

# Clinical Learning – Direct Patient Care Documentation

Student Name: \_\_\_\_\_ D#: \_\_\_\_\_ Date: 2/11/2025

Course: NR 325 \_\_\_\_\_ Session: \_\_\_\_\_ Year: \_\_\_\_\_

## 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						
<b>I – Introduce Yourself</b>	Your Name: D#: Your Title: Student Nurse Reason for being there: N/A					
<b>S – Situation</b>	Patient: M.K. Age: 88 Gender/Identity: M Height/Weight: 172.7 cm and 74.85 kg Allergies: Penicillins and Sulfa Antibiotics 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: 2/11/2025			Attending Physician: N/A Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance: Acute Appendicitis  Pathophysiology of Primary Medical Diagnosis: Acute appendicitis occurs when the appendix becomes blocked, often due to fecal matter, enlarged lymphoid tissue, or, in rare cases, tumors. Once the lumen is obstructed, bacteria inside the appendix multiply rapidly, leading to inflammation and swelling. As pressure builds, blood flow becomes restricted, causing. This weakens the appendiceal wall, allowing bacteria to invade deeper, which can result in thrombosis, tissue death, and, eventually, perforation. If left untreated, the appendix may rupture within 24 to 36 hours, leading to potentially serious complications.		
<b>B – Background</b>	<b>Include clinical significance with each:</b> Past Medical History: Chronic lymphocytic leukemia (CLL), anemia, A. fib, TIA, cerebral infarction, CKD (stage 3), hypothyroidism, benign prostatic hyperplasia, neuropathy, long-term coagulant use, nonrheumatic, aortic valve insufficiency Immunizations Received: Influenza (12/18/22, 10/01/20, 09/13/18, 11/18/16, 11/19/15), pneumococcal (12/02/16), sars- cov-2 (02/20/21, 01/20/21), zoster (01/01/20) Social History/Socioeconomic Factors: No smoking or tobacco, occasional alcohol use twice a week, no drugs. Support received from significant other and children. Stable domestic situation and housing.			Past Surgical History: Colonoscopy, valve repair, flexible bronchoscopy with bronchopulmonary lavage		
<b>A – Assessment</b>	<b>Vital Signs:</b>					
	B/P	HR	RR	TEMP	SP0 <sub>2</sub>	PAIN
	141/73 mmHg	64 bpm	16 cpm	97.4 F	100%	0
	130/69 mmHg	65 bpm	13 cpm	97.6 F	99%	0
	Fall Risk: Low fall risk IV Site: Right anterior forearm	Accu-check: 99 IV Fluids:		Lab/Test Results: WBC – 17.13 10 <sup>3</sup> /uL; RBC – 3.62 10 <sup>6</sup> /uL; Hgb – 10.4 g/dL; Hct – 32.6%; Pit - 129 10 <sup>3</sup> /uL; PT – 14.2 s; aPTT – 24.9 s; AST – 19 U/L; ALT – 9 U/L; Glu – 99 mg/dL; BUN - 28 mg/dL; Na - 137 mEq; K – 4.2 mEq; Cl - 109 mEq/L; Creat – 1.55 mg/dL; CO <sub>2</sub> – 21.2 mEq; Ca – 9 mg/dL; Phos – 37 mg/dL; Mag. – 2.19 mg/dL; T. Pro - 8.4 g/dL; Alb – 3.6 g/dL		
<b>I and O</b>	No data					
<b>Isolation</b>	Isolation Precautions: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>			Contact Air <input type="checkbox"/> Droplet <input type="checkbox"/>		
<b>RESPIRATORY</b>	Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion					
<b>CARDIOVASCULAR</b>	S1 & S2 heard. Pulses equal and normal bilaterally. No edema.					

