

Instructional Module 4 – Adult M/S 2

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.	<ul style="list-style-type: none"> - 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 	<ol style="list-style-type: none"> 1. I was caring for an older patient that had severe rheumatoid arthritis in her hands. I first noticed this whenever I came into the room to administer her medications to her. She was showing signs/symptoms of the ulnar deviation in her hand's, and it was very bad. The condition was actually so severe that she was unable to grasp object or pick anything up. As I was there to give her the medications, I chose to intervene and help administer the medications to her in ice cream. I chose to do this because she not only had trouble swallowing, hence the reason it was being put in ice cream, but I was also feeding them to her. This intervention allowed my patient to safely take her medications, while also helping her out due to her inability to hold things in her hands herself. 2. One patient I was caring for was admitted for a basilar tongue mass that was being monitored for potentially being cancer. The mass on her tongue was so large that it was blocking part of her airway, inhibiting her from eating solid foods or taking big pills. Due to this reason, she had a PEG tube placed and was ordered for her medications to be given via this route. When I was in the room and giving her the scheduled medications, one of them was a PO med that could not be crushed. When attempting to take the pill whole by mouth, she started to gag and felt like the pill was stuck in her throat. The reason for attempting to take it by mouth was because it was an important med that she was needing. However, all of her other meds could be crushed and administered via PEG tube. This intervention is a safe way to administer needed meds to a patient that is unable to swallow or take pills. It is also effective because it allows for more compliance from the patient to take the medication.
Communication	Communicate effectively with members of the healthcare team.	<ul style="list-style-type: none"> - Identify health care team members & their purpose - Interact appropriately with health care team. - Utilize proper SBAR, TEAM Steps, etc. - Evaluate outcomes of communication process 	<ol style="list-style-type: none"> 1. I was taking care of a patient that was wanting to have a bed bath, as she was not able to get up out of bed. It was just me in the room, and I knew that if I gave her a bed bath, I would want to change her old sheets as well. As she was a bigger lady, I kept in mind that I would need some assistance with the bath and the sheets, so I exited the room. Once at the nurse's station, I was able to communicate with one of my fellow peers and ask for help. I informed them of the patient, and a little bit about her, and then that she was a bit on the bigger side, hence the reason why I was needing some help. Once back in the room, we were able to communicate with one another when moving the patient to one side of the bed to get her sheets changed as easily as possible. Communication made this situation a lot easier and run more smoothly in the end, as it would have taken me a lot longer to complete my task had I not asked and communicated that I needed help. 2. One patient that I cared for came in and had a lumbar fusion surgery due to a fall that she had. In order for her to complete therapy, she was needing to wear a turtle shell back brace to keep her spine in alignment. When I was helping her to the bathroom, PT came into the room to complete her therapy for the day which was ambulating down the hall with the brace on. I was able to communicate with the lady from PT about the status of the patient's ability to ambulate with assistance when she asked how my patient was doing with the brace. I told her that my patient was still having some difficulty getting up and out of bed on her own, as it hurt her back trying to do so much movement at once. Even with the brace, she

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			<p>was still experiencing some trouble when trying to push herself up and out of bed without help. This communication allowed the PT worker to be more understanding on how the patient would be able to ambulate that day and the amount of participation to expect. Although the worker was a bit rude towards the patient at first due to being under the impression that she could get up and walk without help, my communication helped the worker to take it down a notch and not be as aggressive with the therapy.</p>
Critical Thinking	Apply evidence based research in nursing interventions.	<ul style="list-style-type: none"> - Analyze pertinent data (subjective, objective) - Identify evidence based practice (EBP) resources - Distinguish EBP nursing interventions - Apply EBP nursing interventions - Document resources & interventions 	<p>1. I was caring for a patient that was admitted for anemia, and when she came onto the floor her labs showed that she was hypokalemic. After looking at and analyzing her labs, I saw that her potassium was at a 3.1, and the normal range is from 3.5-5. For this hospital, it is protocol to give potassium to patients that are below 3.5, so in this case we were going to give potassium to this patient to try and bring the level up. It is an evidence based practice to intervene and administer potassium to a patient that has a low level, as the effects of low potassium in the body are severe and could ultimately lead to death if untreated. Once we obtained this patient low level, my nurse and I were able to administer potassium to her to bring her levels up. While in the room giving meds, my nurse was able to document that potassium had been given to this patient and entered the level that it was at in order to back the reason as to why it was given.</p> <p>2. One patient that I was taking care of was admitted for deep vein thrombosis. When I was looking into his chart and saw his labs, I saw that his PT/INR values were low. This can indicate that someone is more prone to dangerous blood clots, as their blood clots more quickly. It is evidence based practice that when dealing with deep vein thrombosis you want to elevate the legs to help alleviate the pain and edema that is caused by DVT. Elevating the legs can help to prevent the formation of future blood clots. When I got into the room, I saw that his legs were not elevated, and it started to concern me because I didn't know how long he had gone without elevation. I got two pillows and placed them under the patient's lower half of his legs, and then raised the part of the bed where his feet were so that they were above his heart. Although he only had DVT in one leg, this can still increase his risk for getting another clot in his other leg.</p>
Caring and Human Relationships	Incorporate nursing and healthcare standards with dignity and respect when providing nursing care.	<ul style="list-style-type: none"> - Explain need for nursing & health care standards - Apply standards to patient care (HIPAA, QSEN, NPSG) - Communicate concerns regarding hazards/errors in patient care 	<p>1. I was caring for a patient that had diagnosed schizophrenia. When I first went into her room with the nurse, I was shadowing, she seemed a little hostile to talk about her health and other private information while I was in the room. She felt as though I was just another person that would call her crazy if I knew certain things. I was called into her room to help her to the bathroom, as she was an assist times 1. Once I was able to spend some time in the room with her and help her, she opened up to me about her past and about her deceased family. She then started to tear up and cry while speaking, and I was able to consolidate her and be there for her while she was feeling these emotions. I was able to calm her down and be an advocate for her, ensuring her that I didn't think she was crazy. She then thanked me for listening and spending so much time in the room with her, as she hadn't really experienced someone who was willing to take the time to listen to her stories. Sometimes listening to someone's stories and taking the time helps to build the nurse-patient relationship and establish a sense of trust in the patient.</p>

