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.	- 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. My Sim pt. who was admitted for post op hip fracture and the surgical site is actively bleeding. Her pain level was at 7 located in her left hip. Vital signs reading was; Temperature (99.0), Heart rate (120), BP: (79/54 map:62), O2: (96%) RR: (30) The interventions I did first was to inform CN and the Physician. Per physician's order was to reinforce dressing, the blood pressure was at 90/60 that time and to administer PRN pain medication(ketorolac) IVP. After 5 minutes blood pressure was beginning to go down. We again notified CN and the physician. Physician's order was to replace the primary IVF that was running (D51/2NS) to lactated ringers bolus 500 over 30min. In real life scenario we would call rapid response immediately this is an emergency case. 2. As I was doing my vital signs, one of my patient's blood pressures was 150/90. I rechecked again making sure that the patients' legs are not crossed and the blood pressure cuff is in the right place. The result was still the same after rechecking the BP. I reported to my nurse about the blood pressure being high. We both went in to the med room preparing the morning meds for this patient. Prior administering labetalol I first assessed his heart rate. If it was below 60, I need to withhold the med but it was normal, 80 HR. I administered the medication with the RN beside me. After 30 minutes I rechecked the blood pressure, it went down to normal and also went ahead and checked his vital signs to assure everything is in normal range.
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. I was able to communicate with the nurse regarding patients' pain level and concern about the abrasion on his ankle area. I provided her with information regarding the patient's pain scale level of 6 located in the patient's abdominal area and impaired skin integrity. I utilized SBAR communication to my nurse, specifically, assessment and recommendation. After my assessment, I recommended putting on some antibiotic ointment on the wound, which the nurse agreed. We came back to the patient's room and administered the patient's PRN pain med. After 30 minutes of administration, I reassessed patient's pain scale level which went down to 2. The patient was feeling better and asked for a Physical therapist to work with his morning exercises. I told the nurse and she talked to the physical therapist that the patient's pain level is down to 2 and is now able to do his exercises. We as a team provided excellent care for the patient that day. 2.Another example was that I was able to communicate with the nurse aide regarding a patient who was wanting a bed bath. At that time the aide was busy and I could not do the bath alone. I looked for my nurse but she was nowhere to be found and my peers were busy passing out meds. I was done passing out medications with my nurse. The first thing I did was I helped our nurse aide on the floor and eventually get to bathe my patient we utilized proper collaboration and team work for effective patient outcome.
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. Objective data I observed is when I assessed the patient's insertion site it was red, swollen and warm to touch. Subjective data is that the patient told me it burns when he had some fluids running and painful to touch. (Pain scale of 4) Evidenced based practice states to stop/pause IV pump to avoid further complications to the affected vein. The interventions I did was I called my nurse and informed her about the inflamed IV site. She went in to the pts. room, rechecked the site and

			proceeded to let me discontinue the IV and relocate a new one on the other side. I also added a patient teaching to rest and elevate the affected arm above the level of the pts. chest while also providing him a pillow to prop his arm. 2. Another objective/ subjective data was when my patient complained she was cold and clammy. She is a diabetic patient, and it was already 1000am and breakfast tray is still not delivered. My interventions were; I first reported it to the nurse, she told me to check her blood sugar. We both went in to the room to check on the patient and the nurse also brought a juice with her just in case. The patient's blood sugar was around 90 her last blood sugar check was approximately at 110. The nurse went ahead and gave her the apple juice and let her know that the tray is coming late. Evidence based practice for a patient who is experiencing hypoglycemia they can be given juice to elevate their blood sugar and instruct not to leave bed without assistance due to risk of falls.
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. Every time I do my patient's assessment, I provide privacy by closing the door. When I help with baths either with the aide or a nurse, I do not over expose them and cover them with towel. Per HIPPA protocol we are not allowed to expose any patient identification and should always maintain confidentiality even in our paper works, refraining from patient identification focusing only in the admitting diagnosis and treatments. 2.On one of my patients, I was able to communicate with my assigned nurse, in regards to fall risk concerns of the pt. Then, I gave adequate information to the pt. to ask for help when going to the bathroom to prevent fall in sudden seizure activity. Also, I applied teamstepps method in making sure to communicate your concerns not just to the nurse but to the aide as well in order for us to be able to take care of our patients.
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. In regards to assessing my patient's needs, I ask the patient constantly if she needed some help in anything. I make sure to spend some time to talk or listen to her concerns and do my best to care for her in a holistic way. Also, prior getting out of the room, using nonverbal skills I look over to make sure if the patient is comfortable, free from clutter to avoid injury. 2. The resources I used to be able to assimilate care for one of my patients was reading the Lewis's Med Surge Book. It really helped in providing a bird's eye view in the next step of care for the pt. Also, the book gave me a good pathophysiological background of the disease and I was able to tailor my plan of care to the patients' specific needs. Discharge plan is to be referred to a social worker for speech therapist and physical therapist consult. Home health care services is also important to this patient due to stroke or impaired mobility.
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. Interprofessional plan of care is defined from patients, families, caregiver and community working together to deliver the highest quality of care. In achieving this goal, I was able to help transfer/move patient by using sliding sheet to prevent skin tear. With the help of the nurse and nursing aide, we were able to turn patients to prevent pressure injuries. 2. Another example of interprofessional plan of care is when physical therapist

			needed help to stand a patient. Me and one of my peers, the nurse and nurse aide helped the physical therapist to stand the patient and transfer him to the wheelchair. Implementing interprofessional plan of care is by collaborating with my peers in better plan of patient care to increase good patient outcomes. Through the care we provided we also showed trust to the patient. Assuring them that there is a good team effort for the best quality of care.
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. A nurse teaching plan should correlate to the patient's problem that would guide them continual care independently to help cope with their health issues. For example, my patient was admitted for epilepsy she stopped taking the meds for a few days because she thought she felt better. They monitored her through EEG and sleep deprived the patient and meds for her seizure were not given to record seizure activities. The day after they resumed her medications and as I was giving it to her I patient teach about medication adherence and not to abruptly stop the medication. 2. I had a patient who was post op surgery for cervical myelopathy. The appropriate evaluation tools that I used was neurological assessment, including questions (LOC), PERLA for the pupil assessment, the Braden Scale for skin breakdown, gait assessment, ROM's, Cardiac and Lung assessment parameters and checking the dressing for any obvious purulent drainage.
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. My SIM patient's health deficits include ineffective breathing pattern and impaired physical mobility. She was prescribed to be on 4L nasal cannula. The pt. was admitted for post op Hip fracture, Physician ordered bed rest for 24 hours. Interventions that were prioritized for the patient was pain medications as needed. Frequent check of vital signs to note any changes of BP, HR or Temp which could indicate active bleeding in the surgical site. The patient was about to put petroleum jelly on her lips and I was able to teach about avoiding petroleum-based or oil-based products when under oxygen therapy it can result to combustion. I also patient teach about the abductor pillow which prevents pt's hip from turning away from her body and keep her hip straight. 2.On week 2 one of my patients had some health deficits such as impaired gas exchange, sleep deprivation, impaired physical mobility, risk for overweight and impaired skin integrity. My intervention for this patient is to always check his O2 is always set on the right amount and the on the right placement. Assess his oxygen saturation Q4 together with his Vital signs. Making sure to turn the patient Q2 using the pillow tucked behind his back. Assessing if the patient had any Bowel movement or urination under his pad to prevent further skin breakdown. The nurse stated that this patient already has stage 2 pressure ulcer located in the sacral region. Adequate teaching on his diet, encourage small meals throughout the day and reinforce fruits for snacks.