

## Instructional Module 4 – Adult M/S 2

Competency	Outcomes	Secondary Outcomes	Give examples of how you met each outcome
<b>Assessment &amp; Intervention</b>	Implement a plan of care that integrates adult patient-related data and evidence-based practice.	<ul style="list-style-type: none"> <li>- Define plan of care for specific health impairment</li> <li>- Identify signs/symptoms of health impairment</li> <li>- Select &amp; implement proper interventions for specific health impairment</li> <li>- Evaluate effectiveness of interventions</li> </ul>	<p>1.) A patient of mine stated that he was thirsty and wanted some water. I pulled up his chart in the room to check for restrictions. He wasn't placed on a dysphagia diet or NPO, so I left the room to fill up a cup of water at the nourishment area. When I walked back into his room, I raised the head of the bed to prevent aspiration since he was an older adult. I raised the straw to his mouth, and he started drinking it. Within a few swallows, he began coughing hard. I set the cup down on the bedside table and raised the head of his bed even further to help facilitate his breathing while he coughed. It sounded like he was gasping for air, so I asked my classmate to bring me a vital sign machine to check his SPO<sub>2</sub> percentage. After my classmate brought me the machine, I checked his SPO<sub>2</sub> and it read 91%. Once the patient's coughing episode ceased, I instructed him to breathe through his nose and out of his mouth to bring up his SPO<sub>2</sub> percentage. After a few minutes passed his SPO<sub>2</sub> percentage returned to above 95%. I listened to his lung sounds and I didn't hear any crackles. After the incident, I notified his nurse and suggested that she perform a nursing bedside swallow evaluation. She agreed and we went in and did it together. After the evaluation she decided that it would be best to get speech therapy involved. The next time the patient asked for water, I explained to him that he had to wait for speech therapy to further evaluate his ability to swallow liquids. I offered sponges with water in the meantime to keep his mouth moist and he willingly agreed. I found out the next day that when speech therapy evaluated him, they instructed the nurse to change his diet to a dysphasia diet.</p> <p>2.) I was sitting at the nurse's station when the call light went off. I answered it and it was a patient who wanted assistance but didn't specify what she needed over the phone. When I went in her room, she was throwing up. I quickly grabbed a blue emesis bag that was sitting on the counter and raised the head of her bed to prevent aspiration. I decided to stay in the room until she finished throwing up. While I was in there, I looked on her eMAR for an antiemetic and she had Ondansetron 4mg IVP PRN available. After a couple of minutes, she finished, and I instructed her to stay sitting up while I went to notify her nurse. I told her nurse that she was throwing up and how I intervened in the moment. I also told her nurse that according to the patient's eMAR, there was an active order available for Ondansetron. The nurse and I teamed up and pulled the medication from the Pyxis. After pulling the medication, the nurse went into her room, and I went to grab supplies to clean the patient up. We gave the Ondansetron and after it started working, we cleaned her up and changed her linens. The patient felt better after the medication was administered and appeared relaxed afterward.</p>
<b>Communication</b>	Communicate effectively with members of the healthcare team.	<ul style="list-style-type: none"> <li>- Identify health care team members &amp; their purpose</li> <li>- Interact appropriately with health care team.</li> <li>- Utilize proper SBAR, TEAM Steps, etc.</li> <li>- Evaluate outcomes of communication process</li> </ul>	<p>1.) I was sitting at the nurse's station when the call light went off. I answered it and it was a patient who wanted to transfer from the bed to the wheelchair. The patient calling wasn't assigned to me and when I went to his room, I realized that he had paraplegia and I didn't feel comfortable assisting him to his wheelchair without knowing how he transferred. I told the patient that I needed to communicate with his nurse before assisting him and that I would return to his room shortly. I went to main nurse's station to find out what nurse was assigned to that room. Once I figured out who the nurse was, I asked the secretary if she could call the nurse on her Vocera to see how that patient transferred. The nurse picked up and said that he transferred from the bed to the wheelchair using a sliding board. I then asked the secretary to ask the nurse how many people needed to assist him, and the nurse said that he was a two-person assist. I asked the CNA if she could help me, and we both went into his room and safely transferred him to his wheelchair from the bed.</p> <p>2.) After passing morning medications, the nurse that I was following sat down to catch up on her documentation. No call lights were going off and the patients surrounding the nursing</p>

