



# CLINICAL LEARNING – DIRECT PATIENT CARE DOCUMENTATION LEVEL 2 CLINICAL COURSES

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Course: Other

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## 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: with 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:**
  - **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
0900	Amiodarone (PACERONE) tab 100 mg oral daily	Antiarrhythmic
0900	Atorvastatin (LIPITOR) tab 10 mg oral nightly	Cholesterol and Triglyceride
0800	Carvedilol (COREG) tab 3-125 mg oral twice with meals	HTN
0800	Spironolactone (ALDACTONE) tab 25 mg oral every other	Heart Failure/HTN
0900	Enoxaparin (LOVENOX) injection 40 mg sub q every 24 hr	Constipation
0600	Polyethylene glycol (GLYCOMAX) packet 17g daily oral	Laxative

### • 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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### Initial Assessment Findings and Time:

<b>Vital signs:</b>			
T: 98.6 F	P: 58	Resp: _____	SpO <sub>2</sub> : 98
BP: 84/48	Height: 1.778 m	Weight: 72.8 kg	Apical HR: 59
<b>Pain scale used with rationale:</b> 8/10 pain in left arm			
P (Palliative, Provocative) What makes the pain better/worse? pain medication makes it better			
Q (Quality) How is the pain described? score _____			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? stays in left shoulder/elbow			
S (Severity) What is the intensity of the pain?			
T (Temporal) Is the pain constant, or does it come and go? constant pain			
<b>Head and Neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): nonocipitalic, neck midline to body, PE/RRLA intact			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles): lungs clear to auscultation with no crackles, wheezes, or ronchi			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): RRR, no JVD, no S3/S4 noted			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour): soft, non-distended, hypoactive			
Bowel incontinence: _____			
Bowel plan: increase fluids/fiber		Last BM: before surgery	
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): conscious, not in any acute distress, A X O x4			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): 1+ pulse on both legs, 3+ edema on left leg, 2+ edema on right leg			
<b>Genitourinary</b> (burning with urination, frequency, color of urine): _____			
Urinary incontinence: yes		Toileting plan: straight cath	
<b>Pelvic</b> (female: LMP): _____			
<b>Rectal</b> (bleeding, hemorrhoids): _____			
<b>Integumentary</b> (rashes, lesions, wounds, etc.): dry, itchy skin			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.): _____			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.): _____			
<b>IV access</b> (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change): _____			

### Ongoing Assessment Findings and Time:

<b>Vital signs:</b>			
T: _____	P: _____	Resp: _____	SpO <sub>2</sub> : _____
BP: _____	Height: _____	Weight: _____	Apical HR: _____
<b>Pain scale used with rationale:</b>			
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?			
<b>Head and Neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): _____			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles): _____			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): _____			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour): _____			
Bowel incontinence: _____			
Bowel plan: _____		Last BM: _____	
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): _____			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): _____			
<b>Genitourinary</b> (burning with urination, frequency, color of urine): _____			
Urinary incontinence: _____		Toileting plan: _____	
<b>Pelvic</b> (female: LMP): _____			
<b>Rectal</b> (bleeding, hemorrhoids): _____			
<b>Integumentary</b> (rashes, lesions, wounds, etc.): _____			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.): _____			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.): _____			
<b>IV access</b> (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change): _____			