I tried compressing my video for over 3 hours and used multiple apps, but couldn't get it to work. I uploaded my video to YouTube, but the length slightly exceeds 30 minutes. Just wanted to let you know that I tried to get it compressed.

Safety (Physical and Emotional):

- Introduce self: ***MET***
- Identify patient (2 patient identifiers): ***MET***
- AIDET: ***MET***
- Allergies: ***UNMET***
    - I didn't verify whether or not Mrs. CSON was allergic to chlorhexidine and latex before changing her CVAD dressing. This was a mistake because I jeopardized her safety as a patient, and had she been allergic to chlorhexidine and/or latex, I would have triggered an allergic reaction and caused possible injury to Mrs. CSON. If she were to be allergic to one or both of these materials, I would have retrieved a CVAD dressing that was chlorhexidine and latex free, so as to not trigger an allergic reaction. In reality, I should have asked her if she was allergic to chlorhexidine and latex, and if denied, I would've resumed my CVAD dressing change as normal.
- 4 P's: ***MET***
- Fall Bundle: ***MET***
- Med Admin: Medication, dosage, route, reason, assessment of route site(s), medication delivery equipment (IV pump, etc.): ***UNMET***
    - While I verified her meds in the eMAR, I didn't verbalize that I performed my 3rd check of the doctor's orders. This is crucial in preserving patient safety. Looking back, after acknowledging the patient, introducing myself, stating the duration of my procedures, explaining what I was going to do, asking for 2 patient identifiers, asking about allergies, and scanning her armband, I should have seen "Patient Account Verified" and verbally announced that I see the same doctor's orders at the bedside, which is my 3rd check.

Critical Thinking:

- Assessment: See NII for critical elements pertaining to selected assessment(s) ***MET***
- Procedure: Assess, Plan, Implement, Evaluate (APIE), (Selection of appropriate equipment, time management, organization, etc.) ***UNMET***
    - I failed to palpate over her old CVAD dressing before changing it. Doing this would ensure that there is no tenderness or other possible issues, including skin breakdown, irritation, redness, drainage, etc. underneath the bandage. In reality, after performing hand hygiene and donning my sterile gloves, I should have visually assessed her old dressing and palpated it for tenderness before removing the dressing.
    - When removing the dressing, I failed to remove it towards the insertion site, which can cause the patient pain and risks the central line getting loosened and potentially falling out, which could also cause an infection. I also didn't anchor the lumen low enough. Doing this could risk contacting the insertion site, which

increases the risk for infection. Instead, I should have removed the dressing towards the insertion site and anchored the lumen below the insertion site.
    - I should've verbalized that I need to scrub the insertion site for 30 seconds with the chlorhexidine sponge, and allow it to dry. This would assure you that I know how to clean the insertion site properly.
    - When applying the new CVAD dressing, I noticed that the insertion site was touching the edge of the orange box, which is unsterile. I should have removed the dressing, obtained a new chlorhexidine sponge and scrubbed over the site (up and down) for 30 seconds, allowed it to dry, and applied a new dressing so that it completely covers the insertion site.
    - When applying my new dressing, I covered the lumen clamps on accident. I should have removed this dressing and completely started over, since it is now contaminated.
    - When applying the dressing, I also didn't apply the little part of the dressing that goes under the lumens and seals the bottom of the insertion site. Failing to do this resulted in a breach of asepsis. Before signing my initials, etc., I should have applied this part of the dressing to the site.

Standard Precaution: ***UNMET***

- Asepsis:
    - Hand hygiene:
        - Before touching the lumens, I touched the patient and didn't perform hand hygiene or put on gloves. This is contamination, and increases the risk of bacteria entering the patient's central line and causing an infection. Instead, I should have touched the patient, put on hand sanitizer, put on clean gloves, then proceeded with touching the lumens.
        - After touching the bed rail, I didn't take off my gloves, perform hand hygiene, or put on new clean gloves. My actions promoted the transfer of bacteria to the equipment and patient. Instead, I should have touched the bed rail, taken off my gloves, put on hand sanitizer, put on new clean gloves, and then proceeded with my procedure.
        - I also failed to perform hand hygiene on 3 separate occasions: before touching Mrs. CSON's gown, before moving her pillow during my CVAD dressing change, and before removing her mask after the CVAD dressing change. All of these incidents caused contamination and transferred bacteria towards Mrs. CSON, which is poor nursing practice. I should have performed hand hygiene before performing all of these actions.
        - Before opening my sterile gloves, I should have put hand sanitizer on. This would kill any potential bacteria on my hands, and is proper nursing practice to perform before donning sterile gloves. In reality, I should have performed hand hygiene, then opening up my sterile gloves.
        - Lastly, I failed to perform hand hygiene after lowering the bed. This is a breach in asepsis, and promotes the spread of bacteria. After I lowered the bed, I also touched Mrs. CSON, so I also transferred that bacteria to

her. In reality, I should have lowered her bed, performed hand hygiene, then touched Mrs. CSON.

