PHYSICAL ASSESSMENT & CRITICAL THINKING SCENARIOS
LET'S BREAK INTO GROUPS

- Each group will be given one or more scenarios to work through
- The group will have to identify diagnosis, assessment and nursing interventions
SCENARIO USING CLINICAL JUDGMENT

• Mrs. Smith is lying on the stretcher, pale, diaphoretic, pursed lips, breathing heavy.
• VS: BP 158/112, HR 118, RR 26, T 36.2
• She is clutching her chest, you ask her what is wrong and she is grimacing and stating her pain is like her angina pain
• What is your assessment???
ASSESSMENT

Collect data-
• Perform PQRST assessment & vital signs
• Chest assessment
• ECG
• Mrs Smith is in distress, communicating pain, heart rate elevated, sweating, clutching chest, SOB, pale and having chest pain.
DIAGNOSIS

Interpret data-
• Potential for tissue damage due to lack of oxygen at tissue level as evidenced by chest pain & SOB
• Mrs. Smith is obviously having chest pain and quite possibly having a heart attack or other cardiac issues (angina) as her physical symptoms are reflective of her presentation.
NURSING INTERVENTIONS

• USE MONAH-Morphine, oxygen, Nitro, ASA, Heparin
• Chest pain onset immediate, if medications administered (nitroglycerin) should start having relief from pain within a few minutes
• Continue ECGs, cardiac monitoring and medications for pain management
• Reposition patient
• Ensure IV access
• Page MD or CCRT if necessary
Establish priorities, develop outcomes, identify interventions, document plan of care-

- Maintain hemodynamic status, pain level, and cardiac stability.
- Education with patient on use of a Nitro spray and what patient can do to prevent angina pain.
IMPLEMENTATION

Education, counseling, referrals to other Allied Health members-

• Arrange pharmacy to see patient for medication use.
• Cardiac educator to instruct Mrs. Smith on how to care for her heart.
• Refer to cardiologist for continued follow up.
EVALUATION

Evaluate patient’s condition and compare actual outcomes with expected outcomes-

- Mrs. Smith has reduced her episodes of chest pain by reducing triggers.
- Mrs. Smith is able to use Nitro effectively and can control her pain levels.
REVIEW OF SYSTEMS

• When performing a physical assessment, a nurse must consider all systems which a person is made up of.
• Prior to collecting the information for the patient’s systems, a past health review must be taken to paint the fullest picture. i.e. chronic illness, surgeries, family history
CASE SCENARIO #2

Eric, 17, arrives at the triage desk in the Emergency Dept. with c/o’s abdominal pain, nausea, and refusing to eat his dinner d/t the pain. States pain started 30 minutes ago.

-Vital signs: T 36.5, RR 20, BP 120/62, HR 65
-No vomiting, no diarrhea

What would your assessment include?
Past Medical History: None
Skin: normal
Head: normal
Eyes: normal
Ears: normal
Nose: normal
Neck: normal
Respiratory: normal
Mouth and throat: normal
Peripheral Vascular: normal
Breast: normal
Cardiovascular: normal
CASE SCENARIOS

• Gastrointestinal-appetite-decreased
  food intolerance-none known
  nausea-yes, vomiting-no,
  diarrhea-no

• Pain-yes-after eating 6 chocolate bars he ate before dinner!

• Diagnosis-indigestion d/t overeating of chocolate.

• Treatment-antacid or wait until symptoms resolve on own

• Education-teach Eric not to overindulge on chocolate!
CASE SCENARIO #3

- Mrs. Johnson, 71, arrives back to her room, you enter the room to find her gasping for air, slumped over bedside table.

- Mrs. Johnson is not your patient as you are covering while your partner is on break. Her slippers are difficult to get off as her feet/ankles are swollen. She needs assistance to get back into bed.
CASE SCENARIO #3

- Past Medical History-CHF, diabetes
- Skin- normal
- Head- normal
- Eyes- normal
- Ears- normal
- Nose- normal
- Mouth and throat- normal
- Neck- JVD elevated
- Breast- normal
CASE SCENARIO #3

- Respiratory-SOB, pursed lips, bluing noted around lips, accessory muscle use, wheezing, decreased air entry lower lobes.

- Cardiovascular-heart rate elevated

- Peripheral Vascular-both legs/ankles/feet swollen. Feet blue in colour

- Gastrointestinal- normal
CASE SCENARIO #3
NURSING INTERVENTIONS?

• Treatment-oxygen, Ventolin treatment, Lasix order?
• What can you do to promote her safety?
• May restrict fluids
• Continue to weigh daily and monitor outputs
CASE SCENARIO #3
NURSING INTERVENTIONS?

• Education-Instruct Mrs. Johnson that d/t her condition she may become SOB with exertion and in the future try and walk for shorter more frequent periods.
• She may need O2 or frequent usage of her puffers.
CASE SCENARIO #4

• Mrs. King, an 87 y/o woman admitted with syncope, now has difficulty speaking and is holding her head in bed

• What is your assessment?
ASSESSMENT REVEALS

- Subjective- slurred speech (dysarthria)

- Objective- pupils sluggish R>L at 4mm, left-sided facial droop with drooling, left sided arm drift, weakness left leg with +ve Babinski, holding head with right hand

- VS: BP 198/97, HR 90 irregular, T 36.6, RR 24, O2 89% on RA,

- Incontinent of urine & stool
DIFFERENTIAL DIAGNOSIS/NURSING DIAGNOSES

- Right sided cerebrovascular accident or bleed due to ?fall at home or ?emboli from atrial fibrillation
- Potential for airway obstruction due to depressed gag reflex and tongue obstruction
DIFFERENTIAL DIAGNOSIS/NURSING DIAGNOSES

