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.

Welcome to another episode of Nightintales. I'm glad you're all back, and I'm excited to introduce you to our guest. Today we have Keith MacArthur with us. Keith is a pediatric and neonatal critical care registered nurse, and he works currently at the Children's Hospital of Michigan. Keith, welcome to Nightintales, and thanks so much for taking some time to explain your role with us today.

Keith McArthur, BSN, RN, CCRN:

Oh, thanks for having me. I'm I'm happy to be here.

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

Yeah, if you don't mind, I mean, I know your story, but I'd like for us to share it with our listeners today. Tell me a little bit please about how you actually got into nursing and when you came to recognize that nursing was perhaps the profession for you.

Keith McArthur, BSN, RN, CCRN:

Oh sure, I'd love to. Yeah, so I came to nursing as a by way of ... It's a second career for me. I started working at the Children's Hospital of Michigan in 2007. I had recently finished a four-year enlistment in the United States Air Force as a photographer, and that was sort of my career path at that time, was doing photography. When I moved back to Michigan after the Air Force, I came across this job as a medical photographer for the Detroit Medical Center and we were based out of Children's.

I interviewed, it seemed really interesting and started working there in that capacity. And that job's like ... Would be like taking photos of surgeries, pathology specimens. We do a lot of the public relations stuff, portraits. A really cool job in terms of like you see every aspect of the hospital healthcare stuff, and then a lot of just the cute stuff that happens at a children's hospital anyway.

Really interesting. I came there without any sort of formal medical knowledge or anything like that. My background was completely in photography. I did that job for about five or six years, worked for a great guy there. Wonderful boss that was super supportive. I did really like that job, but it was at a time where photography was becoming super easy for people to do right out of their pocket. Photographers started to disappear. We had had like a full crew of photographers at the hospital and sort of, as digital photography and just photography in general evolved, there was just sort of a less need to have us there all the time.

As I started to see some of my coworkers start to disappear from the hospital, I started to think about how to use my GI bill to maybe come back and work at the hospital and do something that, I thought would be like important work to do. I mean, you know when you're at the hospital and someone's coming up to take photos or something weird is going to happen, like usually the nurse is going to be the liaison for that person.

If I show up on a unit and I have to take photos of anything, it could be a dressing change for a burn or something like that. It's always a nurse that I'm dealing with and they were always great to be around and I was really inspired by the work that they did at the Children's Hospital. I knew I wanted to come back and do nursing. Wasn't quite sure how to approach it. As you start to do research, you see that usually the associate's degree seems like the fastest way to get into working in nursing.

But I was quickly talked out of that by a lot of the nurses that I talked to at the hospital and they said, definitely go get your bachelor's degree. That's the way that it's going these days, and so that's what I did. I left my job with the photography department. I was not ready to apply to nursing school actually. I had a bunch of prerequisites to take. I was going to go through Eastern Michigan University. I had a 19 credit in a semester to get all the prerequisites.

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

Oh, wow.

Keith McArthur, BSN, RN, CCRN:

They really tried to talk me out of taking that because your application is scored with a point system based on your grades on some of these prerequisite courses. And they said, this is going to be too heavy of a load and we don't recommend that you do this, but I didn't take their advice. I put all my eggs in that basket and worked really hard. I did four point 19 credit hours in that semester and was able to get in that fall. That was the fall 2013 that I started a traditional BSN program at Eastern Michigan University.

Was there for, I think just four total semesters, because my Gen EDs were basically done at that point and had like a real nice traditional nursing school experience that I really enjoyed. Super stressful and super fun and all that kind of stuff.

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

I was thinking that 19 credit semester really warmed you up for nursing school well.

Keith McArthur, BSN, RN, CCRN:

Oh yeah. Exactly. Yeah, no-

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

That just set the tone for what it would be like the next four semesters.

Keith McArthur, BSN, RN, CCRN:

It did. Yeah. I kind of felt like I knew what I was getting myself into after that. I think, at that time, I always knew I wanted to go back and work at the Children's Hospital in Michigan. I was very intrigued with critical care and I thought maybe emergency nursing would be good for me, maybe ICU nursing. I wasn't quite sure. I got my first job as a student nurse at Harper Hospital's emergency room as a student nurse. At the time, children's wouldn't hire you until you'd done your pediatric clinicals, and so that was sort of my, I guess my second choice, was to do adult emergency.

