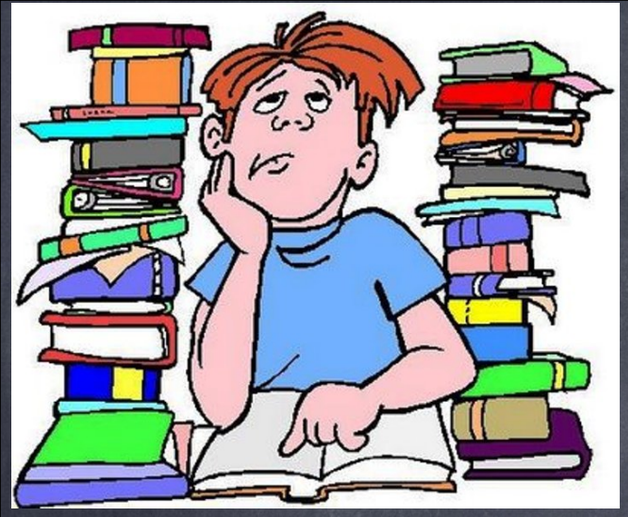


Bridging the Gap Between Theory and Practice for Nurses in Transition

Synthesis project

2013/2014

Karen Hu, Karen Mann, Heidi Voelker

Our project

- The goal of the project was to come up with a workable case study
- Create a patient, create a medical history and create scenarios to help facilitate learning for new grads or nurses in transition

We introduce ...

Augustine Gloop

Patient History

- Ms. Augustine Gloop is a 74 year old Caucasian female. She weighs 170lbs and is 5'4. She works in a flower shop part time. She lives in an apartment on the second floor with her 2 cats. She tries to take the stairs when she feels up to it although there is an elevator as well. The flower shop is on the bus route and her bus stop is three blocks from her apartment. She is single, has no children, but does have a couple of good friends that she gets together with twice a week.

Unfolding Case Scenario: Augustine Gloop

Dehydration, Hypoglycemia and Small Bowel Obstruction

Karen Hu, Karen Mann, Heidi Voelker

A. Gloop Case Scenario

Contents

A. Gloop Case Scenario

Patient History:

Ms. Augustine Gloop is a 74 year old Caucasian female. She weighs 170lbs and is 5'4. She works in a flower shop part time. She lives in an apartment on the second floor with her 2 cats. She tries to take the stairs when she feels up to it although there is an elevator as well. The flower shop is on the bus route and her bus stop is three blocks from her apartment. She is single, has no children, but does have a couple of good friends that she gets together with twice a week.

Past Medical History (PMH)

Coronary artery disease (CAD), hypertension (HTN), Type 2 Diabetes, overweight (BMI 29.2), osteoporosis, patient reported history of bowel problems (constipation/diarrhea)

Past Surgical history (PSH)

Appendectomy and hysterectomy.

Current Medications:

Atenolol (Tenormin), Atorvastatin (Lipitor), Lisinopril, Aspirin, Metformin,

Allergies:

She has reportedly multiple allergies including penicillin (PCN), Morphine, Altace (ramipril), Prevacid (lansoprazole), Norvasc (amlodipine)

A. Gloop Case Scenario

SCENARIO 1

A. Gloop Case Scenario

Scenario 1 description:

Objectives: Assess competency in:

1. Comprehensive physical assessment
2. Communication
3. Critical thinking

Scenario 1 Description:

A 74 year-old female with type 2 diabetes diagnosed for 5 years. Her friend brought her to the emergency department because of drowsiness, confusion, abdominal pain, states 3 day history of nausea/vomiting, one week history of loose stools.

Nursing Report:

74 year old female treated in ED for hypoglycemia and dehydration related to low CBG (1.8 mmol), a one week history of loose stools and a 3 day history of nausea and vomiting. She also complained of distended abdomen with crampy abdominal pain. She had no urinary complaints. The patient has been transferred to medical unit for observation and insulin management. Query further investigation of abdominal pain, diarrhea and nausea. Physician to follow up.

A. Gloop Case Scenario

Simulation Based Learning Activity

Date Created: Janurary 24th 2014 **Date Revised:**

File Name: UBC NURSING SYNTHESIS PROJECT

Authors: Heidi Voelker, Karen Mann, Karen Hu

Institution Affiliation: UBC School of Nursing and Vancouver Coastal Health

Subject/Topic: Simulation Activity for New Grads or other nurses in transition

Participant Level:

Please tick the appropriate box

☒ Beginner	☒ Intermediate	☐ Advanced
(Student)	(Novice RN/New graduate)	

Learning Domains

☒ Critical Thinking	☐ Psycho-motor skills	☒ Communication and Attitudes

Learning Objectives/Outcomes for the simulation:

1. Complete a comprehensive and thorough physical assessment
2. Practice appropriate communication with patients
3. Using history and assessment data to critically think and plan care for a patient with type 2 diabetes, HTN, and not yet diagnosed abdominal pain

Expected Activity Run Time: 15 minutes

Guided Reflection/debriefing Time: 10 minutes

A. Gloop Case Scenario

Location: TBA

Location for Reflection: TBA

SCENARIO 1: info sheet for participant

A 74 year old female was brought into the emergency department at 0400 and was treated in the ED for hypoglycemia and dehydration related to low CBG (1.8 mmol). She also has not yet diagnosed abdominal pain, reported a one week history of loose stools and a 3 day history of nausea and vomitting. The patient has just been transferred to your medical unit for observation, insulin and hydration management. Physician to follow up tomorrow morning. It's 0730, you are the nurse admitting this patient to the unit. You receive the following nursing report from the Emergency Department

Vital signs stable, afebrile. Complaining of nausea/vomiting and abdominal pain since admission. Gave 50mg dimenhydrinate at 0600. Patient is a type two diabetic with a history of other diagnoses. Blood sugars stabilized. IV was inserted in the ED, running at 120cc/ hr, no issues with voiding. Can ambulate and mobilize independently with supervision.

