Directions

This Direct Patient Care Documentation must be completed for one patient whom you are providing direct care in a clinical learning setting. All information within this packet must be handwritten, (with the exception of the reflection journal) reviewed with your faculty on your assigned clinical day and submitted within 24 hours (or as directed by course coordinator). If additional space is needed, please use the back of each page.

- **Grading:** Evaluated as Satisfactory, Unsatisfactory or Needs Improvement on the Clinical Learning Evaluation. Satisfactory rating meets the following:
  - **Clinical Learning Competency:** Completes all clinical learning experiences and requirements successfully (PO 5).
- **Performance Descriptor:** Completes all assignments related to the clinical learning experience within established guidelines.
- **I-SBAR:** Utilized for receiving report. Areas that indicate clinical significance are to be completed after patient report has been received. Students should deliver a hand-off report at the end of their shift to the bedside nurse.
- **Assessment Findings, Labs and Healthcare Provider Orders:** Document your initial and ongoing assessment findings, lab results with why they were drawn specifically for your patient and healthcare provider orders with why they were specifically ordered for your patient.
- **ATI® Active Learning Templates Required:**
  - **Diagnostic Procedure:** Select one diagnostic procedure from the healthcare orders table and complete one Active Learning Template: Diagnostic Procedure. The selected diagnostic procedure should be one in which you have not previously completed a template for this session.
  - **Therapeutic Procedure:** Select one therapeutic procedure from the healthcare orders table and complete one Active Learning Template: Therapeutic Procedure. The selected therapeutic procedure should be one in which you have not previously completed a template for this session.
  - **Nursing Skill:** Select one nursing skill from the healthcare orders table and complete one Active Learning Template: Nursing Skill. The selected nursing skill should be one in which you have not previously completed a template for this session.
  - **Medications:** List medications below and complete one Active Learning Template: Medication for each medication classification in which you have not previously completed a template.

Time Due	Drug/Classification	Clinical Significance
9:00am	Lisinopril	lowering of BP in hypertensive pt's
9:00am	Clopidogrel	Reduces risk of MI and stroke
9:00 am	Insulin	Control of hyperglycemia in pt's with DM
9:00 am	Glipizide	Lowers Blood sugar in diabetic patients
9:00 am	Atorvastatin	Lipid - lowering agent
9:00 am	Metformin	Maintenance of blood glucose

- **Nursing Diagnosis:**

Identify three nursing diagnoses for your patient and list them by priority below. Complete one concept map for your top nursing diagnosis listed below.

1. Risk for fall
2. Risk for unstable blood glucose lev
3. Ineffective Coping

- **Reflection Journal:**

Complete a reflection journal and submit to your faculty within 24 hours of completing your clinical learning experience. Reflective journaling provides a format to share your knowledge, skills, experiences and personal reflection related to concepts and strategies learned throughout your program. The reflection journal is required to be typed, Word document, Times New Roman 12-point font. Minimum of one page and no more than three pages.

Introduce Yourself

Your Title: Student RN
Reason for being there: Assess / care / clinical

S
Situation

Patient: J. P
Age: 75 yr
Gender: Male
Height/Weight: 174 cm / 79.2 kg
Race/Ethnicity: caucasian
Allergies: NKMA
Code Status: Full code
Advance Directive (Durable Power of Attorney, Living Will, Other) & Clinical Significance:
Has legal documents on pts wishes.
Privacy Code:
Date of Care/Time: 3/2/2020 4:00 am

Attending Physician: Dr. Yason, Day
Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance:
left arm weakness
Stroke like Symptoms
Stroke (+)
Pathophysiology of Primary Medical Diagnosis:
Blood supply to a part of brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients. Brain cells start to die.

B
Background

Include clinical significance with each

Past Medical History:
Type 2 DM, Skin cancer

Past Surgical History:
No surgical history

Social History/Socioeconomic Factors: former smokes, no alcohol or illicit drug use.

A
Assessment

Vital Signs:

B/P	HR	RR	TEMP	SPO2	PAIN
148/92	86	19	98.6 F	97%	2/10

Falls risk: Yes Accu check: ✓
IV Site: Left forearm IV Fluids: NS / Heparin drip

Isolation

Isolation Precautions N ☑ Y ☐ Contact Air ☐ Droplet ☐

RESPIRATORY	Lungs clear posterior and anterior
CARDIOVASCULAR	Regular rhythm, no murmur, equal pulses
NEUROLOGICAL	Alert and oriented x 4
GI/GU I&O	No tenderness, soft, non distended, normal bowel sounds x4Q
INTEGUMENTARY	Warm, dry, no rash, no lesions
PSYCHOLOGICAL FAMILY - SUPPORT	Cooperative, Appropriate mood and affect, normal judgment
SAFETY	Teaching needed: Call for assistance to help ambulate, Quality in Safety Education Nurses (QSEN) Risk(s) Identified:

