

S - Situation	Reason for being there: Clinical	Attending Physician: J. Pattaras																				
	Patient: Michelle Gibson P.6 Age: 69 years old Gender/Identity: Female Height/Weight: 172 lb Allergies: Codaine, oxycodone, sulfa Code Status: Full Advance Directive (durable power of attorney, living will, other) and Clinical Significance: N/A Privacy Code: N/A Date of Care/Time: 9/30/23	Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance: right renal mass concerning for cancer. having chest pain imaging shows lesions Pathophysiology of Primary Medical Diagnosis: Right renal mass																				
B - Background	Include clinical significance with each: Past Medical History: anxiety Immunizations Received: COVID -19, H1N1 Social History/Socioeconomic Factors:	Past Surgical History: Tubal Ligation, radial nephrectomy removal of part of right kidney via robotic approach, Hernia repair, Hysterectomy, Nephrectomy Partial, menisectomy																				
A - Assessment	Vital Signs:																					
	<table border="1"> <thead> <tr> <th>B/P</th> <th>(88)</th> <th>HR</th> <th>RR</th> <th>TEMP</th> <th>SPO₂</th> <th>PAIN</th> </tr> </thead> <tbody> <tr> <td>154/65</td> <td></td> <td>63</td> <td>14</td> <td>37.1</td> <td>97</td> <td>3/10</td> </tr> <tr> <td>143/68(87)</td> <td></td> <td>54</td> <td>12</td> <td>37.0</td> <td>100</td> <td>0/0</td> </tr> </tbody> </table>	B/P	(88)	HR	RR	TEMP	SPO ₂	PAIN	154/65		63	14	37.1	97	3/10	143/68(87)		54	12	37.0	100	0/0
B/P	(88)	HR	RR	TEMP	SPO ₂	PAIN																
154/65		63	14	37.1	97	3/10																
143/68(87)		54	12	37.0	100	0/0																
	Fall Risk: LOW Fall RISK Accu-check: N/A IV Site: Right Periphera IV Fluids: lactated ringer's Lab/Test Results:																					
I and O	Left Regular diet																					
Isolation	Isolation Precautions: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Contact Air <input type="checkbox"/> Droplet <input type="checkbox"/>																					
RESPIRATORY	Clear bilateral sounds within defined Limits, No acute distress																					
CARDIOVASCULAR	within defined Limits, normal rhythm, Radial + Pedial Pulse, moderate bilateral																					
NEUROLOGICAL	Alert Oriented x 4 within defined Limits																					
GI/GU	Constipation Last BM Date: 9/30/23 ; GERD																					
INTEGUMENTARY	wound: Abdomen RU, RL, LU, LL, umbilicus																					
PSYCHOLOGICAL FAMILY - SUPPORT	calm, cooperative within defined Limits																					
SAFETY	Teaching needed: N/A Quality in Safety Education Nurses (QSEN) Risk(s) Identified: N/A																					
R - REQUEST/RECOMMENDATION	Hand off report to: N/A	From: N/A																				



Clinical Learning – Direct Patient Care Documentation

Level 2 Clinical Courses

CHAMBERLAIN UNIVERSITY

Initial Assessment Findings & Time			
Vital signs:			
T: 35.8	P: 53	Resp: 12	SpO ₂ : 100
BP: 155/81	Height: 5'5	Weight: 170	Apical HR: _____
Intake: N/A	Output: N/A		
Pain scale used with rationale:			
O (Onset): Did your pain start suddenly or gradually get worse? suddenly			
P (Palliative, Provocative) What makes the pain better/worse? rest / meds			
Q (Quality) How is the pain described? sharp			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? No			
S (Severity) What is the intensity of the pain? NO			
T (Temporal) Is the pain constant or does it come and go? NO			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Trach midline, no pain heard			
Respiratory (lung sounds, breathing effort, accessory muscles): bilaterally clear, no accessory muscles use			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): N/A			
Abdomen (inspection, bowel sounds, palpation, contour):			
Bowel incontinence: Bowel plan: constipated Last BM: 9/30/23			
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): intact			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): Full ROM			
Genitourinary (burning with urination, frequency, color of urine): orange			
Urinary incontinence:		Toileting plan:	
Pelvic (female: LMP): N/A			
Rectal (bleeding, hemorrhoids): N/A			
Integumentary (rashes, lesions, wounds, etc.): wounds			
Specialty assessment (mental health exam, fetal heart rate, etc.): N/A			
Abuse screen (physical, elderly, child, sexual, etc.): N/A			
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): Right + left peripheral IV			
Psychological/Psychosocial/Family Support/Religious/Cultural Dynamics: Husband, daughter			
Growth and Development: (Developmental stage according to Erikson and your assessment findings): appropriate for age			

