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. A patient of mine that was very unresponsive was laying on her right side so much she was practically out of the bed. I saw in her chart and also received in report that she had a stage 4 pressure sores on her bottom. As I stood in the room and tried to get her to respond and communicate with me the CNA let me know that her sister was on the phone. I aroused her and spoke loud and clear for her to be able to understand me. Once she woke up and was able to speak for her sister for about 10 minutes, I hung up the phone for her I was able to speak with her. I asked her "You've been laying on your side for a while is it okay if we rotate you to the other side of your bottom so we can take some pressure off of this side for a little while?". She was able to nod and agree with the intervention. I called for some help from the RN and the CNA to help me readjust the patient. We were able to rotate her sides and get her comfortable with pillows. I asked her after if she was comfortable and she nodded. The RN and I were able to continue to turn her to help her pressure sores. 2. A patient that I was caring for had a pain level that was not controlled, and he was not able to receive any pain medications. After the nurse called the doctor, the doctor would not prescribe any other medications to help the patient with his pain. After walking into the room, I noticed the patient crying and knowing that there were no medications that we could give him I tried to do some other interventions that I knew might help relieve some pain. His affected leg was laying straight on the bed, and I touched it and it was warm to the touch and saw some noticeable swelling. I got 3-4 pillows out of the central supply closet and brought them into the room and told the patient I was going to place them under leg to elevate it to help reduce the swelling. I then went to get an ice pack so I could place on the leg as well. I brought it into the room after getting ready and placed it on the leg to help relieve some of his pain. I then noticed that the other leg did not have a SCD on it and told the patient, "You need to have this on. It is going to help prevent blood clots especially since we are not up and moving around. Is that okay with you?". He then stated, "I thought it was like a massager, I didn't know that it for blood clots. I'll try anything to help with this pain." I placed the SCD on the patient and turned it on. I told the patient I would be back in about 30 minutes to see if my interventions helped his pain. After the time had passed, I went back to check on him and he stated, "The pillows and ice pack help not a lot, but it helped to the point that I'm not in excruciating pain and its bearable until I get some medicine." The patient was able to be calmer until he was able to get his next dose of pain medicine."
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. A patient that I was caring for was admitted for a right femur and right ankle fracture. He had been on the unit for four days post op and was a no weight bearing to the right leg. After doing his assessment he had stated," I haven't showered since before I got here and really want to be able to shower by myself before I discharge.". After hearing this I told him that I was going to see if physical therapy was on the floor and see what we could do to help him. I found physical therapy and explained what the patient had said and how we could come up with a way for him to be able to shower by himself. After looking at their notes we