CLINICAL COURSE OF THE SIMULATED SCENARIO EVALUATION TOOL	TIME

A. Gloop Case Scenario

PHASE 1 **Initial Assessment – Admission to medical unit at 0730**	**Patient Presentation :** **Neuro** - alert and oriented, all normal findings **Vital Signs** - BP 138/78 - HR 90 - RR 18 - O2 Sat : 99% - Tempt: 36.5 - CBG 8.9 mmol **Resp** - breath sounds clear throughout all lung fields - equal entry bilaterally to both bases - no adventitious sounds - no complaints of chest pain or shortness of breathe or accessory muscle use **Cardiac** - heart rhythm regular - S1 S2 sounds noted - weak pedal dorasalis and posterior tibial pulses palpated with +1 edema in lower extremities - strong radial pulses, cap refills less than 3 seconds **Pain** - rates 7/10 at lower abdomen - sharp, crampy and colicky and has been on-off over the past few days - no analgesics taken prior - moving makes it worse, nothing seems to help	**In this phase, participants should…** - collect baseline data and complete admission assessment - complete focus assessments on GI - identify risk factors for deterioration of status **Demonstrated actions** ☐ introduces self ☐Safety equipment check ☐ Assess level of consciousness ☐ Complete full pain assessment, including use of pain scale ☐ Performs a head to toe assessment **Vitals** ☐ takes oral temperature ☐ palpates and auscultates pulse, noting quality of heart rate, sounds and rhythm ☐ manually obtains BP ☐ uses oximeter to obtain SpO2 ☐ Assess respiratory rate, depth and WOB ☐ Records vital signs in appropriate documentation ☐ Interprets any significant findings and trends in vitals ☐ Checks blood sugar **Respiratory** ☐ Evaluates client's respiration rate and WOB ☐Ask about coughing, sputum, SOB and chest pain ☐ Auscultates anteriorly and posteriorly bilaterally ☐ Documents any significant findings appropriately	**15 mins**

A. Gloop Case Scenario

	Skin - warm, pink scaly skin particularly on lower extremities - normal skin turgor - no rashes or pruritis **Mucous Membranes** - dry, chapped lips - oral cavity dry **Gastro-Intestinal *** - abdomen is distended - bowel sounds in all four quadrants with hyperactive bowel sounds in LUQ - surgical scar from previous surgical incision below umbilicus - diffuse tenderness upon palpation - no palpatable masses - colour of abdomen matches overall skin - increased pain in abdomen upon palpation - mild nausea at this time, no vomiting since admission - last BM was loose, liquid stool before admission **GU** - voiding clear, dark yellow urine 3 hours ago reported by patient - no pain or burning sensation with voiding	**Cardiac** ☐Auscultates for heart sounds and HR, recognizes S1 and S2 sounds and checks heart rhythm ☐Palpates radial and pedal pulses ☐Recognizes edema in lower extremities **Pain** ☐performs pain assessment using PQRST guideline ☐recognizes pain as nursing priority and uses data obtained to formulate nursing diagnoses and potential causes **Skin** ☐Assesses CWMS, particularly due to dehydration diagnose **Mucous Membranes** ☐Assesses mucous membranes particularly due to dehydration diagnose **Gastro-Intestinal** ☐Performs GI assessment, recognizes abnormal data ☐Assesses Hx of bowel movements, nausea and vomiting ☐ notes distention, previous scars, auscultating first for bowel sounds, then palpating ☐Interprets data and further performs a focused GI assessment and formulates nursing diagnoses and potential causes **GU** ☐Assesses voiding frequency and urine quality as per patient report	

A. Gloop Case Scenario

	OTHER - participant has access to patient's chart which includes: - client history - transfer orders - admission history - Medical orders - Lab work - Diabetic record - MAR - Fluid balance (last 24hours) - SBAR sheet	☐ reviews medical orders and confirms they are appropriate for the client's situation ☐ Reviews patient Hx, lab work and assessment data, able to predict and identify potential clinical problems and risk factors for deterioration of status ☐ using data collected**,** recognizes and justifies any medical orders that should be included or changed at this point in time, proceeding to call physician ☐ Uses SBAR if necessary

A. Gloop Case Scenario

Debriefing/Guided Reflection Questions for This Simulation

(Identify important concepts or curricular threads that are specific to your organization; use general prompts and focused questions to guide reflection and discussion)
Use an organized and systematic debriefing process such as reaction, analysis, summary (see below)

Reaction Phase (beginning)
Participants are encouraged to express their initial emotional reactions to the simulation and the instructor provides information or facilitates a conversation that clarifies the facts underlying the simulation
Questions are directed toward feelings, reactions, observations.

- What went on/happened?
- How did you feel about that?
- Who else had the same experience? Who reacted differently?
- Were there any surprises/puzzlements?

Analysis Phase (middle)
Allows participants to make sense of simulation events, their concerns, and to move toward accomplishing simulation objectives.
Questions are directed toward making sense of the experience for the individual and the group and drawing on the principles or generalizations

- How did you account for what happened?
- How might it have been different?
- What do you understand better about yourself/your group?
- What might we draw/pull from this experience?
- What did you learn/relearn?
- What does that suggest to you about [communication/conflict/etc.] in general?
- Does that remind you of anything? What does that help explain?
- How does this relate to other experiences you've had?

Summary Phase (end)
Signals the end and reviews salient points. Translate lessons learned from the debriefing into principles that participants can take with them to improve their practice. The debriefer may summarize important points if the participants did not cover them or may recommend reading or activities participants can pursue to improve.
Questions are directed toward having participants summarize what they learned and how they will apply this learning to practice

- How could you apply/transfer that?
- Given similar circumstances, what might you do differently next time?
- How could you make it better?
- What modifications can you make work for you in your practice?

A. Gloop Case Scenario

SCENARIO 2

A. Gloop Case Scenario

Scenario 2 description:

Objectives: Assess competency in:

1. Comprehensive physical assessment
2. Communication
3. Critical thinking
4. Clinical Decision Making

The Participant receives the following information:

4 hours later:

As you are gathering the glucometer machine to do Ms. Gloop's CBG, you note that her call bell is activated and you respond. Ms. Gloop is vomiting over the side of her bed. Her friend is in the room holding a basin and a towel, trying to help. The friend is concerned and asking a lot of questions.