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			<p>station that I was at weren't in need of anything. I asked my nurse if I could go check in with my classmates to see if they needed help. The nurse approved so I walked down the hall to find my classmates. As I was walking down the hall ,a physical therapist asked me if I wanted to learn how they worked with stroke patients, and I said of course. When we went into the room, the physical therapist asked for permission from the patient before teaching me about range of motion and ways to improve it. We communicated back and forth about the different ways we perform patient care and how we can work together as a team to provide the best outcome for our patients. It was insightful to communicate with another member of the patient's interdisciplinary team. I walked away knowing how I can improve my patient's ROM when physical therapy is not around. I am always willing to learn how to be a more well-rounded nurse. I realized why it's so important for patients to have an interdisciplinary team. I believe that effectively communicating with one another helps improve the overall outcome of care being provided to each patient.</p>
<p><b>Critical Thinking</b></p>	<p>Apply evidence-based research in nursing interventions.</p>	<ul style="list-style-type: none"> <li>- Analyze pertinent data (subjective, objective)</li> <li>- Identify evidence-based practice (EBP) resources</li> <li>- Distinguish EBP nursing interventions</li> <li>- Apply EBP nursing interventions</li> <li>- Document resources &amp; interventions</li> </ul>	<p>1.) During simulation lab, a patient was diagnosed with hypokalemia. After the simulation was over, the instructor debriefed us . One of the questions during our debrief was about nursing interventions. I raised my hand and responded that the nurse could request an add on lab for magnesium to check the patient's serum magnesium levels. I was using critical thinking to try and solve the problem. I was thinking that if the patient's magnesium is low then it would be difficult to raise their potassium level while they received potassium sulfate. I learned in lecture that magnesium helps to transport potassium ions in and out of cells so it could contribute to the absorption of potassium leading to hypokalemia. By testing the patient's serum magnesium levels, the nurse would know whether or not they needed to call the doctor for an order of magnesium chloride.</p> <p>2.) During my clinical rotation there was a patient who was in respiratory distress. This patient had a history of COPD and was on a nasal cannula. When I walked into her room, she was breathing fast. When the nurse tried to encourage her to put on her bipap she refused. Her SPO<sub>2</sub> was 88% and she kept insisting that if she took deep breaths that it would get better. After a few minutes of deep breathing through her nose, her SPO<sub>2</sub> was at 93%. When the patient saw that number, she was even more convinced that she just had to calm down and breathe in order for the problem to be resolved. Eventually the respiratory therapist entered the room and tried to explain that just because her SPO<sub>2</sub> was coming back up, it didn't mean that she wasn't out of the woods. When she said that, I had to critically think about why she would tell the patient that, and I remembered that, just because she was perfusing well, it didn't mean that she was ventilating well. I remembered that a patient with COPD operates in the hypoxic drive but if something further impairs their ventilation, they will experience a buildup of CO<sub>2</sub>. This buildup of CO<sub>2</sub> leads to respiratory acidosis. When the respiratory therapist told the patient that, she knew that her pH was low and her PaCO<sub>2</sub> levels were high, indicating that the patient was acidotic. The patient was breathing fast because her body was trying to compensate by breathing off the excess CO<sub>2</sub> in her blood.</p>
<p><b>Caring and Human Relationships</b></p>	<p>Incorporate nursing and healthcare standards with dignity and respect when providing nursing care.</p>	<ul style="list-style-type: none"> <li>- Explain need for nursing &amp; health care standards</li> <li>- Apply standards to patient care (HIPAA, QSEN, NPSG)</li> <li>- Communicate concerns regarding hazards/errors in patient care</li> </ul>	<p>1.) A patient of mine had just been admitted to the unit from a skilled nursing facility. This patient arrived in terrible condition. It appeared as if she had been severely neglected. The worst part was the extent of skin breakdown she had on her butt and hands. I couldn't believe that her caregivers allowed her to deteriorate like that. She was also diagnosed with hypokalemia which most likely came from inadequate nutritional intake since she had no other underlying conditions. As soon as I heard about her in report, I made it a priority to provide the best care I could possibly give to her. I believe that upholding standards in healthcare helps to prevent these occurrences from happening. I felt concerned about her going back to the same skilled nursing facility. I asked the nurse that I was following if they were going to involve case management. The nurse told me that they were already involved.</p>

