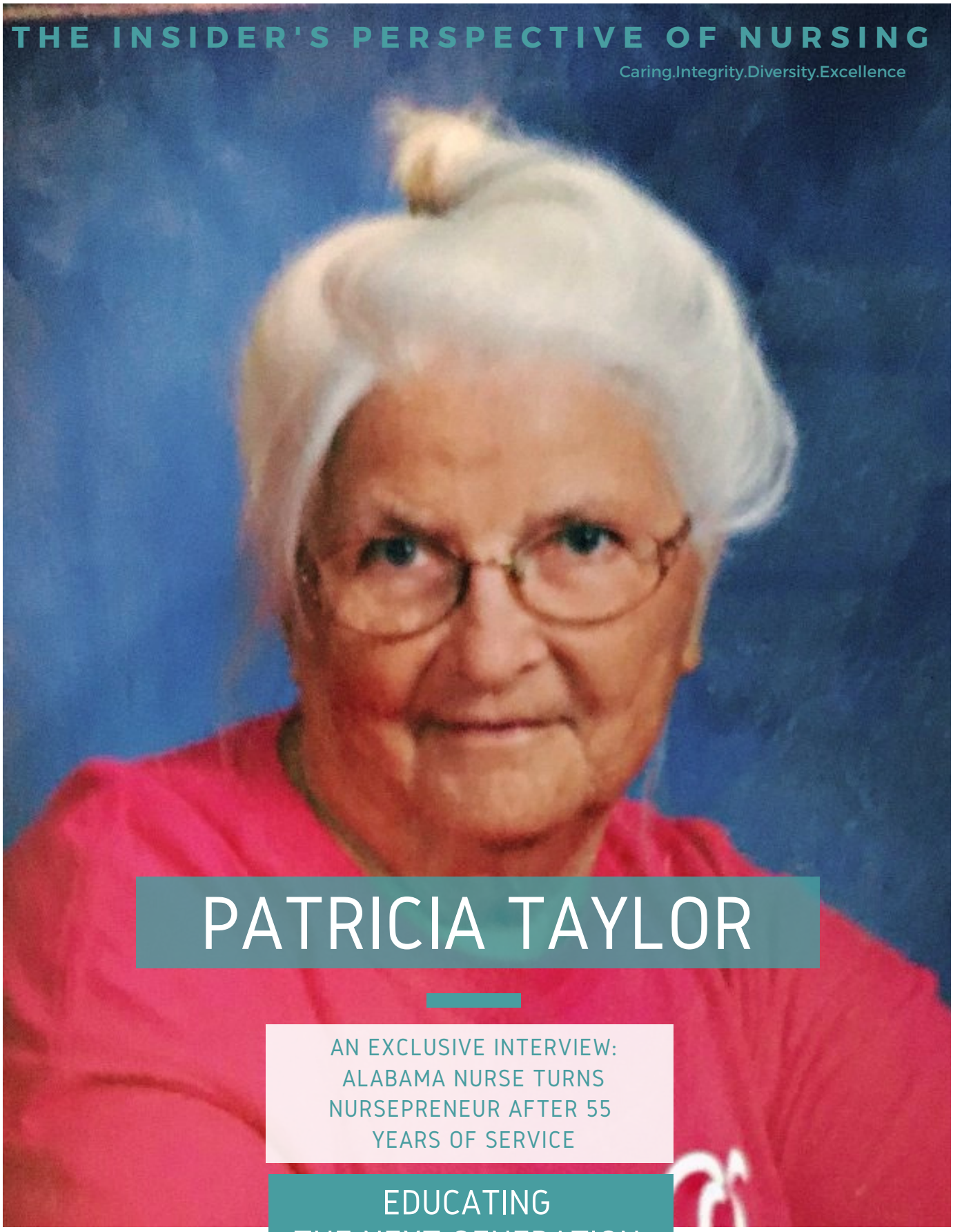

PATRICIA TAYLOR

AN EXCLUSIVE INTERVIEW:
ALABAMA NURSE TURNS
NURSEPRENEUR AFTER 55
YEARS OF SERVICE

EDUCATING THE NEXT GENERATION

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A COMMUNITY OF RESOURCES BUILT FOR REAL NURSES.

