Scenario File: Physical Assessment on Hospitalized Patient
Discipline: Nursing **Student Level:** Fundamentals
Expected Simulation Run Time: 15 min **Guided Reflection Time:** 35 min

Admission Date: XX/XX/XX
Today's Date: XX/XX/XX
Brief Description of Client
Name: Curtis E. Counts Gender: M Age: 58 Race: Caucasian

Weight: _70_kg/lb Height: _170_cm/in

Religion: Non specified Major Support: Wife (Charity)
Phone:

Allergies: Sulfa drugs
Immunizations:

Attending Physician/Team:

Past Medical History: Colon resection for colon cancer followed by combined chemotherapy approximately 22 months ago; Recently diagnosed with a recurrence of colon cancer and additional cycles of chemotherapy have been started 3 weeks prior to admission. Other conditions include hypertension controlled with daily Norvasc and gout for which he takes allopurinal daily.

History of Present illness: Admitted following three days of acute nausea, vomiting and dehydration.

Social History: Married and lives in two story home with wife of 35 years. He has two adult children living in the area. Self-employed as the owner of a plumbing supplies wholesaler. Smoked a pack of cigarettes per day X 38 years but quit nearly 2 years ago. Occasional ETOH.

Psychomotor Skills Required Prior to Simulation

Physical assessment of each individual body system.

Development of a strategy for implementing an integrated full physical assessment.

SBAR/handoff

Patient safety and communication skills

Cognitive Activities Required prior to Simulation [i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]

Review: "Putting it all together" Lab and Comprehensive Physical Assessment section of the NU121 Lab Study Guide

Review: Wilson and Giddons (2009) Chapter 23 Conducting a Head-to-Toe Assessment

Primary Medical Diagnosis: Nausea, vomiting, dehydration and weight loss. **Surgeries/Procedures & Dates: <u>Bowel Resection 22 months ago. Sigmoidoscopy one month ago (confirm the return of colon cancer).</u>** **<u>Exploratory laparotomy may be performed during this admission if N& V persist.</u>**	

Simulation Learning Objectives

Through participation in the simulation, the student will demonstrate the ability to:

1. Explain the rationale for a complete physical examination versus a focused or regional assessment of a hospitalized patient

2. Employ pertinent health history questions in acquiring relevant data on medical/surgical/social history of a hospitalized patient.

2A Ask directed questions based on the patient's individualized data base to facilitate acquisition of data during the physical examination.

3. Gather all equipment necessary to perform a full head-to-toe physical assessment.

4. Perform a complete systematic assessment of a hospitalized patient.

5. Respect and maintain patient privacy within the context of the examination

6. Implement patient safety standards throughout the assessment.

7. Communicate clearly to patient, family member and all members of the healthcare team.

Fidelity (choose all that apply to this simulation)

Setting/Environment

- o ER
- Med-Surg
- o Peds
- o ICU
- o OR / PACU
- o Women's Center
- o Behavioral Health
- o Home Health
- o Pre-Hospital
- o Other _____

Simulator Manikin/s Needed:

Props:

Equipment attached to manikin:

- IV tubing with primary line _D5 LR__ fluids running at _125__ cc/hr
- o Secondary IV line __ running at _cc/hr
- IV pump
- o Foley catheter _____cc output
- o PCA pump running
- o IVPB with ___ running at ___ cc/hr
- o 02 _____
- Monitor attached
- ID band _____
- o Other_____

Equipment available in room

- Bedpan/Urinal
- o Foley kit
- o Straight Catheter Kit
- o Incentive Spirometer
- Fluids
- o IV start kit
- o IV tubing
- o IVPB Tubing
- IV Pump
- o Feeding Pump
- o Pressure Bag
- o 02 delivery device (type)
- o Crash cart with airway devices and

Medications and Fluids

- IV Fluids:
- o Oral Meds:
- o IVPB:
- o IV Push:
- o IM or SC:

