Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Welcome to Nightintales. This podcast was created during the International Year of the nurse and nurse midwife. And what a year that was. This podcast is dedicated to telling stories of nurses from across our profession. Our goal is to introduce you to the seemingly infinite possibilities in nursing and encourage you to find your true passion within this work. I'm your host, Jessica Spruit and I'm so glad you're here. Thank you for joining us for another episode of Nightintales. I'm glad that you guys are back and listening to this episode and I'm glad to welcome our guest today, Renee Dittmar. Renee is an RN House Supervisor at Ascension St. Mary's and she's going to talk to us today about her role as a house supervisor and the journey that led her there.

And I actually am really grateful to Renee for joining us today. And I'm grateful because actually a listener of this podcast and a former classmate of mine suggested that Renee's perspective would be really helpful to listeners, and thought that this was something that we should really highlight. And so, I'm grateful for the opportunity to do that. So Renee, thank you, and welcome to Nightintales.

Renee Dittmar:

Thank you. I'm so happy to be here talking with you and I'm really privileged that you invited me to your program.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Well, happy to have you. I think that the role of RN house supervisor is not one that I've ever done. So I'm really looking forward to learning from you about what this role looks and what this means and helping our listeners understand whether they are working with an RN house supervisor or considering becoming one themselves, what that might look like. So, if you don't mind Renee, let's just start as we always do on this podcast with telling me a little bit please about how you entered nursing and kind of what that first job was like for you.

Renee Dittmar:

Absolutely, I knew when I was in high school that I wanted to be a nurse only because I had been hospitalized as a child twice. The first time I'm aging myself but it was in the early 80s when I had the chickenpox and that was before they advise parents not to give aspirin. So, I was hospitalized with possible rice syndrome. And the nurse who took care of me her name was Barb and I remembered that because my mom's name is Barb. And then three years later I ended up hospitalized again with viral meningitis. So, Barb was the nurse who took care of me the second time. So I had a very young introduction to nursing as far as no one in my family was a nurse but I remembered this particular nurse who took care of me two times in my childhood. And so then I would say I've always been very lucky. Things have always just worked out for me.

I knew I wanted to be a nurse but at that time without the guidance of anyone who could explain to me that I really wanted to pursue a bachelor's degree. I had the opportunity to compete in a competition for a scholarship at Eastern Michigan University. And I won the scholarship and that was a bachelor's prepared program. So thankfully, that's how I ended up, I didn't have to go back to obtain the bachelor's degree which I'm very grateful for. So, but going through nursing school I knew this is what I wanted to do. But in my clinical experiences I was getting really nervous. I would go through each clinical experience and think oh my gosh, did I make a mistake, I didn't enjoy that. I didn't really care for working when we worked in a nursing home. I didn't really like cardiac, I hated the ER.

Only because I was overwhelmed with I have never been someone who can look at people when they are dressed in their normal clothes. That they came in, they got ready for work in the morning or they were going wherever they were going and now their life is completely changed. I couldn't separate myself from that. I hated OB, I hated PEDs. I didn't hate the kids I hated the parents. And so I was thinking oh my gosh, I've made the worst mistake in my life I don't like anything, I'm not going to be a good nurse. But then I had the opportunity to do a clinical in a traumatic brain injury rehab unit at St. Joe's in Ann Arbor. And there I took care of a bunch of different brain injured patients. But I had a patient who was actually an RN and she was 36 at the time and I think I was 19.

And she had been in a nursing conference and she was drinking afterwards and fell off the balcony of her hotel and had this traumatic brain injury. And when I met her in the beginning she had had her trach and she was relearning how to walk and how to communicate and she had an eight year old daughter. And I absolutely loved seeing the progress that she made and I knew that brain injuries were where I wanted to be. And just a side note if I could go back in time I'd like to kick my own butt, because as an 18 year old I thought she's 36 years old she's old enough to know better, what was she doing drinking at a conference? Although now I'm like I totally get it, I know what she was up to as a nurse. But that led me into my career path.