Where nurses share stories, resources & guides to help inspire and motivate.

"When you're a nurse, you know that every day you will touch a life or a life will touch yours."
—Unknown

NEVILLE GUPTA

Founder/CEO

As a strong advocate for the union between humanity and technology, Neville's focus leans toward tech influence on creating highly desirable working environments encompassing altruism, autonomy, human dignity, integrity, honesty and social justice.

GABRIELLE DIDATO

Head of Influencer Marketing & Partnerships

LAKESHIA BATES

Community Engagement Manager

DESTINY GORDON

Brand Marketing Specialist

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THE VOICE OF NURSING

We're on a mission to amplify “being heard” and create connections for the global nursing community of 28M

NurseDeck, which operates through a digital omnichannel model, including social media, all-inclusive NurseDeck network, and nursing communities offers reward and affiliate-based healthcare services and Nursepreneur PR and marketing solutions that will enhance further education, employment, career opportunities, and extra sources of income

"Be a Voice. Not an echo."

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THE VOICE OF NURSING

Empowerment

Empowering is vital for success in healthcare. Giving nurses a community to be their best reaps positive results to be more engaged and excited about what they do.

Impact

Nurses use their voice and experience to advocate for patients within the team playing key role in shaping policies.

Commitment to Patient Care

Commitment to the service of mankind has always been a key concept of professional nursing.

Healing

A nurse is an instrument of healing. Healing is a positive, subjective, unpredictable process involving transformation to a new sense of wholeness, spiritual transcendence, and reinterpretation of life.

Integrity

Integrity, maintaining strong moral principles like honesty, fairness, and honor, is one of the core values in nursing that needs to be maintained.

Dignity

The nursing profession has a professional dignity that is to be continually constructed and re-constructed and involving the recognition of inner worth and social dignity subject to different social factors and moral behaviors.

Diversity

Acknowledgment and appreciation of the existence of differences. We implement the value of diversity that is a growing need for nurses who can collaborate with each other and treat patients from a culturally sensitive perspective.

Excellence

Courage. Compassion. Connection. The promotion of safe, effective, competent, and ethical nursing care where the individual nursing practitioners can evaluate the services being provided by them and act as a catalyst for self-regulation and improvement.

Personal Development

The importance of lifelong learning and the need for a process designed to promote areas of improvement for nurses such as patient care and population health with dedicated resources, customized professional development plans, and an effective measurement system process.

FEATURED STORY

PATRICIA TAYLOR

AN EXCLUSIVE INTERVIEW: HOW NURSING EDUCATION HAS CHANGED IN THE LAST 50 YEARS, AND WHAT STILL NEEDS TO

By NurseDeck

Patricia Taylor has been a nurse in long term care and acute care for 55 years- and is now turning her experience into nursepreneurship. She shares her experience in nursing school and as a new nurse with NurseDeck, as well as her thoughts on what needs to change in nursing Read on for Patricia's belief in the importance of nurses as patient advocates.

PT: I became a nurse from a diploma program hospital based in Mobile, Alabama in 1965. And I've had a wonderful career, both in acute care and long term care. I'll tell you a story right off when I was in acute care. I thought that the nurses in long term care are those who could not make it anywhere else. But when I got into long term care, I realized that the best nurses needed to be in long term care or home health. Because we don't have a supervisor, we don't have a doctor down in the ER. It is you in that situation, and the patient, and what you know, and your judgment is what makes the difference in that patient's outcomes.

ND: I'd love to hear more about the story of how you started in nursing. Because in 2021, there are about 72 different ways to become a nurse. And I think that we have more than 1000 different ways to put letters behind our names through certain certifications and specialties etc. So if you wouldn't mind, tell us what it was like, in 1965.

PT: We had 57 girls in our class, and back then only women were in nursing. You lived in the dorm and the door shut at seven o'clock on Monday through Thursday. It was open till 10 on Friday and 11 on Saturday and 10 on Sunday. Now, if you came in early at 10 on Friday, you could stay out till 12 but you had to let them know, which I didn't always do.

But anyway, director of nurses told us on the first day, "now girls look to your right. And look to your left. Because three years from now one of you will not be here. Because you will have become compromised. We will love you. And we will love your child, but we will help you pack."

> *I think that nurses are dumped out and they're... in an environment [where] everybody is so busy, so they don't feel like they have anyone that they can go to.*

ND: Do you have a little bit extra information in your story about how the steps they made you go through to enter the nursing field? You said something about a test that you had to take?

PT: Oh, yeah, we had to pass an IQ test. If you didn't pass the IQ test, you didn't even get an interview.

ND: So it was a three year program. And did you hit the floor in your whites the very first day? Can you kind of describe what that was like?

PT: Well, we hit the floor with our uniforms and we were there for report. Oh, before we left the dorm, though, we had a lady that was over the laundry that measured your hemline.

ND: What was the relationship like between nurses and doctors?

PT: If a doctor came up you, you stood up and you made sure he had everything that he needed, and you were as unobtrusive as can be. I do want to tell you a story about the first hospital that I worked after graduation,

I worked in a 35 bed medical hospital. And it was staffed on the night shift with one nurse, which was me, and an aide who was 70. And we had to give bed baths to all the patients at night. So if they rang the bell, no matter what they wanted, if it was a bedpan, they got the bedpan on a bath. If they wanted a pain pill, they got a pain pill on a bath, whatever they needed, they got a bath. And then we had to do the laundry. But I had this patient and I won't say her name, but we'll say that it was MW. Okay, and we had little bales that you tapped. You didn't have coal lights back when she had tapped her bell and I'd go in and I'd say "Yes, ma'am. What can I do?" , "Well I want something for pain and I want something to make me shit too."

ND: And the nurse in me goes, "Well, the pain medicine is probably the reason why she can't." That is hilarious. So,I am absolutely falling in love with this next generation that's following me. They're in their 20s really kind of just starting out, and they're reporting to me that they're burning out in two years. And so they're putting themselves through nursing school, and nursing school is the most agonizing thing to get through, because they pack everything that you need to know in that short timeframe. And they're burning out in two years. I mean, what is the good, bad and ugly of nursing?

PT: I talked to a nurse the other day, and she said she actually burned out in nursing school. She graduated, and she managed to work 18 months before she just had to quit.

I talked to another nurse, and he just had no idea of the liability attached to nursing.

He lasted 12 months. But part of that I think they need to back up a little bit in the School of Nursing. And what I have found even as early as the 1900s, when I was happening with education and a hospital, I set up a preceptor program for every brand new graduate, because like, they got out, they knew theory, but they didn't know how to do anything. And they all say that nurses eat their young. Well, that's true, because the nurses on the floor are so stressed out with the jobs they have to do and the responsibilities put on them by management that has no comprehension of what the stress they're under. And then they are expected to precept and teach a new person how to do their job. And so they do a halfway job, they get more stress. And so they're not nice and that person gets burned out. And they both burn each other out if you know what I mean.

PT: Not the science, they had the science of nursing, they just don't have the art of nursing. They're not taught how to do art to organize their work so that they can be more efficient at it.

