

## 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>	<p>1. One of my patients was admitted with altered mental status and we were supposed to keep a very close eye on them and keep 2 or 3 of the bed rails up at all times. However, the patient was agitated and refused to keep both of the lower bed rails up. As a compromise, the nurse and I decided that we could put both of the upper bed rails and one of the lower rails up and we could place the bedside table on the side of the bed that did not have the rail raised. This way, the patient was safe and was less likely get out of bed. After we implemented this intervention, the patient was less upset about the bed rails and was more willing to stay in bed.</p> <p>2. At one point, I was assuming care for a patient that had just come back from a procedure. I knew that this patient had been having low oxygen levels but that was normal for the patient and the levels were stable so I was not worried. However, when the patient returned from their procedure, their oxygen level was at 85%. The patient was complaining of shortness of breath and their extremities were cool to touch and as the patient was talking, their oxygen levels dropped to 77%. At this point, I had already listened to their lungs and the lung sounds were normal so I looked at the nasal cannula and tubing to see if there was a kink or break in the line. I noticed that the oxygen tubing was not connected to the wall oxygen and after I reconnected it, the patients oxygen levels immediately began to increase. By the time I finished my assessments and giving them their meds, the oxygen level was back to 95% and the patient was back to their baseline.</p>
<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>	<p>1. One of my diabetic patients was having trouble with unstable blood sugars. The patient's normal blood sugar level was around 100 but it had been 400-450 since 0600. The night nurse had given the patient insulin based on the sliding scale and the blood sugar had only decreased to 400. The day nurse told the day CNA about the blood sugar issues and informed her that even though the patient was charted as a Q4 accucheck, that patient would need to have their blood sugar checked every hour until the blood sugar was below 250. The nurse and CNA communicated and decided on a schedule to check the blood sugars and to make sure that they both could get other things done as well.</p> <p>2. My nurse and I were assuming care of a patient that was being transferred from the emergency room. The patient was supposed to be arriving on our unit within the next 30 minutes and my nurse was supposed to be getting report at any moment. However, my nurse and I were late passing meds to another patient and we still needed to do some dressing changes so we were unable to get report from the ER nurse. Luckily, the charge nurse was willing to take report for my nurse and she was able to relay the report while my nurse and I were pulling meds for our other patients. Both the ER nurse and the charge nurse used proper SBAR in order to accurately give and take report on the new patient and my nurse and I were able to prepare the new patient's room and finish everything we needed to do before our new patient arrived on our unit.</p>
<b>Critical Thinking</b>	Apply evidence based research in nursing	<ul style="list-style-type: none"> <li>- Analyze pertinent data (subjective, objective)</li> <li>- Identify evidence based practice (EBP) resources</li> </ul>	<p>1. During the medication administration part of my CPE, my patient was supposed to receive Lisinopril if the systolic blood pressure is above 90, Clopidogrel if the</p>

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	<p>interventions.</p>	<ul style="list-style-type: none"> <li>- Distinguish EBP nursing interventions</li> <li>- Apply EBP nursing interventions</li> <li>- Document resources &amp; interventions</li> </ul>	<p>platelets were above 100,000, and acetaminophen if the temperature was above 99.9. I had to look at the patient’s labs and vital signs and decide whether or not to give the patient those medications. The patient had a blood pressure of 88/58, a platelet level of 78,000, and a temperature of 99.7 so I ended up deciding not to give the patient those three medications.</p> <p>2. In simulation, my patient was in the hospital for respiratory problems from their history of smoking. In the chart, it said that my patient had stopped smoking so I assumed that his nicotine cravings were a past problem. After I talking to him and his husband for a while, he told me that he had been sneaking cigarettes in the bathroom at night. I knew he had to stop smoking at least while he was in the hospital so I decided to call the doctor and ask about getting a nicotine patch to help with the nicotine cravings. I called the doctor and he agreed to the nicotine patch and we started the process of getting those orders in place when the simulation ended.</p>
<p><b>Caring and Human Relationships</b></p>	<p>Incorporate nursing and healthcare standards with dignity and respect when providing nursing care.</p>	<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 in patient care</li> </ul>	<p>1. One of my patients would call me and my nurse into his room all the time and ask us to do multiple things while we were in there in an attempt to keep us in his room for as long as possible. Eventually, my nurse was tired of going into that patient’s room and I was the one that spent the most time in the room. After multiple hours in that patient’s room, I realized that he might just need someone to talk to. After this realization, I started a conversation with him and we sat and talked for about an hour and a half. He told me stories about his job before he retired, his wife, his friends, and his life when he was younger. He was a very nice person and most of the time when he called us into his room, he did not really need us to do anything, he just wanted the company. Our conversation ended when transport came to pick him up for dialysis and before he left, he gave me a hug and thanked me for just listening to his stories. He told me that he had not had many visitors and the nurses were always so busy so he was getting lonely.</p> <p>2. I had a patient with an infected wound on the stump of her below the knee amputation and she needed to go down to hydrotherapy. I asked my instructor if I could go with her so I could experience hydrotherapy and because she was scared of the pain that usually came with her hydrotherapy treatments. After I got permission to go, we left. When we got to hydrotherapy, the patient asked me to hold her hand because she was scared and did not think she could do it by herself. I, of course, agreed and told her that if she was hurting, she could squeeze my hand as tight as she needed to if that would make her feel better. She squeezed my hand throughout the entire procedure and when it was over and we were heading back up to the floor, she thanked me for being there for her when she was scared and holding her hand throughout it all.</p>
<p><b>Management</b></p>	<p>Recommend resources most relevant in the care of patients with health impairments.</p>	<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. One of my patients was in pain and the doctors were trying to wean him off of his IV pain medications and it was not time for his next dose of oral pain medications so we could not give him anything to help with his pain. My nurse thought about calling the doctor and asking for a different pain medication but we knew they would say no because they were trying to wean the patient off of his pain</p>

