WID Teaching Portfolio Winter 2011 – Cheryl Stewart, Nursing

C. Charting as Critical Thinking: A Day in the Life of a Patient & Nurse

You arrive at the hospital for your shift at 07:30, March 25, 2011. You are assigned 5 patients to care for. One of them is Mr. Smithfield, a 47 year old man who was admitted to your unit during the night. The following information is available to you when you arrive:

***Mr. Smithfield**, 47 years old, admitted from Emergency at 03:00 with nausea & epigastric pain NYD. History of peptic ulcer 2 years ago.*

***Orders:** AAT (activity as tolerated)*

NPO (nothing by mouth)

IV N/S @125 mLs/hour

For gastroscopy today on call

The following information includes your assessment of Mr. Smithfield, as well as anecdotal information about his course in the hospital during your shift today. You should read all of the information and then, using the DAR method of charting, document as you would have in the patient's chart. You should attempt to be concise without leaving out any important information.

When you arrive in the patient's room at 0745, he is taking a shower. He returns to the room at 0800, and immediately asks when his gastroscopy will be done. You reply that you don't know yet, the patient is on call and the endoscopy centre will let you know later in the day what time he will have the test. You remind him that he can have nothing to eat or drink until after the test is performed. He becomes angry, telling you that it's ridiculous that he has to wait for the test, and the people who work in the hospital are useless.

You then perform a head-to-toe assessment, and obtain the following data:

Vital signs: Temperature 37.2; Pulse 76/min; Respirations 18/min; BP 128/86; Pain: 7/10, described as cramp-like, in the epigastric region.

The patient states he is uncomfortable, but beside the nausea and pain is all right. While performing the assessment, you notice that the intravenous solution is Dextrose 5% in water, is running at 125 mLs/hour. The IV site is not red, and the dressing is intact. You discontinue the current solution and hang a new one of N/S.

The patient has had nothing to eat or drink since his admission, but states he is nauseated and doesn't feel like eating. He complains of feeling a little weak, since he has had little to eat in the past 3 days. He is not coughing up blood. He is somewhat pale, with freckles on his arms. The results of his blood tests from earlier today are not yet available.

He has not had a bowel movement since admission to the hospital, but is urinating yellow urine in the toilet. There is no burning or difficulty urinating.

At 1130, Mr. Smithfield vomits a small amount of bile that is red tinged. You test the vomitus for blood, and it is positive. You inform the resident physician, Dr. Gordon, who goes to see the patient, but decides it is not serious at this point, telling you to continue to monitor the patient. The physician orders Pantoloc 40 mg IV Q8H. The vital signs are Temp 37; Pulse 82/min; Respirations 20/min; BP 139/86; Pain: 8/10, still cramp-like, in the epigastric region.

You administer the first dose of Pantoloc at 1200. The patient asks what the purpose of the drug is, and you explain that it is to decrease the secretion of gastric acid in his stomach. One hour later the patient states the burning has subsided somewhat, and he describes the pain as 4/10, still cramp-like.

Mr. Smithfield's wife arrives at 1330, and brings him some crackers and juice. You remind the patient that he is still NPO, and cannot eat or drink. He looks quite annoyed and asks when "those people in the endoscopy centre" are going to be ready to take him for his test. You answer that you still don't know, but you will try to get some information for him. When you ask the unit coordinator to call the Endoscopy Centre, she finds that he will go for the test shortly. At 1430 the porter arrives to take the patient for the test. The wife asks if she can go with him, but is told that isn't permitted. She states she will wait in the family room on the unit. The patient leaves for the test.

It is 1500, and you sit down to chart for your shift. On the following page, write what you would document in the chart.

Besides doing the charting, you will need to document the vital signs. There is one other document that needs to be filled out because of something that happened during the shift. What is that document, and what would you report?