

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 was 45
 - b. This is a high-risk score
 - c. Dale should have a "fall-risk" armband on securely, bed/chair alarm activated, call bell within reach/with displaying of proper use, 3 bed rails up, ensure shoes or non-skids socks are on properly, assess for dizziness upon changing positions, and ensuring client education about asking for and using assistive devices with ambulation.
- 2) From the pre-op exercises teaching scenario, pick one that Dale demonstrated incorrectly and explain how you would teach the correct technique.
- a. Dale demonstrated improper technique of the incentive spirometer. He was blowing air into it. I would instruct Dale to instead, suck through the mouthpiece rather than blowing. I would describe it to him as "sucking a very thick milkshake through a straw" for better understanding. I would instruct him to suck in and hold it for at least a few seconds (keeping the small ball between the arrows marked on the IS). I would encourage him to do this every hour while he's awake post operatively to prevent respiratory complications.
- 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. The order is partially incomplete (it is too vague). It gives a range for a dose and a range for a time, but it should give an exact dose and an exact time (e.g. Order- Morphine sulfate 4mg IV q4hr PRN for severe or breakthrough pain).
 - b. Morphine is dispensed in 2mg/ml concentration. If Merryll gave 4 mg, how many ml's of morphine did she administer? She administered 2mL of morphine
- 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. Offload pressure by placing foam wedge/pillow/heel protecting boots, reposition q2 hours to increase circulation and minimize pressure, avoid resting heels on direct surfaces, assess heels for redness/blanching/breakdown/discoloration, keep heels clean and dry, encourage small movement as tolerated.
 - b. If no interventions are implemented, Dale is at increased risk for pressure ulcer development> infection> delayed wound healing> and increased pain related to (new) pressure injury.

- 5) Identify three ways that the nursing team demonstrated the promotion of patient safety?
 - a. **The nurses had Dale show them how he would do his post-op exercises and they provided further teaching in necessary areas to ensure he was doing them safely/correctly after his surgery.**
 - b. **They compared verbal handoff to the charted handoff to ensure that all of the information was correct before Dale was transported after surgery, this will help center care and avoid med/or other errors regarding Dales care.**
 - c. **The nurses used proper technique when transferring the patient from chair-to-bed post-op to ensure safety of the client.(they used a gait belt properly, proper body mechanics, proper assistive device (walker), and proper amount of staff to complete the task (2 nurses).**

- 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?
 - a. If **yes**, describe: **Yes, the medical team utilized therapeutic communication techniques during interactions. They asked the patient his pronouns, preferred name, and asked personal questions in a respectful manner. They also included the patients support companion throughout care. They listened to both the patient and support companion through out care and allowed for questions and input. They maintained good distance, eye contact, and tone during each interaction. They did not show any bias throughout care.**

 - b. If **no**, describe:

Reflection

- 1) Go back to your Preconference Form:
 - a. Indicate **(circle, star, highlight)** the components of your preconference form that you saw applied to the care of this virtual patient.
- 2) Review your Nursing Problem Worksheet: Did you select a correct priority nursing problem?
 - a. If **yes**, write it here: Yes, I chose pain and impaired-mobility, and both were displayed in the patient care.
 - b. If **no**, write what you now understand the priority nursing problem to be:

- 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: Yes, there were about 2 interventions that I included on my nursing problems form that were not included in the scenario. One was to “assess for sings of dislocation each shift”- given that he has THA procedure I feel as this is an important assessment to note and avoid post-op complications. I also wrote “assess pain level, intensity, location, and description”- Although they did frequently assess pain in the scenario, they did not get into specifics of pain which can be important to rule out any other post-op complications that may occur.
 - ii. If **no**, describe:
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- 4) Often patient care will take a different direction than we anticipated at the beginning of our shift. Did that happen here? Yes
 - a. How did that impact the nursing care delivered? Originally, our main focus was to promote post THA healing by evaluating vitals, managing pain, and increasing mobility. However, one nurse noted some abnormal findings on the heels during a skin assessment. This redirected the nursing priorities toward implementing skin integrity interventions. Care was adjusted accordingly to help reduce skin breakdown.
 - b. What new, additional priority nursing problem (diagnosis) did you identify? (Refer to your NANDA list)
 - i. Write it here: Impaired skin-integrity

What was your biggest “take-away” from participating in the care of this patient? How did this impact your nursing practice: My biggest takeaway from participating in the care of this patient was the importance of continuous assessment. Early identification of of abnormal findings prevent further problems and improve patient outcomes. This experience reinforced the need to stay vigilant, document all findings, and communicate findings with the healthcare team. This allows for a change in the care plan that will safely promote patients overall being. I also noted the importance of communication and double-checks. There was a time in the experience where the nurse had something slightly misconstrued, and after communicating with her colleagues she was able to straighten her information out. This prevents errors in patient care and promotes safety of the patient, that is why it is so vital to double check and confirm patient information. Overall, I had two big takeaways that I will cary with me throughout my practice as a nurse one day.