Diagnostics Available

- Labs
- o X-rays (Images)
- o 12-Lead EKG
- o Other_____

Documentation Forms

- Physician Orders
- Admit Orders
- Flow sheet
- Medication Administration Record
- o Kardex
- Graphic Record
- o Shift Assessment
- o Triage Forms
- o Code Record
- o Anesthesia / PACU Record
- o Standing (Protocol) Orders
- o Transfer Orders
- Other__Admission Data Base form (or perhaps DocuCare_Access_

Recommended Mode for Simulation (i.e. manual, programmed, etc.)

emergency medications o **Defibrillator/Pacer** o **Suction** o **Other_____**	
Roles / Guidelines for Roles • **Primary Nurse** • **Secondary Nurse** o **Clinical Instructor** • **Family Member #1** o **Family Member #2** o **Observer/s** o **Recorder** o **Physician / Advanced Practice Nurse** o **Respiratory Therapy** o **Anesthesia** o **Pharmacy** o **Lab** o **Imaging** o **Social Services** o **Clergy** o **Unlicensed Assistive Personnel** o **Code Team** o **Other_____** **Important Information Related to Roles** The person running the simulation can take the role of the patient via providing the voice of the mannequin or a student can perform this function either from the control room or at the bedside . The patient is anxious and initially resistant of being subjected to a head-to-toe assessment. The family member at the bedside is supportive of the patient in his reluctance to submit to a full assessment.	**Student Information Needed Prior to Scenario:** • **Has been oriented to simulator** • **Understands guidelines /expectations for scenario** • **Has accomplished all pre-simulation requirements** • **All participants understand their assigned roles** • **Has been given time frame expectations** o **Other _____** **Report Students Will Receive Before Simulation:** Secondary nurse will report that he/she admitted Mr. C.C. and was able to complete the health history however aside from obtaining vital signs and performing a rudimentary assessment (listened to heart, lungs and bowel sounds) has not performed a complete physical assessment on the patient but has medicated him with IV Zofran for nausea 40 minutes ago. **Time:**

Significant Lab Values: Electrolytes are all normal with the exception of potassium which is borderline low at 3.5 mEq/L. CBC is normal except for H/H of 12.0/38 **Physician Orders:** See separate sheet	

References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used For This Scenario: (site source, author, year, and page)

Wilson, S. & Giddens, J. (2009) *Health Assessment for Nursing Practice.* 4th Ed., Mosby / Elsevier Co. Chapter 23 Conducting a Head-to-Toe Assessment

NU 121: BASIC HEALTH ASSESSMENT Lab Study Guide (2013) Pages 34-41 "Putting it all together" Lab and Comprehensive Physical Assessment section.

NURSING ADMISSION DATA BASE FORM was obtained on-line from:
http://www.cantonmercy.org/uploads/File/pdf/6379_Admission_Database.pdf

2007 NCLEX-RN Test Plan Categories and Subcategories

Choose all areas included in the simulation

Safe and Effective Care Environment

Management of Care

- Advance Directives
- Advocacy
- Case Management
- Client Rights
- Collaboration with Interdisciplinary Team
- Concepts of Management
- Confidentiality / Information Security
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Information Technology
- Legal Rights and Responsibilities
- Performance Improvement (QI)
- Referrals
- Resource Management
- Staff Education
- Supervision

Safety and Infection Control

- Accident Prevention
- Disaster Planning
- Emergency Response Plan
- Ergonomic Response Plan
- Error Prevention
- Handling Hazardous and Infectious Materials
- Home Safety
- Injury Prevention
- Medical and Surgical Asepsis
- Reporting of Incident/Event/ Irregular Occurrence/Variance
- Security Plan
- Standard /Transmission-Based / Other Precautions
- Use of Restraints/Safety Devices
- Safe Use of Equipment

Health Promotion and Maintenance

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Disease Prevention
- Expected Body Image Changes
- Family Planning
- Family Systems
- Growth and Development
- Health and Wellness
- Health Promotion Programs
- Health Screening
- High Risk Behaviors
- Human Sexuality
- Immunizations
- Lifestyle Choices
- Principles of Teaching/Learning
- Self-Care
- Techniques of Physical Assessment

