

Practicum report narrative essay

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Samantha Corp Medical Assistant Externship Medical Assistant Practicum

Report In my externship, I split my time between the lab at the hospital and the office. A typical day for me began at 7 in the morning. I started at the lab drawing blood out of patients. Usually on Mondays, it was the busiest. An order would come in through the window, once the patient had registered. On this order, there was the patient's hospital ID number and their demographics, which included: name, address, insurance information, and their primary care physician.

If it was a recent order from the doctor, then it would have the script with the registration page. If it was a standing order, such as a Prothrombin Time, it would just have the registration page, and the laboratory tech would use their hospital number to look up the patient and go into their scanned orders to pull it up. Once the order was pulled up and printed, the tech would then go in and order the laboratory tests to be administered, whether it was a urine analysis, culture, or blood work. Once it was ordered, labels would print out and the tech would go out to call the patient back.

When calling the patient back the tech only uses the patient's first name, never the last name, this way their identity is protected through HIPPA. Once the patient is in the draw room, the patient's identity is double-checked by having the patient spell their last name and confirm their date of birth. Also if the patient was in for a Prothrombin Time test, then I would ask when their last dose of Coumadin or blood thinner was. Once the patient's identity is thoroughly confirmed, then the tech will check the tests to identify the tubes that the specimen will be placed into for testing.

When I was drawing the patients, I would ask them where they normally get drawn at, or if there was a certain place that they preferred. They would usually reply with an answer that I was able to go with. Once I applied the tourniquet, I would feel the antecubital space with my fingers to ascertain if there was a viable vein to go in. If I did not find one, then I would check the other arm. If there were none in that arm, then I would ask if it was okay to go in the hand. If they agreed, then I would tourniquet it off and feel for a vein.

Once I located a viable vein and determined what direction it went, I would determine what needle I was going to use. I had the choices of a butterfly, vacutainer, or a 5-10 mL syringe with needle gauges of 22 and 23. I would then gather my supplies, which consisted of an alcohol wipe, needle of my choice, cotton ball, and/or tape. I would then cleanse the area with the alcohol wipe and let it dry. Once dry, I would then use the needle and poke the patient. In the lab, all of the needle choices, except for the vacutainer, would flash to let me know that I was in the vein.

If I was not in the vein, I would then reposition the needle gently to try to get into the vein. The lab has a two poke limit. This means that I or any tech has a chance to poke the patient twice, before getting another tech to try. Once the blood was collected, I would then label the tubes with the time of collection and my initials, because a tube cannot leave the room that the blood was drawn in until it has a label. This is a precaution against losing or mixing up samples and inconveniencing the patient of having to come back in to be drawn again.

Once the labels were on, I would then take them into the lab. I would have to determine whether the specimens were to be tested in-house or sent out to a larger hospital to be run. If they were to be run in-house, then they would be distributed between the chemistry machine and the hematology machine. If they were to be run at a larger hospital, then they would have to order them through that hospital's system. A courier stops by twice a day to pick up the specimens that are to be run there.

I also needed to verify that the patient's results were faxed to the appropriate offices and that the results were added to that patient's file. In the lab, it is really important that all of their information stays together and confidential from those not authorized to see the patient's medical information. In my first few weeks at the hospital, I also got to see some surgeries. This helped me to understand the reasoning behind a sterile field. In the operating room, it is crucial that every piece of equipment that touches a patient is sterile. If it is not, then the patient is exposed to several kinds of nasty infections.

Before the surgery/procedure starts, a nurse checks the patient's file and then scans in every piece of equipment that is used in the operating room, to insure that nothing gets left in the patient. My Minor Office Surgery class prepared me for the sterile aspect of the medical field. Sometime during the day, I would head over to the physician's office. Once there, I would log into the system and check the daily schedule to see how many patients will be seen in the office that day. Once the patient was checked in, then it would change a colored block on my screen, letting me know that I could take the patient back.

I always call the patient by their first name, once again, enforcing HIPPA. Once I called the patient back, I took them into the lab room to get their weight. If the patient is under 18, then I also have to get their height to monitor their growth. Once those are put into the patients chart, I then take the patient into a designated room. In the room, I proceed to get their temperature, pulse, blood pressure, and respirations. I input those into the computer. I then verify the patient's medications to be clear on what they are taking, just in case the physician prescribes something that could interact with it.

I also verify their allergies, or lack thereof. Once those are all asked and filled out, I return to their chief complaint. I ask them if the chief complaint was the only thing that they were in the office for. This opens the conversation up to the patient, which gives them room to either elaborate on their symptoms or reasons for the appointment. Once I have all of their information into their chart, I then let the patient know that I will inform the physician that they are ready to be seen. After I leave the patient, the physician sees them.

I will then monitor their status on the schedule. If the physician has ordered tests, medication, or treatment plans, then the patients name will light up bright green, which indicates that action is needed. As the Medical Assistant, it is my duty to schedule more tests to be run, draw blood if needed, call in medication to pharmacies, or give injections to the patient. If any of that is done, then it needs to be charted into the patient's record. While I waited for the physician to finish with the patient, I would watch one of the Medical Assistants make follow-up calls or correspondence.

Many of the patients' that walked through either the lab or office were very different. Whether it is the color of their skin or the way that they talked, each and every patient was an individual. I learned to roll with the punches when dealing with new people that I had never met in my life. My time in my classes has made me more aware of what actually goes on behind the doors of the office and hospital. This experience has reaffirmed the fact that this is the field that I want to spend the rest of my life in.