I had applied for an externship position at St. Mary's which was like an intern, a nurse intern. Originally when I left and went to Eastern Michigan in Ypsilanti. My idea was I was never going to come back to Saginaw, Michigan, because you'd never see me again. But my boyfriend at the time lived here and went to school here at [inaudible 00:05:35]. And then we ended up getting married and we're still married so it's been like 24 years. And I moved back home. So, I took this position at Ascension St. Mary's in their neuro step down unit because that was what I was interested in. And I had always told myself that when I got tired of neuro, when it was no longer interesting to me, I would do something different. I was lucky to come in at a time where I can remember patients would come in having strokes and we would just sort of like sit and watch.

Not really necessarily do nothing but our interventions were so minimal that I remember telling families well, we have to wait 48 to 72 hours to see what deficits we're going to be left with and then we'll talk about rehab. And the neurosurgeon there ran our units, our intensive care unit and [inaudible 00:06:29] unit is huge into research. He founded the Field Neurosciences Institute, his name is Dr. Malcolm Field. So Field is his last name, it's his research. And he did a lot of research in stroke, glioblastoma, Huntington's disease. So, he brought the idea of using urokinase as a clot buster before everyone was into using alteplase or tPA as we call it. So, I remember being part of the group where we were just starting to use the urokinase to try to treat these strokes. And it was just fascinating, it just improved, improved. So fast forward, so I was a floor nurse, I loved it. I loved being a nurse, I love taking care of people.

Some of my favorite memories were even working holidays, like I love being there for patients who are stuck in the hospital with these horrible things that happen to them on the holiday to try and make them feel better. But as time went by, I started having children and my husband had lost his job during one of the recessions like in the early 2000s. And so he had to take a position that required him to work second and third shift. And it's hard to find daycare providers who want to keep your kids 12, 13, 14 hours. So, I said to my boss I was like, "I really feel bad, I'm probably going to have to leave you, I'm probably going to have to go to case management. I need more of a Monday through Friday job so I had regular daycare hours." And she said, "No, please stay, we're just starting a new position it's called a Nurse Coordinator. And it's sort of like the old Assistant Nurse Manager role and you'd be perfect for it, I'd love to have you and you'd work 6:30 to 2:00 Monday through Friday."

So, I had no desire to be a leader or do any leadership roles. But because I wanted to be a good mother to my children and be good to my family, I accepted this position. So, I worked in that position telling myself secretly, I'm not going to have to work every single day for the rest of my life because I liked working three twelves a week it was the dream. I didn't have to worry about when I'm going to make my hair appointment or go to the doctor because I always had days off during the week. I didn't have to grocery shop on the weekends with the common folks when the stores are busy and crowded. So, but I found that I think I was good at what I was doing. So when my boss ended up being promoted to the director level at the time, I just naturally had been her succession plan into her position as the manager. So I did that for gosh, it was probably eight or nine years. And it was really an interesting transition to go from being a peer to your group of workers, to being their leader, their boss.

And it was a challenge, to be a good leader you have to separate yourself from your friendships in certain ways. And that was hard and I've matured a lot over the years and perfected it. But I had reached a point where I thought I had hit the wall in that position and I'd been with the same organization for 20 years. Gosh, it seems like such a long time to say but on my 20 year anniversary, I decided to go see if the grass was greener in a different facility. So, I went to our one of our sister hospitals which was newer and prettier and looked so much better and decided, I took the same position as Manager of Neuro trauma ICU and there was a progressive care unit as well. So, it was just a lateral move, but it was a change of scenery and a change of opportunity. And I was happy doing it. But what I thought would happen is, I think I expected to change myself.

So, one thing I've learned as a nurse manager, there's a couple kinds of managers. There's a manager who really nurtures their staff and pours their whole heart into the job and is available 24/7 as the position requires, but then also doesn't set boundaries. And I never set any boundaries. So I would get calls 24/7, I would get calls like it 1:00 am from a nurse who said, "I'm on the schedule for Christmas and it's not my holiday to work."

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Oh, no.

