Preplanning Patient Case Study Expectations

Case Study:

- **Page 2** complete- Patient Information Page
  - be sure each area is filled out completely…**NO** blank areas
  - **Allergies:** Be sure to list all allergies and have **drug cards for each allergy**
  - **Admitting Medial Diagnosis**- You can find this at the bottom of the H&P under Impressions. **(You will need a Diagnosis/Disease Page for each one of these.)**
  - **Mini History for Admission:** Be sure to identify reasons they were admitted. Include symptoms and treatment prescribed.
  - **List of Current Diagnosis/Disease Process:** These would be the same at the Admitting Diagnosis and found at the bottom of the H&P under Impression. ***(You will need Diagnosis/Disease Page for each one)***
  - **Past Medical History:** These are all the diagnoses the patient has had previous. This can be found under the Medical History Section on the H&P ***(You will need Diagnosis/Disease Page for each one)***
  - **List of All Medications & Dosages:** ***(drug card needed for each one)***
    - **Hospital Medications:** These are medications that are on the **all** doctors' orders (in eLearn) **and** listed on the MAR. Be sure to list the dosage of the medication as well. **(drug card needed for each one)**
    - **Home Medications:** These are medications listed on their H&P. Some maybe the same as the Hospital but all should be included in this section if they were on them prior to hospitalization. **(drug card needed for each one)**
  - **Briefly what did you learn:** Please write here your priority of care after reviewing the information on this page.

- **Page 3** Complete- detail explanations
  - **Medical Diagnosis**: This would be why there are admitted to the hospital on this visit.
  - **Pathophysiology/Etiology**
    - Pathophysiology is when you describe in words the change from normal anatomy/physiology to what is occurring with this disease process.
    - Etiology is describing what caused these changes (could be more than one thing)
  - **Medical/Pharmacological Interventions:** These are thing the doctor would typically order for this Disease Process such as treatments or medications.
  - **Complications:** These would be anything that could cause issues (go wrong) based on this disease process. There should be more than one listed in this box.
  - **Lab/Diagnostic Studies:**
    - What lab would the doctor order (be specific not just CBC or CMP (comprehensive Metabolic Profile such as white count, sodium level, etc.)
    - Diagnostic studies any other test that would be performed beside labs such as x-ray (what type- be specific), colonoscopy, Lung studies, CT/MRI, EKG, etc.
  - **Clinical Manifestations**: This is the list of Signs and/or Symptoms the patient is experiencing with this disease process. This should be multiple things listed here and be specific. Ex. You cannot say just Lung Sound changes you must put whether crackles, wheezes, etc.
  - **Nursing Interventions:** These should be things a nurse can do without an order that would help the patient with this disease process. Examples would be dietary considerations, positioning of patient/bed, applying cool cloths, TCDB, etc.

- **Page 4** Diagnosis/Disease Process Pages **(must have one for each diagnosis and past medical history)(YES-** even if this was listed on page 3 you will need to complete a page for that Diagnosis as well**)**
  - **Pathophysiology**- Describe in words what the change from normal anatomy/physiology is and why that is occurring.

- **Medications Associated with this Diagnosis:**
  - *Medication*- list every Medications from home and current medication list for this diagnosis/disease process.
  - *Medication Classification*- What is the **Functional Class** (ex. Ca channel blocker, loop diuretic, etc.) and with Anti-infectives (antibiotics) you need to also include their **Chemical Class** (ex. Penicillin, sulfa, etc.)
  - *Dosage*-what is the dose ordered. If a home med and not listed you can put UTA (unable to Assess)-DO NOT leave blank.
  - *Nursing Considerations*- Things you would check before giving meds such as
    - *Labs*- which specific lab and when would you hold if abnormal
    - *Vital Signs*-What parameters would you use to hold med
    - *What do you assess before **and** after giving med*- be sure to list when you call doctor if abnormal
    - *Other things listed under nursing considerations in drug book for each med.*
  - *How does med work for this diagnosis*-you must write how it works for this disease state. Example: Loop Diuretic for HTN- Removes excess fluid to decrease fluid in veins and arteries therefor decreasing pressure.
- **What Symptoms…**Identify what symptoms are possible for this diagnosis/disease process then state whether it was reported they are exhibiting those symptoms (look at their H&P assessment and complaints- **NO** Blanks if not mentioned use **UTA.**
- **Patient at Risk-**Identify what the patient is at risk for (complications) for this diagnosis/disease process- may be more than one.

