Instructional Module 4 – Adult M/S 2

Competency	Outcomes	Secondary Outcomes	Give examples of how you met each outcome
Assessment & Intervention	Implement a plan of care that integrates adult patient-related data and evidence-based practice.	- Define plan of care for specific health impairment - Identify signs/symptoms of health impairment - Select & implement proper interventions for specific health impairment - Evaluate effectiveness of interventions	1. Patient was returned to the unit after surgery. The nurse gave my nurse and I report and said the patient did not lose much blood. Once a patient is returned to the unit, they are to be started on post-operative vital signs. Patient's blood pressure was low, and it stayed low. Patient was drowsy, and kept going in and out of sleep. We were still taking vital signs every fifteen minutes, and the blood pressure would stop not go up. We raised the head of the bed of the patient and encouraged to have a conversation with her hoping that staying awake could help. It came up a little bit, but then another nurse suggested to place the person in Trendelenburg to try to get blood flowing to the heart. After doing that, the patient's blood pressure started to improve. 2. When giving report from the night shift, they informed my nurse and I that the patient came in with a fall and somehow how two blisters on her knee. The patient had a full leg immobilizer. When we went in to check on the patient, we began to assess the affected extremity. The patient's knee was swollen and bruised with two raised blisters. The nurse decided not to strap the immobilizer because she did not want to pop the blister. We informed the patient to keep their leg straight and not to move it. The following day we came back and it seemed like the blisters fused together and it looked bigger. Our goal was to not pop the blister, and to keep that leg mobilized without injuring the patient. We kept the immobilizer under the patient's leg without strapping it and informed patient to keep it still. We also taught patient not to physically pop the blister because then it is allowing microorganism to enter the body especially if you pop it with an outside object.
Communication	Communicate effectively with members of the healthcare team.	- Identify health care team members & their purpose - Interact appropriately with health care team. - Utilize proper SBAR, TEAM Steps, etc. - Evaluate outcomes of communication process	1. During a clinical, my nurse went to the restroom, so I stayed at the computer to look at my patient's information. The call light at the nurses station kept going off, and I answered the call. I noticed that the patient was not one of ours, but I decided to go in and help. I do not like when healthcare workers say that is not my patient I am not going to help. The patient needed assistance with the a urinal. After helping, I measured and emptied out the patients urinal then noticed he was finished with his tray. I observed to see how much he has eaten and placed it in the soil utility room. I made sure to write down the input and output. Then, I looked for the patient's nurse and aide to inform them so they could know and document because monitoring I&O's helps the nurse see an improvement or not. 2. When giving medication to a patient, I try to communicate as much as I am doing to them. Before giving medications, I have to communicate with my nurse to let her know who is my patient, so she does not give the same medications to that patient. I also have to communicate with my instructor, so they know the medications we are giving, and they can look up information on the patient as well. When we go into the patient's room, I introduce myself and let them know who I am and my instructor. My instructor communicates well informing on their position and how they will watch me to make sure they are comfortable with it. While I am giving medications, I try to communicate the patient about what I am giving, what it is for, and side effects. Not only that, while I am giving intravenous medications I

			communicate what is what and what I am doing, so they do not feel uncomfortable. After leaving the room, I let my nurse know everything we did in the patient's room, and if they had any concerns or complaints because at the end of the day that is her patient.