SBAR communication, anticipated interventions and clinical decision making around the care of a patient with diabetes and suspected small bowel obstruction

A. Gloop Case Scenario

Simulation Based Learning Activity - 2

Date Created: Janurary 24th 2014 **Date Revised:** **Feb 2 2014**

File Name: UBC NURSING SYNTHESIS PROJECT

Authors: Heidi Voelker, Karen Mann, Karen Hu

Institution Affiliation: UBC School of Nursing and Vancouver Coastal Health

Subject/Topic: Simulation Activity for New Grads or other nurses in transition

Participant Level:

Please tick the appropriate box

☒ Beginner (Student) ☒ Intermediate (Novice RN/New graduate) ☐ Advanced

Learning Domains

☒ Critical Thinking ☐ Psycho-motor skills ☒ Communication and Attitudes

Learning Objectives/Outcomes for the simulation:

1. Completes a focused abdominal assessment

2. Communicates with physician using SBAR tool

3. Demonstrates critical thinking around the care of a patient with a possible abdominal obstruction

4. Engages in clinical decision making around care of a patient with a possible abdominal obstruction

Expected Activity Run Time: 15 minutes

Guided Reflection/debriefing Time: 10 minutes

Location: TBA

Location for Reflection: TBA

A. Gloop Case Scenario

SCENARIO 2 : information sheet for participant

4 hours later: As you are gathering the glucometer machine to do Ms. Gloop's CBG, you note that her call bell is activated and you respond. Ms. Gloop is vomiting over the side of her bed. Her friend is in the room holding a basin and a towel, trying to help. The friend is concerned and asking a lot of questions.

Vital Signs

- BP 132/82
- HR 100
- RR 20
- O2 Sat : 99%
- Tempt: 37.8
- CBG 10.6 = sliding scale

A. Gloop Case Scenario

A. Gloop Case Scenario

CLINICAL COURSE OF THE SIMULATED SCENARIO 2

TIME

15 min

In this phase, participants should…

- manage patient who is vomiting
- manage friend's concerns and questioning
- perform a focused abdominal assessment and collects data
- Communicate findings with Physician using SBAR communication tool
- Engage in critical thinking and clinical decision making regarding the care of a diabetic patient with a possible bowel obstruction and identify rationales for nursing interventions

PHASE 2

Focused GI assessment – Prior to lunch on medical unit at 1130

Patient Presentation :

The Patient is Vomiting:

- physically Vomiting (projectile)
- Vomit is odorless slightly yellow and mucousy

Neuro

- alert and oriented, all normal findings

Vital Signs

- BP 132/82
- HR 100
- RR 20
- O2 Sat : 99%
- Tempt: 37.8
- CBG 10.6

Gastro-Intestinal

- nausea persists
- abdomen distended
- no bowel sounds upon auscultation
- surgical scar from previous surgical incision below umbilicus
- increased pain in abdomen upon palpation
- no BM since admission
- has had sips of juice and water
- Abdominal pain is 8/10 – cramp like and colicky subsided minimally after vomiting

Demonstrated actions:

☐ the nurse dons appropriate PPP
☐ the nurse provides support and reassurance for patient
☐ the nurse positions patient in appropriate position to avoid aspiration
☐ obtains vitals
☐ obtains CBG
☐ Completes focused GI assessment

Gastro-Intestinal

☐ Performs GI assessment, recognizes abnormal data
☐ Assesses Hx of bowel movements, nausea and vomiting
☐ notes distention, previous scars, auscultating first for bowel sounds, then palpating
☐ Interprets data and further performs a focused GI assessment and formulates nursing diagnoses and potential cause
☐ Indicates nursing interventions

A. Gloop Case Scenario

A. Gloop Case Scenario

SBAR COMMUNICATION TOOL

Providence HEALTH CARE **Physician Paged:** _____ **Caller:** _____ **Time:** _____

S — Situation

I am calling about (patient's name and location) _____

The patient's code status is _____

I am calling because I am concerned about _____

_____

(e.g. the patient's respiratory status)

B — Background

Have patient chart, flow sheet, MAR and nurse's notes on hand when you make the call!

The patient is in the hospital because _____

Vital signs are:

BP _____ P _____ RR _____ O_2 sat _____ T _____

Previous vital signs (look for a trend)

BP _____ P _____ RR _____ O_2 sat _____ T _____

Procedures performed _____

Current medications _____

Allergies _____

O_2 _____ l/min OR _____ % for _____ (length of time)

Lab results - include date and time test was done, results of previous tests for comparison:

_____

I am concerned about (only one needs to be present to call the doctor or the Outreach team):

LOC because it is	decreased	or GCS is <10	
SBP because it is	over 200	less than 90	or drop of >30mmHg
Pulse because it is	over 110	or less than 55	
RR because it is	less than 10	or over 25	
Urine Output because it is	<100 ml over the last 4 hours		
O_2 sat because it is	<90% with FiO_2 >50%		or pt. requires >60% O_2

These are guidelines only. A change from the patient's normal baseline is more significant than a single value.

Consider other relevant clinical information:

Breath sounds _____

Skin color _____

CWMS _____

Intake & output _____

A different level of detail can be provided depending on how familiar the clinician is with the patient.

A — Assessment

What is your assessment of the situation?

This is what I think the problem is: _____; OR

I am not sure what the problem is, but I am worried; OR

The patient is unstable – we need to do something.

R — Recommendation

What do you need from the doctor by the end of the conversation?

Will you _____

For example:

come to see the patient now?

talk to the patient or family about code status?

ask a consultant to come see the patient now?

Do you need any tests like CXR ABG ECG CBC?

Consider whether you need to ask each of these questions:

1. When are you going to be here to see the patient?
2. What parameters do you want me to continue monitoring?
3. What change should I be expecting that would indicate an improvement?
4. If the patient does not improve, when should I call you again?

Before you end the call, repeat all orders back to the physician!

Please remember that this document is meant solely as an aid for successful communication! If you are comfortable that you have all the information you need, you do not need to use this worksheet. If you do use the worksheet, only fill in the blanks you need. When you have completed your call, and documented the relevant facts, throw this sheet away.