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			<p>medications so I offered to sit with the patient to talk to him and try to distract him from his pain. The patient and I talked for about an hour and a half and he seemed to forget about how bad he was hurting. He thanked me for sitting and talking with him and told me that his pain was better and he was going to try to take a nap. I told him that a nap would probably be helpful and turned his lights out so he could rest.</p> <p>2. When getting report for one of my patients, the night nurse gave us a list of things that needed to be done so my nurse and I were planning on going into that room first so we could get everything finished before we tried to pass medications to our other patients. We gathered all of the patient’s medications, the supplies that we needed to complete all 4 of his dressing changes, and everything needed to draw labs and when we got into the room, he said he needed us to help him to the bathroom, clear off his bedside table, and get him a new spit cup for when he was dipping tobacco. None of his medications were for pain or anything urgent so we helped him with his bathroom and housekeeping needs first. After we finished that, we did all of his dressing changes and made sure he was comfortable and drew his blood for the labs that were ordered. The last thing we did was hang his new IVPB antibiotic and give him all of his oral medications. We were able to cluster all of the care and after those two hours that we were in his room, he fell asleep and did not need anything for several hours.</p>
<p><b>Leadership</b></p>	<p>Participate in the development of interprofessional plans of care.</p>	<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. When I was in Sim lab, my partner and I had a patient with pneumonia and COPD. My partner and I introduced ourselves and I began to assess the patient when he told me that he was having trouble breathing. His oxygen saturation was 90% so I decided to listen to his lungs and when my partner was listening to his lungs after I did, he told me that it was getting harder to breathe and his oxygen saturation had dropped to 83%. I knew he was supposed to be on oxygen and his nasal cannula was in place so I looked at the oxygen meter on the wall to make sure that he was receiving enough oxygen because his oxygen saturation had dropped to 75%. I noticed that when transport brought him back from his procedure, they forgot to reattach his oxygen tubing to the oxygen meter. I quickly reattached his tubing and almost immediately, his oxygen saturation began to increase. He told me that he was having less trouble breathing so I resumed my assessment. By the time I finished my assessment, his oxygen saturation was back up to 80% and when I returned from getting him medications, his oxygen saturation was back up to 93%.</p> <p>2. I was trying to flush my patient’s IV when I noticed that her IV had infiltrated and she needed a new one. My nurse told me to go get the supplies to start a new IV but she was going to start it because this patient was an incredibly hard stick. I was a little bit disappointed that I would not be able to start the IV but the patient was scared and I understood so I decided that I would help my nurse in whatever way I could. I prepped the flushes, opened the IV needles for her, and even taught her how to use the IV needles because she was a travel nurse and had never seen IV needles like the ones Covenant uses. I prepared everything for when my nurse stuck the patient both times and when she decided to stop and said that we would</p>

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			have to call the PICC team, I cleaned up all of the trash and organized all of the supplies that she did not use.
<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>	<p>1. One of my patients was in the hospital for alcohol withdrawals so she was on multiple medications. She was taking multiple scheduled pain medications and the doctors were worried that she was going to become addicted so they decided to do a morphine spinal block so that the patient could have a full 24 hours without any other pain medications. A few hours after the procedure, the patient called and asked me for her pain medications and I asked her if she was hurting. She told me that she was not really hurting right then but she knew that it was almost time for her next dose of pain medications and she did not want to miss her next dose and start hurting. I was able to teach her that she was not allowed to have any more pain medications for the next 24 hours because of the spinal block that they did but the spinal block should allow her to be pain free for at least the rest of the day.</p> <p>2. I was helping another student with a patient who was incontinent of urine and stool and the patient told me that she felt bad that the nursing staff had to keep coming back to her room to clean her up. She told me that she thought we were going to hurt our backs because of her size and she asked me if I could talk to her nurse about putting a Foley catheter in so we would not have to clean her up as often. I was able to teach her about the infection risks that came with an indwelling catheter and I told her that we did not mind coming to clean her up and we would not hurt our backs especially because she was able to help turn. She reluctantly agreed that maybe a Foley was not the best option for her and shortly after that conversation, her nurse came in and was able to tell her that she was going to be able to go home that day.</p>
<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>	<p>1. One of my patients was admitted for drug withdrawals and an infection. The doctors gave him an antibiotic that he did not know he was allergic to so it gave him a horribly itchy rash. This rash and his original diagnoses resulted in many medications for pain, itching, electrolyte imbalances, and many other things. My nurse and I had to plan his care based on his pain level, how bad his itching was, and how he was feeling overall and most of the time we would go into his room with no less than 10 different medications. He was a very understanding patient and was very patient with me when I was explaining why we were giving certain medications first and why we had to wait to give other medications.</p> <p>2. I was caring for a patient that had been in the hospital multiple times within the last year for alcohol withdrawals and she had been admitted the day before our clinicals for her withdrawals and for pancreatic pain. Since she was in the early stages of her withdrawals, she was still at a high risk for seizures and since she would not stick to her clear liquid diet, she was also struggling with horrible abdominal pain, nausea, and vomiting. For the first few hours after my nurse and I took over her care, she would call almost every hour to ask for a different medication. After the first few times she called, my nurse and I realized that we could assess her right before it was time to pass medications and ask her about her pain level and if she was nauseated so we could bring all of the medications that</p>

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			she would need into her room the first time when we came to give her medications. After we started this system, she was finally able to get some much needed rest and we were able to spend more time with all of our patients.
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