Ongoing Assessment Findings & Time			
Vital signs:			
T: 37.0	P: 54	Resp: 12	SpO ₂ : 100
BP: 143/68	Height: 5'5	Weight: 170	Apical HR: _____
Intake: N/A	Output: N/A		
Pain scale used with rationale:			
O (Onset): Did your pain start suddenly or gradually get worse? N/A			
P (Palliative, Provocative) What makes the pain better/worse? N/A			
Q (Quality) How is the pain described? N/A			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? N/A			
S (Severity) What is the intensity of the pain? NO			
T (Temporal) Is the pain constant or does it come and go? NO			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): no pain, no infestation			
Respiratory (lung sounds, breathing effort, accessory muscles): bilaterally clear			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): N/A			
Abdomen (inspection, bowel sounds, palpation, contour):			
Bowel incontinence: Bowel plan: Last BM: 9/30/23			
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): intact			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): Full ROM			
Genitourinary (burning with urination, frequency, color of urine):			
Urinary incontinence:		Toileting plan:	
Pelvic (female: LMP): N/A			
Rectal (bleeding, hemorrhoids): N/A			
Integumentary (rashes, lesions, wounds, etc.): wounds			
Specialty assessment (mental health exam, fetal heart rate, etc.): N/A			
Abuse screen (physical, elderly, child, sexual, etc.): N/A			
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): Removed for discharge			
Psychological/Psychosocial/Family Support/Religious/Cultural Dynamics: Husband			
Growth and Development: (Developmental stage according to Erikson and your assessment findings): appropriate for age			



Clinical Learning – Direct Patient Care Documentation

Level 2 Clinical Courses

CHAMBERLAIN UNIVERSITY

LABS & DIAGNOSTICS

Test	Result/Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
BC	10.8		
BC			
Hgb			
Hct			
Plt	161		
Chol			
Trig			
LDH			
PT			
APTT			
AST			
ALT			
TdI			

Test	Result/Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
Glu			
BUN	24		
Na	139		
K	3.6		
Cl	101		
Creat	1.18		
CO ₂	29		
Ca			
Phos			
Mag			
T.Pro			
Alb			
TdI			

What patient findings and interventions would you anticipate with these laboratory/diagnostic findings?

Bloody in urin , Flank pain in chest

*Therapeutic drug level



Clinical Learning – Direct Patient Care Documentation

Level 2 Clinical Courses

CHAMBERLAIN UNIVERSITY

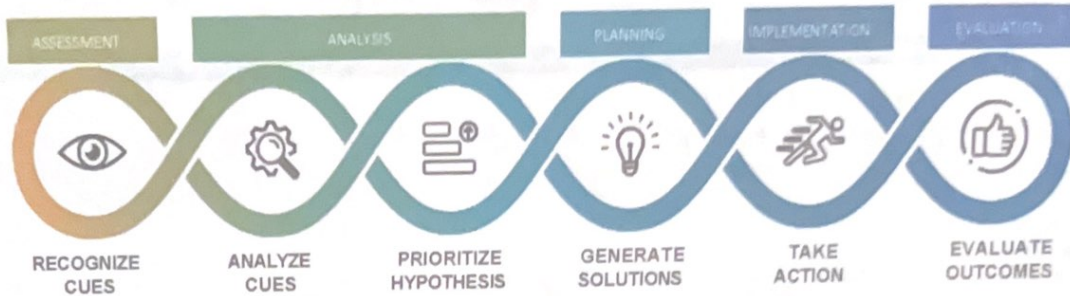
HEALTHCARE PROVIDER PRESCRIPTIONS (ORDERS)