Form No. PHC-NF257 (Oct-06)

Page 1 of 2

A. Gloop Case Scenario

SBAR DIALOGUE SIMULATION CHECKLIST

S – Situation

☐ Hi, Dr. Hakika, this is _____ and I'm calling about Augustine Gloop, patient code status is FULL CODE,
☐ I am calling because I am concerned about her abdominal pain and vomiting

B – Background

☐ Vital signs (now) BP 132/82, HR 110, RR 21, Temp 37.2, CBG 10.5
☐ previous vital signs : BP 140/88, HR 92, RR 18, Temp 36.4,
☐ IV running at 120 cc/ hr on D5 ½ NS with 20mEq KCL
☐ allergic to morphine, altace, lansoprazole, amlodipine
☐ Hx of CAD, HTN, osteoporsis, overweight
☐ patient reports history of bowel problems – frequent constipation and diarrhea
☐ type 2 diabetic, abdominal pain for past 3 days with loose stools + n/v
☐ history of appendectomy and hysterectomy
☐ patient charts, flow sheets, MAR, nurses notes on hand and READY

A – Assessment

☐ I think the problem is Ms. Gloop is experiencing a small bowel obstruction
☐ she is vomiting large amounts of fecal smelling emesis.
☐ Abdomen is distended, was tender now is firm, and there are no bowel sounds
☐ pain is 8/10, continuous and sharp in the LUQ of the abdomen
☐ awaiting Abdominal 3 view x –ray

R – Recommendation

☐ Can you put an order in for the patient to be NPO, and an NG insertion to suction with x-ray to verify placement
☐ Can you also put in orders for replacement fluids and electrolytes?
☐ Do you need any other further tests/orders right now?
☐ Are you going to come see the patient?
☐ What parameters do you want me to keep monitoring?
☐ When should I call you again?

ADDITIONAL CONCERNS - reflects critical thinking and clinical decision making

☐ What about patient's abdominal pain of 8/10 - Recommendation
☐ What about patient's persistent nausea? - Recommendation
☐ The patient has sliding scale insulin due, and is now NPO? – Recommendation

A. Gloop Case Scenario

SBAR – PHYSICIAN SIMULATION RESPONSE

PHYSICIAN ORDERS

- Change to NPO status, insert NG tube with continuous suction at 100mm Hg
- x ray to confirm NG placement
- insert foley catheter, strict monitoring of Ins and Outs
- Increase IV infusion to 150 cc / hr + replacement fluids
- Increase Vitals to Q4H
- Repeat CBC, lytes, creatine, BUN STAT
- Change Xray order to STAT

☐ Nurse/ simulation participant partakes in closed loop communication, repeats all orders back to physician

ADDITIONAL PHYSICIAN COMMENTS

- page me again if no symptom relief within 4 hours
- page me if temp > 38.0 Celsius
- page if WBC > 15.0
- page if SYS > 90mm Hg or drops by 30mm Hg
- page if urine output is < 100cc over the next 4 hours
- will come see patient later this evening
-

A. Gloop Case Scenario

AUGUSTINE GLOOP CHART

A. Gloop Case Scenario

Vancouver Coastal Health

Nursing Admission Assessment

Site: Richmond Hospital

Date to Hospital (dd/mm/yyyy):	Date to Nursing Unit (dd/mm/yyyy):	Time to Unit:	By:
24/01/2014	24/01/2014	730 Hrs.	☐ Walked ☑ Stretcher ☐ Wheelchair ☐ Other:

Contact Person 1:	Phone No.:	Phone No.:
Sandy Brown	604-555-6677	
Contact Person 2:	Phone No.:	Phone No.:

B. Communication

Information obtained from: patient / family / friend / other

☑ English spoken ☐ Other ☐ Translator required: _____

☑ No Hearing Difficulty ☐ Hearing Difficulty: ☐ Left ☐ Right

☐ Corrective Aids: ☐ Left ☐ Right

☐ Information obtained from: ☑ Patient ☐ Family ☐ Other: _____

☐ Special circumstances (e.g. people not to come in, etc.)

Comments: _____

Initials: CB Date: 24/1/14

A. Allergies / Reactions

☐ None

Drugs: Penicillin Morphine Ramipril, Lansoprazole, Norvasc

Latex / Rubber: N/A

Food: NKA

Other: _____

☑ Allergy Band on Patient

☑ I.D. Band on Patient

☑ Patient Risk Profile Alert in Chart

☑ Noted on Care Plan

Initials: CB Date: 24/1/14

C. Advance Care Planning

Ask questions as written.

If you were unable to make decisions for yourself, do you have any written wishes about your future health care? ☐ Yes ☑ No

If yes, would you like us to have a copy to store in the chart and share with the health care team?

☐ Yes Place copy behind Face Sheet (green sleeve if in use)

☐ No

☐ UNABLE TO OBTAIN HISTORY ON ADMISSION (obtain history from other sources within 24 hrs.)

Comments: _____

Initials: CB Date: 24/1/14

D. Brief History of Present Illness

Admission Diagnosis: hypoglycemia, dehydration, abdominal pain N/D.

What do you understand is the reason for your admission?: _____

What concerns you the most at this time?: nausea, diarrhea, pain

What treatments, if any, where you receiving at home?: _____

Initials: CB Date: 24/1/2014

E. Pertinent Medical History (Include major hospitalizations, surgeries, physical or psychiatric illnesses, communicable or blood borne diseases)

CAD, HTN, NIDDM Appendectomy, hysterectomy, osteoporosis hx' bowel problems

Initials: CB Date: 24/1/14

F. Medications

☐ Problem to Care Plan

Medication Reconciliation Orders form (all sections completed) on chart?

☑ Yes

☐ No (Follow up with most appropriate team member as per unit med rec processes)

Did you bring any medication with you to the hospital?

☐ Yes ☑ No ☐ Locked up ☐ Sent home

With whom?: _____

Do you have a list of your current medications?

☑ Yes ☐ No

☐ UNABLE TO OBTAIN HISTORY ON ADMISSION

(Obtain history from other sources within 24 hrs.)

Comments: _____

Initials: CB Date: 24/1/14

A. Gloop Case Scenario

G. Vital Signs Time: 730 Glucometer: 8.9 ☐ NA

Pulse	Blood Pressure	Respirations:	Temperature:
R. 90 /min. ☐ Irregular	Lying: 138/78	18 /min.	36.5 °C
A. 90 /min. ☐ Irregular	Sitting/Standing:	☑ Easy ☐ Shallow ☐ Deep ☐ Laboured	☑ Oral ☐ Axilla ☐ Rectal

O_2 Sat: 99 % ☑ RA ☐ ____ L/min Mode:

Weight: 170 kg/lb ☑ Actual ☐ Estimated Height: 5'4 cm/in ☐ Actual ☑ Estimated

Initials: CB Date: 24/1/14

H. Pain Assessment

Current pain assessment: Pain level: 7 /10 Location(s): abdomen ☐ Denies

Chronic Pain/Other: What provides relief?: ☐ See Pain Assessment Flowsheet

Initials: CB Date: 24/1/14

I. Activities of Daily Living ☐ Assessed and no difficulty ☐ Problem to Care Plan

Current occupation: Florist assistant ☐ Retired ☐ Unemployed

Living Arrangements

☑ Home ☐ Care facility: ☐ Other:

Lives: ☑ Alone ☐ With other adult(s) ☐ With dependent(s) ☐ With adult(s) and dependent(s)

☐ Family NOT to be informed of admission ☐ Family aware of admission

Hospitalization will cause difficulty at: ☐ Work ☐ Family ☐ Child Care

Other:

Community Supports

☑ None used Uses: ☐ Family assistance ☐ Meal delivery ☐ Home Care

☐ Ministry of Social Services/Housing ☐ Other:

Initials: CB Date: 24/1/14

J. Systems Assessment (History and Examination)

Neurological ☑ Assessed and no difficulty ☐ Problem to Care Plan

☐ Paralysis ☐ Dizziness ☐ Tingling ☐ Seizures ☐ Numbness ☐ Weakness ☐ Difficulty expressing self

☐ Alteration in level of consciousness

Pupils: ☐ Unequal/Irregular size ☐ Dilated ☐ Pinpoint ☐ Left ☐ Right ☐ Refer to Neurological Assessment Record

Detailed Assessments:

Cognition ☑ Assessed and no difficulty ☐ Problem to Care Plan

☑ Oriented ☐ Before admission (from family/patient)

☐ Disorientated to: ☐ Person ☐ Place ☐ Time ☐ Fluctuates ☐ Delirium Nursing Assessment Tool initiated

Detailed Assessments:

Respiratory ☑ Assessed and no difficulty ☐ Problem to Care Plan

☐ Home O_2 How much: How often:

Cough: ☐ Unproductive ☐ Productive ☐ Wheezing ☐ Crackles

☐ Shortness of breath ☐ Dyspnea ☐ Tracheostoma/ETT in place: ☐ R.T. notified Appearance:

Detailed Assessments:

Cardiovascular ☐ Assessed and no difficulty ☐ Problem to Care Plan

☐ Chest pain/discomfort ____/10 ☐ Pallor ☐ Cyanosis ☑ Edema: lower extremities Peripheral pulses: ☐ Absent ☑ Weak pedal

☐ PICC ☐ IVAD ☐ Tunneled CVC ☐ AV fistula ☐ IV team notified ☐ NA

Detailed Assessments:

A. Gloop Case Scenario

Urinary ☑ Assessed and no difficulty ☐ Problem to Care Plan

☐ Frequency ☐ Urgency ☐ Discharge, type:_____ ☐ Hematuria ☐ Incontinence ☐ Nocturia
☑ Last voided: 0500 ☐ Intermittent Catheter q:____ hrs. ☐ External condom catheter
☐ Catheter: Type:_____ Size:_____ Inserted:____(dd)/____(mm)/____(yyyy) Reason:_____

Detailed Assessments:_____

Gastrointestinal ☐ Assessed and no difficulty ☐ Problem to Care Plan

☑ Nausea ☑ Vomiting ☐ Constipation ☑ Diarrhea ☑ Abdominal Distention ☐ Bowel sounds absent
☐ Regular laxative use ☐ Last bowel movement:_____ Usual bowel pattern: constipation / laxative use
☐ Stoma type/care:_____

Detailed Assessments: Abdomen distended, hyperactive bowel sounds LUQ. diffuse tenderness to palpation of palpable masses, LBM loose.

Nutrition ☐ Assessed and no difficulty ☐ Problem to Care Plan

Appetite: ☐ Good ☐ Fair ☑ Poor ☐ Difficulty swallowing ☐ Difficulty chewing ☑ Special diet: diabetic
Weight: ☐ Loss ☐ Gain:____ kg/lb Since:____/____ ☐ Nutritional intake prior to hospitalization
☐ Feeding tube; type:_____ ☐ Diet consult required

Detailed Assessments:_____

Musculoskeletal ☐ Assessed and no difficulty ☐ Problem to Care Plan

☑ Joint stiffness ☑ Muscular weakness ☐ Deformity ☐ Decreased range of motion:_____
☐ Alteration in gait or balance
☐ Contracture(s):_____ ☐ Amputation(s):_____

Detailed Assessments: BMI 29.2, osteoporosis

Skin and Wound ☐ Assessed and no difficulty ☐ Problem to Care Plan

☐ Rash ☐ Redness / Discolouration ☐ Bruises ☐ Skin intact ☐ Poor integrity ☑ Dryness ☐ Diaphoresis
Pressure ares:_____ ☐ Braden Scale Flowsheet
Wounds: ☐ Yes ☑ No ☐ Wound Assessment Flowsheet initiated

Detailed Assessments: dry scaly skin lower extremities

Reproductive ☐ Assessed and no difficulty ☐ Problem to Care Plan

☐ Discharge, type:_____ ☐ Perineal sores ☐ Itchiness ☐ Dryness
Last menstrual period:____(dd)/____(mm) ☐ Pre-Menarche ☑ Post-menopausal ☐ Pregnancy:____wks

Detailed Assessments: hysterectomy

Vision ☑ Assessed and no difficulty ☐ Problem to Care Plan

Corrected with: ☐ Glasses ☐ Contact Lenses Blurred vision: ☐ Left ☐ Right
Blindess: ☐ Left ☐ Right Redness: ☐ Left ☐ Right Discharge: ☐ Left ☐ Right

Detailed Assessments:_____

Behaviour During Interview ☐ Assessed and no difficulty ☐ Problem to Care Plan

☐ Demanding ☐ Restless ☐ Agitated ☐ Shouting ☐ Withdrawn ☑ Drowsy ☐ Crying

Affect During Interview ☑ Assessed and no difficulty ☐ Problem to Care Plan

☐ Angry ☐ Flat ☐ Sad ☐ Suspicious ☐ Inappropriate ☐ Labile
☐ Other:_____

Initials: AB Date: 24/1/14

A. Gloop Case Scenario

K. Pre-Admission Status

Pre-Admission Baseline Functioning

	Independent	Needs Assistance	Totally Dependent
Ambulation	☑	☐	☐
Stairs	☑	☐	☐
Transferring	☑	☐	☐
Hygiene	☑	☐	☐
Dressing	☑	☐	☐
Feeding	☑	☐	☐
Meal Preparation	☑	☐	☐
Toileting	☑	☐	☐
Taking Medications	☑	☐	☐
Housework	☑	☐	☐
Transportation	☑	☐	☐
Shopping	☑	☐	☐

