W4- Clinical Log

Throughout my three shifts this week, I cared for many patients, some of them my full responsibility, and others assisting the nurses I worked with.

One patient, an 83 year old male, came in with anemia and possible pancreatitis. After receiving 2 units of packed RBC’s and having tests done that lead to no concluding answers, he was prepared for an upper and lower colonoscopy the next day. In order to empty his bowels and clean out his intestine, I gave him 4 tables of Doculax and had the patient drink citrate magnesium, followed by four cups of clear liquids and by the time I left for the day, he had two bowel movements. Since this patient was also renal insufficient, I monitored his I&O’s, and since he has osteoarthritis, especially bad in his right knee, I applied Bengay to it.

The second patient was a 76 year old male who was legally blind and very confused. On March 25 he had an ileostomy which I measured and emptied three times throughout the day. I looked up the protocol for taking care of patients with ileostomy bag which stated to assess the type of output or drainage, assess the stoma site, and to report any signs of blockage, like drainage stopping, to the MD immediately. It also gave steps to certain interventions, like cleaning the stoma site and emptying and measuring the bag. For example, nurses should empty the bag when it is 1/2 to 1/3 full and check for breaks in the bad when any odor is noticed. I also assisted with a dressing change and used normal saline to cleanse the incision and covered it was gauze. There was an order to bladder scan him every six hours and straight-cath him if the results were 350 mL or greater, which was never the case. He had a very poor PO intake and barely ate anything throughout the day, despite tremendous efforts. I explained to him that the reason he has so much edema, in both ankles and his left arm, was because he is not taking in enough protein and that if he doesn’t eat, it may result in having a feeding tube. Since this patient also had a PICC line, I measured his arm one inch above the line placement to ensure there are no complications. In addition, he went for an ultra sound that showed a DVT in his right leg, in which I immediately removed the TED stockings and the SCD’s from that leg to prevent that clot from breaking off and possibly traveling to the heart, lung, or brain.

Another patient I took care of came in with cellulitis and a necrotic wound on her right heel that was debrided on Friday. She had a wound-vac on it which is changed every Monday, Wednesday, and Friday. Since there was MRSA found in her wound she was on contact isolation and because of her cellulitis she was on a 2 gram Na+ diet to try and help get rid of the extra fluid.

Another male patient was non-verbal and could not communicate. He was a total care patient and came in with dehydration and diarrhea. He had dermatitis and excoriation on his scrotum in which I applied Calmoseptine and skin prep cream. He was receiving NS @ 85mL/hr but when we checked his lab values and saw he had a high sodium level, we notified the doctor, and it was switched to D5W which has no additional sodium. This patient also had a PEG tube which I gave him his meds through. Also, because of the high Na+ level, I also gave him “free water” through his PEG tube. A total of 850 mL was given to him and I noticed that this patient wasn’t having adequate urine output. After first trying to maneuver the foley catheter, I irrigated it and after a lot of sediment coming out, the urine began to flow freely. By the end of my shift he had put out 600mL of urine.

The other patient came in with anemia and pneumonia, and also developed neutropenia. After all of those issues being resolved, this man was still in the hospital because he hadn’t had a bowel movement in at least 5 days. He was receiving stool softeners and laxatives, like Colace, Dulcolax, and Miralax, but nothing had worked. I administered an enema and he was finally able to have two small bowel movements by the time my shift was over. This patient had a PICC line so I measured his arm 1 inch above the site and his blood sugar at 12:00pm was 183 so I administered 2 units of insulin. When I gave him his PO meds, I crushed them and put them in apple sauce and I heard some wheezing in his lungs.

For all of these patients, full physical assessments were done and I gave them their medications, which consisted of PO meds, both whole and crushed in apple sauce, a Lovenox injection, Insulin injections, hanging IV fluids and meds, and giving meds through a PEG tube.

I was also able to work with other patients and do things like give an enema, d/c hep locks, bladder scan patients, listen to the brute/feel the thrill of a patient’s AV graft, and observe a dressing change over a nephrostomy tube. There was also a discharge patient so I was able to help with the teaching which consisted of medications, follow up visits, and post-op instructions.

 My Goals for this week were:

1. Collaborate with peers, agency staff, members of the health care team, patients and families, to effect care management
2. Engage in mutual goal setting and actions with individuals, families, groups, and communities that promote health and well being
3. Recognize one’s own and others attitudes, values, and expectations and the impact on the care of the individual, family, and/or community
4. Evaluate the effectiveness in patient teaching-learning activities

I think the first and second goals were met, and will continue to be met throughout this rotation, because there is not really a time where I am not collaborating with the health care team. Even when I am in the patient’s room doing things independently, I am still carrying out the plan of care that has been developed by the team. The patients and their families are always involved in the plan of care and mutual goals are set between them and the health care team. This is all done in collaboration to manage the patient’s care effectively and to promote optimal health.

 I definitely have seen how nurse’s attitudes and values can affect the quality of care a patient receives and how much of an impact it has on their outcome. For example, I have worked with nurses that the patients have complained about saying they are ruthless or harsh and I have worked with nurses who the patients rave about, and I can see the difference in patient’s attitudes and compliance towards their own care. When the nurses are compassionate and understanding, I truly believe the patients will have better health outcomes and will continue to seek help and strive for good health. When the patients feel as if the nurse doesn’t care or is commanding them to do things without getting their input first, they are less likely to be compliant and their health suffers.

 Throughout the day, patient teaching occurs without even realizing it at times. When I tried teaching my patient the importance of eating and taking in enough protein, to help both the edema and to promote wound healing, the teaching was ineffective. I explained that if he didn’t eat he would most likely need a feeding tube, but throughout the entire day he barely ate anything. He didn’t fully understand the complications he could have if he didn’t eat. An example of when my teaching was effective is when I taught a post-op patient the importance of using the incentive spirometer. He understood how using it prevents pneumonia and any other respiratory complications that can arise after surgery. Almost every time I went into his room after he got back from surgery, he was using the incentive spirometer.

Throughout my three shifts this week I feel that I have learned a lot and gained a lot of hands-on experience.