Renee Dittmar:

So, my intent was at the new place I was going to set boundaries and not like be as involved, I was going to say. Okay, this is work you are people that I'm working with, but this is my home time and this is separate. But then I found out, you know what, it's not the job, it's the person, it's me. I can't do that. I'm too close to people, I want to be available, I'm 110% in no matter what I'm doing. Well, my old boss called me and said, "Hey, would you consider coming back to St. Mary's, we have this position that we're bringing back, it's the RN house supervisor. We need someone who can really help us work with throughput of the patients flowing through the system, like reducing the length of time spent in the ER to the floor. Helping with patient experience, working with the staff, it's going to be 12 hour shift three days a week, would you at all be interested?"

So at that time I was like, heck yeah, my kids are older, my daughter can drive, I don't have to run everybody around. I don't need babysitters, I can go back to grocery shopping on a Thursday if I want. So, I took the plunge and came back. So, the RN house supervisor, one of the top priorities of this position has to do with allocating staff through the hospitals. So, most nurses who work in the floors in the intensive care units in the ERs in the hospitals probably hate their house supervisor because we're the ones who decide if you're getting pulled or floated to a different unit. But the important thing it was, they wanted someone who had a business mind and understanding of HPPDs and productive hours and non-productive hours and census levels to be able to provide the appropriate amount of staffing so that we were still within budget but providing a safe level of care.

And since I had the management background, I knew how to run a budget and I understood all of that. So, the goal that Ascension St. Mary's was trying to do was to get managers into that house supervisory position so that the decisions would be made fiscally responsible. So, that brought me back and the role has evolved due to the pandemic. So, I'm trying to think I came back in 2018. So from 2018 to 2019 we were just living our best lives. And then COVID came. And I like to look back and think like gosh, when we thought we were so short handed or stressed out or so I had no idea what was coming.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

I do not envy you trying to allocate stuff versus nowadays. I mean, sadly, we are in an almost unrecognizable profession in some ways.

Renee Dittmar:

I think like I've told people and I'm sure you are aware of this with your education and teaching experience, but back in like, I graduated from nursing school in 1996. And so back then, like '94, '95, our professors were telling us, 2025 is going to be the perfect storm, the baby boomers are going to retire. We don't have enough new nurses coming in. We don't have enough educators to get the numbers in. We don't have enough people to be able to offer clinical experiences and we're going to have this huge nursing shortage. So, I'm saying and it happened in 2020 because the pandemic hit and I know so many people who retired early just to avoid being there. I'm sure you've experienced or witnessed that same trend.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yes.

Renee Dittmar:

And then it's funny to talk to lay people like my parents who think, well, why can't you just get more nursing students? And I mean, why do they only accept X amount of nursing students? So hard to get into nursing school. And I said, well, if you have a floor that works with six RNs on a daily basis and you have two an orientation and four students, then you're stacking if you get more students. I mean, it's really limited what you can provide for education. So, but that's pretty much, so that's my story. That's a really long story to tell you how I got to today but I can tell you all my day to day work story.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yes, I'm eager to hear about like day to day, what an RN house supervisor looks like both now and the pandemic and hopefully, what you did before so that we can also understand what it might look like eventually quickly again. But I'm curious Renee, when you were sharing, that the initial kind of alternative to TPA that you guys were utilizing at the time. If you don't mind, tell me for a minute about what it's like being a nurse who is starting with a medicine that is not well understood, with a therapy that people, it's not a familiar intervention. We know now in hindsight, right? Like that was brilliant, right? It has changed the outcomes of people who experienced stroke. But at that time as a nurse who is doing something that's so cutting edge and so experimental, I imagine it was also maybe a little bit intimidating. What did that feel like to you?

