

Organization of a Clinical Day – Importance of Diet

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Prepare the night before

- Have everything ready
- Possibly have a clinical bag
- Keep badge in same place at all times
 - Leave in clinical bag or with clothes for following day
- Must haves:
 - Stethoscope, pen/penlight
 - Pen light, scissors,
 - Watch, clipboard



BE IN DRESS CODE

- MAKE-UP SHOULD BE USED MODERATELY
- NO PERFUME PRODUCTS
- LIMITED JEWELRY (WEDDING RINGS, WATCHES, TWO EARRINDG STUDS PER EAR, NO LARGE RINGS OR BRACELETS)
- ONE STUD IS ALLOWED IN THE NOSE, NO BULLRINGS OR LOOPS

BEING OUT OF DRESS CODE CAN LEAD TO AN UNEXCUSED ABSENCE

DRESS CODE CONT.

- May wear black, white, navy, or gray long sleeve shirt under uniform. (Excluding the OR)
- Only ceil blue scrub jackets may be worn while on the units. No sweatshirts or t-shirts over the uniform.
- Tattoos do not need to be covered unless they are deemed offensive.
- Nail polish must not be chipped. No tips or artificial nails of any kind. Fingernails must be kept short and filed neatly.

GENERAL RULES TO REMEMBER

- You **may not** leave the floor for any reason without talking to your instructor first. **Do not leave the OR sites before noon without talking to Mrs Kensing first.**
- Take every opportunity to learn- do not sit back and watch when you can jump in and just do it.
- All paperwork is due at 0630. If you do not have it completed you will be sent home with an absence.
- First and foremost you are responsible for YOUR patient. It is ok to follow your nurse and assist on other patients, as long as you have completed everything for your assigned patient.

General rules cont.

- You may bring a drink, as long as it has a lid. It is allowed at the nurse's station tucked away.
- Bring a snack, as we start early and you may get hungry. You may NOT go to the cafeteria for food.
- Do not bring anything valuable such as iPads, laptops, purses, etc. There have been thefts in the student rooms.
- You need to be looking in Epic to be knowledgeable about your patient. Do not rely just on what the nurse tells you. BE INFORMED!! Go in with the doctor/NP/PA and listen to what is said.

Arrive early

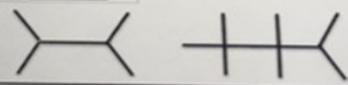
- Getting to hospital early allows you to get organized
 - Can gather assignment—be available for report with the nursing staff going off shift

- Put patients into “My List” in Epic. Do not “assign” the patient to you.

