WRIGHT STATE UNIVERSITY

College of Nursing and Health
ACNP Program

Weekly ACNP Clinical Log

Student: Kimberley Roberts	**Course / Quarter / Year:** NUR 795
Clinical Site: CVICU at UCMC	**Preceptor:** Jonathan Wylie

Wk _5/20_ _

- Each week, complete this document
- For each date, make an entry for every patient you see.
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	Date	Diagnosis	F	M	Age	Comments / Activities	E/M Code
1	5/20	Aortic occlusive disease. S/P aortobifemeral by-pass. Developed abdominal compartment syn-drome, AKI and acute respiratory failure		X	54	Helped with post-operative resuscitation efforts. Observed bronchoscopy immediately post-op	
2	5/20	CABG X 3, LIMA and SG		X	52	Wean propofol gtt and ordered SBT to pursue fast track extubation post operatively.	
3	5/20	NSTEMI post hip replacement surgery. Initial cardiogenic shock, s/p cardiac cath and IABP placement.		X	70	Started Propofol gtt for adequate sedation and ventilation secondary to alkalosis due to tachyp-nea. Mental status change- Head CT ordered without contrast. IVF bolus given for oliguria	
4	5/24	Aortic occlusive disease. S/P aortobifemeral by-pass. Developed abdominal compartment syn-drome, AKI and acute respiratory failure. Ab-dominal incision closed 5/22. Extubated this AM		X	54	Changed around BP meds for HTN. Ordered bowel regimen. Spoke with nutritional support to decide on starting trophic tube feeds	
5	5/24	S/p marginal mandibulectomy, modified right neck dissection, level 1 left neck dissection, left radial forearm free flap, tooth extraction, trache-ostomy, and left thigh split thickness graft		X	73	Wrote post-op H & P, assisted with post-op or-ders. Monitored and evaluated post-op lab values	
6	5/24	S/P Heartmate II LVAD placement		X	70	Mainly observed, discussed plans with MD's and learning important LVAD values and how it works	
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1) In what ways did you feel confident about your abilities this week in clinicals?

I feel confident for the most part with placing orders in EPIC. Interpreting certain lab values: ABGs, renal panels and CBC.

2) In what areas did you feel weakest during this week of clinicals?

Presenting on patients. I presented on two patients this week and just didn't feel like it flowed all that well. Although, the entire critical care team was supportive and said I did a good job, I f eel and know I can do much better and will continue to work on this.

3) List one new skill or piece of knowledge that you learned this week.

How an LVAD works or at least the beginning of understanding this device. What a goal pulse index is and if its low, generally it is indicative of needing more volume for the patient and or increasing inotropic support.

4) List clinical goals for next week.

-Having a better flow for presenting patients

-Writing better progress notes and SOAP notes

-Prioritizing throughout the day of clinical and following up on specifics that was addressed earlier that day

Weekly ACNP Clinical Log

Student: Kimberley Roberts	**Course / Quarter / Year**: NUR 795
Clinical Site: CVICU	**Preceptor:** Jonathan Wylie