R
REQUEST/ RECOMMENDATION

Hand off report to: RN. Kristen From: RN. John

Initial Assessment Findings and Time:

Vital signs: 7:00 am

T: 98.7	P: 2/10	Resp: 19	SpO_2: 99%
BP: 144/86	Height: 174 cm	Weight: 79.2kg	Apical HR: 82

Pain scale used with rationale:

P (Palliative, Provocative) What makes the pain better/worse? Ambulation

Q (Quality) How is the pain described? Dull

R (Radiation) Does the pain travel or spread anywhere else? If so, where? No

S (Severity) What is the intensity of the pain? Not severe

T (Temporal) Is the pain constant, or does it come and go? Comes and goes

Head and Neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea):

Normocephalic, no JVD, symetrical facial expressions

Respiratory (lung sounds, breathing effort, accessory muscles):

lung sounds clear anterior and posterior

Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):

Normal rate, regular rhythm, no murmurs

Abdomen (inspection, bowel sounds, palpation, contour):

Bowel incontinence: No

Bowel plan: stool softener Last BM: yesterday

Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):

Alert and oriented x3, eyes PERLA

Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):

decreased grip strength in the left hand

Genitourinary (burning with urination, frequency, color of urine):

no burning or frequency, yellow

Urinary incontinence: No

Toileting plan: Urinate in the toilet

Pelvic (female: LMP):

Rectal (bleeding, hemorrhoids): No hemorroids

Integumentary (rashes, lesions, wounds, etc.): No lesions or rashes

Specialty assessment (mental health exam, fetal heart rate, etc.):

NIH Assessment

Abuse screen (physical, elderly, child, sexual, etc.):

No signs of abuse

IV access (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change):

Heparin drip and NS to heat stroke symptoms

Ongoing Assessment Findings and Time:

Vital signs: 11:00 am

T: 98.5	P: 1/10	Resp: 18	SpO_2: 98%
BP: 142/90	Height: 174 cm	Weight: 79.2kg	Apical HR: 76

Pain scale used with rationale: Ambulation

P (Palliative, Provocative) What makes the pain better/worse?

Q (Quality) How is the pain described? Dull

R (Radiation) Does the pain travel or spread anywhere else? If so, where? No

S (Severity) What is the intensity of the pain? Not severe

T (Temporal) Is the pain constant, or does it come and go? Comes and goes

Head and Neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea):

Normocephalic, no JVD, facial expressions symetrical

Respiratory (lung sounds, breathing effort, accessory muscles):

lung sounds clear anterior and posterior no visible distress

Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):

Normal rate, regular rhythm, no murmurs

Abdomen (inspection, bowel sounds, palpation, contour):

Bowel incontinence: No

Bowel plan: stool softener Last BM: yesterday

Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):

Alert and oriented x3, eyes PERLA

Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):

Decreased grip strength in the left hand

Genitourinary (burning with urination, frequency, color of urine):

No burning or frequency, yellow

Urinary incontinence: No

Toileting plan: Urinate in the toilet

Pelvic (female: LMP):

Rectal (bleeding, hemorrhoids): No hemorroids

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Intervention for Nursing Diagnosis

1. Educating pt on the importance of Blood Glucose checks
2. Therapeutic care

Signs and Symptoms

- High Blood glucose level
- Dizziness, Shakiness

Lab Values Related to Nursing Diagnosis

Glucose level:
230

Nursing Diagnosis

Risk for ~~Unstable~~ Blood glucose level

Rationales for Interventions

1. Making sure pt is aware of the risks of non compliace with the treatment.
2. Administer medication to control blood glucose levels.

Medication(s) r/t Diagnosis

- Insulon
- Metformin

Patient Outcome(s)

1. Patient ~~States~~ that he understands the importance of checking his blood glucose levels
2. Patient is compliant with his treatment

Medication Side Effects

Confusion
Dizziness

Telemetry Rhythm Strip:

Attach your patient's rhythm strip below and determine the following information:

PRI: 0.16	QRS: 0.13	QT:	Rate:	Rhythm: Normal Sinus Rhythm

Labs

Test	Result/ Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
WBC	7.38	5-10 c.1	
RBC	4.8	4.7-6.1	
Hgb	15.3	14-18	
Hct	46%	42-52	
Plt	324	150-400	
Chol	N/A		
Trig	N/A		
LDH	172	50-150	
PT	12.1	11-12.5	
APTT	N/A		
AST	19	5-30	
ALT	11	10-40	Low
Tdl*	N/A		

Test	Result/ Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
Glu	230	70-110	High (diabetic)
BUN	19	10-20	
Na	136	135-145	
K	4.3	3.5-5.0	
Cl	101	98-106	
Creat	1.13	0.7-1.3	
CO2	27	35-45	
Ca	10.4	9.0-10.5	
Phos	N/A		
Mag	2.0	1.3-2.1	
T. Pro	N/A		
Alb	4.8	3.5-5.0	
Tdl*	N/A		

