IM 2 Simulated Patient Clinical Video Grading Rubric

Student Name: Aubree Lomax Video: #2 Date: 12/17/21

There are three (3) ways to receive credit for the video:

1. *Perform the scenario with all critical elements in each area of the grading tool*
2. *Verbalize a breach or mistake in real time and provide the nursing intervention to correct the breach or mistake then proceed with the video*
3. *When reviewing the video, honestly evaluate the nurse. Recognize all (if any) breaches or mistakes, record them as "unmet" and provide a nursing intervention to correct the breach or mistake*

Universal Competency	Critical Elements	M	U
Safety (physical and emotional)	Introduce self	✓	
	Identify patient (2 patient identifiers)	✓	
	AIDET	✓	
	Allergies	✓	
	4 P's		✓
	Fall Bundle	✓	
	Medication Administration: Medication, dosage, route, reason, assessment of route site(s), medication delivery equipment (IV pump, etc.)		✓
Critical Thinking	**Assessment:** See NII for critical elements pertaining to selected assessment(s)	✓	
	Procedure Assess, Plan, Implement, Evaluate (APIE) (Selection of appropriate equipment, time management, organization, etc.)		✓
Standard Precaution	**Asepsis:**		✓
	Hand hygiene		✓
	Don and change gloves (as indicated)		✓
	Clean equipment (stethoscope, pulse ox, bedside table, med tray, etc.)	✓	
	Sterile procedure		✓
	Medication preparation		✓
	Medication delivery		✓
Documentation	**Teach Patient:**		✓
	Medication		✓
	Procedure	✓	
	Scan patient	✓	
	Scan medication		✓
	Save med documentation	✓	
	Document assessment findings	✓	
	Document procedure	✓	
	Save all documentation	✓	
Human Caring and Relationship	Respect, active engagement, authenticity, empathy, etc.	✓	
Professional Role Performance	Appearance, preparation, behaviors, resource management, etc.	✓	

Comments:

Comments and corrections attached on next pages

Aubree Lomax

Professional Nursing Skills Video #2 Rubric with corrections

Safety (Physical and emotional)

- Introduce self - MET
- Identify patient (2 patient identifiers) - MET
- AIDET- MET
- Allergies - MET
- 4 P's- UNMET
    - I did ask the patient about pain, position, and possessions. However, I did not ask about "Potty". I should have asked if the patient needed help using the restroom especially since she was just given morphine she cannot get up without calling for help and there may have been some issue with constipation due to that morphine. I should have asked this to ensure the patient is comfortable.
- Fall Bundle - MET
- Medication Administration (Medication dosage, route, reason, assessment of route site, medication delivery equipment - UNMET
    - Comments: In the med room I had a bubble in my morphine syringe I did verbalize that in a real situation I would continue to redraw until there were no bubbles present. However, because of the time limit on the video, I did not want to spend too much time redrawing my medication. It is important to not have any air bubbles in the syringe because air bubbles can lead to an air embolism which can be fatal. When labeling my morphine syringe I said I was labeling the morphine vile, however, I meant syringe and I did label the syringe in the video. I got quite a bit of ink on my fingertips and I did verbalize that I would remove those gloves perform hand hygiene and don a new pair of gloves. However, for video purposes I did not remove my gloves because of the time, I should have performed hand hygiene and donned new gloves to ensure that there weren't any more germs introduced. The ink would also make my gloves visibly dirty since there was quite a bit on there and all on my fingertips which I would be using the most. I did inform the patient of the medication, dosage, reason, and I did have the proper equipment. I did verbalize that I assessed the CVAD site for any abnormalities but I should have also asked the patient if she was experiencing any pain or tenderness around the area. I also should have verbalized my assessment of abnormalities such as redness bruising, or abrasions before I administered the TDAP vaccine. Then I should have asked if there was any tenderness or irritation around her arm. I should have assessed for those abnormalities before I gave the med because if there was an issue I would need to withhold the medication to avoid worsening the condition or checking another site. I told the patient that I would be giving the morphine via IV push when I walked in, but I should have reiterated that when I told her

