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This week's clinical experience provided a taste of the challenges and rewards of being a nurse in the real world. I was grateful to be forgiven despite being late for clinics twice. I learned valuable lessons from my assigned nurse, who was short-staffed and had to manage six patients and a few with ventilation. Witnessing her dedication to patient safety and effective communication with medical workers, patients, and their families was awe-inspiring. Although my cultural background initially made me uneasy about the lack of boundary between the nurse and patient, seeing the patients smile in response to her care made me realize the importance of bonding with patients. I was assigned to care for a trisomy 1 patient treated for ARD due to viral pneumonia. Due to the patient being translocated only three days ago, the nurse did not have enough information on this patient. The patient was stable, and her family was eager for her discharge, but she still had a tracheostomy. The patient developed a stage 2 sacrum wound during a month of ventilation in a previous hospital and a wound under the tracheostomy dressing. Due to her prolonged hospitalization and ARD, the patient's ADL decreased, which created the care team’s goal of care decannulation and recovery of ADL from PT. The family and the nurse discussed the patient's diet being changed from a thin liquid between-meal to a thick liquid between-meal diet in this hospital. During the post-conference, my instructor taught me a clear rationale for this: the patient had a history of pneumonia caused by ASD, and the speech therapist had evaluated that she was at risk of aspiration due to swallowing food too fast

without chewing enough, which could lead to second pneumonia by aspiration. This gave me a better understanding of the family and nurse's discussion and the misunderstanding of the order.

My greatest challenge was witnessing a nonverbal pediatric patient undergoing an LVAD driveline dressing change. The procedure required four people to hold her extremities while she cried. It was heartbreaking to see a child rely on the LVAD machine to survive. In terms of personal and professional growth, I improved my SBAR report preparation. I performed technical skills such as taking vital signs and performing straight catheterization independently. Due to my rushing, I did not prepare enough before wearing sterile gloves. Luckily, the nurse was by my side helping me open catheterization tools. I communicated with clients, family members, staff, faculty, and other students, but I recognized the need to be more active in questioning the nurse in the future. I also should not be rushed or hurried in performing sterile techniques and not be late for the clinic.

“Not only so, but we ourselves, who have the firstfruits of the Spirit, groan inwardly as we wait eagerly for our adoption to sonship, the redemption of our bodies. For in this hope we were saved. But hope that is seen is no hope at all. Who hopes for what they already have? But if we hope for what we do not yet have, we wait for it patiently. (Rom 8:23-25)”

We are eager for a world without pain, but all we can do is hope and wait for salvation. Even though it is heartbreaking to see ill pediatric patients, all I can do is put myself down, pray for Father’s endless love, and wait for his healing hands. With this hope, I can care for sick people who need help with love.