Get Report

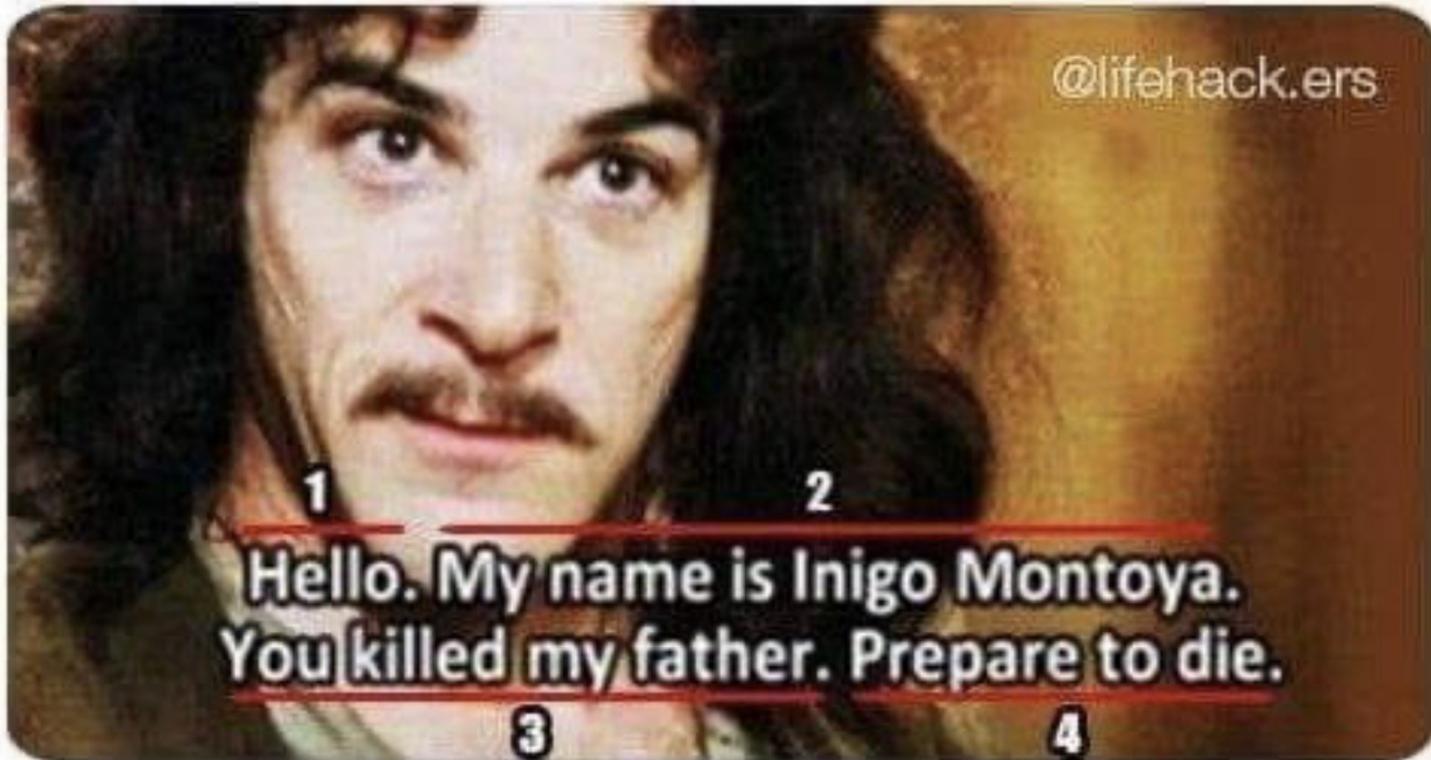
- Bedside report is HIGHLY recommended
- This also allows you to prioritize your patients based on their current condition.
- Although it may be difficult to understand report as they go fast and use abbreviations.
- Be sure to ask any questions you may have after report is finished. **BE INFORMED ABOUT YOUR PATIENT!!**

Nursing Kardex

Admission: Admitting Diagnosis: History: Vital Signs: Rhythm: Rate: CP Mode: RA SaFl: CPAP / BiPAP: TRACH Date: # Heat Settings: VT PDP Rate PEEP PS Wt: Hgt: Pacer Wires: A V Rate: AmA: VmA: Tube/Drain: Date: Tube/Drain: Date: Tube/Drain: Date: Tube/Drain: Date: Dialysis Access: R / L AVG AVF SCHON TESSIO CAPD Last HD: MWP TTS Other: Dialysis Mode: Pressure Ulcers Y N Braden Score: Aquired: Home SS Other: Intermediate Care Unit (S5) Ver.7.3		Attending Physician: Comments: PT OT ST ET Procedures / Test / Treatments: CONTINUE ON BACK G-tube DHT NGT PEG-tube Other: IV Site: Date: IV Site: Date: IV Site: Date: IV Site: Date: NP / Gtt: Date: NP / Gtt: Date: NP / Gtt: Date: Pending Labs / X-Rays / Test / Treatments: PRNS: Surgical Sites: Pressure Ulcers:		Emergency Contact: Emergency Contact: Discharge Planning IP Rehab SNF Hlt Home On GI DME Equipment: Best Care: Current IP Mode: Height: Weight: Mental Status: Diet: Fluid Restrictions: Activity: ISOLATION: Tube Feeding: Valid: Yes No Foley Size Date Date of Last BM: DATE:  Accruals: Code Status: Full DNR Meds Only Limited Code PATIENT STICKER	
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How to be good at talking

1. Polite greeting
2. Name
3. Relevant personal link
4. Manage expectations



Physical assessments

- Assessments must be done prior to giving your medications. If your patient is sleeping, you must still do your assessment.
- Have your assessment charted prior to leaving the unit for lunch.
- Practice charting at bedside: charting bedside allows you to chart while the information is fresh on your mind.
- Assessment sheets are due at 1100. These will be given back to you before we leave for the day.