And spent a couple, I think the first and second semester doing that. That basically talked me out of adult nursing altogether. I recognize that, that's a personal preference, but I knew I wanted to get back to the kids. There was something special about being at children's hospital. I think you'd agree with me that children's hospitals are different than adult hospitals, a totally different vibe, I think.

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

Absolutely. I'm always so grateful that there are people who love children's hospitals and there are people who love to take care of adults as well. I'm always grateful for those colleagues because I think that's hard work. It doesn't have all the perks that we are used to at children's.

Keith McArthur, BSN, RN, CCRN:

Yeah, no, that's true. People will say, oh, I don't know how you take care of sick kids. And I'll be like, well, I don't know how you take care of adults either. Yeah, I think it's a personal preference and I love being around the kids. In the time when I was working in photography, there became a point where I enjoyed being at the hospital working around the kids and around the healthcare workers more than I enjoyed the photography part of it. Yeah, at Harper, that was a good experience. They were really good to me in terms of letting me do things, in terms of procedures and assessments. You put in 40 IVs every day, and that's all great skills.

I do appreciate the time that I had there as a student nurse. Then I did my pediatric clinical at Children's Hospital of Michigan for Southwest, which was sort of their cardiac step-down trach vent kind of unit. That was great. Of course, people knew me around there as a photographer, and I was comfortable in the hospital and I could sort of navigate everything and just let the manager know like, "Hey, can I come work as a nurse extern after this rotation?" And she said, "Yeah, we'll be waiting for you." Shortly after I finished that rotation, I transferred from Harper to children's as an extern in the ICU there. That externship program was really good for me.

At the time, it was a very like one-on-one, you with a preceptor. Your preceptor would basically teach you her job as much as you can legally do as a student or as extern. Super hands-on, super one-to-one. And that just made for just a really smooth transition into the RN role once I was licensed. If you're a student listening to this, I can't recommend enough trying to get into one of those sort of externship programs in an area that you're curious about. And they're usually, at least in my experience, they're usually super flexible with your hours. Even if you're busy or you have other life things going on, you can just getting in there one day a week or something like that, couple days every two weeks, I definitely recommend that.

Being a student extern in the ICU, I knew that was gonna be the place for me. Like I said, transitioned in, went through a four month orientation process in the ICU. I should give a shout out to one of your recent guest, Brad Phillips, who was on your podcast recently. He was my preceptor in the ICU. Great bedside nurse. Learned a lot from him. He, of course, went the academic route, but won't hold that against him.

Then spent the next several years there in the ICU. We had migrated over to this beautiful new critical care tower and was an exciting time to work there. Developed sort of a passion for working with kids with congenital heart defects. I think a lot of those kids are first seen at the ICU level when they're like infants and toddlers. So, I really like that patient population and so I always wanted to sort of work with those patients. One of the other of things about working with those, is that they had a ton of nurse practitioners there that were always in the ICU.

It just makes such a huge difference when you're working at the bedside to have nurse practitioners so accessible to you, where you don't necessarily need to make phone calls and be paging people to try to come in and look at your patient or pick their brain about different things. And you can just poke your head out and they're all right there.

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

That's invaluable when you're working with such a critically ill patient population who can change on you so quickly. Having that resource and building that sense of collaboration is, I think, so important.

Keith McArthur, BSN, RN, CCRN:

Yeah. When you're a newer nurse and you have a resource like that, it just makes it safe to ask questions, safe to say that you don't know certain things. Yeah, I really liked working with those kids, and for that reason especially. Because I think that, at the time, those were the only nurse practitioners directly on the ICU. I did that up until 2020. I was very happy with my time in the ICU. I was really starting to get comfortable working in there, and granted I've only been a nurse now, this is my sixth year as a nurse.

So, still a fairly new nurse. I hadn't moved to transport until just last year and was enjoying myself in the ICU there. Then I was aware of the transport team at children's, which is ... We're called Panda there, which is a pediatric and neonatal dedicated ambulance, and their critical care transport service. They have a reputation as being very experienced, very knowledgeable and skillful, critical care nurses, and it was definitely on my radar.

I can remember seeing the really intimidating laundry list of certifications needed for that job. About that time when I had five or six years of experience, it started to seem like it could be a reality for me in terms of whether or not they'd accept someone with my experience. I sort of lucked out to where a couple people had left the team and they were filling positions in those couple years, because it's not a job that people leave very often and there's not a lot of turnover. It's a great job and people stay there.

