Clinical Learning – Direct Patient Care Documentation

CHAMBERLAIN UNIVERSITY

Student Name: [redacted] D#: D41[redacted]54 Date: [redacted]

Course: Adult Health 1 - NR324 Session: November Year: 2024

DIRECTIONS

This Direct Patient Care Documentation must be completed for one patient whom you are providing direct care in a clinical learning setting. Information within this packet can be handwritten or typed (with the exception of the reflection journal) and must be reviewed with your faculty on your assigned clinical day and submitted within 24 hours (or as directed by course leader). If additional space is needed, please use the back of each page. If any area within this packet was not performed, line out and place "N/A" in that section.

- **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, Nursing Notes, Labs/Diagnostics, and Healthcare Provider Orders:** Complete according to your assigned patient.
- **Medication Information:** List and complete the information for each medication your patient is ordered.
- **Clinical Judgment Measurement Model (CJMM):** Complete reflecting on all the data/cues (Assessment, Labs/Diagnostics, Prescriptions/Orders and Patient Information) from your assigned patient.
- **Concept Map:** Complete reflecting on all the information and assessment findings gathered from your assigned patient.
- **Reflection Journal –** Complete a reflection journal and submit to your faculty (or as directed) 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. What could you or did you delegate and to whom? Include ways you plan to care for yourself throughout your program. The reflection journal is required to be a typed Word document, Times New Roman 12-point font and minimum of one page and no more than three pages.

At least one time during the session, faculty will select one of the following questions for you to reflect on.

1. Describe how racial/health disparities, health equality/inequality, and social justice/injustice could apply to the clinical site/agency's community. Consider the population and determine why this may be occurring.
2. Transportation and housing are drivers of health and equity. Describe the steps you would take as a nurse to evaluate transportation and housing for your identified community population and what actions you could perform to identify resources.
3. How can nurses be change agents and advocate for their community? Provide at least two specific examples.

I-SBAR						
I – Introduce Yourself	Your Name: Florence Senneh D#: D41237254 Your Title: Nursing Student Reason for being there: Adult Health I – NR324 Clinical Rotation					
S – Situation	Patient: W.S. Age: 75 Gender/Identity: Male Caucasian Height/Weight: 5' 10" 197 lbs Allergies: Simvastatin Code Status: Full Code Advance Directive (durable power of attorney, living will, other) and Clinical Significance: Spouse S.S. Privacy Code: NA Date of Care/Time: 11/27 07:00 am			Attending Physician: Thomas G Knight MD Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance: Acute Myeloid Leukemia (AML) in relapse, Chronic Kidney Failure Stage III, Type II Diabetes, Benign Prostatic Hyperplasia (BPH), Neutropenic Fever, Afib Pathophysiology of Primary Medical Diagnosis: AML is a blood cancer caused by genetic mutations that affect the DNA of bone marrow cells. Abnormal blasts multiply quickly, and reduce the production of normal red blood cells resulting in anemia and other conditions.		
B – Background	**Include clinical significance with each:** Past Medical History: HF, AFib, Cardiomyopathy, TACO (Transusfusion Associated Circulatory Overload) Past Surgical History: NA Immunizations Received: Influenza, Covid 19, TD (Teatnus), Zoster Social History/Socioeconomic Factors: WS lives in a ranch style home that is wheelchair accessible to include a ramp. He is supported and cared for by his spouse, and he shares that he has 20 barn cats that live around his home that he enjoys watching.					
A – Assessment	Vital Signs:					
	B/P	HR	RR	TEMP	$SP0_2$	PAIN
	110/60	73	15	98.6° F Axillary	98% on RA	0/10
	NA	NA	NA	NA	NA	NA
	Fall Risk: High Fall Risk IV Site: PICC line left brachial vein		Accu-check: 165 IV Fluids: NS & LR		Lab/Test Results: Thorancentesis & bone marrow biopsy done on 11/25	
I and O	I: 237 & O: 237 as of current					
Isolation	Isolation Precautions: Y ☒ N ☐			Contact Air ☐	Droplet ☐	
RESPIRATORY	R lung weak wet cough					
CARDIOVASCULAR	Orthostatic hypotension, low BP, bilateral lower extremity edema					
NEUROLOGICAL	Delayed speech, slurred, weak bilateral motor strength, drowsiness, fatigue					
GI/GU	Bowel sounds active and audible in all 4 quadrents					
INTEGUMENTARY	Bruising, redness, turgor, epidermis thin with loss of subcutaneous tissue					
PSYCHOLOGICAL FAMILY – SUPPORT	Patient is cared for and supported by spouse who is in hospital with patient most days/nights					
SAFETY	Teaching needed: Patient must ambulate to higher positions very slowly. Laying to sitting and sitting to standing. Quality in Safety Education Nurses (QSEN) Risk(s) Identified: NA					
R – REQUEST/ RECOMMENDATION	Hand off report to: RN Andi			From: RN Andi		