Wk 5/28 & 5/30__	• Each week, complete this document • For each date, make an entry for every patient you see. • There may be multiple entries for the same patient, i.e., a long-term patient in your caseload would be listed again for each date. • Under comments, list any procedures performed, or other pertinent information.					
Date	**Diagnosis**	**F**	**M**	***Age***	**Comments / Activities**	**E/M Code**
1 5/28	Patient admitted on 5/24/13 with primary diagnosis of buchal cancer s/p marginal mandibulectomy, modified right neck dissection, level 1 left neck dissection, left radial forearm free flap, tooth extraction, tracheostomy, and left thigh split thickness skin graft.		X	73	Increased NPH to 10units subcutaneous BID	
2 5/28	Patient seen hospital day 12. Admitted on 5/16 with primary diagnosis of occuluded femoral bypass graft s/p redo aorto bi-fem bypass POD 12. The patient has a known history of HTN, HLD, aortoiliac occlusive disease with past vascular surgery including sright to left fem-fem and LLE fasciotomy in 2000, bilateral iliofemoral graft for pseudoaneurysm with RLE in 04, left srtoriaus flap after left groin infection in 04, right ilio-to left profunda bypass in 04, and thrombecotmy of bypass, RLE fasciotomy in 07. Most recently underwent fasciotomy of the abdomen on 5/20/13 for abdominal compartment syndrome with closure of abdomen and placement of long term HD catheter on 5/22/13. On 5/26/13 returned to OR for abdominal hematoma evacuation and washout with temporary abdominal closure.		X	54	Plan to wean ventilator as tolerated to a spontaneous mode of ventilation. Likely to remain intubated until final closure of abdomen. Speak with vascular surgery and renal consult team about resuming CRRT with citrate and calcium to prevent further clotting of filter	
3 5/28	Patient admitted 5/26/13 with primary diagnosis of STEMI of anterior wall. Patient developed chest pain at home and as husband was driving to the local fire hours she became unresponsive en route. Upon arrival to the fire house she was in pulseless VTACH and subsequently defibrillated X 2 per paramedics with ROSC. Received amiodarone 150mg IV, intubated and transported to UC health via air care. 12 lead ECG positive for anterior ST elevations. Pt. unresponsive in ED. Hypothermia protocol initiated. Patient taken immediately to cath lab and was found to have 100% proximal LAD occlusion. BMS placed. RCA with 50-60% blockage (untreated at this time). EF 10%, LVEDP 28-30, RA/RV 10/27, PAWP 15. IABP placed.	X		54	Wean FIO2 as tolerated for SAO2 >92%. Hold off on diuresis today secondary to still requiring Dobutamine gtt at 6.5mcg/kg/min	
4 5/29	Patient admitted on 5/24/13 with primary diagnosis of buchal cancer s/p marginal mandibulectomy, modified right neck dissection, level 1 left neck dissection, left radial forearm free flap, tooth extraction, tracheostomy, and left thigh split thickness skin graft.		X	73		
5 5/29	Patient seen hospital day 12. Admitted on 5/16 with primary diagnosis of occuluded femoral bypass graft s/p redo aorto bi-fem bypass POD 12. The patient has a known history of HTN, HLD, aortoiliac occlusive disease with past vascular surgery including sright to left fem-fem and LLE fasciotomy in 2000, bilateral iliofemoral graft for pseudoaneurysm with RLE in 04, left srtoriaus flap after left groin infection in 04, right ilio-to left profunda bypass in 04, and thrombecotmy of bypass, RLE fasciotomy in 07. Most recently un-		X	54		

		derwent fasciotomy of the abdomen on 5/20/13 for abdominal compartment syndrome with closure of abdomen and placement of long term HD catheter on 5/22/13. On 5/26/13 returned to OR for abdominal hematoma evacuation and washout with temporary abdominal closure.					
6	5/29	Patient admitted 5/26/13 with primary diagnosis of STEMI of anterior wall. Patient developed chest pain at home and as husband was driving to the local fire hours she became unresponsive en route. Upon arrival to the fire house she was in pulseless VTACH and subsequently defibrillated X 2 per paramedics with ROSC. Received amiodarone 150mg IV, intubated and transported to UC health via air care. 12 lead ECG positive for anterior ST elevations. Pt. unresponsive in ED. Hypothermia protocol initiated. Patient taken immediately to cath lab and was found to have 100% proximal LAD occlusion. BMS placed. RCA with 50-60% blockage (untreated at this time). EF 10%, LVEDP 28-30, RA/RV 10/27, PAWP 15. IABP placed.	X		54	Minimize sedation (propofol gtt) to maintain goal RASS 0 to -1. Increase respiratory rate until sedation minimized. Lasix for diuresis and to improve pulmonary edema (will refer to CCU team for approval of this and dosages). Wean PEEP as tolerated for SAO2 >92%. Hold captopril for MAP <60 to maintain CPP. Start seroquel 25mg pFT BID for delirium, monitor QTC levels Q4hrs, hold Seroquel if QTC >500	
7	5/30	Patient seen hospital day 12. Admitted on 5/16 with primary diagnosis of occuluded femoral bypass graft s/p redo aorto bi-fem bypass POD 12. The patient has a known history of HTN, HLD, aortoiliac occlusive disease with past vascular surgery including sright to left fem-fem and LLE fasciotomy in 2000, bilateral iliofemoral graft for pseudoaneurysm with RLE in 04, left srtoriaus flap after left groin infection in 04, right ilio-to left profunda bypass in 04, and thrombecotmy of bypass, RLE fasciotomy in 07. Most recently underwent fasciotomy of the abdomen on 5/20/13 for abdominal compartment syndrome with closure of abdomen and placement of long term HD catheter on 5/22/13. On 5/26/13 returned to OR for abdominal hematoma evacuation and washout with temporary abdominal closure.		X	54		
8	5/30	Patient admitted 5/26/13 with primary diagnosis of STEMI of anterior wall. Patient developed chest pain at home and as husband was driving to the local fire hours she became unresponsive en route. Upon arrival to the fire house she was in pulseless VTACH and subsequently defibrillated X 2 per paramedics with ROSC. Received amiodarone 150mg IV, intubated and transported to UC health via air care. 12 lead ECG positive for anterior ST elevations. Pt. unresponsive in ED. Hypothermia protocol initiated. Patient taken immediately to cath lab and was found to have 100% proximal LAD occlusion. BMS placed. RCA with 50-60% blockage (untreated at this time). EF 10%, LVEDP 28-30, RA/RV 10/27, PAWP 15. IABP placed.	X		54		
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5) In what ways did you feel confident about your abilities this week in clinicals?

