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Commentary

Nursing Intuition: Finding Your Inner Spidy-sense

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Abstract

Nursing intuition is rapidly growing as an acceptable form of clinical nursing knowledge. This manuscript follows the journey of a nurse's intuition in caring for a neonate in the Emergency Department after a brief, resolved, unexplained, event. The nurse's intuition and persistence helped advocate for the patient and the appropriate definitive care. Ultimately the nurse's intuition was correct, thus validating the important role intuition plays in clinical knowledge.

Have you ever had a nurse tell you they don't know what is wrong, but they just have this feeling that something bad is about to happen? Or better yet, call the doctor because something just isn't right, but has no findings or data to back it up? Nursing intuition over the past decade has gained increasing acceptance and has become a legitimate form of clinical nursing knowledge [1]. But what is nursing intuition? Many people have heard the phrase used across the field of nursing, but unless you have experienced it, it can be hard to define or understand. A systematic review of eight quantitative studies and over 300 abstracts offered these common themes, "Sensing an unconscious and conscious thought process" and "A sudden emotional awareness and reflection, and arousal of conscious thought process." Additionally, they identified a sub theme of the willingness to act, based on one's personal, social and clinical experiences [1].

I've experienced nursing intuition many times throughout my career and it's not always explainable. I've been that nurse claiming something just wasn't right and was about to happen, but unable to rationalize the why or how those feelings came to be. My intuition has been right on numerous occasions, but how does "a feeling" come with validation and support the outcome? Keywords come to mind such as sensing, connection and experience, but how do you prove "just a feeling" to someone? But intuition is just that; a sense of something about to happen, clinical experiences that impact decision-making and interpersonal connections all rolled into one. I refer to it as my spidy-sense, a feeling or sensation that makes the hairs on your arms stand straight up!

I got this exact feeling in the emergency department (ED) as I heard the triage nurse call for a room to evaluate a less than one-week-old neonate for a brief, resolved, unexplained, event (BRUE). A BRUE is defined as a brief transient event of unknown cause that is startling to the observer causing grave concern. It most often includes a combination of choking, color change, apnea, and a change in muscle tone [2] The infant's legs had turned blue during a vomiting or gagging event. To properly assess the neonate, the newborn was taken straight to a room, where they were stripped of their clothing and placed in an infant warmer. Using the Pediatric Assessment Triangle, no abnormalities were noted. All three sides of the triangle were intact including appearance, work of breathing and circulation to skin [3].

I couldn't shake the feeling of uneasiness I was experiencing and despite the resolved episode, I kept coming back to coarctation of the aorta. Coarctation of the aorta is a narrowing of the aorta, making it difficult to adequately supply blood to the lower extremities. Signs and symptoms may not appear until the patent ductus arteriosus (PDA) closes, causing further narrowing [4]. The PDA functionally closes at birth but may take up to 2 or 3 weeks to permanently close [5]. Signs and symptoms may include mottling to the lower extremities, faint or lack of a femoral pulse, elevated blood pressures in the upper extremities compared to the lower, labored breathing and/or a heart murmur. Diagnosis is confirmed via echocardiogram, and it is treated with a prostaglandin (PGE-1) infusion to keep the PDA open until surgical repair [4].

The lab stated that the blood hemolyzed on two different specimens and the urine collected was not enough to be analyzed. With the uneasiness I was feeling, I recommended to the emergency physician that we expedite transferring the neonate to a tertiary care center instead of wasting further time attempting to recollect lab specimens. The ED physician consulted the neonatologist at the tertiary center, who accepted the infant for transfer. The neonatologist also requested blood pressure be taken on all four extremities. My intuition had me on the right track of suspicion. I was starting to think I was crazy for not being able to shake my gut feeling, as everyone kept saying how good the infant looked. It

could be that the vomiting or gagging episode caused just enough increase in oxygen demand, that brief signs of coarctation were seen. After all, given the age of the infant the PDA may still be in the process of permanently closing.

The blood pressures were not alarming, but I still held on to this gut feeling or instinct if you will. The pediatric transfer team arrived to transport the neonate to the tertiary care center. The nurse had a syringe of PGE-1 ready if it needed to be given. Again, I felt validated by my intuition. Thankfully, the infant still looked good, and PGE-1 was not immediately required. The neonate was transferred for higher level of care, where they will undergo further testing and evaluation, including an echocardiogram. While I may never know for sure if this baby had coarctation of the aorta, I rest easily that my personal experiences and knowledge lead me down the right path, which was validated by the tertiary care center's shared concerns and suspicions.

It always feels good when your intuition is right, but the greater moral is to always listen to your gut instinct, no matter how vague it may be. You never know, you might just save a life one day. Teaching nurses about intuition will help empower them to speak up and take action when something doesn't feel right. Likewise, creating a dialogue about intuition and sharing our experiences will further help solidify intuition as a "legitimate form of knowledge."

Ethical Guidelines

Manuscript was submitted to the internal review board (IRB) and determined IRB approval was not needed. The manuscript was also approved by the hospital's regional compliance officer.

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