



CLINICAL LEARNING – DIRECT PATIENT CARE DOCUMENTATION LEVEL 3 CLINICAL COURSES

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Student Name: D#: Date:
Course: Session and Year:

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
	Dobutamine (Dobutrex)	Increase cardiac output
	Furosemide (Lasix)	To increase urination output
	Piperacillin (Zosyn)	For the infection and bacterial
	Lorezepam (Ativan)	To decrease anxiety
	Prednisone	To decrease inflammation and swelling

• 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.
2.
3.

• 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.



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I-SBAR																														
I Introduce Yourself	Your Name: Faoussatou Akande D#: 41045847 Your Title: Student Nurse Reason for being there: Care for a patient with Acute Respiratory Distress																													
S Situation	Patient: LW Age: 56 years Old Gender: Male Height/Weight: 5'8 220 Lbs Race/Ethnicity: Caucasian Allergies: Peanut, Morphine Code Status: Full Advance Directive (Durable Power of Attorney, Living Will, Other) & Clinical Significance: n/a Privacy Code: none Date of Care/Time: 7/8/20																													
B Background	**Include clinical significance with each** Past Medical History: Pneumonia, Renal Failure Past Surgical History: None Social History/Socioeconomic Factors: Married with children. A construction worker, Like to hangout with some friends on daily basis																													
A Assessment	<table><thead><tr><th colspan="6">Vital Signs:</th></tr><tr><th>B/P</th><th>HR</th><th>RR</th><th>TEMP</th><th>SP02</th><th>PAIN</th></tr></thead><tbody><tr><td>92/54</td><td>132</td><td>28</td><td>99.7</td><td>87%</td><td>4/10</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table> Falls risk: ☐ yes ☐ Accu check: ☐ Q 4hr IV Site: ☐ Central venous line ☐ IV Fluids: ☐ 0.9 % Normal Saline						Vital Signs:						B/P	HR	RR	TEMP	SP02	PAIN	92/54	132	28	99.7	87%	4/10						
Vital Signs:																														
B/P	HR	RR	TEMP	SP02	PAIN																									
92/54	132	28	99.7	87%	4/10																									
Isolation	Isolation Precautions ☒ N ☐ Y ☐ Contact ☐ Air ☐ Droplet ☐																													
RESPIRATORY	Shortness of breath, Use of muscle accessory were noted, crackles on left upper quadrant +																													
CARDIOVASCULAR	S1 and S2 were noted with murmurs, Cap refill is > 3 sec, diminished extremities pulses, JVD was noted +																													
NEUROLOGICAL	Alert and orient to person; patient was confuse, slow eyes movement. decrease deep tendon reflexes. +																													
GI/GU I & O	Distended abdomen, low bowel sound in all quadrant. 35 ML urine output in 3 hr																													
INTEGUMENTARY	Clammy and cool skin, no rash, no lesions or words, blueish lips and tongue. Nail bed slightly curved,																													
PSYCHOLOGICAL FAMILY - SUPPORT	He was accompany his wife and another member, they are all at the bedside.																													
SAFETY	Teaching needed: Educate patient and family about importance of Hemodialysis, and the effects of the medication Quality in Safety Education Nurses (QSEN) Risk(s) Identified: ☐ Keep bed in lower position, call withing reach., bed alarm on																													
R REQUEST/ RECOMMENDATION	Hand off report to: ☐ From: ☐ Requesting a prescription of hemodialysis while hospital, Prescription for high flow oxygen, Dobutamine to help increase cardiac output and urination output																													



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Initial Assessment Findings and Time:

Vital signs:

T: 98.6	P: 136bpm	Resp: 28	SpO ₂ : 87%
BP: 92/54	Height: 68 inch	Weight: 220 Lbs	Apical HR: N/A

Pain scale used with rationale: 0/10

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

Q (Quality) How is the pain described?
Throbbing

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

S (Severity) What is the intensity of the pain?

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

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

Head is normocephalic, No tender, no lesions or rash. No lymph nodes palpable, trachea is in midline.

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

Shortness of breath, Use of muscle accessory were noted, crackles on left upper quadrant

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

S1 and S2 were noted with murmurs, Cap refill is > 3 sec, diminished extremities pulses, JVD was noted.