I kind of lucked out. I had to interview a couple times for that job. It took me a year and a half between two interviews to get onto the transport team. I was hired in 2020, like in January, right before things started getting really spooky. Had started orientation and was really excited. If you're listening to this and you're not familiar with like how co I was in the children's hospital, things were really slowing down and that things, surgeries are canceled. We're trying to keep kids out of the hospital at all costs.

They actually sent me back to the PICU for a couple months while things were sort of in this unknown period. Then I resumed my orientation on the transport team at the end of that summer, and that's where I've been since. A year and a half on the transport team. This is a really cool job. I can kind of explain how it works. The Panda team at Children's is ... We have two teams, one at children's and one at one of our sort of outpatient emergency room satellite locations in Troy. Each team is two nurses and two EMTs.

Essentially, we are doing interfacility transports, and so that would be from one hospital to an escalation of care at our hospital, and that's for both pediatrics and neonatal patients, which was a challenge for me too, because I had no neonatal experience at the time. You think there's only maybe six months between those two patient populations, but it's just a whole nother world between a premature infant and even a newborn that needs heart surgery.

There's a really good orientation process on the transport team, and it's a combination of nurses that have PICU and NICU experience. There's just a lot of knowledgeable nurses there, and they really get you up to speed there, and it's an environment where you need to be sharp and you need to be ready to learn and adaptable. You do have to learn that patient population. Those kids are scary to take care of at first, but I really do like taking care of the babies, especially.

Like I was saying, so we're doing inter-facility transports for patients. A lot of these patients are coming from emergency rooms. Kids show up in an emergency room in the community, and they maybe need a specialist that could be a trauma surgeon or anything, just intensive care unit. They're scared of sick kids when they come into the ER, and so they call us and then we go out there and give them an assessment.

Sometimes we're there to just pack them up and bring them to Children's so we know what's going on, but sometimes we don't know what's going on, and we're sort of the eyes and ears of our physicians that are in the ICU, in the emergency room. The role, it's sort of an increased, I guess, scope of practice, or maybe not scope, but more responsibilities in that sense. Because we're working independently, we function sort of off a set of like written algorithms that we use in the field, but sometimes they're really broad. It could just be like, you're responsible for your pals card and everything that's included on there.

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

Which if people are listening and they're not pediatric, PALS is pediatric advanced life support. So, something that, as a nurse, Keith, you are responsible for executing, but that's kind of additional training that we get as pediatric nurses or nurses who care for sick pediatric patients.

Keith McArthur, BSN, RN, CCRN:

Yeah. I should maybe talk about some of the spec certifications that we get to be on Panda because it's a lot more than I was expected to have in the PICU. In the PICU, I got a critical care registered nurse certification, in addition on Panda that you're required to have CNPT, which is certified neonatal and pediatric transport nurse certification. Then, most nurses at the hospital will have their BLS, they'll have their pediatric advanced life support. We also do advanced cardiac life support.

We do advanced burn life support, advanced trauma life support. We do neonatal resuscitation program. We do stable, which is a NICU certification. We do cardiac stable as well. So, there's just this laundry list of special certifications that we get working on the transport team. There's a myriad of sort of procedures that we would not normally be doing at the bedside as nurses that we are responsible for as transport nurses. That could be intubations, putting in umbilical venous and artery lines, doing like needle decompressions.

It's a lot to learn. Also, like I said, you're out there by yourself, and so sometimes you are almost always, you're setting up the vent from scratch, whereas, and the ICU, you have a respiratory therapist and they do everything for you. There's tons of equipment that you have to be familiar with, ventilators, all the respiratory modalities. We do neonatal cooling for hypoxic ischemic encephalopathy. We also get trained by our neonatal attending physicians on doing that exam at the bedside.

It's very intense training. We spend a lot of time training just during our downtime. We do competencies monthly. We do tests and quizzes monthly on top of just maintaining our certifications. Because you never know. You never know if you're going to have to walk in and intubate a newborn and put in umbilical lines, or if you're going to be responding to a trauma situation. Sometimes you just ... I'll be sitting at the computer at work and just think of something that like, what could come in right now that I would not be comfortable doing? Then you're out in your equipment room just reminding yourself and just trading in those aspects.

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

I love that you shared that, Keith, because I think that's such a great exercise for yourself. I think that, as any nurse who's uncomfortable with some elements of the care we deliver, which is probably all of us, I love that kind of self-evaluation of, what could come in right now that would feel overwhelming to me? And that you utilize that time, because I imagine that transport has some time where you're really on and it's very high intensity and some time where you're just waiting for that next call and not sure what's coming next, but in the meantime, kind of at a much different pace.

Keith McArthur, BSN, RN, CCRN:

No, that's exactly right. I should have explained this too, is that we work 24 hour shifts. It depends, sometimes you could be running the whole time, but there is opportunity where there is downtime and sort of like, we really stress on how to utilize that downtime in terms of training. We're also a team that basically is completely autonomous in that we maintain all of our own equipment and supplies and we collect a lot of data. We don't have like any ancillary support or anything like that. We are sort of just responsible for doing everything ourselves. Yeah, you got to utilize your downtime to sort of like stay up on all those kind of things.

Because like I said, I might be sitting in the PICU and think like, oh, I don't remember how to like prime the Prismaflex for continuous dialysis or something like that. But it's like, that's probably not gonna happen on your shift, and maybe it's not, but if it does, someone's going to be there to help you where you know that like, if you can't remember the little pieces that you need to set up nitric oxide in a certain weird situation that you might run into in the field, there's no one to help you besides your partner.

Certainly they're like an invaluable resource when it's just two nurses out there in the field. But those things can haunt you. Just like I said, it'll wake you up out of a sleep thinking like, oh my gosh, I can't remember this one thing. That's it. Like you said, we're sort of otherwise at the mercy of the pager. The pager can go off anytime and it can be for anything. We can travel ... So, we're right now, we're a ground service and so we operate out of ambulances. We're currently in the process waist deep in transitioning our Troy base into a flight team that'll be run out of the Flint Bishop International Airport.

That's super exciting to have the rotor wing helicopter capability and just like a whole new set of challenges flying.

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

That's really exciting. And there's so much diversity in this role. When I think of even just caring for, even if it were only heart diseases, which I know it's not, but from a neonate to an 18-year-old, I mean, even just, that is, there's so much diversity in there and so much complexity. But then you think about all of the things that happen to premature infants, all the way through premature neonates, all the way through young adults who would need care at a dedicated pediatric center. I'm curious, Keith, because you mentioned your team as a couple of nurses, and did you say a couple of paramedics? Is that correct?

Keith McArthur, BSN, RN, CCRN:

Oh, we have, like I said, two EMT, or two EMTs, basically EMTs and two nurses. Yeah.

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

Okay. I was imagining, many of us in nursing are used to also having physician colleagues or nurse practitioner or physician assistant colleagues who are able to help guide our interventions. Can you tell me a little bit about the way that you work through those algorithms, communicate back with your provider colleagues as an extension of them truly in the field?

Keith McArthur, BSN, RN, CCRN:

Yeah, so we'll get a call and we have a sort of a basic report on what to expect when we get there. Then we'll also rely on some information from their referral hospitals, whether it's the bedside nurse or the physician that's there. Certainly, if we're showing up to a NICU, let's say to take a kid from one NICU to our NICU that maybe needs interventional cardiology or something, we'll get really good reports from those. But a lot of times, these are kids that came in through an emergency room and there's not a lot of information.

So, we go out there with, maybe just a small amount of information about what's going on. Then we usually, you and your partner will sort of devise a plan and then talk about it on the way there, like what we're thinking, whether we have some sort of like differential in terms of treatment plans, and just what we're thinking or what the flow's going to be when we get there. Of course, that can all change. Sometimes it does, and sometimes it goes according to plan, and we'll get there and we'll assess the patients.

We'll certainly do any treatments that are life threatening or need to be done right away because that happens too, where you just show up and there's resuscitation in progress. But usually, shortly after we've done like a primary assessment, we are on the phone with our physicians back at home, either in the emergency room or in one of the ICUs, and just paint a picture for them and letting them know what's going on and what we think. Like I said, we have a really good relationship with the physicians that we work with and it's very trusting.

They take us for our word and so it's really critical that we do really good assessments when we're there and then sort of really give them all the pertinent information before we put that kid in an ambulance and bump them down the road back to Children's. We do have algorithms that we can work with, and eventually, as you go deeper into them, you will have to call a physician before you're doing certain things without talking to a doctor, whether that could be like a medication or a procedure, or something like that.

Usually, they'll offer us some guidance and give us verbal orders over the phone. Usually, we'll just sort of work out a plan with them in terms of what we're going to do on the way or what we can do before we leave, and then execute that on the way back to our home base,

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

It sounds like a really exciting and equally intimidating job.

