

## 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>	<ol style="list-style-type: none"> <li>1. My patient was in for cholelithiasis which caused her a lot a pain and nausea. She had many different kinds of pain and nausea medications that she could take as soon as she could. When it was time for the medications to be given, she would ask that the nausea medication would be pushed first and then the pain medication. She said that the pain medication caused her more nausea and that it helps for the nausea medication to go first. I pushed the nausea medication first and her nausea was not bad.</li> <li>2. The CNA checked the blood sugar of a patient and reported back that the blood sugar was 425. The patient needed sliding scale insulin. I looked and the Sliding scale insulin chart and it said that a blood sugar of 425 required 10 units of insulin and also to notify the doctor. I administered the insulin and then waited for the doctor to respond. Once the doctor responded, he ordered that we give 10 units of latus. The Lantus was given and the patients blood sugar went down.</li> </ol>
<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>	<ol style="list-style-type: none"> <li>1. My patient had just come back from her procedure. Because of this, her vitals needed to be taken very frequently to watch for any signs of complications. I took her vitals every 15 mins for an hour and then every 30 mins for an hour. While taking her vitals I would document them in the computer. Even though I was documenting them in the computer, I would still make sure and tell the nurse I was assigned to if any of the vitals were not normal.</li> <li>2. While my nurse was pulling medications, I was checking on a patient who was eating breakfast. Why I walked in, the patient expressed to me that she was finished with her breakfast tray. I looked at the tray and was calculating about how much of the food she had eaten. I then took the tray and put it up. When I saw my nurse, I communicated to him that the patient was finished eating and that I had calculated that she had eaten about 25% of her food.</li> </ol>
<b>Critical Thinking</b>	Apply evidence based research in nursing interventions.	<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>	<ol style="list-style-type: none"> <li>1. At clinical simulation, my patient had hypokalemia. I looked over her labs and her potassium was at a 3.0. The signs and symptoms she was having was nausea, vomiting, abdominal pain, and tachycardia. I first gave her some medication for the nausea and vomiting and that made it go away. I then gave her some potassium. Her potassium level returned to normal and her nausea and vomiting went away. I also gave her some IV fluids to prevent any dehydration from the vomiting. I also elevated the head of the bed to prevent my patient from aspirating.</li> <li>2. My patient was complaining of pain in her stomach. I asked her to rate the pain she was having on a scale from 0-10. She rated her pain at an 8. I reported this to my nurse and we looked at the patient chart to see what pain meds were available. The patient has morphine available. We drew up the morphine and took it into the patient room. In order to administer the patient morphine, you have to do a pain assessment so that's what I did. After that I administered the morphine over 3-5 minutes. I used the resources given to me in the chart and performed evidence based practices to make my patient feel better.</li> </ol>
<b>Caring and Human Relationships</b>	Incorporate nursing and healthcare standards with dignity and respect when	<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</li> </ul>	<ol style="list-style-type: none"> <li>1. At clinical simulation, my patient was complaining of abdominal pain, nausea, and vomiting. She had a family member at the bedside. When I walked into the room the family member was giving the patient "her favorite snack" which was crackers with hot sauce on top. I communicated my concerns to her that this was</li> </ol>

