

## Final Clinical Reflection

Starting on my sixth day of clinical, we had four patients; I had three patients that I did total care and performed documentation. It is a routine on that floor, nurses and nurses aid take report from the night charge nurse before taking report from the night staff, and each nurse call extension to reset patient's cardiac monitor at the beginning of their shift.

One of my patients had high level of ammonia and was confused, I gave lactulose, I also had opportunity to admit sodium bicarb to the same patient I found this one special because it is not a common drug use on floor where I have been before. I did two IVPB, admit subcutaneous med, bolus feeding, and medication admit through the PEG. I also performed wound care on patient neck where the trach was placed, I performed patient ambulation. This day was a sad day because one patient on the floor had a crash card near her room and family had to change her status from full to DNR because her health condition was declining.

My day seven I had four patients that I did total care, we were passing morning medication and had one patient left suddenly when we were notified that one of our patients is having A-fib, we just when ahead and put everything on hold because we received stat order for 12 leads EKG, normal saline bolus for 500 ml 167ml/hr and now lower the other 500 ml over 75ml/hr, digoxin 2ml, and increased dose of levonox 60ml; since his admission, the patient is refusing levonox shot. He was also the one receiving TPN cycling over 12hrs @75-150-75. My second patient was only Spanish speaking I had to use all my Spanish level to communicate with him and his family, he used special bed called envalla bed to help for pressure ulcer. My third patient was showing sign of progression and was on the list for discharge when he suddenly declined again and get very confused, apparently, he straight Cath himself at home because of

neurogenic bladder but we had an order to put an urethral catheter on him, I inserted the urethral catheter on him on one attempt, and he well tolerated it. My fourth patient was having chronic hypoxia using accessory muscles to breathe, she was on continuous O2 sat monitor, she took her medication crush with apple sauce, and other med was not meant to be crush, but still she was having hard time swallowing them, she just chewed them with apple sauce. I did not know that colostomy was affected by gas, and for that reason my patient with colostomy bag was taking simethicone, we must release air from the colostomy bag to help the stoma bag to stay in place.

On day eight we had three ICU patients, and I had one patient. My patient was on aspiration precaution, for that reason I had to monitor his respiratory status and make sure he was awake and alert while eating, his diet was general minced and moist. He was taking coumadin pill because he has a history of mechanical heart valve replacement. One of our patients had a big wound in his abdomen I had to follow and assist the wound care nurse for wound VAC care.

On my day nine I had three stepdown patients. I did my assessment and charting on them, I also admit med throughout PEG tube, give subcutaneous eye drops, and on one of them I gave IM vit 12. One of my patients was ready to get discharge to a rehab facility, he came in for respiratory failure, he had trach, PEG tube, and was there for a while, now he is getting better, the trach was removed, and now he can eat and swallow his pill. We are doing wound care on his incision neck and is healing well. One of my patient's family refused to sign a DNR stating that it is against their religion.

On my day ten, we have two ICU patients, and around noon we have new admit ICU, I took care of one ICU. My patient was experienced bradycardia, and we admit atropine to increase his heart rate. The Picc line specialist was called for a stat Picc line on him, I was in the

room to watch at the Picc line process, how she used ultrasound to visualize and find the appropriate vein on both hand, she finally located the vein on his right hand, but unfortunately the tube did not advance pass the shoulder so she had to remove it and conclude he was not a good candidate for Picc. I also change his inner canula.

Overall, I had a good preceptorship time on that floor, the teamwork, the staff are amazing. I am thinking at that place like one option as my future employee.