Abdomen (inspection, bowel sounds, palpation, contour): Distended; low to inactive bowel.

Bowel incontinence: ContinenceCont

Bowel plan: None Last BM: 2 days agoNo

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

Alert and orient to person; patient was confuse, slow eyes movement, decrease deep tendon reflexes.

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

Weak muscle strength, weak pedis and post tibial pulses

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

Brownish and foul smell urine. 35 ml in the last 3 hour

Urinary incontinence:

Continence

Toileting plan:

None

Pelvic (female: LMP): N/A

Rectal (bleeding, hemorrhoids): None

Integumentary (rashes, lesions, wounds, etc.): Clammy and cool skin, no rash, no lesions.

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):

O.9% normal saline
Dobutamine through the central venous line

Ongoing Assessment Findings and Time:

Vital signs:

T: 98.6	P: 98	Resp: 20	SpO ₂ : 96%
BP: 120/74	Height: 68inch	Weight: 210	Apical HR: N/A

Pain scale used with rationale: 0/10

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):

Head is normocephalic, No tender, no lesions or rash. No lymph nodes palpable, trachea is in midline.

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

Unlabored breathing, lung sound are clear in all quadrants

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

S1 and S2 were noted, cap refill > 3sec.

Abdomen (inspection, bowel sounds, palpation, contour): Soft and non tenderness upon palpation.

Bowel incontinence: Continence

Bowel plan: None Last BM: 4 hour ago

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

Alerted and oriented X 4. PERRLs is intact, cranial nerve II- xII are intact

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

Increasing in muscle strength and ROM

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

Urinary incontinence:

Continence

Toileting plan:

None

Pelvic (female: LMP): N/A

Rectal (bleeding, hemorrhoids): N/A

Integumentary (rashes, lesions, wounds, etc.):

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):

IV 0.9 %normal saline



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Healthcare Provider Orders

Items	Order/Frequency	Reason (explain specifically why ordered for this patient)
Diet	Low sodium +	
I/O	35ml output in +	
VS	Q2hr +	
Activity	Ambulate sa +	
Accu-check	Q4hr +	
Foley	24 FR catheter +	
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	O2 therapy; lv +	
Special equipment	N/A +	
Other		