			collaborated a plan together that would help the patient transfer from his bed to the shower chair and then to a Barton chair. The nurse and I along with PT entered the room and explained the procedure to the patient. We lateral transferred the patient from the bed to the shower chair and then rolled him into the shower and gave him all the supplies he would need in order to shower. After he was done with his shower, we did another lateral transfer from the shower chair to the Barton chair. The patient was so happy to be able to shower by himself with only the assistance of transferring. 2. After shift report my nurse was showing me how to look up the lab values for each patient. As we were looking through the lab values, we noticed that a patient's WBC was elevated along with a low platelet count. The nurse was concerned and notified her charge nurse of the lab values and the charge nurse stated that the patient's health care provider was on the unit enter let them know. While waiting at the nurses' station the nurse had asked, "Have you ever talked to a doctor about their patient status before?". I had stated, "No, only when I call consults and the doctor returns the call but not about a patient's direct care.". She then asked, "Do you want to talk to the doctor about this patient while I listen, or do you want me to do it?". Since this would be a new experience for me, I had told her, "Yes, I want to try.". As we waited for the doctor to come back to the nurses' station, I wrote down the lab values that were that we needed to address and got the Kardex from the nurse. Once a doctor came to the nurses' station and the nurse pointed the doctor out to me, I approached the doctor an introduce myself and explained the situation of my patient an SBAR form. I told the doctor the patient's name date of birth the room number and admitting diagnosis and immediately she knew who I was talking about. I then explained the lab values that the nurse and I had noticed and asked for their recommendation of what to do for these lab values. The doctor stated, "I will see them first and then all put in some orders for a unit of blood and an antibiotic I will prescribe.". After the doctor walked to the patients room the nurse told me that I did a good job in SBAR communication.
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. During my assessment of a patient with an indwelling catheter I focused on the insertion site and any drainage that might be seen. I asked my patient or if it was causing any pain since they inserted it. My patient denied any discomfort and asked why I was asking her and looking at the catheter. I then explained that being in the hospital the one thing we want to prevent is any kind of infections and I asked her if when they inserted the catheter if they told her any side effects that could happen from it. She stated, "I think they told me that as soon as a doctor sees I'm doing better I can get it taken out.". I replied, "Yes because having a catheter in the body is something that the body is not used to it's a foreign object. With it being a foreign object bacteria can get in and to prevent you getting a UTI. So, getting it out as soon as possible is going to help us prevent that also making sure it's cleaned properly every day so while I'm looking at your catheter I'm going to go ahead and clean it.". She nodded as I preceded to clean the catheter. After completing my assessment and cleaning the catheter I documented under patient care of the catheter care, and I also informed the nurse.

			2. While caring for a patient with a total right knee replacement I understood that mobility was one of the main concerns for an orthopedic nurse. As I walked into my patient's room, and they were resting in bed I asked if he needed assistance with anything and he explained that he needed to use the restroom. After receiving reports about this patient prior I was aware of his mobility, and I had seen him walk with physical therapy an hour prior to his calling. As I began to get is Walker ready and grab his nonskid socks from the table key waved at me and said he wanted to use the bedpan instead. I then began to ask him why and he stated, "I just got back into bed, and I don't want to get up just to use the restroom because it's a lot of work.". I then looked at him and stated, "I understand it's a lot of work but the more work we do it's better for you. When you go home are you going to have someone give you a bedpan or are you going to get up and go to the restroom?". He shook his head in denial and I then began to explain to him that getting up and moving is what we want for patience especially total knee replacement patients. After thinking about what I said he agreed to get up to go to the restroom I placed his nonskid socks on and assisted him to his walker and helped him to the restroom. After finishing I held him back into bed, he thanked me and told me that he wants to be able to play and run after his grandkids. I explained to him that our ultimate goal is to be able for him to return to his activities of daily living an if he can do that then we've done our job. Immobility is not our friend, and we want you to be as mobile as you can without hurting yourself. He agreed and as I walked out of the room the physical therapy assistant also thanked me for getting him out of bed.
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. While on the unit I was assisting the CNA with a patient's bath when in the middle of it be patient stated they wanted to get in the shower and did not want a bed bath. The CNA sighed really loudly and stated, well we're almost done with your bath so how about we just take a bath today and we can get in the shower tomorrow?". The patient looked at her and stated, "No I really want a shower today. Can we make that a plan please?". the CNA then nodded her head and told the patient that we would be back with all the supplies they needed. We left the room, and the CNA began to express her agitation to me about the patient's decision to shower instead of getting a bed bath. I could tell the CNA was aggravated and had an attitude about the situation and I explained to her that the patient simply wants to take a shower and that she needed to calm down. After walking back into the room with the supplies the CNA wrapped the patients IV so it wouldn't get wet by the water and placed the rest of the hygiene products in the shower and told the patient to call when she gets out of the shower. I asked the CNA if she was not going to stay in the room until the patient finished with her shower and she stated, "No I'll help her into the shower and wait until she's done to come back in to come get her out and put her back to bed.". I did not feel that was safe and told her I would wait in the room until she was done and put her back to bed myself and she nodded and left the room. I assisted the patient to the shower and waited for her to be done and helped her get dressed and assisted her back to bed. When I left the room, I felt that the situation needed to be addressed and informed the patient's nurse of what had occurred. I explained my feelings of

