Training Scenario: General Nursing

Nursing Report

The patient is a direct admit, per Dr. Andrew Nigh (Dictation # 14031)

- The patient is being admitted for testing due to abdominal pain, shortness of breath when taking deep breaths, dehydration and trouble urinating. He rates his **pain** an **8** (on a 0-10 numeric scale).

Admission Tasks Results

- Patient Data:
  - **Height** = 5'10"
  - **Weight** = 150lbs
- Allergies:
  - **Aspirin** (Hives)
  - **Penicillins** (Hives)
  - **Avocados** (Diarrhea)
  - **Potatoes** (Dizziness)
- The patient is:
  - **Temp** 37 C
  - **BP** 145/88
  - **HR** 94
  - **RR** 18
  - **O2 sat** 93%

Lines: PIV

- Start a Peripheral IV in the patient's Left Hand.
  - **Size**: 20g, **Type**: Angiocath, **Flow/Patency**: No Complications & Positive Blood Return, **Flow Control Device**: IV Pump, **Activity**: Assessment, Insertion, **Present on Admission**: No, **Dressing Condition**: Dry, Intact, Occlusive, **Dressing Activity/Type**: Applied, Tape, Transparent, **Site Assessment**: No Complications, **Infiltration/Phlebitis Scores**: 0.

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Training Scenario: General Nursing, continued

Drains: Foley

- Anchor a Foley catheter:
  - **Activity**: Insertion, **Catheter Size**: 16 Fr, **Balloon Inflation**: 10mL, **Type**: Dependent Drainage Bag, **Surrounding Skin Appearance**: Normal, **Dressing Condition**: Dry, Intact, **Dressing Type**: Dressing Applied (*right-click cell, select Add Comment, type: Foley tube anchored to left leg*), **System Check**: Bag Below Bladder, Closed System, Unobstructed Flow, **Catheter Secured With**: Adhesive Device, **Bladder Catheter Continued Need**: Yes, **Indications**: Urinary Retention, **Output**: 120ml, **Description**: Clear, **Color**: Yellow, **Odor**: Odorless

Routine Hygiene & Safety

- Complete the **I-Flowsheet** Routine Hygiene and Safety sections for 0800:
  - Universal Fall Precautions-**Purposeful Hourly Rounding**: Yes; **All Other Items:** Yes
  - Routine Hygiene-**Linen Changed:** Yes, **Shower:** Self
- After signing the documentation, **Duplicate Results** for 1000.

Note: For the real clinical setting, complete the **Safety**, **Activity**, and **Routine Hygiene I-Flowsheet** sections as appropriate for your unit, *but be sure to at least document the above sections.*

Incision & Wound Management

Document the blister found on your patient's Left Index finger:

- Add a dynamic Group-**Type:** Blister, **Laterality:** Left, **Wound Location:** Finger, Index, **Wound Date/Time:** T for Today(time auto-populates to Now)
- Complete an assessment and application of the dressing-**Activity:** Assessment, Dressing Applied, **Dressing Type:** Gauze, **Dressing Condition:** Dry, Intact, **Drainage**
- **Color:** Clear, **Drainage Amount:** Scant.

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Training Scenario: General Nursing, continued

Non-Violent Restraint Initiation & Monitoring

Complete ***Non-Violent Restraint Initiation*** Documentation:

- **Initiation Time:** T for today (current time will auto-populate), **Non-Violent Rationale:** Climbing out of bed, **Alternatives Attempted:** Bed alarm attempted, **Discontinue Criteria:** Able to follow directions, **Device Type#1:** Soft Wrist, **Device Location#1:** Both arms.

Complete ***Non-Violent Restraint Monitoring*** Documentation:

- Enter a time column for the most current whole hour (i.e.: 1400)
- **Device Type#1**: Soft Wrist, **Device Location#1**: Both arms, **Patient Safety:** Select all, **Patient Comfort:** Select all, **Non-Violent Rationale:** Climbing out of bed, **Discontinue Criteria:** Able to follow directions.

Restraint Patient Education

Document I-Flowsheet Restraint Patient Education:

- Enter a time column for the most current whole hour (i.e.: 1400) on the Patient Education: Restraint sub-section
- Within the **Learner Profile** section, chart-**Individuals Taught:** Patient, **Preferred Learning Method:** Verbal, **Patient Barriers to Learning:** None Evident, **Readiness to Learn:** Communicates Readiness
- Within the Restraint section, chart-**Topics:** Criteria for discontinuation, Restraints/Reasons, Safety/Comfort, **Method:** Verbal Explanation, **Materials:** Restraint education document, **Evaluation:** Teach back.

Note: The **Barriers** and **Readiness to Learn** in this example are simply *for practice only* and are not appropriate for *all* patients. Be sure to choose the appropriate selections for each of your patients in the real clinical setting.

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Training Scenario: General Nursing, continued

Morphine PCA Pump Initiation

Document the Morphine PCA under the Vitals and Pain navigator band, on the PCA/Epidural subsection:

- Add a dynamic group PCA pump and select:
  - **PCA/Epidural Type:** PCA mg, **PCA/Epidural Medication:** Morphine Sulfate (Morphine)
- Enter a time column for the time that the PCA was initiated and select:
  - **PCA-Epidural Assessment:** PCA mg, **PCA Dose:** 1mg, **Lockout Interval:** 10 minutes, **Lockout Timeframe:** 4-Hour, **Max Limit:** 20mg.

PCA Pump Totals and Pump Clearing

Document the patient's PCA demands and usage under the Vitals and Pain navigator band, on the PCA/Epidural subsection:

- Enter a time column for the next straight up hour (i.e.: 1400)
- Select **Total Drug Delivered:** 18, **Total Demands:** 20, **Injections Delivered:** 18, **Shift Totals Cleared:** Yes.

Note: Per your unit/facility policy, you will document the **PCA Total Dose Delivered**, **Total Demands**, and **Injections Delivered**.