Title: Interventions

Learning Objectives:

1. Implement a daily organizational tool which focuses on anticipation of change, prioritization of interventions and delegation, where appropriate. Analyze the value of this tool.

2. Compare and contrast assessment findings and relevant nursing interventions implemented based on these findings.

3. Describe the standards of care specific to the patient’s diagnosis and condition.

4. Discuss the process of medication administration in caring for specific patients.

5. Recognize potential complications or changes in a patient’s condition that would require immediate intervention.

6. Describe how to incorporate age specific interventions into a plan of care.

7. Discuss pain management across the lifespan.

Interactive Exercises:

Objective #1:

1. In the first days of orientation, prior to caring for patients, practice prioritization skills through a situational learning activity. Ask your preceptor to provide you with a typical workload assignment for the unit you will be working on. Have the preceptor give a short report on each patient and practice taking report. After hearing this report, describe how you will decide which patient to see first, second, and so on. Analyze your decisions and provide rationales for them. Describe interventions you would delegate, to whom, and why. Provide rationales for your approach. Ask your preceptor to provide you with verbal feedback on your decisions and discuss what, if any, changes should have been made and why.

2. Repeat this activity in the patient care setting with your first few assignments to gain input from your preceptor about how you prioritized your patient assignment. At the end of each shift, take time to evaluate the plan you made at the beginning of the shift, using the organizational tool, the activities you delegated and any alterations you made, as well as what you might have done differently, with your preceptor.

3. Talk with other nurses about the organizational tool they use, why they use it, and changes they have made in its use over time.

Objective #2:

1. Complete a head to toe assessment on one patient. Create a concept map that correlates each assessment with the appropriate nursing interventions for this patient. After completion of the
concept map, explain to your preceptor the correlations you made for each assessment and nursing intervention. Have your preceptor provide you with specific feedback on the correlations you made. Clarify and discuss any suggested changes from your preceptor.

2. Practice doing a head to toe assessment on 2-3 patients with different diagnoses, in a simulation lab. Be sure the diagnoses are similar to the patients you will be caring for on your unit of hire. After assessment of each patient, compare and contrast the similarities and differences in nursing interventions for each patient. Implement specific nursing interventions for each patient in the simulation lab and analyze the patient response to each intervention.

Objective #3:

1. Research a nursing journal article specific to the types of patients you will be caring for on your unit of hire. Identify the standards of care/nursing interventions for the type of patient discussed in the journal article. Compare the standards of care in the journal article with the standards of care for specific diagnoses at your institution. Discuss these findings with your preceptor.

2. Chose two patients with similar diagnoses. Create a Venn diagram comparing and contrasting the standards of care between these two patients with similar diagnoses. (See diagram below for an example of a Venn diagram). Place the differences for each patient’s standard of care and nursing interventions in the outer sections of the Venn diagram and the similarities in the middle where the two circles overlap. Discuss your findings with your preceptor.

Objective #4:

1. Review the medication administration policy at your institution. Choose a patient on your unit and review this patient’s medication administration record. Conduct an audit of the medication record and determine if the six rights of medication administration were followed. If one of the six rights was not followed, try to determine the reason for this. Record your findings and share them with your preceptor.

2. Go to the following website: [http://ismp.org/](http://ismp.org/)

Under the Medication Safety Tools and Resources heading, click on Error-Prone Abbreviation List. Look at the abbreviations on this list. Choose one patient on your unit and conduct a chart review of all orders for this patient. Document each time an abbreviation on the Error-Prone Abbreviate List is used. Determine if the abbreviation was transcribed to the medication administration record correctly. Discuss your findings with your preceptor.
Objective #5:

1. Complete an assessment on a patient. After this assessment, list potential complications or changes to the patient’s condition you should anticipate during your shift. After each potential complication, list specific nursing interventions you can do as the nurse to prevent any complications. Discuss your plan of care with your preceptor.

2. If your institution has a rapid response team, discuss with your preceptor how this standard of care should be used. Formulate a list of possible clinical situations where you might call the rapid response team. Discuss your list with your preceptor.

3. If your institution does not have a rapid response team, go to your institution’s medical library or a nearby research library and conduct a search on rapid response teams. Complete a critique of one journal article on rapid response teams. Discuss the findings of the article with your preceptor and how to prevent failure to rescue at your institution, through the use of rapid response teams.

4. Discuss the journal article “Is failure to rescue really failure to communicate?” (Classen, 2010) with other nurses in orientation or other nurses on your unit. Discuss ways new graduates can assist in preventing failure to rescue and share these findings with individuals in staff development.

Objective #6:

1. Determine the age of your patient and discuss with your preceptor age specific interventions that would be appropriate for your patient related to his/her specific diagnosis. Utilize textbooks specific to pediatrics or adults for this activity. Suggestions for this activity include the following textbooks: (LeMone, Burke, 2008) and (Kyle, 2008).

2. Chose a geriatric patient (age 65 or older) and outline a specific plan of care that utilizes principles of geriatrics. Discuss your findings with your preceptor. Use the following website for additional information to complete this exercise:

Objective #7:

1. Discuss the age of each of your patients with your preceptor. Identify specific pain assessments, management techniques and interventions for pain control based on each patient’s age. Compare your decision with the standards of care for pain management in your institution.

2. Read the following journal article on “Managing pain in the older person” (O’Mahony, 2008). Complete a matrix outlining the different barriers to effective pain management in the older adult. Compare the information in this journal article with the information and recommendations from the following website http://consultgerirn.org/topics/pain/want_to_know_more.

Then discuss your findings with your preceptor.
References


Supplemental Resources


