IM1 Hospital Clinical Simulation: Physical Assessment Activity – SBAR and Documentation Form

Scenario: Nurse Report	You are a nurse caring for a patient admitted to an Orthopedic med-surg unit 2 days ago after undergoing surgical repair of a fractured femur. During bedside report, the nurse who provided care to the patient during the nighttime shift informs you that the night shift was very busy admitting new patients and states "I feel like I'm leaving some information out of my report, but I need to hurry and get home to get my kids to school on time". The bedside report is rushed leaving you unsure as to what to anticipate you will find when entering the patient's room.
S **Situation**	**The following is the Bedside Report You Receive:** • Kelly John (DOB: 06/18/1955) is a 70yr old female. • She was admitted to the floor 2 days ago after undergoing surgery to repair a right femur fracture. • She is a daily weight before the breakfast. Her current weight is 96 lb. • She is on a regular diet and can have Ensure 120mL every 4 hours during the daytime via her percutaneous feeding tube (PEG). • She's allergic to Latex, Peanuts, and Penicillin. • Vital signs are every 4 hours. Her vital signs 2 hours ago were: BP 160/94, HR 82, RR 20, T 102.2° F, and she has reported pain of 7/10 to her surgical site. She received hydrocodone/acetaminophen twice during the night. • She wears adult briefs for incontinence. They're too big for her and sometimes her bed gets wet. There is chux pad and drawsheet on her bed, but they haven't been changed during the night. • Her last BM was before she was admitted to the unit. • She is on strict Intake & Output (I&O) because the dietician wants to calculate the number of calories she's consuming in a day because of her poor appetite. I haven't emptied her bedpan or measured how much she drank during the night, so you'll have to do that during your shift. • She has an order for O2 at 2L/NC for saturation < 94%. • There is an IV site to the right wrist. The site looked good the last time I checked. • Her medications include: Timolol (glaucoma), Promethazine (PRN nausea/vomiting), Metoprolol (hypertension), Nystatin (for yeast on the skin of both axilla), Albuterol inhaler (asthma) and Norco (post-operative pain) • She had a rough night and has been c/o itching to both underarms, but I have been too busy to assess that area. • She wears glasses and dentures for eating but I didn't see them in her room during my shift because the lights were off in her room. • She is a widow and lives alone. She has no family locally and is unsure of where she will go for rehab when she's discharged.

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B **Background**	Kelly John is 70 years old and was involved in a motor vehicle accident (MVA) 2 days ago. She wasn't wearing a seatbelt and ran into a telephone poll. Upon arrival to the Emergency Department (ED), she was observed to be incoherent and did not appear to understand the healthcare team when spoken to at times. She was transferred from the ED to surgery to undergo a repair of her fractured femur. When she woke up after surgery, she told the recovery room nurse that she has hearing loss in both ears and wears hearing aids. She said it is difficult for her to hear without them and she has a hard time putting them in by herself. The recovery room nurse told Ms. John her hearing aids would be sent with her to the med-surg unit. The patient has complained of nausea and has vomited twice since surgery. She has a history of hypertension (HTN), arthritis, glaucoma, asthma, and an eating disorder that has caused her to be malnourished due to a poor appetite.
A **Assessment**	**Based on the information above, assess your patient and document any abnormalities you observe.** ***This is an independent activity - NO TALKING DURING YOUR ASSESSMENT**

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R **Recommendation**	**Based on your Assessment Findings, what are your recommendations?** **What should YOUR next steps be to provide high quality care to this patient?**