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. My patient was completely bed bound recovering from a severe spinal infection. During my initial assessment, the thought of potential skin breakdown came to mind. I assessed the skin paying close attention to the bony prominences and recorded my findings. I was able to be active in the turning schedule of this patient to prevent the formation of pressure injuries. I was also able to apply the specialized boots to the patient's feet to reduce drop foot and pressure sores on the heels. My nurse and I ensured pillows were placed to separate the patient's knees and ankles and pillows under the arms to protect the patient's elbows. Before leaving for the day, I did another skin assessment to evaluate if the turning and pillow placement were proving beneficial for the patient, no new injuries were observed. 2. My patient was severely confused and had BLE weakness and unsteady BUE movement with poor coordination upon assessment. When my patient's breakfast tray arrived, I helped get her situated and removed the lid from her coffee cup. I watched my patient attempt to feed herself and use the utensils unsuccessfully. The patient was determined to be independent and did not want to accept help with getting food on the fork and placing the food in her mouth. After a few minutes of sitting with the patient I offered to just assist getting the food on the fork for the patient to place to her mouth which she finally agreed to. The patient was able to eat her breakfast effectively while still maintaining some independence.
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. I went to go check on my patient after the lunch trays were delivered to the unit. Upon entering my patient appeared to be uncomfortable. I asked her if everything was okay, and she informed me she felt very nauseous and asked for a ginger ale. I was aware the patient had a PRN antiemetic medication to help with nausea from a previous conversation with my nurse. I asked the patient if she wanted her nausea medication, but the patient declined and stated she would prefer to try and drink ginger ale first. My nurse was on his lunch break, so I found the charge nurse and asked her for assistance on where the sodas are stored on the unit. The charge nurse gave me instructions for which cabinet to look for and handed me a key to unlock it. Proceeded to retrieve the ginger ale and found the charge nurse to hand her back the key. Thanked her for her assistance and delivered the ginger ale to my patient. I felt good knowing even if my nurse was unavailable for a period, I still had resources to communicate with and receive assistance. 2. I was able to participate in the communication process with the social worker for skilled nursing placement for my patient anticipating her discharge. It was a unique experience seeing how closely the case manager, nurse, and charge nurse work together to get the necessary information together. The social worker worked very hard for the patient in finding a facility that accepted the patient's insurance and had availability to accept the patient. The family at bedside were very grateful to everyone involved and praised the teamwork of Covenant.
Critical Thinking	Apply evidence based	- Analyze pertinent data (subjective, objective)	1. One morning of clinics I assisted with getting morning vital signs on my patients.

	research in nursing interventions.	- Identify evidence based practice (EBP) resources - Distinguish EBP nursing interventions - Apply EBP nursing interventions - Document resources & interventions	One patient had a slightly lower than normal blood pressure during my initial assessment. I notified my nurse and charged the findings. Later that morning my nurse and I prepared this patient's medications in the med room. While pulling the medication Amlodipine I asked my nurse would we still be administering this medication if the blood pressure was already on the slower side of normal. My nurse stated we would still pull the medication but recheck the patient's blood pressure again before administering. When the time came, I rechecked the blood pressure, the reading had come up slightly, but the systolic pressure was still low. After rechecking, my nurse and I decided to not administer the Amlodipine in fear of the blood pressure dropping to an unsafe level. I explained this to the patient and confirmed she understood why we were holding the medication. We replaced the medication to the Pixis and documented it in the patient's chart. 2. While taking noon vital signs on my patient, her oxygen saturation was reading in the low 90's. She was on room air and had been oxygenating fine earlier in the morning. On observation the patient did not look to be in distress or having labored breathing. Lip and mouth color appeared to be appropriate to race and no cyanosis was noticed. I listened to the patient's lung sounds and could hear clear, strong breath sounds. I raised the patient's bed up slightly so she was in a better sitting position. I asked her to take a few deep breaths. After a few deep breaths I placed the pulse oximetry on the opposite hand to test a different finger. After receiving the new reading the oxygen saturation was now reading in the mid 90's where the patient had been during morning vital signs. I let the patient know those deep breaths and switching fingers seemed to help improve the reading. After looking in the patient's chart, her O2 sat seemed to be trending mid 90's to high 90's. That was an "AHA" moment for me as I really got to use my critical thinking and assess my patient against the vital sign readings to figure out what was going on and how it could be improved.
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. A patient on fall precautions continually tried to get out of bed to go to the restroom and do other activities without using a call light regardless of the numerous reminders to call for help when needing to use the restroom and to sit in the bedside chair. After a couple times of noticing the patient attempting to get out of bed, I found my nurse to discuss potentially placing a bed alarm in the patient's bed to see if that may help the patient stay in bed or ask for assistance when needed. The nurse agreed to the suggestion, and I was able to assist with getting the bed alarm hooked up and able to discuss the purpose of the alarm with the patient. 2. My patient was an older gentleman admitted for lumbar spondylosis with lower extremity stiffness and swelling in the foot and ankles. Upon entering the patient's room to take noon vital signs, the patient expressed he has not been able to brush his teeth or wash his face for the last few days and he felt awful. I noticed the patient had a toothbrush sitting on the counter by the sink and asked him if he would like some toothpaste to brush his teeth. The patient was reluctant at first and tried to shrug off the suggestion. After finishing his vital signs, I went and grabbed toothpaste from the central supply closet and a hand towel from the clean