Psychosocial Integrity

- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End of Life Care
- Psychopathology
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Support Systems

- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Therapeutic Communications
- Therapeutic Environment
- Unexpected Body Image Changes

Physiologic Integrity

Basic Care and Comfort

- Assistive Devices
- Complementary and Alternative Therapies
- Elimination
- Mobility/Immobility
- Non-Pharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Palliative/Comfort Care
- Personal Hygiene
- Rest and Sleep

Pharmacological and Parenteral Therapies

- Adverse Effects/Contraindications
- Blood and Blood Products
- Central Venous Access Devices
- Dosage Calculation
- Expected Effects/Outcomes
- Medication Administration
- Parenteral/Intravenous Therapies
- Pharmacological Agents/Actions
- Pharmacological Interactions
- Pharmacological Pain Management
- Total Parenteral Nutrition

Reduction of Risk Potential

- Diagnostic Tests
- Lab Values
- Monitoring Conscious Sedation
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests/Treatments/Procedures
- Potential for Complications from Surgical Procedures and Health Alterations
- System Specific Assessments
- Therapeutic Procedures
- Vital Signs

Physiologic Adaptation

- Alterations in Body Systems
- Fluid and Electrolyte Imbalances
- Hemodynamics
- Illness Management
- Infectious Diseases
- Medical Emergencies
- Pathophysiology
- Radiation Therapy
- Unexpected Response to Therapies

Scenario Progression Outline

Timing (approximate)	Manikin Actions	Expected Interventions	May Use the Following Cues
First 5 min.	Patient appears to have a flat affect (possibly irritable). BP is 110/62, HR 96, RR 18 and temp 98.1 F, pulse ox is 97% and abdominal pain level is 5. L. IV is infusing D5 LR @ 125 mL/HR via angiocath in R arm	Primary nurse receives report from off-gong nurse (Secondary RN). Introduces self to patient	Role member providing cue: Cue:
Next 5 min.	Patient replies: "Is that really necessary? I was at my doctor's office 6 hours ago and he checked me out pretty good—told me I had to come to the hospital for fluids and tests."	Primary nurse explains his/her plans of beginning a full physical assessment. Primary nurse explains the rationale for performing a complete head-to-toe assessment in this setting.	Role member providing cue: Cue: Family member concurs . . .that since he was just seen by the doctor that a full assessment is unnecessary
Next 5 min	Patient continues to verbally resist	Primary nurse continues to employ communication and interpersonal techniques to attempt to facilitate patient cooperation	Role member providing cue: Cue: Family members asks is there a

	Patient eventually acquiesces to the examination with the stipulation that he does not "poke and prod my belly. . .or at least don't do it till the end."		**doctor's order for this or is it hospital policy or is it just the RN's idea. "He's not a guinea pig you know"**
Next 20 minutes	**The patient complains of significant tenderness throughout the abdomen but most acutely in the left lower quadrant.**	**Primary nurse performs a full assessment of the client's body systems modifying the sequence to defer to the patient's request that the abdomen is last to be assessed.** **The primary nurse asks relevant questions for the purpose of physical assessment throughout the examination**	**Role member providing cue:** **Cue:**
			Role member providing cue: **Cue:**

Debriefing / Guided Reflection Questions for This Simulation

(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?
2. Describe the objectives you were able to achieve?
3. Which ones were you unable to achieve (if any)?
4. Did you have the knowledge and skills to meet objectives?
5. Were you satisfied with your ability to work through the simulation?
6. To Observer: Could the nurses have handled any aspects of the simulation differently?
7. If you were able to do this again, how could you have handled the situation differently?
8. What did the group do well?
9. What did the team feel was the primary nursing diagnosis?
10. What were the key assessments and interventions?
11. Is there anything else you would like to discuss?

Complexity – Simple to Complex

Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners