**Behavioral Questions**

1) I made a mistake in the clinical setting; however, I did not know I had made a mistake. I did not directly manage it, but I did what I thought was right. During my medical-surgical clinical rotations, I was working under a regular staff nurse. The nurse mentioned that a client in her room complained that her intravenous line (IV) was irritating her. Earlier, we had assessed the IV site and saw no infiltration or redness. The IV line also flushed well, showing it was still patent. However, the nurse said it still should be changed. I said to the nurse that I would insert a new IV line. The nurse gathered all of the equipment and placed it on the counter. By the time I entered the client's room, the nurse had left and gone someplace else. The client was a retired nurse. She was cognizant of me being a student nurse, as we had established a good rapport. I looked in the hallway for the nurse to return, but she had not returned after several minutes. Regretfully, I took the equipment to the client and told her that I would establish a new IV line in one of her upper extremities. After cleaning my hands, I looked for a site. After finding one, I inserted the IV with its saline lock. The staff nurse entered the room where the client said that the student nurse performed well. The staff nurse did not say anything to me; however, I thought everything was sufficient. The client received a new line and was satisfied. As I gathered miscellaneous things and exited, the overhead pager was requesting for the house nurse supervisor. I mentioned to another student nurse something must have happened. Fast-forward to our student conference. Our clinical instructor released everyone except me. I was puzzled. After my clinical instructor criticized me constructively, I was nervous about the possible consequences. I was the one "in trouble." As my clinical instructor re-read my duties, apparently, but not purposely, I had forgotten its stipulations. I indirectly managed this incident by first apologizing to my clinical instructor. Second, I asked my clinical instructor to accompany me to the staff nurse to apologize to her and explain I was not trying to supersede her authority. Thirdly, we then went to the client and explained to her about my incorrect behavior. She reiterated to my clinical instructor that I had done an outstanding job, but she did understand. I managed this situation indirectly by apologizing to the parties involved and honing my mistake. This incident was a lesson that I have remembered because another incident needing supervision came up another time, but I did not make that mistake twice.

2) Working above and beyond is a phrase where different people have different definitions. While working as a paramedic, my partner and I prepared to transport a young adult to the hospital. He had just had a seizure in his house before our arrival. After rendering advanced life care, I decided to bathe the client who had passed stool in his underpants. He could not do it himself, for he was still groggy. His wife was initially too upset as she watched her husband have another seizure. I, therefore, took the client into the bathroom as his wife stood less nervously nearby. My partner gave me a soapy, warm, wet towel for me to wipe and clean the client's buttock. At that moment, a fire department Inspector General entered the residence and saw what we were doing. He and the client's wife began discussing what this crew was doing was above and beyond what was expected from paramedics. She was thankful that her husband did not have to go to the hospital in an undignified way. The Inspector General was grateful to have an

excellent crew under his watch. I explained that the little time to clean him makes him feel better and have the nurses less work to do at the hospital. I did not interpret this as above and beyond, but I know many others would not have done it. I did it as I hoped someone would assist me in my moment of illness.

3) I would take the last set of vital signs before calling the provider. As I have noticed my client's level of consciousness decrease along with ominous vital signs, I would have an SBAR with the client's provider. After the provider does not give any new orders, I would ask the provider if something needs to be done to correct the client's state of matter. I would explain that the client was not like this the last couple of days. If the provider still says no, I ask why not implement a corrective measure. If the provider does not hint that something is wrong, I initially would demand that the provider come to the client's room. Assuming the provider will not come to the room, similar to not giving new orders, I would address my concerns to my charge nurse. I would explain that the client is circling the drain, i.e., the client is deteriorating. Hopefully, my charge nurse will see my point of view and use some supervisory authority to assist my client. Lastly, I would document this in an incident case report and submit it through the proper channel. I recognized a failure. I relayed the information. Sadly, the provider did not remedy the situation. These are the three Rs in failure to rescue as written by Burke et al. (2022), which I shall further read because this is an actual situation for a nurse to have. Knowing the proper procedure will help my client.