

## 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. I was able to identify a significant problem in a recovering stroke patient. This patient had some arm and finger movement after his stroke and it was believed that he could feed himself; and that he was just refusing to eat. My nurse and I were able to identify that this was not the case; and when the patient went to feed himself he was actually spilling all of his food on himself so our plan of care was that someone would feed him for every meal whether that was me, the nurse, or the nurse aid.</li> <li>2. Once we implemented feeding a stroke patient versus having the patient attempt to feed themselves the effectiveness was seen immediately. When I began to feed the patient he was able to eat about 80% of his meal, tell me what he wanted to eat, and even communicate with me on how he felt. Towards the end of the day I felt as though this intervention was beyond effective when the patient actually smiled at me as he asked for chocolate ice cream.</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. I was able to communicate with a resident and a Spanish only speaking family. I did not interpret what was being said between both the patient and the resident as I am not certified to translate, however I was able to speak to both the nurse and resident and identify a few problems after the interaction with the patient came to an end. I respectfully let my nurse and the resident present know that what the resident was saying to the family member was not what the family member was translating to the patient and that I thought getting an actual translator on the floor would be more appropriate.</li> <li>2. In one patient interaction the patient had on special boots that were to be worn at all times by the patient who just had a bilateral amputation done on toes of both feet. When I began to interact with the patient and also do my assessment with the patient I began to realize that the patient was in fact not wearing her special boots and did not seem to understand the importance of wearing them. I was able to communicate with physical therapy and they were able to thoroughly explain the purpose of wearing the boots and why they were so important in our patients recovery process. The outcome of my communication to physical therapy seemed to be very effective because they were able to use their vast knowledge to patiently speak and educate the patient.</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. When I was shadowing a nurse I was able to identify EBP when a nurse asked me to hang ofirmev by gravity. I learned from an instructor that you hang everything through the pump so the patient gets there medication over a correct amount of time and that they are getting the adequate dose. When she asked me to hang this medication I got the correct tubing and put it through the pump as a secondary medication and when she asked me why I did this I explained that this was the way I was taught based on EBP but since I was practicing under her license if she felt as though this was not correct I did not have to give the medication. She allowed me to give the medication and told me I did a great job and we went on our day.</li> <li>2. On my first day of clinical for the week I met a patient who had severe bed sores and when the nurse asked if she was being turned frequently the nurses and nursing aids said yes, however the patient was not turned once in over 3 hours. I</li> </ol>

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<b>Caring and Human Relationships</b>	Incorporate nursing and healthcare standards with dignity and respect when providing nursing care.	<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>	<ol style="list-style-type: none"> <li>1. In one of my clinical days I was doing med passes with my instructor when we found a patient with a flask. I communicated my concerns with my instructor who then told the nurse who then got the charge nurse involved. It was a process of getting the correct individuals involved and learning how to correctly identify and remove the hazard from the patients room.</li> <li>2. In another patients case a patient who was a nurse over 30 years ago had progressive dementia but was unaware of there circumstances. This patient had begun to mess with there IV pump because this patient believed that she knew what medication was being given and at what rate the medication was being given. When I identified this hazard and what the patient was doing I immediately communicated it with the nurse, and we were able to cover the nurse/patients IV site, and also move the pump out of her reach and site and this seemed to completely solve the issue.</li> </ol>
<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>	<ol style="list-style-type: none"> <li>1. I came in contact with a patient who had been using substances she was buying from random individuals. The patient was not oriented at all and it was believed this was due to whatever substances she may have ingested. The nurse was able to put the patient and the patients family in the care of a social worker. The social worker was able to get the patient drug rehabilitation resources as well as nursing homes the patient may need to be put into to have full supervision until the patient was able to care for themselves again.</li> <li>2. In another case I was able to meet a patient who was in a car accident who did not have any health insurance and was concerned how they were going to see follow up appointments or even get the medication they needed. The nurse was able to speak with nurse management and a few other people who then were able to connect the patient and the patients family with the correct resources to be able to afford the medication and follow up appointments. Due to certain income issues the patient qualified for a lot of recourses that they were unaware of and once the patient communicated this with the nurse and the nurse communicated this with other employees who could help the patient the entire problem was solved and upon discharged the patient already had follow up appointments scheduled and got the medication they needed at no cost.</li> </ol>
<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>	<ol style="list-style-type: none"> <li>1. We had a diabetic patient who refused to wear these padded boots that were supposed to help the patient avoid pressure sores after the patient had received a bilateral toe amputation. Physical therapy came in to speak with the patient and they were obviously irritated as they could not keep these padded boots on the</li> </ol>

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			<p>patient. The nurse was able to use inter professional communication to ask both physical therapy and the physicians in charge of the patient care if we could use pillows instead of the boots to both prevent sores like physical therapy and the physician wanted but to also accommodate the patient and not make the patient wear the boots. In the end everyone was happy with the compromise.</p> <p>2. A COPD patient who could not keep up there oxygen level above 88% had a daughter who did not want anyone to raise the patients oxygen because they knew if the oxygen flow was not a low enough rate they would not be discharged. The nurse had to use inter-professional communication with both respiratory therapy and the charge nurse to not let any family members touch the oxygen flow meter and to constantly monitor the patient and the oxygen the patient was receiving.</p>
<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. We had a newly type 1 diabetic diagnosed at 18 who had never checked his blood sugar and had no idea how to identify hypoglycemic symptoms to know when to take something or drink something to increase the patients blood sugar. The nurse and I were able to teach the patient and the patients family member how to check there blood sugar at home, when to check the blood sugar, and what to do when hypoglycemia was beginning to set in. Over the next few days before the patient was discharged the nurses had begun to make the patient and his family member take his blood sugar on his own with supervision so when discharge day came he was comfortable enough to check his blood sugar regularly. Upon discharge the patient and his family members were checking his blood sugar before the nurse or nurse aid could even ask them and they also had several plans in place for the even that a hypoglycemic event took place.</p> <p>2. In another case we had a patient who was an out of state student who was in a bicycle accident and had broken his wrist and his ankle. The patients family was able to fly out and be with this patient. The patient had rods and dressings in place, the dressings needed to be changed regularly until the patient could follow up with there physician in a few weeks to see the patients progress. Due to the patients broken wrist it became a concern on how his wound care would be handled. The family had made arrangements to stay in town to take care of the patient and the nurse and physical therapy were able to show the patients family how to properly take care of them, upon discharge the family could wrap the patient in less than 5 minutes and they all felt comfortable going home until there follow up appointment.</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. A patient who had a trach in place with a machine that was controlling her breathing had extreme anxiety when she felt alone or when she started to panic and the begin to feel like she could not get enough oxygen. The priority I was able to identify for this patient was to sit the patient up slightly first so the patient could breathe better. The patient had extreme anxiety so I was able to talk to the patient and reassure her she was not alone, and then when the nurse was able to step away from where she was and come in the room I let the nurse take over the patients care and she was able to increase her oxygen some as well as make sure I had elevated the HOB enough for the patient.</p>

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