the dosage, adverse effects, etc. I would just tell her again because there is a chance she didn't catch it when I walked in or maybe she has more questions. I should have told the patient that the TDAP shot would be going in her arm arm and I should have verbalized that the shot was IM and going in her deltoid muscle. I did tell her it was a shot but to properly tell her the route I should have stated that the medication would be delivered via shot in her arm. When teaching the patient to increase her fluid and fiber intake I said "that will help your bowels a lot better" I meant to say that it would "help your bowel movements" the increase of fiber in water encourage digestion therefore can help with any constipation issues. I feel that it sounded a bit rude and unclear to say that would help her bowels "a lot better". I did take the vitals I needed to administer Morphine and I did scan the vile before I administered morphine. I did not SCAN my TDAP vaccine before I administered it. I should have scanned the TDAP before I administered it and after she signed the consent to receive the vaccine. I also should have given her an actual consent form and verbalize that I documented her consent when I documented my medications. I just pretended to use the vaccine info sheet as the signed consent as well but the hospital would need a copy of the consent for medical records. I should have scanned the morphine vile after the nurse witnessed the wastage of medication to ensure that the medication was correct and I should have verbalized that I was checking the medication again instead of me checking it before I scanned. I would need to scan the med and vaccine before I could complete my 3rd check of the orders,and then I would need to verbalize my 3rd check. there could have potentially been a pop-up upon scanning either one of the meds that could have warned me to not administer a med. It is important to scan to prevent med errors by verifying the med is correct for the patient, without scanning we cannot be sure that the med is correct and will not potentially harm the patient. I should have also verbalized that the nurse was witnessing my morphine wastage, in my video, I used the word verify and I should have said that she would document that she witnessed my wastage of morphine. I did say that I would document my wastage and I did verbalize in the beginning that another nurse would witness my wastage but I should have said it again and stated that she would document her witnessing my wastage. This would prevent me from potentially being in a situation where I could be accused of not wasting meds properly. I would also have verbalized the proper wastage of the vile. The vile should be disposed of in the proper container and the disposal should be witnessed as well. I did properly assess the CVAD site for any redness, drainage or other abnormalities but I should have asked the patient if they were experiencing any pain or tenderness in the area to ensure that I was good to go ahead and give that medication. If the patient reported pain at the site I may need to withhold the medication

and reassess. I would do this to just be as clean as possible and prevent all the germs from the bed rail from getting near the site. When I was assessing the CVAD site I did notice that one lumen was unclamped and did not have an orange cap, I did verbalize that I would get a new clamp and orange cap for that lumen and clean the lumen and needless connector. Liquid could be dripping out onto the patient and bacteria could be getting on that needless connector. I also noticed that the distal lumen clamp was underneath the dressing. Therefore I went to move it since that is the lumen where I should have given the medication through. However, I had to lift the dressing and put it back down which would call for further interventions. Since I touched the dressing and put it back down I should have performed hand hygiene and donned new gloves before continuing to administer that morphine via IV push. I would do this to ensure that I do not bring any possible bacteria from under that dressing onto the lumens, needless connector, or any of my other supplies. Then I would go ahead and perform a CVAD dressing change to clean the site that I touched, and prevent bacteria from getting into the site. Another option would have been using a proximal lumen instead of the distal one and not touching the dressing. While the distal lumen is ideal since it dispenses medication directly into the superior vena cava, the proximal lumen is fine to use as well; it is just not as fast-acting. If there were no signs of abnormalities such as redness, swelling or drainage, I could have not touched the dressing and administered the medication through the proximal lumen. That brings me to my next error, when I moved the clamp from the distal lumen, I accidentally picked up the proximal lumen instead of the distal. I should have double-checked that I had the best lumen before I started to administer anything. The distal is the ideal lumen to use since it dispenses medication directly into the superior vena cava and therefore is the fastest acting. However, the proximal lumen is fine to use instead. When I removed the clamp off of the distal lumen I accidentally started to administer the flush in the proximal lumen. The clamp that I undid to move from under the dressing was the clamp to the distal lumen and I intended to use it. However, after I dropped the distal lumen to secure the dressing, I picked up the proximal lumen and gave meds through the proximal lumen.The administration of medications through a central line should be done through the distal lumen. This was a med error on my part and honestly eye opening how easy it was to make that mistake. Medications given via IV push should be given through the distal lumen to ensure that the medication reaches the bloodstream the fastest. The distal lumen dispenses medication directly into the superior vena cava, therefore making it the fastest acting. Since I started to use a different lumen than the distal one I forgot to go back and clamp the distal lumen. I would need to have clamped the lumen to properly follow procedure, this would prevent any fluid leakage