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			<p>During my time on the floor, I made sure she was comfortable and felt cared for. I tried my best to be gentle and soothing by going at her pace in everything that I did and offering therapeutic touch. I discovered that her hair was matted in the back, so I gently brushed it out and braided it to protect it from matting again. When I was touching her hair, I noticed that it soothed her to the point that she fell asleep. It made me feel good to see her relax after all she had been through. Every vulnerable person deserves to be cared for with dignity that aligns with good nursing and healthcare standards.</p> <p>2.) I experienced a younger patient who had suffered from a stroke. This patient was a husband and father who lived a relatively normal life prior to this incident. As a result of his stroke, he lost his coordination due to flaccidity and weakness in his lower extremities. I was called into his room to get him up to walk to the restroom for the first time since his stroke. We had three people plus his wife at his side to help him ambulate. It took the four of us plus a gait belt and walker to get him to the bathroom. It took a lot out of him to make it to the bathroom, but he did it. As soon as he sat down on the toilet he accidentally peed on the floor, and he started sobbing. As he was crying, he kept apologizing for having an accident even though he made it to the bathroom. He kept telling us how defeated he felt. In that moment I cared more about his mental wellbeing than the urine on the floor. I wanted to make him feel like it wasn't an inconvenience because I was there to help him get better. I told him how great he did, and we all took the time to acknowledge his progress. He expressed concern about how long it was taking to get better, and I told him that slow progress is still progress. His feelings and emotions were valid, and I made sure to let him know that. I also did my best to be there for his wife by listening to her fears and concerns. Expressing care during these vulnerable moments when a person is in their most fragile state is so important. I am just glad that I could be there.</p>
<b>Management</b>	Recommend resources most relevant in the care of patients with health impairments.	<ul style="list-style-type: none"> <li>- Assess patient needs during acute care to promote positive outcomes.</li> <li>- Assimilate co-morbidities into plan of care</li> <li>- Identify appropriate resources</li> <li>- Initiate discharge plan</li> </ul>	<p>1.) I was working with a patient who was recently diagnosed with type 2 diabetes mellitus. The doctor explained to the patient what their diagnosis meant earlier in the day, but the patient expressed to the nurse and I that he still felt very confused. The nurse sat down with him and educated him about diabetes and how he had to manage it. After she was done with her education, I asked her if there was any way that they could have a diabetes educator come in to walk him through his new life change and the modifications that would be involved. The nurse agreed to my suggestion and when I came back the next day, I learned that the diabetes educator stopped by. When I went back into the patient's room and asked him how he felt, he told me that he felt a lot better than when we spoke yesterday. Even though I am a student, I am still able to participate in the management of my assigned patient. I felt like I made a difference.</p> <p>2.) During clinical, I had a patient who was struggling to eat enough to maintain adequate nutrition. The patient explained to me that she doesn't have an appetite most days and that she didn't like to force herself to eat either. She told me that she had lost a lot of weight in the past year because of it. After talking with her for a while, I found out that her husband had passed away from COVID in 2020 and that she was still having trouble coping with it. I realized in that moment that her loss of appetite could possibly be from depression. Although I couldn't diagnose her, I did let the nurse know about my thoughts. The nurse agreed and came up with the idea that she may need to get the attending doctor involved to possibly put her on an antidepressant. I also suggested that the patient may benefit from some sort of support group that helps surviving spouses cope. I asked the nurse if case management would have access to that resource and she said that she would look into it.</p>
<b>Leadership</b>	Participate in the development of	<ul style="list-style-type: none"> <li>- Identify/define interprofessional plan of care</li> <li>- Integrate contributions of health care team to</li> </ul>	<p>1.) I had a patient who came in experiencing UTI-like symptoms. After receiving report, I decided to look through their chart to learn more about the patient. I noticed that they had a</p>

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	interprofessional plans of care.	<p>achieve goals</p> <ul style="list-style-type: none"> <li>- Implement interprofessional plan of care</li> </ul>	<p>urine culture ordered but not a urinalysis. I notified the nurse about my finding and when she investigated a little deeper, she saw that the doctor ordered the urinalysis incorrectly. By taking the initiative to look up my patient's lab values, the order may have been completely missed. The nurse contacted the doctor to correct the order and we ended up collecting a urine sample to perform a urinalysis.</p> <p>2.) I had a patient who needed labs drawn and I was sharing the patient with my classmate. The nurse asked which one of us wanted to draw labs and I told my classmate that they could do it since they never did it before. My classmate was doing an excellent job, but the patient's vein rolled. The nurse was busy on the computer, and I could tell that my classmate was beginning to stress. At this time the needle was in the patient's arm, and I told him to pull out a just little and change the angle of insertion. My classmate asked if I could just do it but I told them that one day it will be the nurse and although there is nothing wrong with asking for help, giving up in the middle of a challenge does not help you grow. I encouraged them to keep going and they did. My classmate drew three labs that day. True leadership lies in guiding others to success.</p>
