Mayra Garcia **SLO's** **1-26-2022**

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. One of my patient's had a scrotal abscess present. It was on the underside of the scrotum. It looked painful, but the patient insisted it had been healing and looked better than before. The patient required dressing changes 2X per shift. My nurse and I gathered all the supplies needed to do the dressing change. One of the biggest risk factors was skin integrity. We first, assessed the wound making certain there wasn't any abnormal drainage of any kind. We put on a wet-to-dry dressing. The patient had an implemented turning/ambulation schedule of being allowed in one position or bed for so many hours. The patient took turns switching positions in bed and then sitting in the bedside chair to avoid prolonged pressure on his affected wound and further breakdown of skin. 2. My patient was admitted due to having a UTI. She was presenting with urgency and frequency of urinating which resulted in incontinence. Since she had impaired urinary elimination related to frequent urination as evidence by urgency, there were certain nursing interventions that were done to help the patient with this specific health impairment. With a UTI, one of the most important things to assess and prevent is irritation or breakdown of the skin. One way to prevent such thing from happening is I cleansed my patient's perineal area well and patted completely dry. In providing proper perineal hygiene, the risk of skin irritation or breakdown is decreased. Furthermore, it decreases the development of a future ascending infection.
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. One morning during clinicals, after finding my nurse for the day, we prepared to get report from the previous nurse that was on shift. I witnessed the nurses give report using SBAR. This method is very helpful when giving and receiving report because it gives you a general idea or picture of your patients of that day. As a student, I try and ask questions if I hear something that I'm not too knowledgeable about. I wait until I can politely interrupt, because I know report is supposed to be done rather quickly and without interruptions. My nurses that I've shadowed, thus far, have all been great in answering my questions and involving me during the report process. 2. Before going to lunch to one day at clinicals, my nurse had already mentioned to me that she wanted me to take one of our patient's blood sugar levels and report it back to her. She told me this at 10:45 AM. Our patient ended up having to go to hydrotherapy and I hadn't realized they had gone down until I went to their room. The nurse aide was aware that my nurse wanted me to take it and the nurse aide did not communicate to me that they were about to go to hydrotherapy so that I could take it prior to the leaving. My nurse had stepped out into the area where the elevators are for a prolonged period, she was on an emergency phone call regarding her mother. I was not able to tell her that I did not have the opportunity to get the patient's blood sugar until she was off the phone. I feel that if I had been told that the patient was about to leave, I would have had the chance to get the blood sugar like my nurse wanted me to. I feel I let her down because of the poor communication between all of us.

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. My patient had sustained a hip fracture. On first day of clinicals for that week, the patient had surgery performed the evening prior. Since my patient was not able to ambulate the next day due to pain, it was important to take measures to avoid deep vein thrombosis (DVT). Po-op patients are at greater risk for developing DVT's since most are immobile. This is why the administration of a Lovenox injection is given to most hospitalized patients to avoid thrombophlebitis. Lovenox is an anticoagulant, which will prevent the formation of blood clots. Carefully monitoring the patient's platelet levels are extremely important when administering this injection. The levels must be within a normal range to prevent the patient from bleeding excessively. If the patient's levels are not within the normal range- you DO NOT give the injection. 2. One of my patients had just returned to the floor from having a procedure performed in which she required an indwelling catheter. When doing my assessment later in the day on her I made sure to look at her catheter. I wanted to make sure there were no kinks in the loop and that there were no signs of drainage. I asked my patient if she was experiencing any discomfort regarding the catheter. She assured me that she had none and asked if there was something she should worry about concerning the catheter. I explained to her that while being in the hospital, catheters are something we try and avoid, if possible, so that our patients do not get any unwanted infections from it. She told me the reason why she had one was because of her procedure and I explained to her that yes, it was normal to receive an indwelling catheter if the patient is undergoing surgery or having a certain procedure done. I told her that a catheter is considered somewhat of a foreign object entering the body, and that there are possible risks associated with catheters. I explained that those risks can be greatly reduced if good catheter care is performed. Also, that the doctor will want to discontinue the catheter at the earliest convenience for the patient to avoid such risks and infections.
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. On my last day of clinicals I was assigned to a nurse I had already been paired with previously in the module. The first time I was paired with her, she did well in teaching me things and I believed her nursing was done correctly. However, the second time I was paired with this same nurse, it seemed like she was a completely different person. Not sure if she had recently experienced something or just had a bad morning, but that last day I followed her, she didn't seem as empathetic as the first time I was paired with her. We entered one of our patient's rooms to get report from the previous night shift nurse, and this patient had a JP drain that was leaking. My nurse was quick to point it out and the previous nurse said she would take care of it. This patient was a Spanish speaking patient and seemed a bit disoriented. This patient was also supposed to be NPO due to a possible procedure later in the day. The patient complained a bit about that, but my nurse really didn't explain to her fully why she was NPO. The patient's husband came with food, so my nurse made sure to follow him into the patient's room and tell him to make sure he didn't feed his wife (our patient) in a very aggressive manner. The husband went on to tell her that just yesterday his wife was allowed to eat and that today he didn't understand why she wasn't allowed to. My nurse was already frustrated and spoke