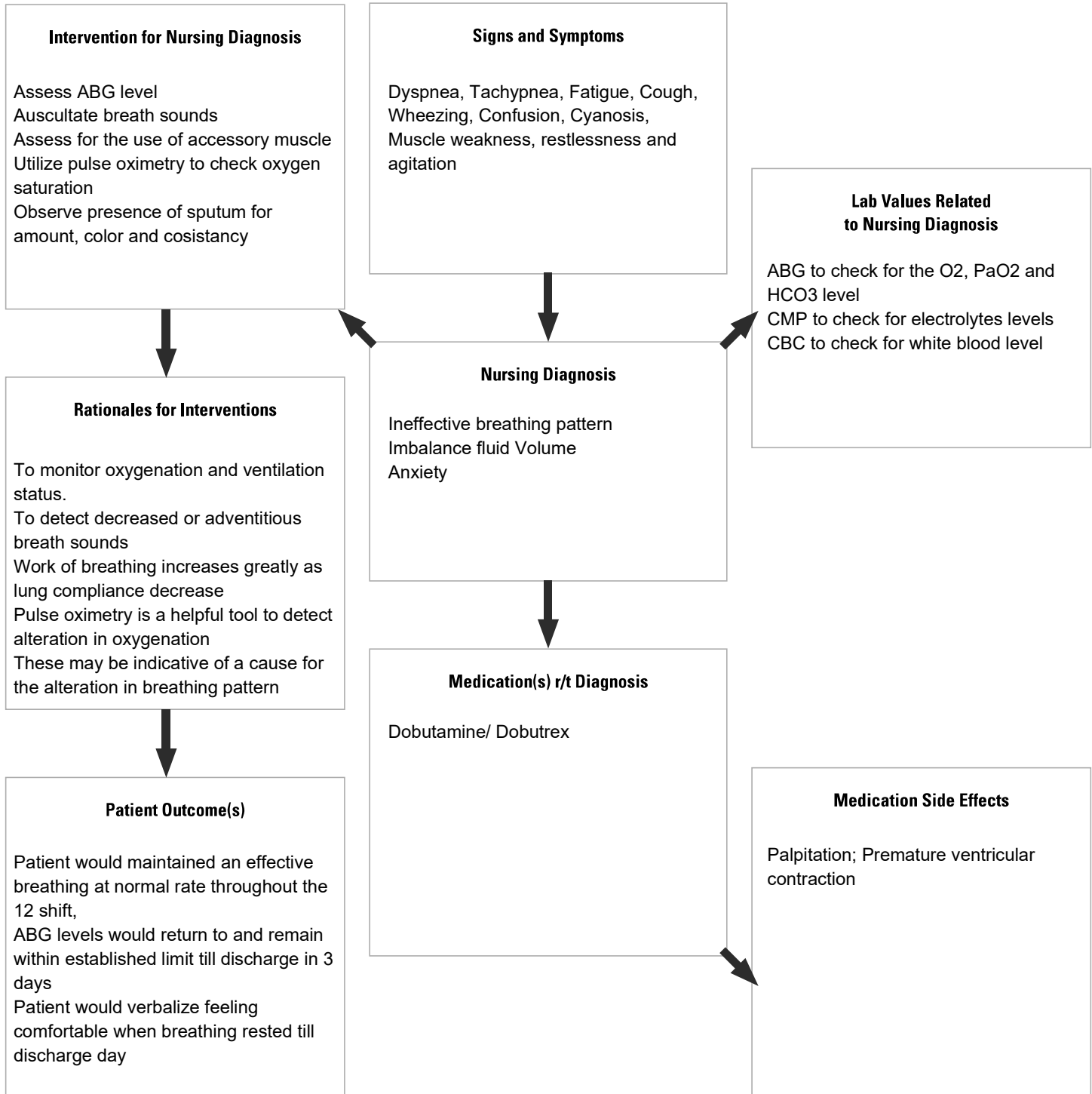
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Concept Map

Student Name: Faoussatou Akande

Date:





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Telemetry Rhythm Strip:

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

PRI: QRS: QT: Rate: Rhythm:

Labs

Test	Result/ Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
WBC	13.0	Abn	Infection
RBC	5.0	Normal	4.3- 5.7 x10 ⁶
Hgb	15.0	Normal	13.2-17.3
Hct	42%	Normal	39%- 50%
Plt	388	Normal	150- 400 x10 ³
Chol	N/A		
Trig	N/a		
LDH	N/A		
PT	N/A		
APTT	N/A		
AST	N/A		
ALT	N/A		
Tdl*	N/A		

Test	Result/ Date	Norm	Reason out of norm/reason for drawing if normal or N/A if not drawn
Glu	96	Normal	70-100
BUN	22	Abn	Renal failure
Na	150	Abn	Renal failure
K	5.8	Abn	Renal failure
Cl	100	Normal	96-106
Creat	0.2	Abn	Renal failure
CO2	N/A		
Ca	12.1	Abn	Renal failure
Phos	N/A		
Mag	5.6	Abn	Renal failure
T. Pro	N/A		
Alb	N/A		
Tdl*	N/A		

* Therapeutic drug level



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Active Learning Template: Diagnostic Procedure

Student Name: Fa

Procedure Name: Chest X-Ray

Review Module Chapter:

Description of Procedure

An x ray of the thorax—illustrates the contours, placement, and chambers of the heart. It may be done to identify heart displacement



CONSIDERATIONS

Indications

Infection
Major trauma
Acute chest pain
Asthma/bronchiolitis with unclear diagnosis and/or not responding to usual therapy
Suspected mass such as metastasis or lymphadenopathy

Nursing Interventions (pre, intra, post)

Use a protective lead apron/gown

Interpretation of Findings

Providers use the information from the CXR together with medical history, physical examination and other clinical data to help make a clinical decisions

Client Education

If possible, remove ↑ waist level clothing and jewelry as they can obscure the CXR images