Vital Signs

- Several floors have vital signs due every 4 hours

- 0700 & 1100

You are responsible for YOUR patient's vitals only. The aides should obtain the nurse's vitals on their other patients. You are not required for all of the nurse's patients. (If no aide available then help with VS/Accudata)

- You must know recent vitals **before** giving certain medications. (HTN meds, antiarrhythmics)

Critical Thinking

- The nurse is receiving change of shift report on four patients. Which patient should be seen and assessed first by the oncoming nurse?
 - A. Confusion, serum sodium level of 130 mEq/L & fatigue
 - B. Shortness of breath on exertion, SaO₂ of 92% & fatigue
 - C. Foley catheter, B/P of 178/104, HR - 126 & confusion
 - D. Constipation, intermittent abdominal pain 0/10 – 4/10

Rationale

- Answer: C
- a. Confusion and fatigue are commonly occurring symptoms or a patient with hypernatremia.
- b. Though concerning, shortness of breath on exertion, SaO₂ of 92% and fatigue may not be negative changes for a patient suffering from chronic lung conditions.
- c. A Foley catheter increases the patient's risk for urinary tract infection while the elevated vital signs and confusion are symptoms of sepsis which can be life threatening and will be highest priority.
- d. Mild to moderate intermittent abdominal pain commonly accompanies constipation and though may warrant nursing care, is not life threatening.

Prepare your patient for day

- Are they going for any procedures?
 - Do you need to do anything prior to procedure?
 - Have they been NPO past midnight?
- Sit them up in chair for breakfast
- Explain planned schedule for the day
- Fill out Best Care board

Best Care Board

Your Covenant Health Professional Care Team: Su Equipo Profesional del Cuidado de la Salud Covenant Health

NURSING Enfermería
Navy And Maroon

SUPPORT Apoyo
Hunter Green

TRANSPORTATION Transporte
Black

HOUSEKEEPING Limpieza Domestica
Maroon

ASK ME WHO I AM Programa Guía
Not Sure? ¿No está seguro?

Erin Whitley - Nurse Mgr. 725-0915

My room #: S568
Cuarto #

My phone #: 725- 2568
Teléfono de mi cuarto

Nurse: Shay, RN
Enfermera

Unit phone #: 725-4798
Teléfono de la unidad

Nurse Aide: Connie
Auxiliar de enfermería

My DOCTORS are: My Doctors
Kurdi

Charge Nurse: Scott, RN
Superior de enfermería

Social Worker/Case Mgr.: Trabajador Social

Diet: 37777
Diet

Respiratory Therapist: healthy
Terapeuta Respiratorio

CovenantHealth
Today is: 7/27/16 Wednesday

Pain medication I may have: Medicación para el dolor

Medicine Medicina	How Often Frecuencia	Last Dose Última Dosis

PATIENT SAFETY PRIORITIES
Preocupaciones para la seguridad del paciente

Fall Risk **Other:**
Riesgo de caídas Días

TODAY'S PLAN OF CARE GOALS Los objetivos de su plan de tratamiento para hoy son

Activity: Actividad
Bedrest

Procedures: Procedimientos
Ø

How can we WOW you with BEST CARE?:
¿Qué podemos hacer por usted hoy, para que se sienta bien atendido(a)?

Control pain & keep informed
Questions: Preguntas

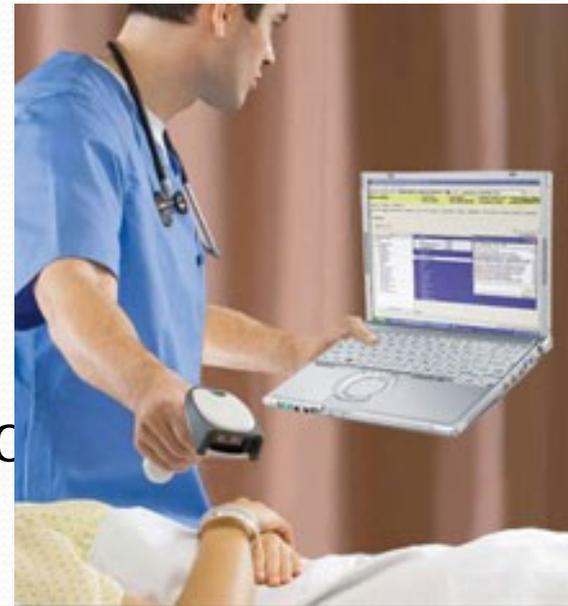
FAMILY CONTACT INFORMATION:
Información para comunicarse con su familia

Hourly Rounding

- Continue throughout the day
- Do it and document it!
- 4 Ps
- Patients often get more “attentive” care when a student is present