Initial Assessment Findings & Time			
Vital signs: 07:20 am			
T: 98.6° F Axillary	P: 71 BPM	Resp: 15	$Sp0_2$: 95% on RA
BP: 100/61	Height: : 5' 10"	Weight: 197 lbs	Apical HR: 71
Intake: 237	Output: 237		
Pain scale used with rationale: 0/10			
O (Onset): Did your pain start suddenly or gradually get worse? Patient reports no current pain.			
P (Palliative, Provocative) What makes the pain better/worse? NA			
Q (Quality) How is the pain described? NA			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? NA			
S (Severity) What is the intensity of the pain? NA			
T (Temporal) Is the pain constant or does it come and go? NA			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Impaired vision, missing teeth, coated/cracked tongue, loss of hair			
Respiratory (lung sounds, breathing effort, accessory muscles): Bilateral breath sounds diminished, R lung wet with weak cough			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): Telemetry on, fatigue, bilateral lower extremity edema			
Abdomen (inspection, bowel sounds, palpation, contour): Bowel incontinence: WS will notify staff when BM/restroom is needed			
Bowel plan: Absorbet brief on	Last BM: 11/25		
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): AO x3, patient is slightly confused, speech is slow and slurred			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): Overall generalized weakness throughout the entire body			
Genitourinary (burning with urination, frequency, color of urine): Purwick external male urinale			
Urinary incontinence: Absorbet brief	Toileting plan: WS will notify staff		
Pelvic (female: LMP): NA			
Rectal (bleeding, hemorrhoids): NA			
Integumentary (rashes, lesions, wounds, etc.): Stage 2 pressure ulcer bilateral buttocks, clean, dry, intact			
Specialty assessment (mental health exam, fetal heart rate, etc.): NA			
Abuse screen (physical, elderly, child, sexual, etc.): NA			
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): PICC line left brachial vein, clean and dry			
Psychological/Psychosocial/Family Support/Religious/ Cultural Dynamics: Pleasant demeanor, able to express feelings			
Growth and Development: (Developmental stage according to Erikson and your assessment findings):			

Ongoing Assessment Findings & Time			
Vital signs: NA – One healh assessment completed. Pt left unit for xray			
T:	P:	Resp:	$Sp0_2$:
BP:	Height:	Weight:	Apical HR:
Intake:	Output:		
Pain scale used with rationale:			
O (Onset): Did your pain start suddenly or gradually get worse?			
P (Palliative, Provocative) What makes the pain better/worse?			
Q (Quality) How is the pain described?			
R (Radiation) Does the pain travel or spread anywhere else? If so, where?			
S (Severity) What is the intensity of the pain?			
T (Temporal) Is the pain constant or does it come and go?			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea):			
Respiratory (lung sounds, breathing effort, accessory muscles):			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):			
Abdomen (inspection, bowel sounds, palpation, contour): Bowel incontinence:			
Bowel plan:	Last BM:		
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):			
Genitourinary (burning with urination, frequency, color of urine):			
Urinary incontinence:	Toileting plan:		
Pelvic (female: LMP):			
Rectal (bleeding, hemorrhoids):			
Integumentary (rashes, lesions, wounds, etc.):			
Specialty assessment (mental health exam, fetal heart rate, etc.):			
Abuse screen (physical, elderly, child, sexual, etc.):			
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):			
Psychological/Psychosocial/Family Support/Religious/ Cultural Dynamics:			
Growth and Development: (Developmental stage according to Erikson and your assessment findings):			