Renee Dittmar:

Oh, it was so scary. Because with neuro, when you're doing a neuro assessment, the changes are so subtle and you're not looking at an EKG monitor that can tell you like this rhythm has changed. It's all based on your subjective assessment of a patient. Like, is he more awake or is he less awake than he was? In that subtle that lethargy is huge in a patient. It's not always everyone thinks, oh, I got to check their pupils. Usually if you've noticed their pupils have changed, you've missed a few things along the way. And the saving grace was that Dr. Field was so, he is I shouldn't say was because he's 93 years old now. But he is such a proponent of nursing education, that he was available for us at all times. And I'm so aging myself. When we would get CAT scans back then, like you'd run a patient down for CAT scan. And the film was actually, like this big huge rectangle like a negative, with the head scans and it'd be like 20 different films and we put them up on this bright box.

And I would specifically remember one night, and this is bad practice. So please, any nursing students listening or young nurses don't do this. But Dr. Field had expectations for us. Let's say they were like pretend they were order sets because everything was handwritten so nothing is in the computer. So let's pretend we just had like an algorithm order set. So, I knew like if my patient had increased lethargy, maybe a little bit more weakness or his speech was a little bit more slurred. Before I call Dr. Fields and woke him up because I was on night shift at the time, before I called and woke him up, I have better already have like ran down and got a CAT scan. Like he expected us. You treat fevers with Tylenol, you get a CAT scan if X, Y and Z is happening, you get an EKG if this is happening. So anyways, I ran down, I was down in the CTE room and I was looking at the machine while the CAT scan was going.

And you could see just this patient had a huge bleed and with a shift of the midline. And I remember calling doctor Field and I was so scared and said, "Dr. Field, this is Renee, I'm taking care of so and so and I am down in CTE because he was more lethargic. And so, you know the line?" I couldn't think there. "You know the line that goes down the middle of the brain, well, shift to the right a lot. He was there in the building like at 4:00 a.m. before I even got the patient back up to our room and the patient was in surgery. And to me that just shows his trust in how well he educated the nurses that worked in those areas and his dedication to this new idea. So, I think as scary as it was, we were so supported by our physicians. It was like the best collaboration I've ever experienced in my life.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

It sounds like you must have had to have so much trust in that relationship with the different colleagues. But also I imagine you had to really learn to trust yourself when doing either neuro exam is one of the toughest of the nursing exams. Like you said, each individual may assess something a little bit differently. I imagine you really had to learn to trust yourself too.

Renee Dittmar:

And the most wonderful thing that I had at that time too is that the nurses who worked in those areas, we had so many with experience that I never felt ashamed to ask someone, "Will you double check my assessment? Can you tell, this is what I think I'm seeing, what do you see?" So, I always had someone to validate what I thought I was seeing and to coach me if I wasn't reading it appropriately, or assessing it appropriately. But I think that what was scary also and it's the same now I know because I see it. But I remember a time where there was a night shift where it was me and a friend of mine named Tracy, and then another nurse, Tina, and we were all so new. And we were alone that night with all those patients, and we were so scared. But there's always someone we could reach out to at that time like in a different unit, someone who was willing.

So, I just always, I can't say enough to nurses like please just remember, take care of your new people. Because sometime they're going to have to take care of their new people and you need to model that behavior.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Oh, that's so true. That really resonates with me. And I know that you did model that behavior because I know that the person who recommended you for this podcast as someone that you took care of when she was new. So, I appreciate that. And I feel like she's paying it forward by taking care of people by sharing your story. I appreciate that. I love hearing stories of nurses watching the evolution of health care and the therapies that we deliver the way that we are able to treat patients and family [inaudible 00:22:00] for sharing that. Now, if you don't mind Renee, if we could talk a little bit about what it means to be the RN house supervisor. What's your day to day or maybe week to week looks like?

Renee Dittmar:

Okay, so day to day, I will talk about it as though we're not in a pandemic first just so it sound, this is what you would get into. On a day to day the RN house supervisors provide 24/7 coverage to the organization. So, we are the people that you get a hold of when your manager isn't there to try to solve problems in the absence of everyone else. So, I'll start from beginning. So whoever was working the night shift because I work the day shift last 7:00 A.M. to 7:00 P.M. I'll get a rundown of the night shift and we keep a close eye on all of our ICU patients. So, at any given time in that hospital, I could tell you probably every single patient who's in an ICU. Now granted our hospital is a 238 bed hospital so it's not huge. But we have four ICUs. So it's quite a few patients, but we keep track of the acuity whether they are ventilated or not ventilated. What special equipment they might need, what special procedures may need to be done that day or night.

If there's any like if they're going to have any CT scans or MRIs or any procedures that would take one of the RNs, the ICU RNs off of the unit. We try to provide support so that we can anticipate what unit is going to need more help at a certain time of day or night. So our handoff goes like that. So we talk high level about the patients in the units, the patients on the floors, we talk about any patient that may be at high risk for a poor outcome. Patients on a floor that maybe let's say the nurses have alerted us to a big change in lab values or just a status change that might require a higher level of care potential poor outcome. We keep an eye on that. And we had rapid response nursing coverage 24/7 in the past. So that's our nurse, there's different names for it. Some hospitals call swat nurses, some call cadre nurses, some we call them rapid response.

But those are the nurses that you call when you want someone to take a second set of eyes on your patient and guide you through an emergent situation. But in the absence of a rapid response nurse, the RN house supervisor acts in their role also where usually you need some years of clinical experience behind you to be an RN supervisor, just so that you have the ability to critically think and to help advise nurses on what the next step should be for their patients. And we talk a lot about visitors and families if there's any special situations. Because we focus a lot on patient and family experience. Well, end provider experience as well. So if we've had someone who maybe this family is making end of life decisions and we need to make a different accommodation for their visiting, we will keep track of that.

If we've had a family that came in where there's visiting restrictions or issues, we're in charge of that. So, then we discuss the staffing matrix. So, every unit has a grid I'll call it that if you have X amount of patients, you get X amount of RNs and X amount of nursing assistants or patient care technicians. So, we're the ones who have to decide how to allocate the resources based on what's available. So, again like I said, the unfavorable people who decide that you know what? The orthopedic floor, their acuity level is a little lower than the medical oncology unit, oncology is down a nurse, we're going to pull from ortho to oncology because this is why, or which ICU is going to be shortage a nurse. Lately, we've had a huge shortage also of assistive personnel like the nursing assistants, patient care technicians.

So a lot of times we'll have to decide which unit is going to be down that particular service. So, once we have all those decisions made and relay it kind of go about the day. So, we run a meeting in the morning and we call it our bed huddle or our manager huddle. And so the nursing floor is they do their unit huddles and pass along information. So, that's our huddle is with managers. And sometimes the directors to just discuss what the hospital looks like. Like, we have this many surgeries planned today for ortho, we have this many surgeries planned for general surgery. We have three craniotomies, two open hearts. And these are where beds are needed, this is where our staff is. These are the procedures that may be done today that may not end up outpatient may need to be admitted. And we just kind of make a tentative plan for how the day is going to flow.

We look at the ER, what's in the ER right now, what potential there may be. And then the expectation is just to work through the day making sure everything happens as smoothly as possible with the least amount of hiccups.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

It's easier said than done, I'm sure.

Renee Dittmar:

Yeah, it sounds so easy. And then we spend a lot of time rounding on the unit. So I love this job because as a nurse on the unit I knew the people I worked with, and some of the other people depending on if I mingled. As the manager, I knew my areas really well, really, really well. And then maybe a few other areas if I covered for another nurse manager on their vacation. But as our RN house supervisor, I know everybody, everybody everywhere. And depending on how much of a people person you are, you can know so much. But it really helps you to get to know nurses and their skills and who you can count on and who you can rely on and not that I always want to take advantage of someone that I think is a strong nurse. But there are certain people you know that you can count on or stretch more than what you would maybe want to and I can also tell where there's going to be problem days.

I can look at the schedule in the morning and I always joke around and say like, well, I have to look to see what kind of day I'm going to have. But really it's like, okay, is like okay, so [inaudible 00:28:37] this unit. And that's where I'm going to spend more time helping is in this area or that area. But we're also a sounding board for I believe in providing a safe place for nurses to vent. There's nothing more important than providing that opportunity. You have to have the emotional maturity to know that they're not mad at me, Renee Dittmar. They're upset with whatever situation we're in. But it helps to validate that their feelings are real, that I understand I want to do anything I can help and they aren't a specific target of like any sort of, we took your help because we don't like you. I don't know how to word it otherwise.

But they need to rely on that, they need a safe place because so many times they're just told to oh, come on, come on, you can do this, work through it. So, I like to provide that emotional support to the staff. I feel like I may not be at the bedside providing the care, but if I can help the nursing staff at the bedside bring their best selves forward, then I've done what I need to do for that patient. So, the other thing we do is intervene on concerns that patients or family members may have. If they want to talk to a supervisor then we will go in and I go in and talk to a lot of patients and smooth things over. I'm trying to think if the physicians will call with concerns or issues and they always want to talk to the supervisor. And you have to have a relationship with all of them, with all the physicians, the managers, the directors, the staff so.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Yeah, it's evident to me Renee, that you have such a good grasp on the needs of the whole hospital and what that looks like, rather than just an individual patient or an individual unit. And that we need someone present like you who has that vision, who is able to kind of see it for in its entirety, for all that it's worth. I'm curious because I imagine that people listening would benefit from your wisdom on this. When you have a family that is upset, or has requested to reach out to the supervisor. Are there any things that you would recommend a nurse who maybe first they are speaking with their nurse. If you were kind of advising a newer nurse or a nurse who was struggling with a family who was concerned, do you have any tips or tricks for approaching that that work especially well for you?

Renee Dittmar:

Oh, yeah. The one thing is it's really hard to not become defensive because immediately you're going to feel like, well, what they're complaining about was not me, it was the night shift nurse or the day shift nurse, or they're perceiving it wrong. And if you can just kind of take that deep breath and hear them without responding or being defensive, that's the first step. And then if a new nurse is not able to do that, if you can't separate yourself, call your supervisor right away and kind of rundown the situation. It's a lot, it's so much easier for me if someone calls and says, "Hey, Renee, I got this patient who's really upset. He's saying that I didn't give him his [inaudible 00:32:08] at 2:00 P.M and I did. But he is irate and wants to talk to somebody." Versus "I need you come and talk with the patient right now, he's mad." I really need to know what I'm walking into so I kind of know what approach to take.

Because what I do is before I go into any room, I do a little bit of a chart review to get a feel for what the patient is in for, what their background is, medical history. And I'm not going to bother the nurse asking all the information, because usually their hands are full or they are so busy and now they are already upset because someone is criticizing, critiquing, or like tattling on their work. So I don't want them to feel that I'm undermining anything or thinking that they don't know anything, I just want to get a feel for what I'm going to walk into with this particular patient. And sometimes, it's easier for me, I don't have a team to read the last few days documentation from the physician, the case manager, the other nursing staff, versus that nurse might only know the crucials that she needed to take care of it. This is what they're in for, this is what they've had done, these are their labs, these are their meds and that's about it.

So, the approach I always take though is to validate whatever the patient and family are bringing forward, whatever concern they may have, but also support the nursing staff. So, one thing that I find that I'm good at is I do not allow a family to say I will not let this nurse take care of me. Because once you give that inch, then they think they can pick and choose and that's a disaster for a nursing unit. It's a disaster for the unit's morale, for individuals morale, it's not the right thing to do. If an RN says to me, "I can't take care of this patient anymore." We talk through it and I will support that. But I try really hard, even though the patients have their rights and they have all the authority, there's usually a way to work through it. And I really found that to be helpful. And I think one of the things that got me to that point, I mean, I've always kind of had that philosophy.