Prepare for Med Administration

- Know class of medication
- Indication for patient
- Is dose within normal range
- Route to be given
- Right time to give it
- Side effects need to watch for
- Patient teaching
- Vital Signs!!!
- **ALLERGIES**



AM Care

- Bathing—You are responsible for YOUR patient first and foremost.
 - Showers are best to get patient the cleanest
 - May be able to use a shower chair to roll patient into shower
 - Bathe patients daily
 - Team up to be more efficient
- Brush teeth
- Comb hair
- Change linens



Basics of Delegation

- Nurse Aides/Nursing Assistants are a wonderful help to nurses.
- However, nurses are responsible for ALL patient care, even tasks delegated out to others.
- Do not waste time searching for someone else to do a job you could do on the spot.
- Treat your nurse aides well!! They will be a major help to you!!

Daily activities

- Orders to ambulate
- PT/OT
 - Manage time well.
 - Change linens while they have patient out of bed or ask them to walk them into shower.

Procedures

- Plan well....
 - If I need to change a dressing should I do it before or after a shower?
 - Bring all needed supplies into the room.
 - Bring a helper if anticipate need for assistance
- **ALWAYS bring a licensed person if required.**

RULES TO REMEMBER

- DO NOT JUST SIT AT THE DESK
- GET UP AND ANSWER CALL LIGHTS
- DO NOT LET THE CALL LIGHTS CONTINUE TO GO OFF WHILE YOU SIT AT THE DESK
- DO NOT DO YOUR CLINICAL PAPERWORK DURING CLINICALS

As Lunchtime Approaches...

- Accudatas can be performed 1030-1100
 - Can perform those on your own on YOUR patient only
- 1100 vitals on floors where required
- Follow-up assessments on floors where required
- Up to chair for lunch

LUNCH TIME

- We will all go to lunch together.
- We will go to lunch from 11:30-12:00
- Be aware of the time as lunch approaches so that you are not holding up your classmates.
- When you return to the floor, get back to your patient care. Do not wait for your instructor to get started on pm care.

Winding up the day...

- Straighten up the room
- Empty trash
- Do a final “hourly rounding” assessment
- Report off with your nurse

Importance of Diet

- Several different diets.
- Each have their own significance.

No Food No Drink



After Midnight

NPO

- So VERY important to know if patient is NPO
 - For surgery
 - For procedures
 - For testing
 - Due to diagnosis
- PIVOTAL to know if your patient is NPO
 - Giving food or drink can delay treatment and increase hospital length of stay.

NPO

- Often nursing staff will place a sign on the door
- Remind the patient/family
- Make sure the order gets changed in Epic or tray will not be delivered to patient
- If you get called in to a room of a patient you do not know, ALWAYS ask nurse before providing food or drink.

NPO

- Some exceptions....
 - Most physicians want beta-blockers to be given prior to surgery/test
 - If surgery/test is scheduled later in the day the physician may order a clear liquid breakfast
 - May want other specific meds given prior to surgery/test

Diabetic Diets

- Blood glucose levels are often elevated during illness and after injury because of stress.
- Many patients with diabetes come to the hospital with high BG levels, or their BG levels become elevated during hospitalization.
- Certain medications and decreased physical activity during hospital stay contribute to elevated BG levels.

http://www.mc.vanderbilt.edu/root/pdfs/humannutr/Information_for_Unit_Staff_on_Consistent_Carb_Diabetic_Menu.pdf

Diabetic Diets

- This amount of CHO is distributed throughout the day into 3 meals.
- CHO distribution is the same each day. For the “standard” Consistent CHO Diabetic Diet:
 - Every breakfast has the same amount of CHO ~65 grams.
 - Every lunch has ~60 grams.
 - Every dinner ~60 grams.

Diabetic Diets

- If you don't know the patient, check with the nurse before giving snacks and drinks.
- May have increased need for family education.

Thickened liquids/meals



Dysphagia Diets

- Thickened liquids
- Mechanically altered
- Pureed

Other Special Diets

- Controlled Fat/Heart Healthy
- Bland diets
- Soft Diets
- Full liquid
- Clear liquid

Fluid Restriction

- Seen often in heart and renal patients
- Strict measurement of intake
- Often 1500, 1800, or 2000 ml/day
- Good to put a sign on door and in patient room



- **QUESTIONS??**