Understanding the hospital and EPIC system.

6) In what areas did you feel weakest during this week of clinicals?

Understanding my role as an ACNP student and changing my focus from a nurse to a provider.

7) List one new skill or piece of knowledge that you learned this week.

How nightshift management is completely different and the ACNP is the primary provider and looked upon for guidance.

8) List clinical goals for next week.

-Prioritize patient's effectively

-Follow up on orders and labs

-Critically think through differentials

Weekly ACNP Clinical Log

Student: Kimberley Roberts	**Course / Quarter / Year:** NUR 795
Clinical Site: CVICU	**Preceptor:** Jen Clark

Wk 6/4 & 6/7

- Each week, complete this document
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	Date	Diagnosis	F	M	Age	Comments / Activities	E/M Code
1	6/4	Burn involving 10-19% of body surface with 3rd degree burn of 10%. PMH. Of ETOH. Withdrawal from ETOH and cocaine. On CIWA protocol		X	51	Maintain goal RASS -2/-3 overnight. Sent blood cultures and u/a and c& s for temp. 102.1 overnight.	
2	6/4	s/p MLB with subglottic and pharyngeal pathologies sent and had some stridor with extubation, therefore he was reintubated with 6.5 ETT and given IV steroids for tracheal inflammation. PMH. Asthma and tracheal stenosis after a prolonged intubation in 1/2012 for influenza/pneumonia.		X	37	Wean ventilator settings to extubate in am, have cook catheter at bedside for extubation. SBT in am. Wean propofol gtt to maintain goal RASS 0/-1	
3	6/4	Patient has a known history of PAD, s/p right external iliac stent 1/2013 with f/u angiogram showing total occlusion of right EIA and right SFA and severe stenosis in LLE. S/p aorto-bifemoral bypass with prosthetic graft		X	67	Obtained bladder pressure. Ordered abdominal KUB xray. Ordered NG to be placed	
4	6/4	Presented to the ED with pain in BLE at rest that initially was exertional pain that started 3 months ago. The pain is worse in RLE compared to LLE. The patient underwent a thrombectomy of RLE of prior aortobifemoral bypass and a right femoral to right popliteal bypass surgery on 6/2/13. She was transferred to the CVICU on 6/3/13 due to FSBG was > 300 and uncontrolled with subcutaneous insulin. Here for intensive insulin therapy		X	49	Replaced K with KCL 20meq IV. Encouraged use of IS Q1hr, C& DB and wean O2 for sats >90%, monitor labs daily, encourage ambulation.	
5	6/7	Presented to the ED with pain in BLE at rest that initially was exertional pain that started 3 months ago. The pain is worse in RLE compared to LLE. The patient underwent a thrombectomy of RLE of prior aorto-bifemoral bypass and a right femoral to right popliteal bypass surgery on 6/2/13. She was transferred to the CVICU on 6/3/13 due to FSBG was > 300 and uncontrolled with subcutaneous insulin. 6/6- Off insulin gtt. Continues to have uncontrolled FSBG		X	49	Increased NPH to 25 units BID from 20units, increased meal time lispro to 7units from 5units. Increased oxycodone to 15mg Q 3hrs PRN pain, increased frequency of dilaudid to Q3hrs PRN breakthrough pain. Consulted endocrine and spoke with MD about ways to better control patient's FSBGs	
6	6/7	patient has a PMH of DM, CAD, HLD and to CAD stents placed in 2008 (location unclear). Patient presented to ED on 5/13/2013 with chest pain during a stress test. 5/20/13- CABG X 3 vessels LIMA to LAD, saphenous vein to sequential OM and right distal. POD # 18		X	52	Decreased QHS NPH to 15 units, stopped scheduled regular insulin with meals. Replaced electrolytes.	
7	6/7	Patient seen hospital day 12. Admitted on 5/16 with primary diagnosis of occuluded femoral bypass graft s/p redo aorto bi-fem bypass POD 12. The patient has a known history of HTN, HLD, aortoiliac occlusive disease with past vascular surgery including sright to left fem-fem and LLE fasciotomy in 2000, bilateral iliofemoral graft for pseudoaneurysm with RLE in 04, left srtoriaus		X	54	Ordered metoprolol 5mg IV Q4hrs prn HR >100bpm. Ordered dysphagia 3 diet and calorie counts. Monitor ARF. HD today removed 1.6L	