Potential Complications

Radiation exposure

Nursing Interventions

Use a protective lead apron/gown



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Active Learning Template Therapeutic Procedure

Student Name:

Procedure Name: O2 therapy

Review Module Chapter:

Description of Procedure

oxygen is administered in an attempt to maintain an SaO₂ of 95% to 100% by using the lowest amount of oxygen without putting the cli



CONSIDERATIONS

Indications

Hypoxemia and hypoxia

Nursing Interventions (pre, intra, post)

Monitor for manifestations of respiratory depression, such as decreased in RR and LOC;

Outcomes/Evaluation

O2 saturation level
Respiration status

Client Education

Explain all procedures to the patient, place patient in Semi-fowler's position to promote chest expansion and to facilitate breathing.
Instruct the patient to verbalize if he/she is comfortable with position

Potential Complications

oxygen toxicity
oxygen induced hypoventilation
combustion

Nursing Interventions

Monitor for manifestations of respiratory depression, such as decreased in RR and LOC;



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Active Learning Template:
Nursing Skill

Student Name: Fa

Skill Name: Blood Glucose Check

Review Module Chapter:

Description of skill

Blood glucose monitoring by using a glucometer to take a small sample of blood to determine the concentration of the free glucose in



CONSIDERATIONS

Indications

Used with patients who have diabetes; patients who are taking some Corticosteroids and those are on TPN

Nursing Interventions (pre, intra, post)

Ensure strips are not expired or inappropriate for the machine and that adequate sample of blood is obtained

Outcomes/Evaluation

Blood glucose level between 70-100
Compliance with glucose checks

Client Education

Teach patient the proper way of using glucometer.;
Instruct patient to perform hand hygiene before and after procedure;
Teach patient a proper way to dispose the lancet and instruct not to reuse the lancet.
Advise patient to keep records of blood glucose levels and to notify the provider if it is out of normal range.

Potential Complications

Infection of the puncture site;
Inaccurate readings

Nursing Interventions

Ensure strips are not expired or inappropriate for the machine and that adequate sample of blood is obtained



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Active Learning Template: Medication

Student Name:

Medication: Dobutamine

Review Module Chapter:

Category Class: Inotropic

PURPOSE OF MEDICATION

Expected Pharmacological Action

Stimulates beta1 (myocardial) adrenergic receptors with relatively minor effect on HR or peripheral blood vessels

Therapeutic Use

Increased cardiac output without significantly increased HR

Complications

Hypertension; increases HR;
premature ventricular contractions; angina pectoris; skin rash;
fever

Medication Administration

Administer into a large vein and assess administration site frequently.
Administer via infusion pump to ensure precise amount delivered

Contraindications/Precautions

Hypersensitivity to dobutamine or bisulfites; idiopathic hypertrophic

Nursing Interventions

Monitor for manifestations of respiratory depression, such as decreased in RR and LOC;

Interactions

Use with Nitroglycerin may have a synergistic effect on increasing HR; Beta blockers; MOA's

Client Education

Advise patient to inform nurse immediately if chest pain, dyspnea, numbness, tingling or burning of extremities

Evaluation of Medication Effectiveness

Increase in cardiac output
Improved hemodynamic parameters
Increased urine output

F. Alkande.

Reflection

It was a frustrating experience when having to create my own patient. The ATI study refreshed my memory. I thought the direct patient care document would be easy, but it was more frustrating when needing for a lot of information to build my own patient, even though it gave me an opportunity to conduct more research on the particular disorder. Overall, it was more interesting than I-HUMAN. I only hope that any further clinical experiences in the coming weeks would be less stressful than this one.

References

- Bleza, S. J., & Lewis, S. M. (2017). *Virtual clinical excursions -- medical-surgical: For Lewis, Dirksen, Heitkemper, and Bucher: Medical-surgical nursing: Assessment and management of clinical problems, tenth edition*. Maryland Heights, MO: Elsevier.
- U.S. Department of Health and Human Services. *Acute Respiratory Distress Syndrome*. National Heart Lung and Blood Institute. <https://www.nhlbi.nih.gov/health-topics/acute-respiratory-distress-syndrome>.