from the lumen. I did not aspirate for blood return before I gave my first flush. I should have aspirated for blood return in the lumens to check the patency of the lumen before I administered the first flush. I also did verbalize that I was checking the clock and giving my medication over 2-4 minutes, however you could not see very well in my video. I tried to use the technique Mrs. Allison showed us, which was to slowly twist the plunger to administer the medication at a slower speed. The video also doesn't show it well but I gave 9ml for both flushes as a push pause. It was also a little difficult to tell but I would have given the first 3-5 mLs at the same rate that I gave my morphine which was 2-4 mins per mL. I also should have verbalized that the alcohol was fully dry in between administering flushes and medications, this just ensures that wet alcohol on the site would not interfere with the med admin. The correct action would be to verbalize after alcohol pad use that the site has fully dried before continuing to the next step.

Critical thinking

- Assessment - MET
- Procedure- UNMET
    - Comments: I stated that moisture getting on the cvad could cause bacteria, a better way to phrase that would have been "condensation causes the cvad kit to no longer be sterile." This is because it has been contaminated by the moisture on the table. When I was looking at the lumens I lifted up the dressing and then put it back down, I should not have done this because it could cause bacteria to enter the site and therefore cause complications. The proper action after I lifted the dressing was what I did, I removed my gloves, performed hand hygiene, and I began to remove the dressing and clean the CVAD site. I started to open my cvad kit towards me instead of away, I did verbalize that mistake and I would open away to reduce the risk of contaminating my field and getting any additional germs on the kit. I should have performed hand hygiene before I applied my patient's mask and informed her to look to the side to prevent breathing on the site. I should have verbalized this instruction to the patient because it is important she understands that breathing on the site can increase the risk of bacteria entering the insertion site.Doing hand hygiene before I applied my patient's mask would ensure that I kept my patient free of any of the germs I picked up from touching things around the room. Hand hygiene should always be done before touching a patient to prevent the spread of bacteria. By telling her to look to the side with her mask on I would decrease the likelihood of her breathing on the site and possibly allowing any bacteria to enter the insertion site. My first pair of sterile gloves had been folded near the bottom and the gloves were exposed near the cuffs which would make them not sterile. I did verbalize that this is a breach in the sterile field and I would need to get a new pair of sterile gloves. I would do this to ensure my gloves are

completely sterile. The paper also came up in the bottom corner when I folded my gloves and then it touched the gloves again. If that happened in a real situation, I would get a new pair of sterile gloves before continuing because my gloves are no longer considered sterile.
I could improve my sterile gloving technique by picking up the glove a little bit higher on the cuff, I did not contaminate my sterile gloves but it would make donning my gloves and for you watching to see that I am sterile a little easier. When I was removing the CVAD dressing I should have verbalized that I assessed for redness and drainage before I began to remove the dressing. I did this before I donned my sterile gloves but I need to verbalize that I checked before I removed it. I also forgot to ask about pain, tenderness, or irritation at the site before I removed the dressing. I would want to be sure to ask those questions and assess for those findings because if there was an abnormality or issue at the site I would assess further. I also did not PALPATE for tenderness, I should have palpated for tenderness and ask if the site was tender just to ensure that there is nothing out of the ordinary because any kind of lumps, distention, or tenderness to the patient is abnormal. This is important to do to ensure that nothing is becoming infected, tenderness would be abnormal with palpation or without. In my video I stated that I was “staying on the one-inch border” I should have verbalized that I meant the one-inch border of my kit and gloves package were touching each other but it was okay because only the one-inch borders were touching which does not contaminate my sterile field. If the borders would have crossed I would have a new one-inch border and potentially have to start over if the one-inch border was in the area my sterile supplies or sterile gloves were laying. I partially reached over the corner of my cvad kit when I went to get my second pair of gloves, I should have backed up and only stood behind my gloves instead. By reaching over the sterile field I would have contaminated it with epithelial cells and broken sterility. I would have needed to start over if that occurred in a real situation. My second pair of gloves got a little too close for comfort on the one inch border. I feel that it went over the one inch border and in that case I would need to get a new CVAD kit and start over. II should have moved my cvad kit or gloves to give myself more room and decrease my risk of contamination and breaking sterility. I should not have reached over my sterile gloves to stabilize my paper. By doing that I contaminated the sterile gloves with my epithelial cells. I should have touched the one inch border closest to me or changed my position where I was not reaching over anything. If that situation were to occur in a hospital setting I would get a new pair of sterile gloves. I did verbalize that the glove touched my fingers when I picked it up, if I would have been holding the paper down at a better spot that breach in sterility could have been avoided. I did say in the video I would need to get new sterile gloves and that is correct. When I walked