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	providing nursing care.	in patient care	<p>not a good snack to be giving the patient because of the symptoms she was experiencing. I explained to her that the spicy hot sauce could increase the effects of her symptoms and make them worse. The family member was very understanding and stopped giving the patient the snack.</p> <p>2. I walked into the patient's room with my nurse and realized it was one of the same patients that I had the previous week for clinicals. While getting report I was wondering why she was still in the hospital, and that is when the nurse said that she had experienced a fall. After coming out of the patient's room, the nurse was able to tell us in more detail that the patients family member was trying to help her to the bathroom and that is when she fell. It was obvious that this family member was the patient's primary caregiver and was very upset about what had happened. After this incident, she was very understanding when the nurse told her that she really needed to let the nurses and the aids assist her mom when she needs anything because we are trained to do it and can do it in a way that is safe for the patient.</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. My patient was in the hospital for pneumonia. When a patient has pneumonia there is always a risk that atelectasis can form in their lungs because they are not moving around. While in the patient's room, my nurse and I recommended that she do incentive spirometer exercises. We were explaining to her how to do it and she was doing it wrong. She was taking short, shallow breaths. We explained to her that the goal was to take long, deep breaths to open up her lungs and get them moving. We stayed in the room until she was able to do it right.</p> <p>2. My patient was in the hospital for cellulitis. He was also confused so he had what you call a telesitter which was a big camera. The camera live records the patient while somebody watches the patient and make sure that they do not do anything wrong. This is great for patients who are confused but unfortunately not great for patients who are confused and can't hear. My patient could not hear and anytime the telesitter would tell him not to do something, he couldn't hear her. When getting report from the night nurse, the patient was trying to tug on his catheter and pull it out. It was very hard to get through to him that he could not do that and that it would hurt very bad if he pulled it out. My nurse decided that it would be best to take the catheter out and just have the patient wear briefs. That way he did not hurt himself.</p>
<b>Leadership</b>	Participate in the development of interprofessional plans of care.	<ul style="list-style-type: none"> <li>- Identify/define interprofessional plan of care</li> <li>- Integrate contributions of health care team to achieve goals</li> <li>- Implement interprofessional plan of care</li> </ul>	<p>1. At clinical simulation, my patient was experiencing hypokalemia. My patient needed potassium and the orders called for potassium PO. The other nurse with me was communicating with me and we decided that since my patient was vomiting, it was not a good idea to give her PO meds. We contacted the doctor and told him our situation in SBAR communication and he told us to look at the potassium protocol. We did not have the potassium protocol in our chart so we then contacted the charge nurse and asked her for the potassium protocol and she gave it to us. We checked the protocol and carried out orders for IV potassium.</p> <p>2. At clinical simulation, I was getting an IV piggy back medication for my patient. When I was checking the compatibility between the piggy back and the primary fluids that the patient had running, it was blank on the chart. I made the decision to call the doctor and ask him about the fluids and what I should do. He insisted that I</p>

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			hang a bag of normal saline and then run the piggy back. After the phone call I went back to the med room and grabbed a bag of NS along with my piggy back and primed tubing. I then took it to the patient room and ran it through the pump.
<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>	<ol style="list-style-type: none"> <li>1. My patient was in the hospital because he just had a procedure. He was on the antibiotic, vancomycin. Because the patient was on this antibiotic, labs needed to be drawn for a peak and trough. When I went to draw my patient's blood, I explained to him that we were going to need to draw two times. I explained to him that the first blood draw was going to be for the trough, which was measuring the lowest amount of antibiotic in his system. I then explained to him that four hours later I would draw again measuring the peak of the antibiotic which is the highest amount of antibiotic in his blood. He then understood why I was doing what I was doing and understood that this action was important for the medication he was on.</li> <li>2. My patient was upset because he had been in the hospital for quite some time and dietary could never get his food order right. Because he had just been placed on dialysis, his doctor put him on a renal diet. I went into his room and he was very upset and asking why he had to be on a renal diet. I explained to him that he was on this diet because when he goes to dialysis some of his nutrients are lost in the process and that this diet helps him gain those nutrients back. He was then very understanding and apologized for being so angry.</li> </ol>
<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>	<ol style="list-style-type: none"> <li>1. My patient just got back from surgery which meant that she needed to have her vital signs checked very frequently. To my nurse, this automatically made this patient priority over all of her other patients. Especially because the patient just had a procedure done to her kidney, which put the patient at risk for bleeding. My nurse and I were constantly checking on the patient and making sure she was doing okay. We were taking vital signs, and checking her pain because any changes in vital signs could mean that she was bleeding and that something was wrong.</li> <li>2. I had a patient that was could not hear at all. They weren't deaf to where they used sign language, they just couldn't hear. It was very difficult trying to explain to the patient what we were doing or telling the patient that he couldn't do certain things. The best way for us to communicate with him was to talk to him very loudly. It was very hard not to pull our mask down, because it probably would have been so much easier for him to understand us if he could see our lips moving. Another way we had to communicate with him was to simply just act out what we were about to do and he would just nod his head if he understood what we were doing.</li> </ol>