* Therapeutic drug level

Healthcare Provider Orders

Items	Order/Frequency	Reason (explain specifically why ordered for this patient)
Diet	Diabetic	Patient has Diabetes mellitus
I/O	N/A	
VS	Q4	Every 4 hours (Regular check)
Activity	with Assist	Patient is at fall risk because of left side weakness
Accu-check	Regular	Patient is diabetic
Foley	N/A	
NG tube	N/A	
PEG tube	N/A	
PEJ tube	N/A	
Chest tube	N/A	
Trach	N/A	
Suctioning	N/A	
Drains	N/A	
Ostomy	N/A	
Dressing change and/or wound care	N/A	
Treatments	Heparin	Heparin drip IV to treat his stroke symptoms
Special equipment	N/A	
Other	—	

Procedure Name: Blood pressure check

Review Module Chapter:

Description of Procedure

Checking BP with a blood pressure cuff. Blood pressure is the force that blood applies against the vessel wall during each heartbeat.

CONSIDERATIONS

Indications

BP is often asymptomatic
Vital signs monitoring is crucial
Correct BP reading (arm, position, cuff size)

Nursing Interventions (pre, intra, post)

Pre: Perform hand hygiene, provide privacy, explain procedure
Intra: Check BP appropriately
Post: Remove BP cuff, perform hand hygiene, document the results.

Interpretation of Findings

Understanding normal vs abnormal readings
Decide on treatment options

Client Education

Instruct how to check their BP at home.
How to approach a healthy lifestyle.
Explain the risks if BP is left untreated

Potential Complications

Uncontrolled BP
Incorrect health history
Hypertension / Hypotension
Stroke, MI

Nursing Interventions

Make sure to ask pt about the meds they are on
Regular measurements as needed
Document findings.

Description of Procedure

Therapeutic communication is defined as the face to face process of interacting that focuses on addressing the physical and emotional wellbeing of a patient.

CONSIDERATIONS

Indications

Focus on pt and his/her issues
ongoing process of interaction
Sending the right message in the right medium.

Nursing Interventions (pre, intra, post)

Pre: Exhibit reliability, integrity
provide assistance, show empathy.
Intra: Encourage a non judgmental open communication
Post: Discover what your client feels and thinks.

Outcomes/Evaluation

Encourage open communication
Patient trusts you
Decreased anxiety fear in pt.
Building of trust.

Client Education

- Teach the pt the importance of talking about their concerns
- When and where to seek help
- Introduce activities that will help them get better

Potential Complications

losing pt trust
client feels insignificant
Failure to remain client-centered

Nursing Interventions

Demonstrate empathy
Respect for clients beliefs and values.
Maintain confidentiality
Build trust

Description of skill

Injection directly into the bloodstream, is a therapy that delivers liquid substances directly into a vein via a tube

CONSIDERATIONS

Indications

Provide fluid and electrolyte maintenance, restoration and replacement.

Administer medication and nutritional replacement.

Nursing Interventions (pre, intra, post)

Pre: Hand Hygiene and universal precaution

Intra: Check vital signs during therapy

Post: Observe urine output / maintain fluid balance chart

Outcomes/Evaluation

Instant rehydration
Reduced reliance on pills
Faster results
Boosted energy

Client Education

All blood products should be correctly prescribed.
Watch for IV therapy related Infection.
Check IV site frequently

Potential Complications

Fluid overload
Hypothermia
Electrolyte Imbalance
Embolism

Nursing Interventions

Check for signs and symptoms of infection or problems
Teach pt how to prevent IV from clothings or being pulled out

PURPOSE OF MEDICATION

Expected Pharmacological Action

Decreases hepatic glucose production
Increases sensitivity to insulin
Maintenance of blood glucose

Therapeutic Use

Regulate blood glucose levels
Management of type 2 diabetes

Complications

Lactic Acidosis
abdominal bloating, diarrhea
nausea, vomiting, ↓ vitamin B12

Medication Administration

Administer with meals to minimize GI effects.
XR tablets must be swallowed whole do not crush or chew.
PO

Contraindications/Precautions

Hypersensitivity
Hepatic Impairment
Metabolic acidosis
Renal Impairment

Nursing Interventions

Monitor serum glucose and glycosylated hemoglobin periodically during therapy to evaluate effectiveness
Assess renal function before initiating
Monitor serum folic acid and VB12 every 1-2 yr.

Interactions

Acute or chronic alcohol ingestion or iodinated contrast can ↑ risk of lactic acidosis
Nifedipine ↑ absorption effect
Cimetidine and furosemide ↑ effect

Client Education

Take at same time each day
Do not double dose
Follow prescribed diet
Have proper testing of blood glucose
Explain the risk of lactic acidosis

Evaluation of Medication Effectiveness

Control of blood glucose without the appearance of hypoglycemic or hyperglycemic episodes.