But I was very, very affected by one of the cases, I can't remember what year it was, but it was one of the nurses I think she was in one of the Flint hospitals an African-American nurse who the family was refusing to allow her to provide care. And part of what had been reported on the news and I know you have to take everything with a grain of salt that you hear in the media was that her leadership team had said that they didn't want any African-Americans to care for this particular patient. And I just felt morally and ethically opposed to their idea. So, it doesn't matter to me who is taking care of the patient. We are going to work through this. So, I guess for new nurses then all I can think of is just still remain confident in what you've been doing. I don't know any, I haven't met any nurse who wakes up in the morning and thinks I'm going to be the worst nurse I can be today. I'm going to treat everybody like crap and I hope I get picked up for assignment.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Right. I mean, that's the beauty of nursing, right? We show up every day no matter what awaits us. And we serve the people that need us the most and I totally agree. Renee, I really enjoyed listening to this, like I said, I really enjoy hearing about, you know it's kind of reassuring to think that there's someone really looking over kind of the whole hospital. It makes me feel a little bit better when I think about my time as a nurse on the floor and the different experiences. It's just nice to know that there's an additional set of eyes and ears who's aware of different maybe patients that are of greater concern at the time or units that need extra help, or maybe those units who have the more novice team. It just makes me feel better to know that someone's looking at that and looking over them. And I'm sure [inaudible 00:36:19] appreciates that. Is there anything else that you would want us to know or that you'd want to share with listeners as we wrap this up?

Renee Dittmar:

What I would tell everybody and I still do is to remember that I honestly believe you are born into the generation of nurses that you have the special talents and skills to provide the care that is needed at that time. So I look at myself and I'm a Gen X er so I started when we were paper charting and I rolled in a technology. But some of the stuff we're doing now and the new coming in, the ability that they have... I'm sorry. So, the generation who's coming into nursing right now, they know nothing other than technology. So I think back to when Dr. Field who I talked about, we used to, he had a pager but when he was in surgery, we would write a question to him on a piece of paper, fax that to OR, the OR nurse would read it to him, he would either tell her what to write back or they would collect all of these faxes. And when he was in between cases, he would write the answers back and send them back.

Well, the neurosurgeon who works there right now is in his early 40s, there's no way he would be patient enough to collect these faxes and respond. Yeah, he's texting and responding and perfect sir. So, I just think that every generation is ready for the technology and the patient load and the hospital. They are ready to take on and the rest of us need to support them and nurture them and help them grow in the role. And there's nothing worse than saying, "Well, when I was new, we did it like this, or we used to do," Because that's gone. This is what we're doing right now. And so just remember when you're frustrated, you are born directly into the generation of nurse that you're supposed to be in. And there's a specialty for you.

And if you don't like any of them I promise you'll find one eventually. And honestly I've learned over the years that it doesn't even matter if you think you've done nothing. If you've reached one person, you've met all of your goals in life that's just that one person.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

I love the way you said that Renee, I think you're so right. I've never thought about it, about being born right into the generation where you belong of nursing. But I do agree the way we've always done it is certainly never a good reason, right? That's never good enough, never adequate rationale. I agree with you. But you have definitely inspired me and I definitely I hope that all the listeners have a mentor and have someone take them under their wing the way that it sounds like you do. Because I think that that would definitely benefit our profession.

Renee Dittmar:

Find somebody and if you've reached out and you're not finding the right person, go back to some of your nursing professors or instructors, I'm sure they will know somebody to connect you with. Just don't be afraid to ask because there will be someone who'd be willing to mentor.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

That's such a great suggestion. I appreciate your time tonight Renee, thank you for telling us about the role of an RN house supervisor and about the journey that led you there. It was really nice to host you on that entails. Thank you.

Renee Dittmar:

Thank you. Thanks for having me.

Jessica Spruit, DNP, RN, CPNP-AC, CPHON, BMTCN:

Thank you for listening to this episode of Nightintales. As you do we encourage you to consider the unique nature of each person's journey through this profession. The views shared on this podcast are those of an individual, not the academic institution that they graduated from, their employer or the professional organization that they are active in. The stories of their career path and progression are not intended to suggest that there's a uniform approach to achieving similar accomplishments. But to open your mind to all that is available to you. Each journey in nursing is as unique as each individual that we serve. We hope you'll listen again next time.