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			<p>2. I was taking care of a patient who had right sided weakness on her left leg. When me and one of my peers came into the room to do a check on her and take her vitals, we saw that her bed linens were very soiled and looked like they hadn't been changed in a long time. The patient had just been sitting in her own urine and hadn't been cleaned up. <u>After seeing this, me and my peer left the room to grab some clean sheets to change her bed and also got some wipes so we could give her a bath. Once we were back inside the room, we were able to give her a full bed bath and changed the sheets for her, so she was no longer sitting in her own filth. Afterwards,</u> we started talking with the patient and she just expressed how thankful she was that we gave her a bath and how much better it made her feel. I think it's very important to keep up with the hygiene of your patients because being clean can make a huge difference in how someone is feeling that day and can even impact their healing mentally while in the hospital. Once we were done and left the room, I made sure to tell the nurse aides and nurses that whoever was taking care of this patient the night before did not do their job and let the patient sit in her dirty linens. This was a cause for concern due to the fact that sitting for prolonged periods of time in urine and/or feces increases the risk of skin breakdown and could eventually lead to a pressure injury.</p>
<p>Management</p>	<p>Recommend resources most relevant in the care of patients with health impairments.</p>	<ul style="list-style-type: none"> - Assess patient needs during acute care to promote positive outcomes. - Assimilate co-morbidities into plan of care - Identify appropriate resources - Initiate discharge plan 	<p>1. One patient I had was in the hospital for osteomyelitis of the toe that was secondary to diabetes, that ultimately led to an amputation. He was on his last days in the hospital and was about to be discharged. I started talking with him about his diabetes while I was in the room helping him to the bathroom. He told me about how he couldn't afford diabetes medication, so it was very poorly controlled. I started to talk to him about other ways to help keep his glucose not so high and avoid infection of the feet. I explained the importance of foot care to him for someone that's a diabetic, and I also talk about avoiding things in his diet that could increase his glucose severely. I told him about the tool that shows you how much sugar could be in an item at the grocery store, so that way next time he could be more cognizant about what he buys. Although I was unable to be a part of his discharge planning, I was able to recommend alternative proactive things that he can incorporate to his everyday life once he was able to be discharged.</p> <p>2. I was taking care of a patient that was admitted for schizophrenia. Upon being in here room for a long period of time, she started to talk to me about her living situation and how she didn't want to go back to the nursing home she was currently at. She told me how she experienced very negative things while residing there, so she wanted to be transferred somewhere else. After talking with her, I was able to speak with my nurse about potentially transferring her or getting a referral for a transfer so that the patient could be more compliant with being discharged. The nurse had told me that a transfer was already in place. Once back in the room with my patient, I was able to share with her that she would be going to a new facility, so that she wouldn't have to go back to the one that gave her negative experiences. I then started talking to her about outside resources, and how case management would be involved, and they would be able to help her determine where she could stay that would be good for her. Although I'm not able to initiate a discharge plan, I was able to present my ideas about what facility she</p>