Critical Thinking	Apply evidence based research in nursing interventions.	- Analyze pertinent data (subjective, objective) - Identify evidence based practice (EBP) resources - Distinguish EBP nursing interventions - Apply EBP nursing interventions - Document resources & interventions	1. Patient had a stage 2 pressure injury on their sacrum, and was unable to turn on their own. To help prevent the injury from getting worse, the nurse placed a bandage on the patients bottom. Even though that is protecting the injury, we did not want any more to occur. The nurse and I went in every 2 hours to turn the patient to keep the patient off us his bottom. We also placed pillows on his heels, and one between his legs. Doing this, helps alleviate pressure off of bony premises and prevents injury in the future to occur. 2. A patient came back from post-op and was on oxygen. When walking into the room to check on the patient, the patient had his oxygen above his nose. I was going to fix it, but he insisted on leaving it off because he was about to eat breakfast. I try to inform him that it is important we keep our oxygen on to make sure our whole body is receiving the efficient amount of oxygen it need to work effectively. He said he did not like wearing it to eat. I told him to let me monitor his oxygen saturation while he ate to see how it was doing. While eating, the patient's oxygen was sitting at 94% room air. I asked the nurse if we could take him off, and just continue to monitor throughout the day. She said yes he is good on room air right now. We do not want overflow the patient with oxygen when they do not need it.
Caring and Human Relationships	Incorporate nursing and healthcare standards with dignity and respect when providing nursing care.	- Explain need for nursing & health care standards - Apply standards to patient care (HIPAA, QSEN, NPSG) - Communicate concerns regarding hazards/errors in patient care	1. Patient was admitted for delirium. She was seeing people in her room, Patient had a history of depression. When walking into the room patient was poorly groomed. Her hair look tangled. She had left sided weakness and so it was hard for her to move. While I was in the room, patient was up, so I decide to ask if she would like to brush her teeth and comb her hair. Patient was willing to. She was talking more, and not only answering question, but asking questions. It made me happy to see her up and talking. Sometimes nurses are so concerned with doing medications and skills, we forget about the little things. Patient's hair was knotted, so it took some time to brush them out. She was up and looked better than what she did before. She was also in a better mood, and was not just lying in bed sleep. 2. I was with my instructor giving a patient her antibiotic by intravenous push. The patient was nice, and she knew a lot. Sometimes I get so concerned about doing task that I forget about lifting the bed to push a medication , so I would not hurt my back. The patient told me you could lift my bed up, so you do not break your back. I kind of felt a little dumb, but I am glad she noticed and cared for safety. Also, I told patient that I would be pushing her antibiotic. Patient said this is the one you push for four minutes correct. I informed patient yes and I will let her know when I start pushing the medication right now I am just doing the normal saline push. While I was pushing, I always ask if the patient is okay and if it hurting to let me know. Patient said that I was pushing it fine, but one of the nurses just slammed it the last time and she felt uncomfortable. I let the nurse know what we did and the patients concerns. I informed patient she can always express her concerns.

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Management	Recommend resources most relevant in the care of patients with health impairments.	- Assess patient needs during acute care to promote positive outcomes. - Assimilate co-morbidities into plan of care - Identify appropriate resources - Initiate discharge plan	1. Pt was admitted because of his AV fistula pot was bleeding. The bleed was caused do the patient picking at it. It was my first time to ever see a AV fistula. The healthcare team was doing the best to save that AV fistula because it was the last access he would have for his dialysis treatment. The patient was also having trouble maintain his blood glucose level. He was having hypoglycemic states and not wanting to eat food. During his hospital stay, we were managing trying to keep the save the AV fistula because that is his only and last access to receive his dialysis. We placed a no band on his extremity. We also had to manage on controlling his blood sugar because that also affects the function of the kidney. 2. The first day of clinical we followed the nurses and not did much because it was we have not had much clinical experience. Nurses have a lot on their plate so learning how to manage and prioritize is an important part to caring for patients. Throughout the clinical experience, I would right down the patients we would want to see due to report we were given. I would try to talk to the nurses to understand and see if I am doing it correctly. Sometimes I was right and other time I was not and the nurse would explain why. Which helped me understand and learn how to critically think more.