Accompanying Personal Belongings

		NA	Sent Home	Locked Drawer	Bedside	Safe-keeping
Optical	Glasses	☑	☐	☐	☐	☐
	Contact Lenses	☑	☐	☐	☐	☐
Dentures	Upper	☑	☐	☐	☐	☐
	Lower	☑	☐	☐	☐	☐
Hearing Aid(s)	Right Ear	☑	☐	☐	☐	☐
	Left Ear	☑	☐	☐	☐	☐
Prosthetics		☐	☐	☐	☐	☐
Clothing		☐	☐	☐	☐	☐
Money	$:	☐	☐	☐	☐	☐
Medications		☐	☐	☐	☐	☐
Others		☐	☐	☐	☐	☐

Initials: CB Date: 24/1/14

L. Cultural / Spiritual

☐ Noted on Care Plan

What cultural practices, religious customs/rites, or health beliefs are important for us to consider in your care?

☑ None or specify: _____

Would like a visit from: ☐ Own pastor or religious leader ☐ A hospital chaplain (where available)

☐ Referral made to Spiritual Care (where available)

Initials: CB Date: 24/1/14

M. Risk Assessment Screening

Interventions

Fall Risk: CAMP + V (two or more = at risk → develop a care plan)

☐ Cognition impaired ☑ Altered elimination ☐ Mobility impaired

☐ Fall in last 90 days ☐ Vision Impaired

CAMP Scale: 1 /5 ☐ At risk

☐ Falls Prevention Care Plan initiated

☐ Reviewed and no concerns identified

Alcohol, Medication and Drug Use: CAGE

(Ask the questions exactly as written on all patients ≥ 16 years old)

Tell me about your use of alcohol, medications or drugs:

Have you ever felt you ought to cut down on your use of alcohol, medications or drugs?

☐ Yes ☑ No

Have people ever annoyed or angered you by criticizing your use of alcohol, medications or drugs? ☐ Yes ☑ No

Have you ever felt guilty about your use of alcohol, medications or drugs? ☐ Yes ☑ No

Have you ever used alcohol, medications or drugs to get your day started or to steady your nerves? ☐ Yes ☑ No

Last drink/drug:

Date: _____ Time: _____

CAGE Score: _____ /4

CIWA tool required when:

CAGE score is ≥ 2 **OR**

Pt. exhibits ≥ 2 signs of withdrawal

☐ Illicit drug use identified

☑ Reviewed and no concerns identified

Tobacco Screening

Tell me about your use of tobacco:

☑ Non-smoker ☐ Ex-smoker: _____ (amount) for: _____ /yrs

Have you used any tobacco products in the last 6 months? ☐ Yes ☑ No

☐ Smoker: _____ /day _____ /yrs Chewing tobacco amount: _____

Would you like support with nicotine replacement? ☐ Yes ☐ No

☐ Concerns identified:

☐ Provide QuitKit

☐ Follow up with physician to initiate NRT

(Refer to Nicotine Dependency Educator/ Counsellor)

☑ Reviewed and no concerns identified

Violence & Aggression

☐ Previous Violence Alert (on record)

☐ Past violent behaviour (as reported)

☐ Current violent or aggressive behaviour (as observed)

☐ Current risk factors (2 or more of the following):

☐ Confusion ☐ Disorientation ☐ Paranoid ☐ Suspicious ☐ Agitated

☐ Impulsive ☐ Angry ☐ Irritable ☐ Substance intoxication

☐ Withdrawal

☐ Violence and aggression alert has been initiated

☑ Reviewed and no concerns identified

Domestic Violence:

Is anyone hurting/threatening or making you feel afraid at home? ☐ Yes ☑ No

☐ Social Worker referral required where available

☐ Reviewed and no concerns identified

Initials: CB Date: 24/1/14

A. Gloop Case Scenario

Richmond Hospital
part of the Vancouver Coastal Health Authority

Graphic Record

LABEL
PHN: 9163744899
MRN: 01234567
Gloop, Augustine 74F 7Jul1940
Adm: Green, Forest (MD)
Fam: Wonka, Bill (MD)

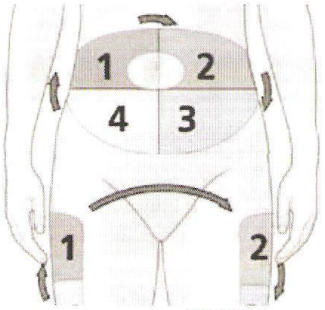
Month / Yr.	January																						
Day	24																						
Time	730																						
Temp. Oral • Axilla x	39																						39
	38																						38
	37	36.5 •																					37
	36																						36
	35																						35
BP / Pulse	240																						240
	230	138/																					230
	220	78																					220
	210																						210
v Systolic	200																						200
	190																						190
Diastolic ^	180																						180
	170																						170
	160																						160
	150																						150
Pulse •	140	v																					140
	130																						130
	120																						120
Apex x	110																						110
	100																						100
	90	90 •																					90
	80																						80
	70	^																					70
	60																						60
	50																						50
	40																						40
Resp./min.	18																						
Sp02	99																						
O2 route: np/m	RA																						
02 rate: L. or %	1																						
Acceptable Pain Level/ Comfort Level 0-10		**Sedation Score** 0 = None; S = Normal sleeping; 1 = Occasionally drowsy, easy to rouse; 2 = Frequently drowsy, easy to rouse; 3 = Somnolent, difficult to rouse																					
Sedation Score 0-3	0																						
Pain Location A	7/10	WRITE PAIN LEVEL 0 -10 IN EACH BOX BELOW																					
Pain Location B	1	WRITE PAIN LEVEL 0 - 10 IN EACH BOX BELOW																					
Ht 5'4 Wt. (kg)	170																						
Initials	OB																						

A. Gloop Case Scenario

Richmond Hospital
part of the Vancouver Coastal Health Authority

DIABETES RECORD

PHN: 9163744899
MRN: 0234567
Gloop, Augustus 74F 7Jul1940
Adm: Green, Forest (MD)
Fam: Wonka, Bill (MD)



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Legend: A-abd T-thigh (i.e. A1=abd site 1)

Important Safety Considerations:
INSULIN IS A HIGH ALERT MED

1. For CBG less than 4 mmol/L:
   - See VCH-H-2080, Appendix A and B on PolicyNet.
2. DO NOT PHOTOCOPY prescriber orders for insulin.
3. Check prescribers orders for scheduled basal and/or nutritional insulin scheduled prior to meals.
4. **HS CBG CAUTION**: Insulin HS correction dose may be ordered and is a different dose to TID correction scale on pre-printed order set.