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<p>Leadership</p>	<p>Participate in the development of interprofessional plans of care.</p>	<ul style="list-style-type: none"> - Identify/define interprofessional plan of care - Integrate contributions of health care team to achieve goals - Implement interprofessional plan of care 	<p>could be transferred to when it came time to discharge the patient.</p> <ol style="list-style-type: none"> 1. One patient I was taking care of was in the hospital for osteomyelitis secondary to diabetes. His plan of care was to remain in the hospital while on IV antibiotic therapy due to the infection being very life threatening, hence a toe amputation was a result. Part of his care on the nurse’s end was to ensure that he had proper dressing changes after the surgery had been done, and to monitor his CBC over the course of the antibiotic therapy. When I had clinical and had him as my patient, he was towards the end of his hospital stay so discharge planning had already been written up by the nurse. However, I was able to talk with the nurse about his situation and how he was unable to pay for diabetes medications, which could have been a contributing factor to his poorly controlled diabetes that led to his toe infection. I was able to talk with the nurse about options for him when he’s discharged on ways, he could try to maintain his disease without taking medication. Although I’m not able to help with discharge planning, the nurse took my contributions into consideration to try and see how we could help the patient once he was discharged. 2. I was taking care of a patient who was admitted to the hospital for a fall and needed to have a lumbar fusion surgery. For her interprofessional plan of care, physical therapy needed to be involved because she had a major back surgery that would require rehabilitation. Although she had only done one session of PT, I was talking with the nurse that maybe the patient could try hydrotherapy, as regular therapy seemed to be a bit painful for her. My thinking for this was that maybe hydrotherapy would be a little bit easier on the patient for a start, and then she could gradually get into the aggressive portion of physical therapy. Although I’m not allowed to develop a care plan for my patient, I was still able to work with physical therapy and helped the patient ambulate down the hall. Helping ambulate the patient was implementing her plan of care as it was ordered by the physician for her to complete before she was discharged.
<p>Teaching</p>	<p>Evaluate the effectiveness of teaching plans implemented during patient care.</p>	<ul style="list-style-type: none"> - Identify/define teaching plan - Implement teaching plan - Identify appropriate evaluation tools - Appraise patient outcomes 	<ol style="list-style-type: none"> 1. I was taking care of one of my patients and it came time for me to administer her medications to her. As I was scanning all of her meds and explaining what each one was for, I came to the last medication which was Enoxaparin. I explained that this would be an injection in her abdomen, and that’s when she stated she didn’t want the shot. I investigated further and asked why she did not want the shot, and she stated, “because I hate shots and I’ve gotten so many, I don’t need another one.” That’s when I was able to educate her on the reason for the shot, and that it was needed to help prevent her blood from clotting due to being bedbound. I explained to her that she was at risk for blood clots, due to her being a complete bedrest patient, and how this could cause further complications. After explaining all of this, the patient became more compliant to agreeing to receiving the shot. 2. One of my patients that I was taking care of was in the hospital for osteomyelitis of the toe secondary to diabetes and needed to get an amputation. While I was talking to him, he stated how he didn’t have enough money to pay for diabetes medication. This meant that he had poorly controlled diabetes, which led to him being more prone to diabetic foot ulcers that could get infected. When I was in the room helping him get dressed after his shower, we started talking about diabetes.

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			<p>That’s when I started to educate him on diabetic foot care and how important it is to manage your feet when you have this disease. I told him about that people with this disease, especially type 2, have poor blood flow in their lower extremities, and often times neuropathy occurs so there’s a decreased ability to detect when you have a wound on your foot. I also taught him how having diabetes causes poor wound healing, so when you mix neuropathy in the feet and a lack of sensation with wounds that won’t heal you can get a bad infection. Once I told him this information, he told me that he had not really been educated or told this and he didn’t really think about how important foot care could be with diabetes. I think that my teaching was effective in making the patient aware that he needs to manage his foot care in order to prevent future infections.</p>
<p>Knowledge Integration</p>	<p>Deliver effective nursing care to patients with multiple healthcare deficits.</p>	<ul style="list-style-type: none"> - Identify patient health deficits - Prioritize care appropriately - Adjust plan of care based on patient need - Identify system barriers - Modify health care deficits identified 	<p>1. I was helping take care of a patient that got admitted for anemia. Once she was on the floor, we found out that she was hypokalemic, and needed to be given a blood transfusion and IV iron supplement. Although my nurse knew what to do already, I spoke to her about how I would go about prioritizing which issue to resolve first. First, I would do the blood transfusion, while also correcting the hypokalemia, due to the levels being highly dangerous if they reached too low. I would choose to do the transfusion first, because if she doesn’t have enough red blood cells or HGB/HCT in the body, then the IV iron wouldn’t be as effective. Secondly, I would start the IV iron when the transfusion is complete, and the potassium has been corrected so the patient isn’t in danger of experiencing signs or symptoms of hypokalemia like cardiac issues. I am unable to adjust the plan of care for patients, however, I was able to identify multiple health deficits of this patient and be included in the process of how I wanted to go about correcting each one with priority.</p> <p>2. One patient that I was helping care for was admitted for a UTI and confusion also had jugular bleeding due to a jugular IV line being placed. She had a dressing over the site where it was bleeding that needed to be changed, however, it was time to administer her medications. When looking at her chart, I saw that she had severe rheumatoid arthritis and was unable to grasp object with her hands, meaning that she couldn’t take her medications without help. While we were in the room, I was able to help deliver her meds to her with some ice-cream because she had difficulty swallowing. The meds that she was taking were for her UTI to help fight the infection, and these needed to be in her system, so they took priority over the jugular dressing change. Once we were done with medications, that’s when we were able to do the dressing change. The care of the patient was prioritized this way due to medications being more vital for the patient to have first versus a dressing change.</p>