<b>Teaching</b>	Evaluate the effectiveness of teaching plans implemented during patient care.	<ul style="list-style-type: none"> <li>- Identify/define teaching plan</li> <li>- Implement teaching plan</li> <li>- Identify appropriate evaluation tools</li> <li>- Appraise patient outcomes</li> </ul>	<p>1.) During clinical there was a patient who was receiving anticoagulant therapy. The nurse and I were sitting at the nursing station while she charted, and the sound of a bed alarm echoed down the hallway. I immediately looked for the flashing light above each door and I saw that the bed alarm was going off in my patient's room. I jumped up and quickly walked to his room and saw him trying to get out of bed. I walked into the room, and I asked him to wait until I could assist him. The patient waiting but insisted the entire time I helped him to the bathroom that he could walk by himself. He had no clue why we were monitoring his movements so closely, especially since he was used to walking around on his own at home. After I helped him return back to bed, I explained to him why we had a bed alarm on. I explained how dangerous it would be if he fell while receiving anticoagulation therapy. I taught him the importance of calling before getting out of bed as a preventative measure to keep him safe. After our conversation he understood why and called every time he needed to get up.</p> <p>2.) I had a patient who was NPO because they were scheduled to have a procedure done later that day. While they waited to go down, family was at the bedside to support them. When I walked into the room, I saw the patient's family member opening up a brand-new bottle of Dr. Pepper to give to the patient. When I saw that, I asked the family member if they were about to give that to the patient and she said yes. After she said yes, I kindly reminded her that the patient couldn't have anything by mouth because they were scheduled to go down for a procedure. The family member insisted that just a little bit wouldn't hurt and that the patient was begging for one all morning. I simply reiterated that the patient was going to a procedure and that the doctor ordered for them to have nothing by mouth. I taught her that it was to prevent vomiting that could lead to aspiration during the procedure. I told the family member that it was a measure used to keep her loved one safe. After our conversation, the family member had a better understanding and followed the rules.</p>
<b>Knowledge Integration</b>	Deliver effective nursing care to patients with multiple healthcare deficits.	<ul style="list-style-type: none"> <li>- Identify patient health deficits</li> <li>- Prioritize care appropriately</li> <li>- Adjust plan of care based on patient need</li> <li>- Identify system barriers</li> <li>- Modify health care deficits identified</li> </ul>	<p>1.) I assisted my classmates with a patient who had a hearing impairment. When I was called into the room to help my classmate change her patient, I realized that the patient had a delay in their command response time. I asked my classmate if they had any barriers and she told me that the patient was deaf in one ear and was hard of hearing in the other. As we were instructing the patient what to do, my classmate kept talking loudly in his ear. It took her multiple attempts to communicate with the patient when it dawned on me, I remembered something I learned in my lecture over auditory and visual. I learned that people have hearing loss cannot hear high frequency noises. When someone speaks loudly in</p>

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			<p>a high pitch tone, the person who is hard of hearing cannot pick up on the sound. After remembering that, I repeated the instruction in a low tone of voice at a slower pace in their better ear. The patient responded instantly to my instruction. We continued to communicate with him in that way and the job was able to get done quickly and efficiently.</p> <p>2.) I was working with a patient who had an order for a 24-hour urine collection. My nurse and I were in another room assisting a patient. After we finished up, we left the room, and my classmate came up to me and told me that he helped my patient to the bathroom. The first thing I asked was if he saved the urine. My classmate looked at me confused and said no. I told my classmate that my patient was in the middle of a 24-hour urine collection. At that moment, my classmate realized what just went wrong. I remembered that if a void is missed during that 24 window, then the entire urine collection I would have to be redone. Fortunately, the void that was missed was the very first void. We were able to continue with the 24-hour urine collection because the first void had to be discarded anyway. It worked out perfectly, but it was important to remember to never discard the urine of a patient that isn't assigned to you without checking with the nurse first.</p>
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