Patient Care Scenario

You are the nurse working in the Medical Intensive Care Unit (MICU) this morning and you receive the following report on one of your assigned patients:

Freddy Mack is a 64 year old retired farmer from Olton with a history of Type I diabetes, CHF, and Renal failure requiring outpatient dialysis 3 times a week. He was admitted to MICU yesterday following a below the knee amputation of his right leg due to a non-healing wound that advanced to gangrene.

In PACU he was slow to wake up. Once awake, he experienced nausea, vomiting and severe pain requiring high doses of pain medication.

During the night he was restless and irritable. He refuses to look at the operative leg and has voiced concerns that he may have difficulty caring for himself at home. His blood sugar has been running in the 200's despite sliding scale Regular insulin being given subcutaneously every 4 hours per protocol.

He has a right arm AV fistula that has a palpable thrill and audible bruit and a left forearm peripheral IV with NS infusing at 150 ml/hr.
The right leg stump dressing is clean, dry and intact.
He has coarse crackles to the bilateral lower lobes of his lungs.
Current vital signs are: BP 150/90, HR 88, RR 22, SaO2 91% on room air and temp 99.2 F.

Today's lab:

Lab	Patient	Ref. Range	Lab	Patient	Ref. Range
Glucose	346	60 – 100 mg/dL	**WBC**	14	5.5 – 15.5 x 10^9/L
Calcium	10.0	8.6 – 10.2 mg/dL	**RBC**	3.4	3.9 -5.3 – RBC x $10^6/\mu L$
Sodium	140	135 – 145 mEq/L	**Hgb**	8	11.5 – 16.5 g/dL
Potassium	5.1	3.5 – 5.0 mEq/L	**Hct**	25	35 - 45%
CO_2	17	23 – 29 mEq/L	**Platelets**	160	150 – 400 x 10^9/L
Chloride	101	96 – 106 mEq/L	**Neut.**	60	54 – 62%
BUN	52	2.1– 7.1 mg/dL	**Lymphs**	33	25 – 33%
Creatinine	4.3	0.6 – 1.3 mg/dL	**Mono**	6.7	3% – 7%
			Eos	0.2	1 – 3%
			Baso	0.1	0.0 – 0.75%

CSON Clinical Judgement Model

NCSBN Clinical Judgement	Application of CJM
1. **Recognize Cues** (assessment) – The filtering of information from different sources (i.e., signs, symptoms, health history, environment). **What matters most?** 2. **Analyze Cues** (analysis) – The linking of recognized cues to the client's clinical presentation and establishing probable client needs, concerns, and problems. **What does it mean?** 3. **Prioritize Hypotheses** (analysis) – Establishing priorities of care based on the client's health problems (i.e., environmental factors, risk assessment, urgency, signs/symptoms, diagnostic tests, lab values). **Where do I start?** **4. Generate Solutions** (planning) – Identifying expected outcomes and related nursing interventions to ensure a client's needs are met. **What can I do?** 5. **Take Actions** (implementation) – to implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health. **What will I do?** 6. **Evaluate Outcomes** (evaluation) – To evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met. **Did it help?**	

Example CSON Clinical Judgment Model

NCSBN Clinical Judgement	Students Clinical Performance
7. **Recognize Cues** (assessment) – The filtering of information from different sources (i.e., signs, symptoms, health history, environment). **What matters most?** 8. **Analyze Cues** (analysis) – The linking of recognized cues to the client's clinical presentation and establishing probable client needs, concerns, and problems. **What does it mean?** 9. **Prioritize Hypotheses** (analysis) – Establishing priorities of care based on the client's health problems (i.e., environmental factors, risk assessment, urgency, signs/symptoms, diagnostic tests, lab values). **Where do I start?** **10. Generate Solutions** (planning) – Identifying expected outcomes and related nursing interventions to ensure a client's needs are met. **What can I do?** 11. **Take Actions** (implementation) – to implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health. **What will I do?** 12. **Evaluate Outcomes** (evaluation) – To evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met. Reassess. **Did it help?**	**This document is for faculty use only!** **We want you to start thinking about how your patient care, interventions, and interactions with your patients and their families and how you apply the clinical judgment model.** **Ex: A 68-year-old male patient presents to the ED with as he describes, a pounding headache with nausea and vomiting. Vital signs are BP 180/110, HR 105, RR 21, Sats 95% on RA, Temp 98.8. The patient has a history of CAD, and HTN, he smokes 1- PPD for many years, has hyperlipidemia, and states he drinks a six-pack of beer on the weekends.** **Recognize cues: BP 190/110** **Analyze cues: Pounding HA, N/V** **Prioritize hypothesis: at high risk for stroke based on presentation and standing history.** **Generate solutions: Inform the physician of the assessment findings and VS.** **Take Actions: Administer physician's order of antihypertensive, to lower blood pressure to reduce the risk for stroke.** **Evaluate Outcomes: 30 minutes after antihypertensive administration, BP 145/90, HR 95 bpm, RR 19, Sats 95% on RA. The patient states "my headache pain is not as bad".** {This is like a Bowtie & Highlighting NCLEX style question}