- **Page 5 & 6** Labs & Diagnostic tests/treatments
  - **Normal Range-** List the normal range for the labs posted on your patient. These will be listed on the Labs.
  - **Patient Range-** List the Date the labs were drawn start with the oldest date first. You must write down **every** lab on **every** date whether normal or abnormal. **Highlight abnormal labs either with highlighter or different color ink.**
  - **Which patient med/s affects this lab:** List the medication that could be linked to this lab value **whether abnormal or normal. No Blanks**- if no med is associated with this lab then write **none**.
  - **Notify Doctor-** Check yes or no if you need to contact the doctor regarding this lab (if you checked yes, then you should put this on your Nursing Brain sheet as well and write why you are contacting them not just that the lab is abnormal.)
  - Remember: Every lab value in the patients chart should be posted on these pages even if you have to add them at the end. Also **DO NOT** leave the columns blank!
  - **Diagnostic Tests & Treatment-** Mark Yes or No if any additional test were ran, if yes, then list any test that were ran on your patient with dates and results.

- **Page 7** Additional Medications
  - if med is not listed on one of the Diagnosis/Disease Pages then it is listed here
  - Be sure every medication prescribed or taken at home have been listed either here or on a diagnosis page.
  - Refer back to Diagnosis page above for description of columns.

Nursing Brain:

- **Column 1-** Fill out this information from the H&P and other information from the chart.
- **Column 2**-
    - **Report**-Make note of the highlights of the nursing report such as previous assessment, VS, tasks to be completed.
    - **Labs-** You can list the most current labs here and highlight the abnormals. (I would recommend the 2 most current lab days. You can do this by using one color of ink for one day and another color for the next.) Also highlight the abnormals-then on back write down what you would call the doctor and why that lab maybe abnormal.
- **Column 3-**
    - Assess- This is where you can take notes about YOUR assessment you do during the simulation so it would be blank for preplanning
    - TX/I&O- you can put your treatment you will be giving or you performed here.
- **Column 4-**
    - Vital Signs-This is where you will write the patient's vital signs during assessment. The first set is from admit listed on H&P to be able to compare to current vital signs.
    - Meds-
        - Mark what time your meds are given.
        - List your meds below and make notes of things you already know or need to know before giving the med. If you already see an issue regarding a med, list it and highlight it to call the doctor about.
        - Write why your patient is on this med-you will have to explain it to your patient.
- **On Back of Nursing Brain** (these are my suggestions to give you a better experience with simulations)
    - **Is there any areas you need to focus on during your assessment:** Based on what you know what are you going to focus on during your head to toe assessment?
    - **List reasons you have found during preplan to call the doctor. Such as:**
        - **Abnormal labs- and why**
        - **Medication issues-and why**
        - **Anything you are concerned about**
    - You can add to this list during the simulation so all your information to talk to the doctor is in one spot.

Drug Quick Reference Sheet

- **Drug Name:** Write both generic and brand name
- **Classification:** This is more on whether it is an ACE Inhibitor, Diuretic, etc. On antibiotics/anti-infective list the chemical class as well.
- **Drug actions:** How does the drug work, Mechanism of action.
- **Diagnosis/Reason for Drug:** Why is this patient taking this drug?
- **Things to Check Before Giving (Nursing Considerations):** Identify in the different sections what you need to check prior to giving this drug.