Yasmin Perez

Responding:

What I noticed about the patient was she was complaining of nausea and vomiting. She was also complaining of pain that was a 6 out of 10. Pain was located in her abdomen. While the nurse assessed her, I noticed her BP had dropped to 99/56 and her heart rate had increased to 110. She had bowel stool that was tarry, and an emesis that had blood in it as well. Lab work showed red blood cells of 4.9 X 106 µ/L, hemoglobin 9.5 g/dl, potassium 3.4, glucose 122, PT 17 seconds, PTT 90 seconds, and INR 2.2 seconds. Patients have also been taking aspirin every 6 hours for the past 2 weeks for severe headaches. Patient was also put on NPO. With this information, the patient was diagnosed with gastrointestinal bleed. With her vitals and admitting diagnosis the patient was going into hypovolemic shock. As the med nurse I administered 1 ml of promethazine intramuscular for the nausea and vomiting. I then administered morphine through IV 1 ml for the pain she was having in her abdomen. While the other nurse was assessing she noticed the patient was going into hypovolemic shock, so she called the provider. The provider then gave her new orders to start a nasogastric tube insertion so the stomach could rest and also gave the order to give 125 ml of normal saline. I then grabbed my iv tubing and normal saline of 500 ml and started the IV pump to 125 ml/h. Once the patient got fluids and electrolytes replacement and NG tube inserted the patient was stable.

An example of collaborative communication was when I asked the nurse who was assessing to double check and make sure I had infused the normal saline at the right rate. I also had the nurse double checked on me making sure the morphine I was giving was the exact amount and if I needed to waste any, she was there to double check. As a medication nurse and as assessment nurse we both helped each other out and talked things out in making sure we did everything we needed for the patent and were not missing anything.

One communication I could improve is asking the patient when it was the last time she vomited and how it looked. I can help the assessment nurse in asking for that communication. Instead of just standing there and waiting for the nurse to assess and get a response I can go in and say I see you have promethazine ordered for nausea and vomiting are you having any right now and what color was your emesis if you did? That way the patient does wait to long for her medication and I can give her the medication before getting worse.

A conflict that I experienced with this stimulation was the doctor who was impatient and did not want to be bothered and seemed annoyed with the nurse. A CUS statement I would say is” I am concerned for my patient who is showing symptoms of hypovolemic shock, I understand you are busy, but I would like clarification in what you want me to do so I won’t have to keep calling and bothering you. As her Nurse her safety is my priority so I am asking if you could please let me what orders exactly you want done for this patient?”

Reflecting:

I did not evaluate an intervention in this stimulation. I realized that I should have given an intervention in the patient overusing aspirin. I should have told her that taking so much aspiring can cause gastrointestinal bleeding and that she needs to stop taking that medication and can longer take anymore. As intervention I could have told her that instead of taking aspirin for severe headaches she could try going into a room where it is quiet, and lay down, with the lightning being low to see if that helps decrease her headaches.

Patient is complaining about nausea and vomiting. Administered promethazine as ordered for nausea and vomiting. Patient also complained of pain in their abdomen rating it a 6 out of 10 on a pain scale. States pain is only in her abdomen and not radiating anywhere else. Administered Morphine for pain as ordered. Asked patient if they needed anything else. Let patient know if they needed anything to let us know.

I need improvement in making sure I clean the tops of the medication before I insert a needle to pull the medication to avoid infection. I need to take my time and remember that any medication that has a cap needs to be disinfected. Another improvement when recapping instead of recapping I can use the counter. This will help avoid getting poked and possibly run the chance of getting infected if a patient has a disease and go through the whole process of blood work and making sure I am not contaminated with anything.

Before sim: “Nervous” Not knowing what the seem was about or what could go wrong with the patient me get nervous and start overthinking of different scenarios in my head

During sim: “Panicked” I felt so panicked that I had forgot how to program the IV pump as I have not had much practice and was panicking in my head thinking I am going to fail this.

After sim: “Relieved” I was relieved, it was over and that I had completed it and that I didn’t forget how to program the IV pump on.