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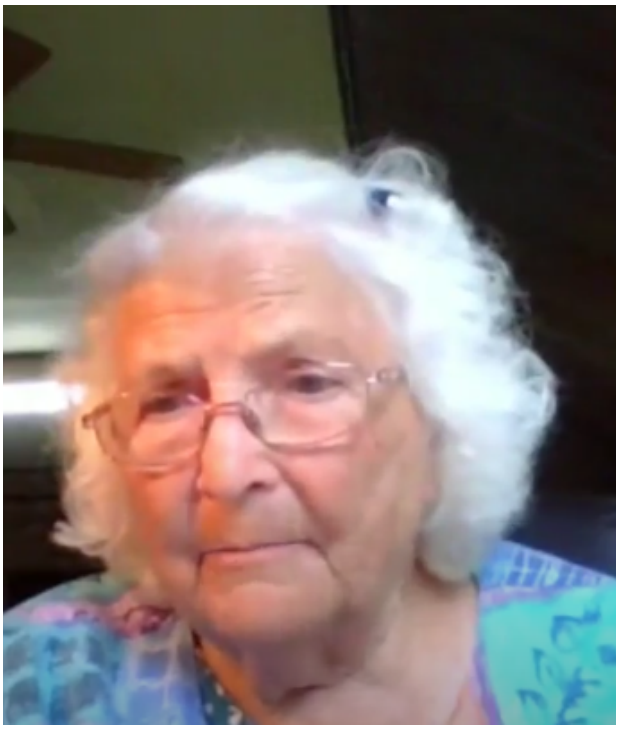

And I think schools of nursing does them a disservice. One is they don't teach them the art of nursing. And they also don't teach them the reality of nursing. They get them out there and the poor kids have never worked a full shift. They've never been completely responsible for patients. They don't know about how the evening shift works. And the night shift works and the weekend works. And so they have no concept of the reality of what they're getting into. And employers are expecting them to be able to go and do.

ND: And the whole dynamic of the hospital system has changed so much. I was thinking also our with our classes that we took in nursing school that we didn't really need to take, you know, there's something we can carve out of the theory and the philosophy things.

And I don't know the answer to that. I mean, I really don't, but we need more clinical time for the new ones. They need to understand what you're idealistically taught is not the real world. This is one of the reasons why I'm actually doing this for NurseDeck. That I feel sorry, so sorry for them.

I just can't imagine. It's like they're being thrown to the wolves.

PT: I can remember, a couple of years ago, we didn't have a pump on this patient and they wanted so many drops per minute, over cc's per minute. And I said, "Well just count the drops." "What do you mean counting the drops?" I said, "every drip has X number of drops per CC, right? So you keep the drops and you regulate it to get the amount of cc's you want to give in an hour." And they have never heard of that. I said "Okay. Just go get a Dial-a-flow." "What's a Dial-a-flow?"

ND: Yeah, I know, we can sit here and laugh. But I mean, I remember. Right? I remember when they were throwing patients out of the ICU faster, and bringing them to the telemetry floor, and we would have butamine and dopamine drips going. It's just the safety concerns. One of my favorite things I started saying about 20 years or so ago was the very last place you want to be when you're sick, is in the hospital. Right?

So let's talk about patient safety. That has probably I think that's probably one of the biggest burnout, the cause of burnout, because we are here to care for and protect our patients. It's that kind of job. And when we can't, that just compounds our stress. We could talk about that for 100 years.

PT: You know, I think that nurses, they're dumped out and they're not in an environment that is canned and everybody is so busy, so they don't feel like they have anyone that they can go to.

And what I see as supervisors are in an office somewhere, are animating with upper management instead of being on their units, helping these people out.

And have forgotten that that is their role. And that's part of it.

And the other thing is you got to listen to these people, you got to listen to the patient. You got to listen toyour staff. Because the way people communicate things vary so much between ethnic groups and educational levels and that kind of thing. I've always been taught you try to communicate on a sixth grade level, the most most everybody can understand the sixth grade level. So you try to keep it as simple as you can, so that everybody understands.