		flap after left groin infection in 04, right ilio-to left profunda bypass in 04, and thrombecotmy of bypass, RLE fasciotomy in 07. Most recently underwent fasciotomy of the abdomen on 5/20/13 for abdominal compartment syndrome with closure of abdomen and placement of long term HD catheter on 5/22/13. On 5/26/13 returned to OR for abdominal hematoma evacuation and washout with temporary abdominal closure. Abdominal wound closed 6/1/13. POD 22/17/11/9/6					
8	6/7	STEMI. Distal RCA BMS placed and POBA of circumflex artery. 6/7/13-CABG X 4, vein to RCA, OM, DIAG, and LIMA to LAD		X	65	Obtained post op CXR. Identified RLL pleural effusion.	
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9) In what ways did you feel confident about your abilities this week in clinicals?

Recognized need for replacement of NG and post op ileus. Identified obvious pleural effusion on CXR in RLL

10) In what areas did you feel weakest during this week of clinicals?

Finding a balance with sedation for an individual going through ETOH withdrawals to maintain goal RASS 0/-1

11) List one new skill or piece of knowledge that you learned this week.

Initial goals for post-op CABG.

12) List clinical goals for next week.

Continued improvement of progress notes in a timely manner in order to present all 3 patients within a 1&1/2 hrs from start of shift. Slow down with presentation of patients and make sure that the plan for each system is clearly delineated prior to moving on to next system.

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Wk _6/13-6/14__

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	Date	Diagnosis	F	M	Age	Comments / Activities	E/M Code
1	6/13	**The patient has a history of AAA repair in 3/2013 who presented to the ED with acute BLE weakness and urinary incontinence. He was transferred to UCMC from an OSH after being profoundly hypotensive and anemic (in hemorrhagic shock). Work up thus far has shown probable chronic intramural hematoma involved with his previous aortic repair. On admission patient had received 8 units of PRBC, 4 units of FFP, 3 6pack of platelets and 1 unit of cryoprecipitate. Neurology consulted and believe that the BLE weakness/numbness is a result of decreased perfusion to the thoracic spine causing a spinal cord infarct.**		X	78	-Monitor and report any new findings: JVD, low urine output, crackles heard in lung fields and hemodynamic instability - Replaced with Mg. 6gm IV X 1. Continue to monitor daily renal panel. - Continue to monitor daily CBC. Notify if any obvious signs and symptoms of bleeding	
2	6/13	**Pt. was admitted 6/10/13 with a primary diagnosis of CAD. He was recently at UCMC in 4/2013 for an aortofemoral bypass and post operatively developed volume overload and respiratory failure and was found to have an NSTEMI. He had a left heart catheterization at that time which demonstrated 2 vessel CAD with chronic total occlusion of the RCA and LAD. Patient reports episodes of chest pain**		X	69	Continue ASA 81mg po daily, atorvastatin 10mg po QHS. Restart Plavix 75mg po daily per approval with primary team. Do not restart ACE inhibitor or beta blocker until hypotension has resolved without need of further volume resuscitation - Albumin 25g 500ml IV ordered X 1 and repeated at 1100 with 12.5mg of albumin 250ml IV X 1. Assess orthostatics and document. Con-	