			aggressively to the husband saying she didn't know why either but that's just how it was going to be today. My nurse didn't take the time to explain to the husband exactly why the patient was NPO. I later returned to do an assessment on this patient and of course they asked me why exactly the patient was NPO. I reassured them that this is what the doctor wanted because the patient might possibly be having a procedure done later in the day. I speak Spanish, and so I wanted to make sure I made them feel comfortable because they didn't get that from my nurse. Keeping in mind that I could only say so much, but if they had questions, I could get the nurse or charge nurse for them. 2. One of my patients had been in the hospital for some time now and he was beginning to feel depressed. His family, especially his two daughters who had not been able to visit him recently or frequently due to being exposed and having Covid and also because they did not live in town. They didn't live too far either, but still not close enough to where it was easy for them to visit. I told him that I was very sorry for that but that he had great nurses here at the hospital to care for him and help him recover fast so that he could go home. It was sort of slow that day during clinicals and I remember that each time I went in there to take his vitals or ask if he needed anything, he always wanted to conversate with me. I knew he just wanted someone to visit with. He shared stories about his daughters and their professions. He even asked about my life and about my schooling. He had a question about a procedure that he was having coming up and had asked if I could get more information about it. I said sure I will ask your nurse about it. He then asked if I could talk to his daughter over the phone and explain it to her. I told him I didn't think I could do that; I am not allowed to share any health information about you to someone else even if it was his daughter. I explained to him HIPPA and he understood clearly and was not mad about it. He told me that he understood it was a law and didn't want me to get into any trouble.
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. My patient was admitted with pneumonia and promoting an effective airway clearance was vital for the patient's overall health. In order to have a positive outcome, the patient was highly encouraged to use the incentive spirometer. An incentive spirometer allows your lungs to inflate fully. This helps break up fluid in the lungs to prevent further damage or accumulation of fluid. In relation to pneumonia, an incentive spirometer helps break up mucus buildup that builds up in the lungs resulting in lungs being fluid-free and active. 2. The elderly experience UTI's more often. Because of this it can result into a really big problem, not only medically, but it can take an emotional toll on the patient as well. A good resource offered to my patient because they were experiencing psychosocial problems due to frequent UTI infections was a UTI support group. My patient was experiencing polyuria and it was beginning to interrupt her daily life. It was becoming an unwanted problem she felt herself dealing with and needed a place where she could share how frequent UTI's was affecting her life and meet other people experiencing this issue. A support group could bring the patient some sense of relief and encouragement to know she wasn't the only one dealing with

			this issue.
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. A good resource to have when a patient with pneumonia is going home is home health. This type of patient will need tools such as an incentive spirometer or humidifier to help thin their sputum secretions. A referral to home health can help the patient obtain these useful tools to use in the home setting. Without home health, the patient might not have the needs to obtain the proper tools to help them optimize their health. For example, home health can help the patient obtain a humidifier. A humidifier will come in handy for a patient that had pneumonia because it can increase the moisture in the air and aide in the liquefication of secretions. 2. Physical therapy was working with one of my patients one day at clinicals. That day, my patient just seemed more tired than usual and was not being too cooperative with physical therapy. My patient just wanted to stay in bed and asked if she could skip physical therapy for that day. My nurse and I explained that it was important for her health and a faster recovery so that she could go home soon. We also explained that in doing physical therapy, it would prevent further complications. Our patient was ready and eager to go home so after we explained that in participating in physical therapy would help her go home soon, she became more compliant. We also explained that our goal was to get her back to a level of independence where she could complete her daily activities of life.
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. My patient's admit diagnosis was pneumonia. To prevent further complications, and promote an effective airway clearance, I instructed my patient to use splinting techniques and TCDB. Splinting techniques such as utilizing a pillow or hand splinting the abdomen would promote effective coughing by increasing abdominal pressure and upward diaphragmatic movement. TCDB exercises help mobilize secretions from smaller airways to larger airways to promote an effective airway. I instructed my patient to TCDB various times, and not just once. 2. Since my patient was dealing with pneumonia, a moderate amount of phlegm was being produced. To promote their health and help my patient with the phlegm they were producing, I instructed my patient to stay hydrated and increase their fluid intake to 3L per day. Of course, if they had certain fluid limitations due to any cardiac or renal disorders, I took that into account. Increasing their fluid intake would help minimize mucosal drying and help loosen mucus in the lungs. The sputum produced wouldn't present itself as being as thick as it was if more fluids were taken in.
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. One of my patients was having 24 hr. urine output measure. We had just studied about this in class and so it was interesting to see it applied in the clinical setting. I knew how important it was to keep up with measuring every urine output. If a urine measurement was skipped, not only would the doctor be upset but I knew that it would have to be restarted. One of my other patients needed Accu-checks done frequently. Their blood glucose hadn't been extremely high, but they did need Accu-checks. I was responsible for getting the Accu-check for this patient before lunch time. However, about the same time it was time for me to get the Accu-check

			from this patient, my other patient needed to go to the bathroom. I didn't necessarily need to be present to help my patient to the bathroom because they were a self-assist, but I also didn't want them to accidently discard of their urine without me measuring it first. I had to prioritize which patient's room I was going to go first. I already knew who I thought I should go to first but when ahead and still asked my nurse whose room I should go to first. She advised on what she would do, and I was right. I assisted the patient to the bathroom and directed them to not discard of the urine. That it was important that I measure their urine output to put towards their 24 hr. urine count. I then went to the other patient's room to get their Accu-check. 2. After completing an assessment on my secondary patient, he explained to me that the previous night he had been in pain but could not quickly call the night nurse because he wasn't able to see where his call light was. He shared with me that earlier in the day his wife had accidently broke his glasses and was supposed to return later in the evening with a new pair. The weather had prevented the wife from returning to the hospital with his new pair of glasses and so my patient was having a difficult time seeing things. He was frustrated. Since it was the next day, his wife was supposed to be coming later that evening to give him his glasses. But I told him that in the meantime, I was going to place his call light directly on his bed next to him so that he only needed to reach down to feel it. To make it easy for him, I told him that the big green button in the center of the call light remote is what he needed to press to call for help. My nurse knew that this patient was struggling to see and that we would have make things easier for him to see to accommodate his vision problem until he received his glasses and could see again.