Items	Order/ Frequency	Prioritization (Prioritize the healthcare provider prescriptions (orders) based on your assessment cues)	Reason (Explain specifically why ordered for this patient, potential complications anticipated interventions and teaching required)
Diet	Regular diet		
I/O			
VS	8:00 + 11:00		Q4 to see any changes
Activity	walking		
Accu-check	N/A		
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	JP		
Ostomy			
Dressing change and/or wound care	wound care		avoid infection
Treatments			
Restraints			
Safety devices			
Special equipment			
Other			
	JP drain		place to remove blood from kidney after mass



THE CLINICAL JUDGMENT MEASUREMENT MODEL

The Clinical Judgment Measurement Model (CJMM) identifies six cognitive skills needed to make appropriate clinical judgments. Complete the following section using the CJMM and reflecting on all the data/cues (Assessment, Labs/Diagnostics, Prescriptions/Orders and Patient Information) from your assigned patient.



Recognize Cues – Identify relevant and important information from different sources (e.g., medical history, vital signs).

	Significant Data/Cue 1	Significant Data/Cue 2	Significant Data/Cue 3	Significant Data/Cue 4	Significant Data/Cue 5
List the data/cues that are relevant and are interpreted as clinically significant.	Flank pain	Hypertension	weight loss	edema	pallor

Analyze Cues – Organizing and linking the recognized cues to the patient's clinical presentation.

	Potential Problem 1	Potential Problem 2	Potential Problem 3
Interpret the relevant clinical data/cues. Identify the top three most likely problems. Is additional data needed to confirm the clinical significance of the cues at this point? Be specific; what additional data is needed to confirm?	Flank pain	Hypertension	Weight loss
	Additional Data • you would feel the pain in your rib/hip, lower back	Additional Data • kidney help regulate arterial blood pressure by maintain sodium homeostasis	Additional Data • excess fluid retention when your kidney can no longer turn toxins + waste into urine.

Prioritize Hypothesis – Evaluating and ranking hypotheses according to priority (urgency, likelihood, risk, difficulty, time, etc.).

Of the potential problems you identified, which problem(s) is most likely present? Which problem is the most concerning and why?	High blood pressure can be at a high risk for Heart attack and stroke
--	---



Generate Solutions – Identifying expected outcomes and using hypotheses to define a set of interventions for the expected outcomes.

	Priority Action/Intervention 1	Priority Action/Intervention 2	Priority Action/Intervention 3
Based on the most urgent problem, what are the priority actions/interventions? For each priority action, what are the desired outcomes?	Removal of mass	regulate blood pressure	
	Expected Outcomes	Expected Outcomes	Expected Outcomes
	it will eliminate the growth of the kidney	take medicine	
Are there any interventions or actions that should be avoided? Include rationale.			



Take Action – Implementing the solution(s) that addresses the highest priorities.

How should the interventions or actions above be accomplished? (Performed, administered, requested, communicated, taught, documented, etc.)						
List environmental and/or individual factors impacting the ability of the nurse to generate solutions and take action.	Environmental Factor 1	Individual Factor 1	Environmental Factor 2	Individual Factor 2	Environmental Factor 3	Individual Factor 3



Evaluate Outcomes – Comparing observed outcomes against expected outcomes.

Compare observed outcomes to expected outcomes – has the patient's status improved, declined or remain unchanged?

	Observed Outcomes	Observed Outcomes	Observed Outcomes
Does the observed outcome match expected outcome? If not, what are the additional actions/interventions that should be considered?	Matches Expected Outcome?	Matches Expected Outcome?	Matches Expected Outcome?
If the patient status has not improved, what other issues may be present?			
List environmental and/or individual factors impacting the achievement of outcomes.	Environmental Factor 1	Individual Factor 1	Environmental Factor 2



CONCEPT MAP

Student Name: Aaliyah Ward

Date: 9/30/23