		since vascular surgery in April. He is now s/p CABG X 2 (LIMA to the LAD and SVG to PDA)				tinue to monitor U/O and report if < 30ml in 1hr	
3	6/13	**Patient was admitted with a primary diagnosis of an anterioseptal STEMI in leads V1-V5 with inverted T waves in V6. Patient awoke with acute shortness of breath when walking to the bathroom accompanying diaphoresis and stated "I just don't feel right". She was hypertensive en route to the ED and received ASA. She was started on a beta blocker and NTG gtt in the ED for SBP in the 240s which abruptly dropped after the medication was initiated down to the 80s. At that time she became unresponsive, was found to be acidotic, and was subsequently intubated. She was then emergently taken to the cath lab for ST elevations. Her left heart cath did not require any interventions.**		X	71	-. Continue to trend troponins daily now. Start lisinopril 20mg po daily. Continue ASA 325mg daily. Continue atorvastatin 80mg po QHS. - Wean NTG gtt for MAPs of 60-80 to off. Notify MD if MAPs >80 or if SBP >180mmHg - Continue Insulin gtt and titrate per protocol. Increase NPH to 15units BID. Change diet to 1800cal diabetic diet. Goal blood glucose < 150mg/dL. Consult endocrine for further follow up. Diabetic education prior to discharge. - Continue to monitor daily CBC and Q4 hour temperatures. Monitor for S & S of infection	
4	6/14	**The patient has a history of AAA repair in 3/2013 who presented to the ED with acute BLE weakness and urinary incontinence. He was transferred to UCMC from an OSH after being profoundly hypotensive and anemic (in hemorrhagic shock). Work up thus far has shown probable chronic intramural hematoma involved with his previous aortic repair. On admission patient had received 8 units of PRBC, 4 units of FFP, 3 6pack of platelets and 1 unit of cryoprecipitate. Neurology consulted and believe that the BLE weakness/numbness is a result of decreased perfusion to the thoracic spine causing a spinal cord infarct.**		X	78	Spoke with consult neurology service regarding restarting Benicar with MAP <100. (neuro recommended to keep MAP >100 to ensure adequate spinal perfusion)	
5	6/14	**Pt. was admitted 6/10/13 with a primary diagnosis of CAD. He was recently at UCMC in 4/2013 for an aortofemoral bypass and post operatively developed volume overload and respiratory failure and was found to have an NSTEMI. He had a left heart catheterization at that time which demonstrated 2 vessel CAD with chronic total occlusion of the RCA and LAD. Patient reports episodes of chest pain since vascular surgery in April. He is now s/p CABG X 2 (LIMA to the LAD and SVG to PDA)**		X	69	Ordered CXR secondary to increased O2 requirements. Replaced K+ and Mg+	
6	6/14	Primary diagnosis of supra-renal AAA and possible large infra-renal AAA. S/P endovascular AAA repair.	X		78	Ordered Zofran X 2 for post-op nausea/vomiting	
7	6/14	Primary diagnosis of inferior wall NSTEMI. Now s/p CABG X 2		X	61	Ordered EKG for post op crushing chest pain with no changes noted. Patient takes large doses of pain meds prior to surgery	
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13) In what ways did you feel confident about your abilities this week in clinicals?

Doing better with presenting patients.

14) In what areas did you feel weakest during this week of clinicals?

Understanding the physiology of diastolic heart failure and how it all related to flash pulmonary edema. Have a better understanding now, but at the time of taking care of this patient I stumbled somewhat on this.

15) List one new skill or piece of knowledge that you learned this week.

All about diastolic heart failure. Also, learned how Pro-BNP levels obtained prior to SBT and post SBT if elevated significantly increase the risk for a poor extubation outcome. The attending physician went over several articles regarding issues discussed in rounds and explained why we are doing what we are doing based on evidence based practice.

16) List clinical goals for next week.