			how the CNA had no regards to the patient safety or feelings. the nurse said that she would speak to the CNA and let the charge nurse know. 2. After giving 8:00 AM meds with my nurse I was walking down the hallway and noticed my patient trying to get out of bed. I went in the room and asked if she needed some help. She stated that she needed to use the restroom and that she knew where it was. I explained that she was a fall risk patient and that she needed to call for help to get out of bed. She then stated, "I live at home by myself and go to the restroom alone every single day. I don't understand why I need to call for help when I do this every day by myself.". I stated, "You fell when you were at home remember? That's what brought you here. I just want to make sure you're safe and help you so we can get you home faster. I understand you're independent, I'm just here as an extra set of hands if you need it. I'll let you do it on your own and just stand back. But you need to have someone else in the room with you when you get out of bed, so you don't have another fall.". She then agreed and I assisted her to the bathroom and back into bed when she was done. I reminded her one more time before exiting the room to call for help before she got out of bed. She then agreed that she would call for help and that she appreciated me for caring about her. I found the nurse and I let her know about what had happened.
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. While preparing a patient for discharge the nurse some questions about his discharge. There were some concerning answers to these questions such as," Yes, I have stairs" and "I live alone". When talking to the nurse at the nurses' station I raise some concern about these answers to her because the patient had just undergone a total hip replacement. I had asked the nurse about home health care and about going to a rehab facility instead of going home and talking to the case manager about maybe setting something up. The nurse agreed and we went to the case managers office and explained to her about the patient situation and our recommendation for discharge. After hearing the situation, the case manager also agreed and told the nurse and I that she would get started on the process and she would let the patient know about the new discharge plan. 2. I had a patient that was transferred from another unit that was being discharged within the next two or three days. While sitting in the room talking to the patient about his experience while being in the hospital and how it was going to change when he got home. The patient shared with me the good quality care he received while being on the unit and expressed how appreciative he was of the health care team that took care of him and how he was going to miss everyone. I asked the patient about transitioning from having dietary and kitchen staff assisting with his meals to having to go home and cook his own meals. The patient stated, "Since being here I've been diagnosed with type 2 diabetes and now I have to change the way I eat. Food is so expensive now that eating healthy is a really big expense when eating non healthy can be so much cheaper.". I sympathized with my patient and recommended that they speak with a dietitian and also explained the help that a diabetic educator could give them and asked if he wanted to utilize those resources. The patient agreed and I notified the nurse to ask about what the next

			step was for me to help with that.
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. Well in my patient's room assisting physical therapy and the nurse get my patient into a Barton chair my patient began to complain about having to get out of bed and just wanting to go home. I explained to the patient that sitting in the chair was a positive way to show the doctor that they were complying with physical therapy and his orders. I also informed the patient that sitting in the chair or at least two or more hours a day would help them go home faster. The nurse also explained that I had a good point and that physical therapy and us wanted him to be able to go home. I told my patient that he had to listen to physical therapy and to do what they said because they were here to help him be able to get back to his normal activities. Physical therapy told the patient that we were all on the same team and that we all wanted the same goals for him. 2. While sitting at the nurses' station I could hear my patient down the hall arguing with the doctor. The nurse and I walked in we realized it was our patient and we asked the patient what was going on. The patient began to express their feelings of anxiety and confusion because they did not know who the doctor was that was in the room with them. The nurse and I began to explain that the doctor in the room was their heart doctor and that they were there to look at her heart to make sure it was working right and to make sure she was OK. The patient began to calm down and we were able to help her understand the purpose of her cardiologist. As the doctor explained that he was going order and EKG and some labs to be drawn the patient nodded her head in understanding. I explained to the patient that all her doctors and nurses were all trying to get her home to her family and that we all wanted the same thing. The patient smiled and nodded in understanding.
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. While assisting my nurse discharge a patient, she allowed me to assist with teaching of wound care of an external fixator. I began reading the district paperwork that the nurse had printed out for the patient to take home. The discharge paperwork stated that the patient could shower with the device and to allow the warm soapy water to run over it. it also stated for the patient not to touch the insertion sites and to call the health care provider if he saw any noticeable redness and swelling or any kind of drainage come from the insertion sites. As a patient and his mother nodded as I continue to read, I wanted to be sure that they fully understood the directions as I read them. I asked if they could teach back what I had read them so the nurse and I could be certain that they understood the discharge teaching that we had implemented. 2. The nurse was educating a patient on their meds before discharge while I showed the patient which medication she was talking about. the patient had about 7 to 8 medications that they were taking home with them. As the nurse was explaining I noticed a confused look on my patients face and I asked her to stop so the patient could ask the question that they were thinking. the patient stated, "I'm scared I'm not going to know which medication is for pain which medication is the