I can tell you I had a patient one time in Home Health when I was working infection control. And I needed to give Amphotericin B to a patient in this city. And I needed to give an IV antibiotic to a patient 35 miles away, nurse friend of mine, and she met me at the Kroger parking lot. I taught her the use of a Hebrew needle to access support, taught her about the Amphotericin B and the side effects and how it had to be administered. And then how to use the pump. After one hour of instruction, she was able to go and do that successfully.

But she again was a diploma graduate just like I was so she had a good basis for this. Your idea of slowing the educational process down and including clinicals is better, and that's going to help patient outcomes. The other thing I see is nurses have forgotten that they are on the patient's side, they are the patient's advocate.

And when they get an order that they don't understand they have the right and actually are mandated to question that physician. And I don't care if he says "Just do it."

You don't do it until you are satisfied that that is the safest thing for that patient.

> *They're dumped out and they're not in an environment that is canned and everybody is so busy, so they don't feel like they have anyone that they can go to.*

ND: What advice that you would give a nurse starting out in COVID-19? During the pandemic, I would say "Just hold on, this isn't reality. We're gonna get through this together." So tell me, what kind of advice would you give this poor person?

PT: Well, I'm going to remind them that they are the liaison between the patient, the family, the physician, other staff workers, and if they have any questions, they should communicate them with you. And you need to be open, listening attentively to that patient. This is the worst thing that could ever happen to patients and families. They're estranged from each other when they need each other the most. So you have to be the person that is the go between.

I had a patient last year that I came on, I work six to midnight, the night shift. And she would call every day on the day shift and nobody would tell her anything. So she would call 30 minutes after I got on duty and I would say "okay, everything's okay you call me tonight at 11:30 and then we will have time to discuss everything. Because right now I need to go make patient rounds. I will make patient rounds, but I want you to know, everything's fine." And we will talk tonight. So every night she called me at 11:30. And she called me at 4:30 in the morning

to get an update before I went on off. And we did that for about five weeks. And he got better. And actually, what was going on with this patient, is the doctor had ordered a medication discontinued, but when the hospital sent the transfer discharge orders, they left the medication on it. So it took us about a week and a half to figure out what was going on. And he was having an adverse reaction to that medication and was basically semi comatose.

ND: Right, the accountability, you know in the current infrastructure where everything is in the cell, you know, the respiratory therapist comes in and takes care of the vent, and they leave, the phlebotomist comes in and draws the blood and they leave... this segmented system in which these nurses are working. And you probably have experienced this- to where you have five primary treating physicians on a client. I'm sorry, that's 1980s term, for the patient. And they're disagreeing with the orders, and they cross through them and scratch it out. And then another one comes in and writes some more, and you're just like, "Timeout here, fellas, we need a powwow, we need to figure out what's in the best interest of this patient, because this is insanity. Something is gonna fall through the cracks."

So how do we get that accountability component built back into what we're doing?PT: I think it unfortunately falls back on the nurse. And I had a doctor come in and write orders. And I would read the order. And I said, this is not what he told me he wanted. And I would call him and I would read it to him. And he said, "yeah, that's what I want". I said, "No. So this is not what you verbally told me you wanted." "Yeah, that's exactly what, can I just this call the next doctor up."

And I said, "I want you to read me this order. And tell me what it says to you." And he read it. And he told me what I said, well, that's not what he told me he wanted verbally. I said he needs to learn how to write an order. That's clear in what he wants. So he just took this guy aside and talked to him.

A couple of years later, this guy was actually in charge of my brother when he had cancer. And did a great job. But he had learned how to write orders. Because a nurse was willing to stand up and say, "Hey, right, this is not clear, and it's gonna create bad situations for patients." Nurses have to do that, it's part of our responsibility. And that's part of our patient safety. Right? Because if you go with that case, it would go to court. And they'd ask you, "why did you do that? When he had already told you that wasn't what he wanted?" And it produced outcomes. So you have to for your own liability, as well as patient safety.

ND: I absolutely just loved our conversation. Thank you so much, Pat.

PT: Thank you. Take Care.

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