• Potential for aspiration related to loss of gag reflex, impaired swallowing, weakness of affected muscles as evidenced by drooling

• Impaired physical mobility related to generalized weakness and paresis as evidenced by flaccid limbs, limited range of motion, decreased muscle strength and decreased physical activity

• Potential for skin breakdown related to decreased mobility & potential decrease in nutritional intake
INTERVENTIONS

• Address oxygenation & potential airway obstruction first...raise HOB, apply Oxygen, insert airway prn, call CCRT for assistance if needed
• Address BP & prevent further neurological damage- Call MD, report findings and obtain orders
INTERVENTIONS

• Address risk of aspiration-NPO until swallowing assessment done
• Monitor skin integrity and turn q2h to prevent breakdown, consider specialty surface if Braden < 16
• Create safe environment: side-rails up, call bell and tray on non-affected side, IV on non-affected side, use ceiling mounted lifts. Bedpan in initial phase
CASE SCENARIO #5

- 35yr old male paraplegic admitted for g-tube insertion
- VS: BP 130/80, T 37.2, RR 18, O2 97% on room air
- Pt deteriorated on floor and required ICU admission—
- What do you think caused the admission?
CASE SCENARIO #5

- Pt had 12hr history of not voiding. Nurse did not question it...
- Pt had no sensation below waist.
- Pt died in ICU.
- What should all nurses assess & how frequently?
- Knowing the pt’s condition of paraplegia, what should the nurse be watching for?
FINDINGS

• Spinal cord injury at T5-6
• Dilated pupils
• Increased heart rate
• Hypertension
• Sluggish bowel sounds, distended abdomen
• Drum sounding abdomen upon percussion
• Cold hands and feet
• Sweating, pounding headache
• Blotchy skin around the neck
• Tingling sensation on face & neck
• Goose bumps
CASE SCENARIO #6

- 82 year old female, DNR, admitted with pneumonia
- Lives at home with her husband and is fully functional
- Day 2, IV antibiotics, O2 sats >92%, 2L NP, up walking in hall
- Pale, decreased energy
- Daily blood work
- CXR
CASE SCENARIO #6

• You start your assessment, congested upper airways audible (heard from the door)
• Pale
• Accessory muscle use
• O2 sat 89% on 2LNP
• Patient is hard to wake up
CASE SCENARIO #6

What further assessment would you do?
- Neurological Assessment
- Blood glucose monitoring
- Cardiac Assessment
- Respiratory Assessment
CASE SCENARIO #6

What further interventions would you put in place?

• High flow oxygen
• IV/fluids
• Place patient in sitting position/High Fowlers
• Vital signs
• Suctioning
• Blood work-CBC
• CXR

• Patient is a DNR but that doesn’t mean to “Do Not Treat”!!!

CASE SCENARIO #6

Who would you call?
• MRP
• Family
• CCRT/RT

What would you document?
• Respiratory/Cardiac/Neurological Assessment
• Communication/Notification to MRP
• Any medications/treatments provided
CASE SCENARIO #7

• You and a new grad are assigned to Mrs. Singh, 85 year old who had an umbilical hernia repair 3 days ago
• Your assessment findings indicate:
  • T=35°C, RR 24, BP 79/49, HR 110, SaO2 85 on Room Air, ↓LOC
CASE SCENARIO #7

• The proximal portion of her incision has dehisced and has foul smelling drainage. The incision line has a >2cm border of redness and is warm to the touch
• Chart review reveals WBC 14.0
• You page the MRP to communicate your concern
PUTTING IT TOGETHER

You ask the new grad to identify the signs of sepsis in this patient... (she’s sharp!) What does she say?

• Altered level of consciousness
• Temp < 36 & HR > 90, RR > 20
• Hypotensive
• Low oxygen saturation
• WBC > 12
• Dehisced wound
• Foul smelling drainage
• > 2cm border of redness
• Warmth at incision line
FURTHER INVESTIGATIONS REVEAL THAT...

- Mrs. Singh’s bowel was nicked during surgery and she needs to go back to the OR.

- You along with the MRP decide the priorities in her care.

- What nursing actions do we need to take?
NURSING ACTIONS

- Protect/monitor airway since altered level of consciousness
- Ensure adequate oxygenation to prevent any further hypoxemia
- Initiate Sepsis Bundle
- Establish IV access and commence fluid boluses to manage blood pressure, since hypotensive (Vital signs q15min for first hr, then as per patient condition)
NURSING ACTIONS

• Draw STAT blood cultures, lactate and any other blood work or culture ordered by MD
• Administer antibiotics as soon as possible after cultures drawn (but don’t delay if unable to).

Studies have shown that for each 1hr delay, mortality increases by 7.6%
NURSING ACTIONS

- Continue to monitor for lactate levels and give bolus for lactate $>4$ mmol/l, as per MRP
- Inform the family
- Document in the “Sepsis Screening Tool” and “Sepsis Screening Actions” Powerforms
- Celebrate your success in intervening early for your patient!
LET’S HAVE SOME FUN...TAKE A GUESS AT THESE PICTURES

WHAT’S DO YOU THINK IT IS????
WHAT IS YOUR ASSESSMENT OF THESE SKIN SITUATIONS?

Edema
Scabies
Shingles
Psoriasis
Cyanosis to toes and fingers only
Necrotizing Fasciitis
Frostbite
RAYNAUDS SYNDROME
Lyme Disease-Tick embedded in skin
QUESTIONS