			antibiotic and which medication is for nausea.". The nurse and I looked at each other and I noticed she had multiple sharpie colors in her pocket, and I asked if I could borrow them. The patient had three pain medications, two antibiotics and one anti-emetic and one blood thinner. I grabbed the discharge paperwork that had the medication list on it and wrote a P next to the pain medications, a A next to the antibiotics, a in next to the anti-emetic and a B next to the blood thinner all in different colors. I then grabbed the bottles of medications ended the same but on the lid of the medication. I then explained my method to the patient and the patient smiled at me and said thank you. I asked if he understood the difference between each bottle and he nodded. I asked if he could show me which medication was which and he did so.
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. Sitting at the nurses' station I could hear a patient from across the hall speaking loudly in frustration. Upon my curiosity I walked into the room and asked the patient if they needed any assistance. The patient looked at me and shook her head and squinted her eyes to see me and began to cry while rubbing her eyes vigorously and I asked what was wrong even though I could tell it was going to be a problem with her eyes. She stated, "When I fell, I broke my glasses and I need them to be able to see. I asked her what she was having a hard time seeing. She began to tell me that she was having difficulty seeing the buttons to operate the bed and to call for help. I asked her if she couldn't see the words or if she couldn't see the shapes and she said the words. I then explained that to make it easier on herself that the big green button in the center of the call light is her button to call for help and that the buttons to operate the bed we're on the outside the bedrail. I then explained that if she wanted to readjust her bed to push on the green button that I showed her and that someone would come in here to help her with that so she wouldn't have to stress about not being able to see. I informed the nurse of what had happened and told her that we would have to accommodate for her vision problems. 2. While caring for a patient with a stage four pressure ulcer that was nonverbal the nurse informed me that we would have to perform wound care to her ulcer sometime today when she more awake. After trying multiple times in the morning to arouse her and wake her up and failing after she spoke with her sister on the phone and readjusting her, I asked her if she wanted a bath. she nodded her head and I told her I was going to get the supplies I needed and get the nurse to assist me. I found the nurse and informed her that I finally had the patient awake and alert and suggested that since the patient was awake and alert to go ahead and give her bath and to perform wound care to her ulcer. The nurse agreed and we gathered everything we needed including the wound care supplies. we entered the room and began her bath and as we were washing and drying the folds of her body, we applied the Nystatin powder to keep areas that get moist quickly not moisten and sweat so much. as we began to get ready to turn her on her side to wash her back, we informed her of performing her wound care so she wouldn't have to turn so many times and she could rest instead. She agreed and she turned to one side

			while the nurse performed her wound care and then she turned to the opposite side and the nurse rushed around so she could finish the wound care on the opposite side. After we were done, I asked the patient if she was OK, and she nodded and said that she was tired. The nurse and I cleaned up our mess and we adjusted our patient and let her rest.

References

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