over to drop my CVAD dressing paper, I crossed over the sterile field. I would have once again contaminated the sterile field with epithelial cells and since the field was no longer needed to be sterile I could still continue. The dressing did fold back a bit and I verbalized that if that occurred in a hospital setting I would get a new dressing which would mean I would most likely have to start over. I would not want to take the chance of bacteria getting on the chlorhexidine patch that was exposed and then the insertion site. I also should have performed hand hygiene before I removed my patient's mask.

Standard precaution

- Asepsis - UNMET
    - When I was assessing the CVAD site I did notice that one lumen was unclamped and did not have an orange cap, I did verbalize that I would get a new clamp and orange cap for that lumen and clean the lumen and needless connector. Liquid could be dripping out onto the patient and bacteria could be getting on that needless connector. I also noticed that the distal lumen clamp was underneath the dressing. Therefore I went to move it since that is the lumen where I should have given the medication through. However, I had to lift the dressing and put it back down which would call for further interventions. Since I touched the dressing and put it back down I should have performed hand hygiene and donned new gloves before continuing to administer that morphine via IV push. Then I would go ahead and perform a CVAD dressing change to clean the site that I touched, and prevent bacteria from getting into the site. Another option would have been using a proximal lumen instead of the distal one and not touching the dressing. While the distal lumen is ideal since it dispenses medication directly into the superior vena cava, the proximal lumen is fine to use as well; it is just not as fast-acting. If there were no signs of abnormalities such as redness, swelling or drainage, I could have not touched the dressing and administered the medication through the proximal lumen. That brings me to my next error, when I moved the clamp from the distal lumen, I accidentally picked up the proximal lumen instead of the distal. I should have double-checked that I had the best lumen before I started to administer anything. The distal is the ideal lumen to use since it dispenses medication directly into the superior vena cava and therefore is the fastest acting. However, the proximal lumen is fine to use instead. When I observed that a lumen was unclamped I lifted the dressing and I should not have done that because it can spread more bacteria. I should have performed hand hygiene before I applied my patient's mask and informed her to look to the side to prevent breathing on the site. This would ensure that I kept my patient free of any of the germs or germs I picked up from touching things around the room. Hand hygiene should always be done before touching a patient to prevent the spread of bacteria. My first pair of sterile gloves had been folded near the

bottom and the gloves were exposed near the cuffs which would make them not sterile. I did verbalize that this is a breach in the sterile field and I would need to get a new pair of sterile gloves. I would do this to ensure my gloves are completely sterile. The paper also came up in the bottom corner when I folded my gloves and then it touched the gloves again. If that happened in a real situation, I would get a new pair of sterile gloves before continuing because my gloves are no longer considered sterile.
I could improve my sterile gloving technique by picking up the glove a little bit higher on the cuff, I did not contaminate my sterile gloves but it would make donning my gloves and for you watching to see that I am sterile a little easier.

- Hand Hygeine - UNMET
    - Comments: I should have performed hand hygiene right before I put my patient's mask on her. When I was assessing the CVAD site I did notice that one lumen was unclamped and did not have an orange cap, I did verbalize that I would get a new clamp and orange cap for that lumen and clean the lumen and needless connector. Liquid could be dripping out onto the patient and bacteria could be getting on that needless connector. I also noticed that the distal lumen clamp was underneath the dressing. Therefore I went to move it since that is the lumen where I should have given the medication through. However, I had to lift the dressing and put it back down which would call for further interventions. Since I touched the dressing and put it back down I should have performed hand hygiene and donned new gloves before continuing to administer that morphine via IV push. Then I would go ahead and perform a CVAD dressing change to clean the site that I touched, and prevent bacteria from getting into the site. I also should have performed hand hygiene before I removed my patient's mask. I should have performed hand hygiene after I touched the bed rail to lower the patient because I then touched the lumens. Even though I was just trying to get a better angle for the video I would need to perform hand hygiene because I would not want to contaminate those lumens. I also would have performed hand hygiene because I then touched the patient after I touched the bed rail. I should have performed hand hygiene and changed gloves before I started to administer the first flush because I touched the bed rail. I would do this to just be as clean as possible and prevent all the germs from the bed rail from getting near the site.
- Don and change gloves (as indicated) - UNMET
    - Comments: When in the med room I said I would "clean my gloves" I meant to say I would remove them. I did remove them and perform hand hygiene properly. When I was assessing the CVAD site I did notice that one lumen was unclamped and did not have an orange cap, I did

verbalize that I would get a new clamp and orange cap for that lumen and clean the lumen and needless connector. Liquid could be dripping out onto the patient and bacteria could be getting on that needless connector. I also noticed that the distal lumen clamp was underneath the dressing. Therefore I went to move it since that is the lumen where I should have given the medication through. However, I had to lift the dressing and put it back down which would call for further interventions. Since I touched the dressing and put it back down I should have performed hand hygiene and donned new gloves before continuing to administer that morphine via IV push. Then I would go ahead and perform a CVAD dressing change to clean the site that I touched, and prevent bacteria from getting into the site. I should have performed hand hygiene and changed gloves before I started to administer the first flush because I touched the bed rail. I would do this to just be as clean as possible and prevent all the germs from the bed rail from getting near the site.

- Clean equipment - MET

- Sterile procedure - UNMET
    - I started to open my cvad kit towards me instead of away, I did verbalize that mistake and I would open away to reduce the risk of contaminating my field and getting any additional germs on the kit. When I observed that a lumen was unclamped I lifted the dressing and I should not have done that because it can spread more bacteria.I should have performed hand hygiene before I applied my patient's mask and informed her to look to the side to prevent breathing on the site. Performing hand hygiene before applying the patient's mask would ensure that I kept my patient free of any germs I picked up from touching things around the room. Hand hygiene should always be done before touching a patient to prevent the spread of bacteria. My first pair of sterile gloves had been folded near the bottom and the gloves were exposed near the cuffs which would make them not sterile. I did verbalize that this is a breach in the sterile field and I would need to get a new pair of sterile gloves. I would do this to ensure my gloves are completely sterile. The paper also came up in the bottom corner when I folded my gloves and then it touched the gloves again. If that happened in a real situation, I would get a new pair of sterile gloves before continuing because my gloves are no longer considered sterile.
      I could improve my sterile gloving technique by picking up the glove a little bit higher on the cuff, I did not contaminate my sterile gloves but it would make donning my gloves and for you watching to see that I am sterile a little easier. When removing my first pair of sterile gloves I accidentally removed my gloves improperly, I should have used the glove-to-glove skin-to-skin method where I would keep the dressing inside the two gloves since there is Chlorhexidine in there, there could be bacteria from

the site and even possible bodily fluids. Since I was just removing my gloves it was okay because I then did hand hygiene before I donned my next pair of sterile gloves. I did catch this and verbalize it in the video but I still need to document it here. In my video I stated that I was “staying on the one-inch border” I should have verbalized that I meant the one-inch border of my kit and gloves package were touching each other but it was okay because only the one-inch borders were touching which does not contaminate my sterile field. If the borders would have crossed I would have a new one-inch border and potentially have to start over if the one-inch border was in the area my sterile supplies or sterile gloves were laying.

- Medication Preparation -UNMET
    - Comments: In the med room I had a bubble in my morphine syringe I did
    - verbalize that in a real situation I would continue to redraw until there were no bubbles present. However, because of the time limit on the video, I did not want to spend too much time redrawing my medication. It is important to not have any air bubbles in the syringe because air bubbles can lead to an air embolism which can be fatal. When labeling my morphine syringe I said I was labeling the morphine vile, however, I meant syringe and I did label the syringe in the video. I got quite a bit of ink on my fingertips and I did verbalize that I would remove those gloves perform hand hygiene and don a new pair of gloves. However, for video purposes I did not remove my gloves because of the time, I should have performed hand hygiene and donned new gloves to ensure that there weren’t any more germs introduced. The ink would also make my gloves visibly dirty since there was quite a bit on there and all on my fingertips which I would be using the most.
- Medication Delivery - UNMET
    - Comments: I did have the proper equipment. I did verbalize that I assessed the CVAD site for any abnormalities but I should have also asked the patient if she was experiencing any pain or tenderness around the area. I also should have verbalized my assessment of abnormalities such as redness bruising, or abrasions before I administered the TDAP vaccine. Then I should have asked if there was any tenderness or irritation around her arm. I should have assessed for those abnormalities before I gave the med because if there was an issue I would need to withhold the medication to avoid worsening the condition or checking another site. I told the patient that I would be giving the morphine via IV push when I walked in, but I should have reiterated that when I told her the dosage, adverse effects, etc. I would just tell her again because there is a chance she didn’t catch it when I walked in or maybe she has more questions. I should have told the patient that the TDAP shot would be going in her arm and I should have verbalized that the shot was IM and

going in her deltoid muscle. I did tell her it was a shot but to properly tell her the route I should have stated that the medication would be delivered via shot in her arm. When teaching the patient to increase her fluid and fiber intake I said “that will help your bowels a lot better” I meant to say that it would “help your bowel movements” the increase of fiber in water encourage digestion therefore can help with any constipation issues. I feel that it sounded a bit rude and unclear to say that would help her bowels “a lot better”. I did take the vitals I needed to administer Morphine and I did scan the vile before I administered morphine. I did not SCAN my TDAP vaccine before I administered it. I should have scanned the TDAP before I administered it and after she signed the consent to receive the vaccine. I also should have given her an actual consent form and verbalize that I documented her consent when I documented my medications. I just pretended to use the vaccine info sheet as the signed consent as well but the hospital would need a copy of the consent for medical records. I should have scanned the morphine vile after the nurse witnessed the wastage of medication to ensure that the medication was correct and I should have verbalized that I was checking the medication again instead of me checking it before I scanned. I would need to scan the med and vaccine before I could complete my 3rd check of the orders, and then I would need to verbalize my 3rd check. There could have potentially been a pop-up upon scanning either one of the meds that could have warned me to not administer a med. It is important to scan to prevent med errors by verifying the med is correct for the patient, without scanning we cannot be sure that the med is correct and will not potentially harm the patient. I should have also verbalized that the nurse was witnessing my morphine wastage, in my video, I used the word verify and I should have said that she would document that she witnessed my wastage of morphine. I did say that I would document my wastage and I did verbalize in the beginning that another nurse would witness my wastage but I should have said it again and stated that she would document her witnessing my wastage. This would prevent me from potentially being in a situation where I could be accused of not wasting meds properly. I would also have verbalized the proper wastage of the vile. The vile should be disposed of in the proper container and the disposal should be witnessed as well. I did properly assess the CVAD site for any redness, drainage or other abnormalities but I should have asked the patient if they were experiencing any pain or tenderness in the area to ensure that I was good to go ahead and give that medication. If the patient reported pain at the site I may need to withhold the medication and reassess. When I was assessing the CVAD site I did notice that one lumen was unclamped and did not have an orange cap, I did verbalize that I would get a new clamp and orange cap for that lumen and clean the lumen and needless connector. Liquid could be dripping out onto the patient and bacteria could

be getting on that needless connector. I also noticed that the distal lumen clamp was underneath the dressing. Therefore I went to move it since that is the lumen where I should have given the medication through. However, I had to lift the dressing and put it back down which would call for further interventions. Since I touched the dressing and put it back down I should have performed hand hygiene and donned new gloves before continuing to administer that morphine via IV push. I would do this to ensure that I do not bring any possible bacteria from under that dressing onto the lumens, needless connector, or any of my other supplies. Then I would go ahead and perform a CVAD dressing change to clean the site that I touched, and prevent bacteria from getting into the site. Another option would have been using a proximal lumen instead of the distal one and not touching the dressing. While the distal lumen is ideal since it dispenses medication directly into the superior vena cava, the proximal lumen is fine to use as well; it is just not as fast-acting. If there were no signs of abnormalities such as redness, swelling or drainage, I could have not touched the dressing and administered the medication through the proximal lumen. That brings me to my next error, when I moved the clamp from the distal lumen, I accidentally picked up the proximal lumen instead of the distal. I should have double-checked that I had the best lumen before I started to administer anything. The distal is the ideal lumen to use since it dispenses medication directly into the superior vena cava and therefore is the fastest acting. However, the proximal lumen is fine to use instead. When I removed the clamp off of the distal lumen I accidentally started to administer the flush in the proximal lumen. The clamp that I undid to move from under the dressing was the clamp to the distal lumen and I intended to use it. However, after I dropped the distal lumen to secure the dressing, I picked up the proximal lumen and gave meds through the proximal lumen.The administration of medications through a central line should be done through the distal lumen. This was a med error on my part and honestly eye opening how easy it was to make that mistake. Medications given via IV push should be given through the distal lumen to ensure that the medication reaches the bloodstream the fastest. The distal lumen dispenses medication directly into the superior vena cava, therefore making it the fastest acting. Since I started to use a different lumen than the distal one I forgot to go back and clamp the distal lumen. I would need to have clamped the lumen to properly follow procedure, this would prevent any fluid leakage from the lumen. I did not aspirate for blood return before I gave my first flush. I should have aspirated for blood return in the lumens to check the patency of the lumen before I administered the first flush. I also did verbalize that I was checking the clock and giving my medication over 2-4 minutes, however you could not see very well in my video. I tried to use the technique Mrs. Allison showed us, which was to slowly twist the

plunger to administer the medication at a slower speed. The video also doesn't show it well but I gave 9ml for both flushes as a push pause. It was also a little difficult to tell but I would have given the first 3-5 mLs at the same rate that I gave my morphine which was 2-4 mins per mL. I also should have verbalized that the alcohol was fully dry in between administering flushes and medications, this just ensures that wet alcohol on the site would not interfere with the med admin. The correct action would be to verbalize after alcohol pad use that the site has fully dried before continuing to the next step.

Documentation

- Teach Patient - UNMET
    - I should have verbalized to the patient that the reason I was telling her to not get the site wet was because it could increase bacteria by loosening the dressing and letting more bacteria in which could lead to infection and irritation. I should have verbalized that she should not pull on her lumens because that can cause irritation and potentially pull the site out. I would also verbalize a little clearer that breathing on the site would cause bacteria to enter the site and could lead to irritation and infection. I should have also taught the patient to report loose dressing, soreness, wetness, redness, and onset of fever or chills. All of those symptoms could indicate infection.

- Medication - UNMET
    - Comments: I did verbalize that I documented that I administered both meds. However, I did not properly do my TDAP vaccine since I did not scan it. I did however verbalize that I documented and saved my meds.

- Procedure - MET
    - Comments: My procedure corrections are noted. The documentation was completed properly.
- Scan Patient - MET

- Scan medication -UNMET
    - Comments: I did not SCAN my TDAP vaccine before I administered it. I should have scanned the TDAP before I administered it and after she signed the consent to receive the vaccine. I also should have given her an actual consent form and verbalize that I documented her consent when I documented my medications. I just pretended to use the vaccine info sheet as the signed consent as well but the hospital would need a copy of the consent for medical records. I should have scanned the morphine vile after the nurse witnessed the wastage of medication to ensure that the

medication was correct and I should have verbalized that I was checking the medication again instead of me checking it before I scanned. I would need to scan the med and vaccine before I could complete my 3rd check of the orders,and then I would need to verbalize my 3rd check. there could have potentially been a pop-up upon scanning either one of the meds that could have warned me to not administer a med. It is important to scan to prevent med errors by verifying the med is correct for the patient, without scanning we cannot be sure that the med is correct and will not potentially harm the patient.

- Save Med documentation - MET
- Document Assessment findings - MET
- Document procedure - MET
- Save all documentation - MET
-

Human Caring and Relationship

- Respect, active engagement, authenticity, empathy, etc. - MET

Professional Role Performance

- Appearance, preparation, behaviors, resource management, etc. - MET

Additional Comments