- Don and change gloves:
  - When opening up my sterile gloves, the paper fell over the gloves, which resulted in contamination. In reality, I should have retrieved a new pair, performed hand hygiene, and started over.
  - At one point in my sterile gloving, my finger went over the 1 inch border as I was straightening out my gloves, which resulted in contamination. In reality, I should have retrieved a new pair, performed hand hygiene, and started over,
  - At one point in my sterile gloving, I dropped my gloves below waist, which is contamination. In reality, I should have retrieved a new pair, performed hand hygiene, and started over.
- Clean equipment: (stethoscope, pulse ox, bedside table, med tray, etc.) ***UNMET***
  - Before opening my CVAD dressing kit, I failed to put on clean gloves before cleaning the bedside table with the alcohol wipe. Doing this breaches asepsis, and increases the risk of bacteria contaminating the table. I should have put on clean gloves, then cleaned the table with the alcohol wipe.
- Sterile procedure:
  - During my morphine administration, at one point in the video, it looked like the lumen may have touched Mrs. CSON's cheek, but I just wanted to let you know that it didn't. In the video, it looks very close, but I zoomed in and watched it in slow motion and it didn't contact her cheek.
  - I should have opened up my CVAD kit (away from my body) before donning my sterile gloves so I don't breach asepsis and risk spreading bacteria to my equipment and patient. Instead, I opened my CVAD kit after putting on my gloves, which is incorrect.
  - I accidentally turned my body away from the sterile field during my CVAD dressing change, which breaks the sterile field and implies contamination. Instead, I should have kept my body facing the field the entire time to ensure that the sterile field is preserved.
  - I accidentally set my CVAD dressing down before removing the paper, which is incorrect. I also should have gotten a new chlorhexidine sponge to clean the site, since it was contaminated. Instead, I should have removed the paper from the new dressing, then applied it to the site, and I should have retrieved a new chlorhexidine sponge since mine was contaminated.
- Medication preparation: ***UNMET***
  - In the med room, I failed to charge the morphine vial before pulling the morphine itself. Doing this helps to ensure that nothing but the morphine is pulled into the syringe, and reduces the risk of air bubbles from entering the syringe. I should have charged my vial, then pulled the morphine into

my syringe (only 1 mL for video purposes, but in real life, I would pull the entire volume of morphine).
        - I accidentally began to put the red blunt fill needle cap on my morphine syringe, instead of attaching the blue syringe cap. This was an unnecessary, incorrect step in preparing my morphine. Instead, I should have attached the blue syringe cap to my morphine syringe, instead of recapping it with the blunt fill needle cap. Even if I were to re-cap my syringe with the blunt fill needle cap, I should have done it 1-handed to minimize the risk of breaching asepsis.
    - Medication delivery: ***UNMET***
        - Before administering her morphine, I should have taken her vitals, including BP, RR, and O2 Sats. Doing this would ensure that Mrs. CSON is still in need of morphine, and that after receiving it, she wouldn't go into respiratory distress, extreme hypotension, or plummet in oxygen saturation. Instead, I should have cleaned off a Pulse Ox, allowed it to dry, put it on her finger, and while it was obtaining a reading, count her respirations. After that, I should have taken her blood pressure, and documented all of these numbers in her eMAR. If all of these numbers were within the proper range, I would then administer her morphine.
        - I should have reiterated that I would call a second nurse to witness me wasting the excess morphine. After that, the second nurse and I would both document that this occurred. Doing this prevents drug diversion, and is a necessary step to take when working with narcotics.
        - Vaccine consent: you need to also do this with the TDAP vaccine it should be inform patient, let her look at paper, then ask if she has questions, have her sign, scan med and document that she consented and then document that you gave the vaccine and save the consent form form medical records. also don't forget do all those same rights before you give the patient meds
        - After educating Mrs. CSON about the TDAP vaccine, I should've given her the TDAP education sheet, allowed her to read over it if desired, and given her time to sign a consent form, which enables me to go forward with the TDAP vaccination. I failed to do this. After she consents, I would then scan the TDAP, document that she consented and that I administered the TDAP, and save both the consent form and the other documentation.
        - During my morphine administration, I accidentally flushed the full 10 mL in the second flush, instead of flushing 9 mL. Flushing the full 10 mL increases the risk of potentially pushing air into the lumen and causing an air embolism. After purging the second flush for air, I should have connected it to the lumen, flushed the first 2-3 mLs for 2-4 mins (the same rate as I would administer the morphine), and push-paused the remaining fluid until I reached 9 mLs.

Documentation: ***UNMET***

- Teach patient:
    - Medication:
        - I failed to verbalize the dose of morphine that I was giving Mrs. CSON, and failed to palpate her deltoid before administering her TDAP shot. While I communicated to her the medications that I was going to administer (Morphine and TDAP), the route for both, and the reason for both, I should have told her that I was going to administer 1 mg of morphine, and palpated her deltoid before giving her the TDAP shot. She may have wanted to know how much morphine she was getting and why. In addition, it's imperative to palpate any injection site any feel for any abnormalities, including redness, irritation, drainage, or hardness.
        - I failed to verbalize that I was going to administer her TDAP vaccine into her deltoid via IM injection. This is a part of the patient's rights. Instead, I should have verbalized that I am going to administer her TDAP vaccination via IM injection into her deltoid, and then proceeded with med administration.
    - Procedure: ***MET***
    - Scan patient: ***MET***
    - Scan medication: ***UNMET***
        - I failed to scan my TDAP vaccine. This is bad practice, and failing to do so doesn't provide any proof that I administered the vaccine, and results in a med error. Instead, I should have administered the vaccine, scanned the med, disposed of it in Sharps, then documented this on the computer.
    - Save med documentation: ***MET***
    - Document assessment findings: ***MET***
    - Document procedure: ***MET***
    - Save all documentation: ***UNMET***
        - I should have saved my meds after documenting them, so the computer doesn't time out, documented my CVAD dressing change and assessment, then saved everything altogether. This ensures that everything is properly documented and that I wouldn't commit a med error.

Human Caring and Relationship: ***MET***

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

Professional Role Performance: ***UNMET***

- Appearance, preparation, behaviors, resource management, etc.
    - When taking off my 2nd pair of sterile gloves, I dug my finger under the second glove too hard and it shot into the air. This is unprofessional and I should have apologized for this.

- I should have collected all my supplies and CVAD kit as I was going through the 4 P's, and disposed of these supplies in a more organized manner. Doing this would have made a more professional impression on the patient.