Keith McArthur, BSN, RN, CCRN:

Yeah, it's a really scary job for sure. If you're a person that can keep their cool under pressure, it may be your line of work, it's very different within the ICU. I thought it would be closer to what I was doing in the ICU than it actually turns out to be, because the ICU can be chaotic for sure, but I always ... One of the things I appreciate about working in the PICU was that I always felt that you sort of had time to organize chaos or prepare yourself for whatever the worst that could happen to you on your shift. It's different. It's different not having the people resources available to you when you're out in the field.

Even though our referral hospitals are great and they're willing to help, but a lot of times, they're not comfortable with kids and they are looking for you to take care of that kid and get them out of there, and so it's different. On transport, it's you and one other nurse and two EMTs, and that's your team. I think working in small groups like that, that just have to function so precisely together, I think that was one of the hardest challenges of working on transport. It wasn't necessarily that the kids were more sick or anything like that, because in the ICU, you do see the sickest kids.

It's not necessarily the kids. It's the environment and it's working in small teams and really having to be one unit with just four people there. Because transport is, it's austere conditions. Being in the back of an ambulance is not like being in the back of a car. It's rough on the nurses and it's rough on the patients too. Then, of course, you're showing up in the year and a half that I've been on transport. I've been to almost 50 other hospitals. Yeah, it's having to be able to walk into anywhere. Anywhere and then just sort of adapt to that environment you're going to be in some sort of a NICU that you've never been in or an emergency room.

You don't know where I'm anything at, you don't know who your resources is. You don't know who the person is that's bagging your patient at the bedside, or are you my doctor? Are you a respiratory therapist? Yeah, I think those are some of the bigger challenges with transport besides just learning procedures and the training and stuff like that. It's sort of like learning to work independently, and then also learning to collaborate with people you've never met before in, sometimes really scary situations with some really sick kids.

Those have been, I think, some of the more unique challenges of working in transport, have not necessarily been the kids, but the environment for sure.

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

Great. I'm curious, I know we talked at one point and you shared a story of going to an outside hospital to pick up twins that were born at 25 weeks gestation and just the needs of those twins and how critically ill they were at the time that you met them. I'm curious if you have any tips for people, because I think we could apply this to any aspect of nursing, if you have any tips for keeping your cool and staying calm and being really effective, despite feeling really overwhelmed and recognizing that the situation in front of you is a really significant challenge.

Keith McArthur, BSN, RN, CCRN:

Yeah. I mean, I think a lot of that comes down to who you are as a per and generally what your comfort level is as a nurse. But I think generally, I think the first thing to do is to be able to admit to yourself where your boundaries are in your practice. That happens at the bedside in the PICU. It definitely happens in transport, but being able to say like, I need help, is a big deal. I know that's scary for new nurses, especially is that you don't want ... You're always afraid to admit that you don't know what you're doing or that you're not comfortable in a situation because you think it's going to be looked down upon but just yeah, knowing what your boundaries are, knowing what you don't know is always a huge thing.

And then, sort of knowing what your resources are. You walk into a really bad situation and just identify, like I said, identifying everyone that's in the room, and then really just metaphorically, just stopping to take your own pulse. Yeah, just trying to just focus on what you do, know how to do, and then asking for help when you don't know what to do. I think that's pretty good advice. It's hard to give advice because, like I said, you're walking into, usually a life or death situation and it's hard to predict on how you're going to perform under those conditions.

That's the reason that you don't just walk into a transport nurse job and that they want experienced ICU nurses because they're hoping that you've sort of developed those skills along the way, at least at some point. Like I said, I came from the military. I was a photographer in the Air Force, but I think there's a certain amount of discipline instilled in you. You go through basic training and people scream at you all the time and you're expected to just stand there and be professional and be disciplined under those circumstances.

I think that personally helped me and not everyone's going to go enlist in the military before they take on a role in critical care. But certainly, I think, like simulations are really good. I think, no matter what job you work in, I think you should try to take part in the simulations that they offer. Because everyone hates simulations and they think, well, I don't know what to do. I mean, it's not real. Maybe it's not realistic, the situations of having to ask questions about what your vital signs are, but what is real is the stress that you feel in a simulation of just being anxious in that way.