DATE	CAPILARY BLOOD GLUCOSE (CBG) TIME	CBG	ADMIN TIME	Oral and Parenteral MEDICATION NAME/DOSE/RATE/ROUTE • COMMENTS	PHYSICIAN ORDERS CHECKED (INITIALS)	2ND NURSE VERIFICATION (INITIALS)	ADMIN. BY (INITIALS)	SITE # (see legend)
Jan24	730	8.9	800	regular insulin 2units	dB		dB	#1

A. Gloop Case Scenario

IF YOU RECEIVED THIS FACSIMILE IN ERROR, PLEASE CALL 604-244-5114 IMMEDIATELY

Richmond Hospital
part of the Vancouver Coastal Health Authority

PHN: 9163744899
MRN: 01234567
Gloop, Augustine 74 F 7Jul 1940
Adm: Green, Forest (MD)
Fam: Wonka, Bill (MD)

GLYCEMIC CONTROL: INSULIN SUBCUTANEOUS BASAL, NUTRITIONAL & CORRECTIONAL ORDERS

Items with tick box not ticked will be considered not ordered

Nurses Initials

GLYCEMIC CONTROL: For patients who are eating meals or NPO ; Insulin dosing MUST be reviewed daily by MD

MONITORING: Capillary blood glucose (CBG) TID and at HS
If HS correction insulin given, repeat CBG at 03:00; **do NOT give any insulin at 03:00**
If diet changes to unable to eat or NPO, HOLD nutritional insulin only and call physician for orders

MEDICATIONS: Discontinue all previous insulin orders

1) **Basal Insulin (Longer acting):** Can be ordered even if NPO; may reduce dose by 25% if NPO / poor intake / glycemia well controlled

☐ insulin NPH _____ units subcutaneous at breakfast or 08:00 if NPO

_____ units subcutaneous at ☐ bedtime or ☐ dinner or 17:00 if NPO

OR

☐ insulin glargine (LANTUS) _____ units subcut at bedtime (restricted to patients receiving prior to admission)

2) **Nutritional Insulin (Shorter acting):**

	Breakfast	Lunch	Dinner
insulin regular **OR** _____ subcutaneous	_____ units	_____units	_____units

3a) **Correction Scale (Shorter acting) TID dosing: to correct for hyperglycemia despite basal +/- nutritional insulin. If patient is ordered nutritional insulin, add dose below to the nutritional insulin dose otherwise give just this dose TID**

insulin regular **OR*** _____ subcutaneous as per scale below:

Physician to select low, medium or high dose from the scale below

CBG (mmol/L)	correction insulin TID dose		
	☐ Low Less than 40 units/day*	☑ Medium 40 to 99 units/day*	☐ High 100 units/day or more*
Below 4	Follow hypoglycemia protocol and call MD		
4 to 8	0 units		
8.1 to 10	1 unit	2 unit	3 units
10.1 to 12	2 unit	3 units	4 units
12.1 to 14	3 units	4 units	6 units
14.1 to 16	4 units	6 units	8 units
16.1 to 18	5 units	8 units	10 units
Above 18	6 units	10 units	14 units

*Total daily insulin requirement from all sources. See guidance on reverse for selection of dosing.

January 24/2014 DR. Green _____ 010625
Date and Time | Printed Name | Signature | College ID

A. Gloop Case Scenario

Name: Gloop, Augustine
Date of Birth: May 04 1939 **Age:** 74
MRN#: 94236841687
Doctor: Hakika, B
Bed: EMRG – 03A

COMPLETE OR REVIEW ALLERGY ST

DATE	TIME	ORDERS, SIGNATURE plus printed name and PCIS number	Time processed RN/LPN Initials Comments
Jan. 24 /14	0630	Hydrocodone 2.5 – 10mg q 3-6 hrs PRN	
		Dimenhydrinate 50mg q8 hrs PRN	
		Metoclopramide (Maxeran) 10mg IV q4 hrs PRN	
		IV Start, 1000 cc D5 ½ NS @ 120cc/hr with 20mEq KCL	
		over 8 hours	
		Clear Fluids only	
		Abdominal, 3 view X-ray	
		CBC, lytes, urinalysis	
		Dr. Hakika (signed)	
		R3, # 953170	

A. Gloop Case Scenario

MAR AND LAB VALUES

See attached documents accompanying this project

A. Gloop Case Scenario

Scripts

Subjective Data specific to the Abdomen

Has there been any change in appetite?

Not been able to drink/ eat adequate amounts due to persistent nausea and vomiting over the past 3 days.

Other than your prescribed medications, have you taken any other drugs or medications in the past week or few days?

In the past few days I've taken Gravol at home to help with the nausea but it didn't seem to relieve much of it. I've taken laxatives in the past when I get constipated but that's it.

What have you eaten in the past 24hrs?

Salty crackers, chicken noodle soup, bit of pasta, apple juice

Who prepares your food or buys groceries?

Herself most of the times once a week, however her friends occasionally drop off some groceries if they are visiting

Do you eat alone?

Yes, I live alone and don't go out to eat at restaurants much. Occasionally my friends and I go to the nearest coffee shop, or they drop by to have dinner with me at my apartment.

Have you gained or lost weight recently?

Recently, I've gained some weight. I've been having more and more trouble mobilizing around my apartment and I'm getting tired more easily.

Do you have any difficulty swallowing?

No, not that has been noticed.

Are you allergic to any foods?

Bananas and pineapples.

Are you experiencing any abdominal pain?

Yes. It comes in waves.. like a pulse. It's sharp and excruciating and gets worse when I move around. I've never felt this pain before.

A. Gloop Case Scenario

How often do you have a bowel movement?

I have a bowel movement about every 2-3 days, sometimes it can be every 4 to 5 days.

Has there been a recent change in your bowel movements?

I feel as if I've been getting more and more constipated in the past two months. I've been straining at a lot more when I go to the bathroom and sometimes I get cramps. I started taking laxatives in the past few months and it has helped with my constipation a bit.

Has there been any change to the consistency of the stool?

I've had a few instances lately with really watery stool like diarrhea. My stool has been harder to pass lately. Like I mentioned I've been straining more and the stool is more rigid and stiff.