<b>NEUROLOGICAL</b>	Alert and Oriented x4. Coherent speech. No focal motor deficits. Sensation to light touch grossly intact.
<b>GI/GU</b>	Abdomen soft, non-distended, RLQ tenderness on palpation, bowel sounds present in all quadrants, last BM 2/10, clear and yellow urine
<b>INTEGUMENTARY</b>	Skin matches ethnicity. Skin warm and dry. No rashes or lesions. General bruising.
<b>PSYCHOLOGICAL FAMILY – SUPPORT</b>	Support received from family.
<b>SAFETY</b>	Teaching needed: Quality in Safety Education Nurses (QSEN) Risk(s) Identified: Patient-Centered Care
<b>R – REQUEST/ RECOMMENDATION</b>	Hand off report to: N/A From: N/A

Initial Assessment Findings & Time			
<b>Vital signs:</b> 0733			
T: 97.4 F	P: 64 bpm	Resp: 16 cpm	SpO <sub>2</sub> : 100%
BP: 141/73 mmHg	Height: 172.7 cm	Weight: 74.8 kg	Apical HR: 64 bpm
Intake: No data		Output: No data	
<b>Pain scale used with rationale:</b> 0			
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? N/A			
T (Temporal) Is the pain constant or does it come and go? N/A			
<b>Head and neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Soft, supple, symmetric, and normal ROM			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles): Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): S1 & S2 heard. Pulses equal and normal bilaterally. No edema.			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour):  Bowel incontinence: Continent Bowel plan: Self-toileting with supervision Last BM: 2/10			
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): Alert and Oriented x4. Coherent speech. PERRLA. No focal motor deficits. Sensation to touch grossly intact.			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): No gross deformities, moves all four extremities, all extremities 5/5			
<b>Genitourinary</b> (burning with urination, frequency, color of urine): Clear and yellow urine  Urinary incontinence: Continent Toileting plan: Self-toileting			
<b>Pelvic</b> (female: LMP): N/A			
<b>Rectal</b> (bleeding, hemorrhoids): No Data			
<b>Integumentary</b> (rashes, lesions, wounds, etc.): Skin matches ethnicity. Skin warm and dry. No rashes or lesions. General bruising.			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.): No Data			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.): No abuse			
<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): Right anterior forearm			
<b>Psychological/Psychosocial/Family Support/Religious/Cultural Dynamics:</b> Support received from family			

**Growth and Development:** (Developmental stage according to Erikson and your assessment findings):  
Integrity vs. Despair

Ongoing Assessment Findings & Time			
<b>Vital signs:</b> 1500			
T: 97.6 F	P: 65 bpm	Resp: 13 cpm	SpO <sub>2</sub> : 99%
BP: 130/69 mmHg	Height: 172.7 cm	Weight: 74.8 kg	Apical HR: 65 bpm
Intake: No data		Output: No data	
<b>Pain scale used with rationale:</b> 0			
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? N/A			
T (Temporal) Is the pain constant or does it come and go? N/A			
<b>Head and neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Soft, supple, symmetric, and normal ROM			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles): Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): S1 & S2 heard. Pulses equal and normal bilaterally. No edema.			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour):  Bowel incontinence: Continent Bowel plan: Self-toileting with supervision Last BM: : 2/10			
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): Alert and Oriented x4. Coherent speech. PERRLA. No focal motor			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): No gross deformities, moves all four extremities, all extremities 5/5			
<b>Genitourinary</b> (burning with urination, frequency, color of urine): Clear and yellow urine  Urinary incontinence: Continent Toileting plan: Self-toileting			
<b>Pelvic</b> (female: LMP): N/A			
<b>Rectal</b> (bleeding, hemorrhoids): No Data			
<b>Integumentary</b> (rashes, lesions, wounds, etc.): Skin matches ethnicity. Skin warm and dry. No rashes or lesions. General bruising.			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.): No Data			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.): No abuse			
<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): Right anterior forearm			
<b>Psychological/Psychosocial/Family Support/Religious/Cultural Dynamics:</b>			