

Student Name: ALEJANDRA SALAZAR

Clinical Instructor: Mrs. Snyder

### ATI Real Life THA Virtual Clinical Reflection Questions

- 1) What was Dale's fall risk score? Is that score considered low, medium, or high risk? What interventions in Dale's care should you be implementing?  
(Use your resources from class and clinical Fall Risk Score Interventions)
  - a. Dale's fall risk score is a 45
  - b. HIGH RISK
  - c. Will need assistance with getting up/out of bed and when ambulating. Will have to use a call light whenever he wants to participate in getting up/ambulating to get assistance. Bed/chair exit alarms should be on.
  
- 2) From the pre-op exercises teaching scenario, pick one that Dale demonstrated incorrectly and explain how you would teach the correct technique.
  - a. One of the pre-op exercises that Dale demonstrated incorrectly was the inadequate use of the incentive spirometer. To teach the correct technique, I would take the device, sit it up, and extend the mouthpiece. Then I would tell him that he would have to exhale completely without his mouth on the mouthpiece, then breathe in (slowly) with his mouth sealed tightly around the mouthpiece (rather than blowing out). I would also inform him to make a note of the indicator and the level it has reached. To show that Dale has the right technique, I would have him re-demonstrate after I would educate him on the adequate use of the spirometer to ensure effective use.
  
- 3) Dale receives morphine sulfate for his hip pain. The morphine order is for 2-4mg IV Q 3-4 hours for severe or breakthrough pain. What is wrong with this order?
  - a. Nurse had administered 1.5 mg IV dose at 1425. Medication dosage administered was not within ordered range.
  - b. Morphine is dispensed in 2mg/ml concentration. If Merryll gave 4 mg, how many ml's of morphine did she administer? 2 mL of morphine administered.
  
- 4) Dale is assessed for skin integrity on his heel. What are some interventions the nurse could implement to protect his skin? What are the concerns if no interventions are implemented?
  - a. The nurse can reposition the patient Q2, which she did in this instance by elevating the heels and offloading that pressure.
  - b. When the nurse repositions the patient, she should perform another skin assessment to make sure there are no more skin injuries (frequent skin assessment) and to make sure that the present injuries don't worsen.

- 5) Identify three ways that the nursing team demonstrated the promotion of patient safety?
- The nurse emphasized and reminded Dale that they have hip and fall precautions and emphasized for them to use the call light and to not try to get up independently. Nurse Merryll also lowered the bed before she exited the room.
  - Nurse checked the incision/wound, double checked the dressing to make sure everything looked good and that there were no signs of infection or a concern on Dale.
  - Nurse went to go get ice to refill his ice pack to help reduce swelling and pain, she is assisting with pain relief.
  - Merryll and Shannon communicated to work together to get Dale back in bed from sitting in the chair. This ensured that they had assistance and was not ambulating independently, which would reduce fall risk. The nursing staff also made sure to use adequate body mechanics, and ensured Dale had a walker and a gait belt, and that the chair brakes were on.
- 6) Do you feel the nurse and medical team utilized therapeutic communication techniques when interacting with individuals, families, and health team members of all cultural backgrounds?
- If **yes**, describe: I feel like overall the nurse and medical team did utilize therapeutic communication when interacting with Dale and their partner. The first nurse went over personal demographic information and made sure to use adequate non-verbal communication paired with effective communication techniques such as open ended and direct questions to promote patient understanding and future recovery effectiveness. With this, she got to know the patient as a person and how (they) identify. I also noticed a lot of direct therapeutic communication (and silence from the other team member), to allow for effective communication and information sharing about Dale and his care.

## Reflection

- Go back to your Preconference Form:
  - Indicate (**circle, star, highlight**) the components of your preconference form that you saw applied to the care of this virtual patient.
- Review your Nursing Problem Worksheet: Did you select a correct priority nursing problem?
  - If **no**, write what you now understand the priority nursing problem to be: I now understand the priority nursing problem to be **risk for falls**. Impaired musculoskeletal function and impaired gas exchange may be valid problems and

concerns following THA, but the most important is to make sure that he is safe and is not falling post-operatively.

- 3) Review your Nursing Problem Worksheet: Did you see many of your anticipated nursing assessments and interventions used?
  - a. Indicate (**circle, star, highlight**) the ones you saw utilized during the scenario.
  - b. Were there interventions you included that *were not* used in the scenario that could help this patient?
    - i. If **yes**, describe: One intervention that I included in my interventions was to assess SPO2 levels, to then potentially have an intervention with supplemental oxygen (add nasal cannula). Another intervention that I included in my Nursing Problem worksheet was to elevate the head of the bed to promote more effective breathing. Another intervention that could have been helpful for this patient that was not used, was to potentially use the intervention of non-pharmacological relaxation techniques and encourage bedrest to maintain stability in terms of vital signs [a systolic pressure < 120, diastolic < 80, HR 60-100, SPO2 above 92% on RA, and RR 12-20].
  
- 4) Often patient care will take a different direction than we anticipated at the beginning of our shift. Did that happen here? ***Impaired skin integrity***
  - a. How did that impact the nursing care delivered? It then emphasized the importance of doing continuous skin assessments and ensuring that the patient is repositioned and moved to maintain skin integrity. This is also important because it can reduce the likelihood of skin breakdown and reduce further risks for infection (outside the incision site from the surgery).
  - b. What new, additional priority nursing problem (diagnosis) did you identify? (Refer to your NANDA list)
    - i. Write it here: **Risk for falls**

What was your biggest “take-away” from participating in the care of this patient? How did this impact your nursing practice: One of my biggest takeaways from participating in the care of this patient is the fact that although this patient may just be treated post-operatively for a total hip arthroplasty, there are other *extremely* important health problems that need to be observed and addressed. One of the biggest “take-aways” is the emphasis on prioritizing the problems, which then prioritizes the care, assessments, and interventions that take place as a nurse. We must do a thorough health assessment and have as much subjective, and objective data to paint a complete picture of the patient before we treat them and monitor and follow-up effectively throughout our time of care to promote the best health outcomes for our patient. Although I initially thought impaired musculoskeletal function and impaired gas exchange would be important, new problems took priority, such as risk for falls. Following this, he had impaired skin integrity, which is also important since this is now an open wound and can be a site for potential infection

(which can also be extra stressful for the patient to consider in addition to recovering post-operatively).