Do you have a history of any problems with your gastrointestinal system?

As I've mentioned, I've been experiencing constipation and diarrhea over the past few years since my surgeries. It's not too bad but recently I find that it has worsened. I had an appendectomy 7 months ago and was hospitalized for a few days.

Do you exercise at all? If so, what do you do and for how long?

I don't exercise much… it's sometimes hard for me to manoeuvre around the house and apartment let alone have a full workout! I get out of breath more easily now when I try to go up the stairs or walk far distances. The most exercise I do is commuting to work at the flower shop and walking back to my apartment or picking up groceries at the supermarket across the street.

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Name: Gloop, Augustine
MRN#: **94236841687**
Date of Birth: May 04 1939
Physician: Hakika, B (MD)

Laboratory Results

Date: January 24th 2014
Time: 0630

Blood Serum Chemical	**Value**	**Reference**	**Indication**
Sodium (mmol/L)	**120**	135-145	**L**
Potassium (mmol/L)	**3.2**	3.5-5.0	**L**
Chloride (mmol/L)	**89**	98-106	**L**
Calcium(mmol/L)			
Total	**2.19**	2.18-2.58	
Ionized	**1.06**	1.05-1.30	
Magnesium (mmol/L)	**0.80**	0.75-0.95	
Bicarbonate (mmol/L)	**20**	24-30	**L**
Creatinine (µmol/L)	**89**	50-90	
Glucose (mmol/L)	**2.2**	3.3-5.8	**L**
Phosphorus (mmol/L)	**0.9**	0.8-1.5	
Blood Urea Nitrogen (BUN) (mmol/L)	**8.9**	2.5-8.0	**H**
pH	**7.41**	7.35-7.45	

Urinalysis			
Colour	**Dark Yellow**		
pH	**7.1**	4.8 – 7.5	
Specific Gravity	**1.037**	1.010 – 1.030	**H**
Protein (mg/ dL)	**Y - 50**	<30	**H**
Glucose	**N**	Negative	
Ketones (mg/ dL)	**Y - 35**	Negative	**H**
Nitrites	**N**	Negative	
RBCs	**N**	Negative	
WBCs	**N**	Negative	

CBC			
Hematocrit (Hct)	**0.53**	0.37-0.46	**H**
Hemoglobin (Hgb) g/L	**135**	123-157	
Red Blood Cells (RBC) 10^{12}/L	**6.1**	4.0 -5.2	**H**
Platelet count 10^9/ L	**200**	130-400	
White blood cell count (WBC) 10^9/L	**7.1**	4-10	
Band neutrophils 10^9/L	**0.3**	<0.7	
Basophils 10^9/L	**0.02**	<0.10	
Eosinophils 10^9/L	**0.32**	<0.45	
Lymphocytes 10^9/L	**3.0**	1.5-3.4	
Monocytes 10^9/L	**0.58**	0.14-0.86	

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Name: Gloop, Augustine
MRN#: **94236841687**
Date of Birth: May 04 1939
Physician: Hakika, B (MD)

Laboratory Results

Date: January 24th 2014
Time: 0630

Blood Serum Chemical	**Value**	**Reference**	**Indication**
Sodium (mmol/L)	**120**	135-145	**L**
Potassium (mmol/L)	**3.0**	3.5-5.0	**L**
Chloride (mmol/L)	**100**	98-106	
Calcium(mmol/L)			
Total	**2.20**	2.18-2.58	
Ionized	**1.00**	1.05-1.30	
Magnesium (mmol/L)	**0.73**	0.75-0.95	
Bicarbonate (mmol/L)	**20**	24-30	**L**
Creatinine (µmol/L)	**60**	50-90	
Glucose (mmol/L)	**4.0**	3.3-5.8	
Phosphorus (mmol/L)	**1.0**	0.8-1.5	
Blood Urea Nitrogen (BUN) (mmol/L)	**9.1**	2.5-8.0	**H**
pH	**7.35**	7.35-7.45	
CBC			
Hematocrit (Hct)	**0.50**	0.37-0.46	**H**
Hemoglobin (Hgb) g/L	**135**	123-157	
Red Blood Cells (RBC) 10^{12}/L	**5.7**	4.0 -5.2	**H**
Platelet count 10^9/ L	**210**	130-400	
White blood cell count (WBC) 10^9/L	**12.3**	4-10	**H**
Segmented neutrophils 10^9/L	**7.9**	2-7	**H**
Band neutrophils 10^9/L	**0.9**	<0.7	**H**
Basophils 10^9/L	**0.11**	<0.10	**H**
Eosinophils 10^9/L	**0.45**	<0.45	**H**
Lymphocytes 10^9/L	**2.0**	1.5-3.4	
Monocytes 10^9/L	**1.0**	0.14-0.86	**H**

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MEDICATION ADMINISTRATION RECORD

Medication	Start/Stop Date	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	00	01	02	03	04	05	06
Atorvastatin (Lipitor) 20mg PO qD			0800																							
ASA 81mg PO qD			0800																							
Lisinopril 10 mg PO qD			0800																							
Metformin 500mg PO BID			0800											1600												
Insulin glargine (Lantus) 15units qD			0800																							
Blood Glucose Acucheck q.d.s a.c. (before meals)			0730			1130					1630						2200									

Name: **Gloop, Augustine**

MRN#: **94236841687**

Date of Birth: **May 04 1939**

Age: **74 years old**

Allergies: Penicillin, Morphine, Altace, amlodipine, lansoprazole

Physician (MD): **Hakika, B**

Orders checked by_____

Time_____

Vancouver CoastalHealth
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MEDICATION ADMINISTRATION RECORD

Medication	Start/Stop Date	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	00	01	02	03	04	05	06
Dimenhydrinate 50mg q3-6hrs PRN																										
Metoclopramide 10mg IV q4hrs PRN																										
Hydrocodone PO 2.5- 10mg q4-6hrs PRN																										
Hydrocodone IV 2.5- 10mg q4-6hrs PRN																										
Acetaminophen PO 325- 650mg q4-6hrs PRN																										

Name: **Gloop, Augustine**

MRN#: **94236841687**

Date of Birth: **May 04 1939**

Age: **74 years old**

Allergies: Penicillin, Morphine, Altace, amlodipine, lansoprazole

Physician (MD): **Hakika, B**

Orders checked by_____

Time_____