-Continue to improve my note skills
-Continue to take the full assignment.
-Ask questions if I don't know
-Improve on follow up with the plan of care set forth

Weekly ACNP Clinical Log

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Clinical Site: CVICU	**Preceptor:** Jen Clark

Wk 6/26 &6/28

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	Date	Diagnosis	F	M	Age	Comments / Activities	E/M Code
1	6/26	Hospital day 4 with primary admission R/T ante-riolateral STEMI. POD 2, S/P CABG X 5 LIMA to LAD, SVG to RCA, OM1, OM2, SVG to Diag		X	62	Started patient on coreg 6.25mg po BID, started Lasix 20mg IV BID for a dieresis goal of 2L. Ordered prn Labetolol 10mg IV Q2hrs for SBP >140	
2	6/28	s/p CABG, s/p aortic valve replacement 3 months ago whom recently sustained a 3rd degree burn to his LLE and a K+ 7.2 and elevated creatinine		X	82	Ordered SMOG enema as patient had not had a BM in several days. Changed insulin regimin.	
3	6/28	Hospital day 6 with primary admission R/T ante-riolateral STEMI. POD 4, S/P CABG X 5 LIMA to LAD, SVG to RCA, OM1, OM2, SVG to Diag		X	62	Started metoprolol 50mg Q8hrs, noted low Na+ 126 with afternoon renal. Water restricted patient and ordered Gatorade for consumption instead of water.	
4	6/28	POD #1 CABG X 2 (LAD & OM2)		X	52	Started metoprolol 12.5mg po today. Ordered Lasix 20mg IV this am, and repeated at 1600 for a diuresis goal of 1-2L.	
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17) In what ways did you feel confident about your abilities this week in clinicals?

Understood heart failure a lot better which allowed me to really understand discussions with other patient's during rounds

18) In what areas did you feel weakest during this week of clinicals?

Infectious disease antibiotic coverage

19) List one new skill or piece of knowledge that you learned this week.

Understanding ARDS and how to treat, attempt to re-recruit with ventilator, and further understanding of interventions done.

20) List clinical goals for next week.

To have a systematic approach to completing notes and getting them done in a timely manner. Take it all in as it will be my last clinical in the CVICU.

Weekly ACNP Clinical Log

Student: Kimberley Roberts	**Course / Quarter / Year**: NUR 795
Clinical Site: CVICU	**Preceptor:** Jonathan Wylie

Wk _7/3__		• Each week, complete this document • For each date, make an entry for every patient you see. • There may be multiple entries for the same patient, i.e., a long-term patient in your caseload would be listed again for each date. • Under comments, list any procedures performed, or other pertinent information.					
Date		**Diagnosis**	**F**	**M**	***Age***	**Comments / Activities**	**E/M Code**
1	7/3	A 68 y.o. female seen on hospital day 2. Pt admitted on 7/1/2013 with a primary diagnosis of ruptured AAA who presented to the emergency department with Abdominal Aortic Aneurysm. 7/3- Infrarenal repair with a suprarenal clamp of AAA. POD # 1	X		68	Noticed increasing PIP on ventilator, worried for abdominal compartment syndrome. Bladder pressure-16, however PIP continues to increase to 40's and abdomen more distended and tight since this morning. Patient chemically paralyzed after sedated with minimal response in PIP. Anuric since operation. Patient returned to OR for exlap which did not reveal any significant findings. -Intrinsic AKI, consulted renal team for possible dialysis	
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21) In what ways did you feel confident about your abilities this week in clinicals?

Much more comfortable and confident in managing post CABG patients. We had a discussion/teaching during lunch about what sort of patient's are cared for with this critical care consult team. In this discussion, we talked about each system as it pertains to this clientele and what potential complications can arise and how to treat them. I was able to answer a lot of the questions which may have been a lot different at the beginning of clinical.

22) In what areas did you feel weakest during this week of clinicals?

Although, I knew to look at the whole picture I had a hard time understanding initially that the bladder pressure of 16 meant nothing and that the PIP increase was more of an indicator with this patient that her decreased compliance was likely due to abdominal compartment syndrome.

23) List one new skill or piece of knowledge that you learned this week.

PIP changes and how to interpret them in a real situation as opposed to learning and remembering what was taught.

24) List clinical goals for next week.

Done with this clinical. Truly an amazing experience. The ACNP's in the CVICU are awesome and are treated with the utmost respect by all. They are the heart of this service and inspiring.