That's sort of like a stress inoculation that comes with doing simulations, I think, is another helpful thing, and just putting yourself in those sort of under comfortable positions. If you're a new nurse and you hear the code button go off or something like that, and you're not sure what to do, I'd say still show up and see what the situation is and just sort of get a feel for it, ask what you can do to help, and maybe start putting yourself in those situations and just getting more comfortable and sort of just yeah, trying to keep your cool when there's a lot going on and a lot to think about.

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

Yeah, I appreciate that. I think that's a lot of good advice. I think that recognizing what you don't know and taking your own pulse, as you described, are really valuable reminders. I think we all find ourselves in those situations that are quite uncomfortable, and that's just part of this profession, and things that we will always grow from, I believe, as well. Keith, I'm curious, you described going, right from your role, which admittedly, you had a nurse externship in critical care, but I noticed that you didn't say that traditional, I graduated from nursing school and I spent a year in med surg, that obligatory year in med surg that we all hear about.

I'm just curious, how did you feel that transition went, and have you ever regretted not spending a year in med surg and going straight into pediatric critical care?

Keith McArthur, BSN, RN, CCRN:

Yeah, I was told the same thing that I think a lot of students are told in traditional programs, in that, you need to do your med surg until you specialize in ... I would disagree. I think there is something to be said. I mean, I don't want to sound like I'm disparaging med surg nurses because they do amazing work. We both know that, but it's not necessarily where you have to start in nursing for sure. Certainly students will get told that they can't just go straight to an ICU, and maybe ICUs won't hire you right away, but some ICUs will hire you. I would say, if that's what you want to do, do what you want to do.

People get into nursing for a lot of different reasons and they have different things that lead them there and they have different expectations of what they want out the profession. I wouldn't try to tell any students that they have to be forced in one aspect of the job or another. I would say, definitely, if you know what you want to do, pursue it. I think, most of the time, people will give you chances as a new grad. I think, if you apply yourself, I don't think that there's a situation that you can't function in a healthy way. I mean, pediatrics is a specialty. Pediatric ICU is a subspecialty.

I walked right into that situation. I had good support. I had good preceptors. And you can make kind of thing work. You don't necessarily need to do like a med surg for a couple years or anything like that. Go where you want to go. There's a lot of cool things to do in this profession. We can't do them all, and so I would say, what sounds good to you, definitely go after it.

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

I agree with you, and I think you would make a really important point. It is absolutely nothing against med surg or our colleagues who do go into med surg. I think, if you're someone who knows that working with children is the thing for you or who has always had a desire to go to an intensive care unit or an emergency department, and that, that's really where your passion lies, then I think our message probably is that encourage you to pursue that. We need excellent med surg nurses just as badly as we need excellent pediatric nurses and critical care nurses and emergency department nurses.

Yeah, definitely nothing against them, but I just like to highlight that there isn't any one way into any of these specialties or subspecialties that we hear about, and I think that's really important. Keith, I've really enjoyed hearing about your story and hearing this really unique trajectory that took you where you are. Is there anything else you'd like to add or share with listeners as we wrap this up today?

Keith McArthur, BSN, RN, CCRN:

I think, if you're listening and you're a student nurse and you're going to be graduating soon and you're graduating into a sort of a COVID environment, I guess I would just encourage new students to know that they're leaving as new grads and that they're valuable to healthcare. That there's really no excuse that they should be treated poorly by someone that's going to hire you. I would say, know that you're valuable. You don't have to take the first job that's offered to you as a new grad. You can shop around.

I would say look for those kind of places that can keep their nurses. A lot of nurses are burning out in this environment, and sometimes it's understandable. Sort of been lucky in the pediatric environment that COVID hasn't been hitting our population as hard as it has to adults. I've been to a lot of emergency rooms recently, and so I can understand where those sentiments come from. You don't want to graduate and then end up doing something that you don't like and being burnt out fast. So, I would say, look for those opportunities where they're going to of treat you well, for sure.

Just because you're a new grad doesn't mean that you shouldn't have the expectation that you get a good orientation or anything like that, COVID or not. I would say you should be treated well still.

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

Awesome. Well, I am so appreciative of your time and your dedication to sick kids and their families and everything that you're doing for our community. So, thank you so much, Keith, for sharing this information with us and offering the pearls that you have tonight.

Keith McArthur, BSN, RN, CCRN:

Oh, thanks, Jessica. It was nice talking to you today.

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

Thanks a lot. Bye-bye.

Keith McArthur, BSN, RN, CCRN:

Thanks.

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 view 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're active in. The stories of their career path and progression are not intended to suggest that there is 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.