Leadership	Participate in the development of interprofessional plans of care.	- Identify/define interprofessional plan of care - Integrate contributions of health care team to achieve goals - Implement interprofessional plan of care	1. A student and I were following our nurse. She was at the computer checking things, and while she was doing that I decided to go ahead and check the patient's brief. The patient said they were clean, but I always like to double check especially if it is a new patient for me. I had experiences where patients have had a soiled brief, but say it is clean so no one will mess with them. I decided to check his brief and he had, had a bowel movement. I begin to start lifting the bed and getting the supplies ready. The other student was by the nurse, and I asked her to help me so the nurse can continue her work and not to have to worry about us waiting on her help. The patient was a little heavy and had a harder time turning, so I need some help turning the patient. I turned the patient towards the other student and began cleaning the patient as best as I could. With help we were able to complete some task and have the nurse do her work on the computer in the room. Afterwards, the student said "Great job. You just went in there and started doing it, and I was impressed." It made me feel great, and I also encouraged her to just go in and help. 2. A patient was walking in the hallway with physical therapy and she became unconscious. They immediately took her into her room. The students were all wanting to see what was going on so we were in the hallway watching through the open door. I noticed the room next to the us had the door open and was looking at all of us. I noticed we were drawing attention to that one room so I went to the next room and asked if they needed anything. The patient was wanting to get back into bed. She was in her wheelchair and was a bigger lady. So I asked the students in the hallway to help because she was also non-weight bearing. It took the attention from the hallway and help another patient who was in need.
Teaching	Evaluate the effectiveness of teaching plans implemented during patient care.	- Identify/define teaching plan - Implement teaching plan - Identify appropriate evaluation tools - Appraise patient outcomes	1. Patient was wondering why she needed to call every time she needed to go to the restroom. She said she goes to the restroom by herself at home and does not understand why she needs to call here. I taught the patient how their safety is our highest priority. We do not want to cause any injury to the patient when they are under our facility. We take precautions, so other healthcare workers can know if a

			patient is a high fall risk. There is a sign on the side of the patient's door when they come in telling what level they are at. Our yellow gown and socks lets a member know that a patient is a high fall risk. I informed the patient that she was a high fall risk because she met the criteria. The patient had a below the knee amputation putting her at a greater risk for falls. 2. Patient was a Type 2 diabetes and was admitted because he had an ulcer on the bottom of his foot. The ulcer was open and you could stick a cotton swab in it. The patient said he did not feel the pain until it was unbearable. I asked the patient what he did for a living. He stated that he did labor work. I assumed and asked to clarify if he wears the same boots every day. He stated yes, and then I asked if he checks his boots for any objects before putting them on. Patient stated no. I informed patient that it is important for a diabetic to check his shoes for any sharp objects to help prevent injury. Diabetics are more at high risk for injury to the foot and is often worse because it is hard for them to heal. I informed him that his diet is really import to follow because bacteria loves sugar, and makes it harder to heal.
Knowledge Integration	Deliver effective nursing care to patients with multiple healthcare deficits.	- Identify patient health deficits - Prioritize care appropriately - Adjust plan of care based on patient need - Identify system barriers - Modify health care deficits identified	1. I decided to do my assessment on a patient who had a left hip fracture. She was minimal weight bearing after she came back from surgery. She did not want to move because she was in pain. Patient had sutures on her left side. On our daily physical assessment, there is a section for the Braden Scale. The Braden Scale consist of sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Patient responded well to verbal command and had no sensory impairment which scored her sensory at a 4. Patient's skin was dry scoring her moisture at a 4. Patient had little activity and mobility scoring both at a 2. Patient's nutrition was at a 3, and her friction and shear was at 2. The combine to create her overall scale at a 17. I notified the nurse of how I scored the patient because on our daily assessment worksheet says if less than 18 to initiate skin care protocols. Patient was about the age of 65 and is at mild risk for skin breakdown. 2. Covenant is uses the MEWs tool to monitor and prevent sepsis in a patient. The nurse let us practice on using the tool by writing down the patient's vital signs and scoring it. When we were finished, she looked over it, and all our patients stayed in the green which is very good. She explained to me what we would do, and how to explain to the charge nurse what is going on. We have not practiced much on the MEWs, so I enjoyed that she let us practice. I often think since a majority of the time aides take the vital signs. Since the MEWs score is based on vital signs, I think that sometimes the aides may start using it to notify the nurses of what is going on.