			linen closet. I grabbed a cup of water and an extra cup for the patient to sit in after brushing his teeth. When I returned to his room, the patient gave me a smile and expressed his appreciation and explained he did not want to bother me with the request. I explained to him it was not a bother and it's important for him to express his needs. Patient was able to brush his teeth and wipe his face.
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. My patient needed clothing upon discharge since he was transferred from a smaller hospital and came only in a hospital gown. I was able to utilize the good Samaritan closest within the hospital to get a discharge outfit for my patient to leave the hospital in. It was a great learning experience as I was not aware of that recourse provided by the hospital, and my patient was beyond thankful. 2. A patient I was caring for was being discharged to a skilled nursing facility later that afternoon. My nurse and I planned the patient's care around his pending discharge as he was an older gentleman who took a little extra time to move around and get situated. We were able to utilize dietary to have his lunch brought up a little earlier than usual, so the patient had ample time and opportunity to eat before transportation arrived for him. I was able to assist in setting up his lunch tray and positioning the patient to his desire. Once the patient was finished, my nurse and I helped to wash his face and brush his hair. I removed the telemetry leads from the patient and discontinued his peripheral INT. The gentlemen had a colostomy bag that needed to be emptied prior to discharge. We were able to perform proper bag maintenance. Once that was completed, we helped the patient into his discharge outfit and placed his shoes on his feet. Once transportation arrived for the patient, I was able to assist him from his bed to the wheelchair and gathered his belongings for transportation to take with him. It was a unique experience as I have not been able to participate in discharging a patient up until this module.
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. Before starting clinicals that morning, we were informed there was only one aid for the entire unit and that extra help would be needed. After finishing my morning assessments and medication administration, I found the aid and informed her I would take care of the noon vital signs and blood sugar checks for my patients so relieve her from having to perform those tasks. The aid confirmed that plan and wrote down the room numbers I would be responsible for. Once my noon vitals and blood sugars were completed, I documented the results in my patients charts. I realized I had more time before going to lunch and offered to help the aid with any remaining vital sounds or blood sugar checks. The aid communicated what she needed and I was able to assist her in completing the remaining vital signs. 2. While checking on my patient after returning from lunch, she informed me she had soiled her brief. After assessing her I realized this would require another person to help reposition the patient for a complete linen change and clean up. I knew that the aid on the unit was extremely busy as she was the only one on the unit for that day. I was able to find a fellow student who was free to come assist with cleaning up my patient. We gathered the necessary supplies such as a new fitted sheet, a draw sheet, bed pad, top sheet, new gown for the patient, wipes and a new brief.

			We successfully changed the patient's linens and got her cleaned up. Once she was in a comfortable position in bed, I was able to clean up around the patient's room and discard the soiled linens in the appropriate bag.
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. My confused and disoriented patient stated he did not want to eat his food when his lunch tray arrived. I asked the patient why he did not want to eat his lunch and assessed if he was nausea or not feeling well. Patient assured me he felt fine; he just did not feel like he needed to eat his lunch. Educated patient on the importance of keeping up with his nutrition, especially while in the hospital. Patient asked why he needed to stay on track with his nutrition. Informed patient nutrition plays a key role in how the body regulates and functions, he needs to have a balanced diet with protein, carbohydrates, and adequate fiber. Fiber is important to get his motility and GI contents moving through successfully and protein to keep up with skin and muscle formation. Patient eventually decided to eat a small amount of food with assistance. 2. My patient was one day post op of a fusion surgery. She stated multiple times that the incision was bothering her and felt itchy. My nurse offered to give the patient famotidine to help suppress any histamine reaction that could be occurring. My patient was aware that famotidine was used for stomach ulcers, so she asked why we would be giving her this medication to help reduce itching. I was able to teach the patient that though stomach ulcers are the primary reason to take this medication, the action of the medication is to block histamine at the histamine H2 receptor sites in stomach cells. By blocking histamine, it can help improve and reduce itching around the incision site. The patient communicated she understood the teaching and showed appreciation for the explanation while agreeing to take the medication.
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. My patient was admitted for a CVA with a complete carotid occlusion. He sustained severe deficits as a result. He displayed left sided weakness to his upper and lower extremities, and a facial droop of the left side. His speech was severely slurred and incoherent. He was not able to articulate his words or communicate effectively. My nurse and I made it a priority to keep the patient propped up to display proper alignment in bed with multiple pillows. Keeping the patient free of pressure injuries, clean and dry were the main priority of care for this patient. Another important priority for this patient was having speech therapy perform a swallow evaluation as the patient had NPO for more than 24 hours. A swallow test was performed, and the patient was placed on a dysphagia diet and was able to enjoy lunch that afternoon! 2. I cared for a patient with multiple tumors in the brain that severely impaired her cognitive function. The patient was frequently confused and often became combative and aggressive as a result. Her plan of care needed to be altered due to the frequent disorientation. We needed to keep the patient's choices simple and commands simple and direct. The patient seemed to become irritated with more stimulation, so as a result we needed to cluster her care into one big intervention. The patient had her initial assessment, vital signs, medication administered, brief changes, repositioning in bed and morning breakfast all in one interaction. Once that was complete, we darkened the room and allowed the patient to rest for a

			while before the next visit, which seemed to help keep the patient calm.