Case Study 2

Facilitator Card

CASE 2 (Hypovolaemia)

- The important things to get across in this case are:
  - Recognise that the patient is deteriorating
  - Recognise the Seagull sign on the observation chart
  - Simple management: IVC, IV fluids, Oxygen
  - Working out for themselves what is going on with this patient
  - Use the COMPASS flowchart
  - Communicate using ISBAR

- Mr. Eastwood presents with abdominal pain due to self inflicted stab wound, not initial observed due to small puncture wound. The subsequent internal bleeding requires surgery to stabilise. Blood volume has decreased due to the bleeding, leading to decreased Cardiac Output, resulting in decreased UOP & BP (BP = CO x TPR) and to compensate an increased HR (because SV fallen and compensatory increase HR to maintain CO) and increased RR (either due to pain or lactic acidosis from inadequate oxygen delivery because CO fallen [Delivery O2= CO x Arterial O2 content].
  - MEWS increasing
  - Pain increasing
  - Bloods- Decreased Hb
Case 2:
Aim: To recognise a deteriorating patient

Learning Objectives:
- Obtain adequate history
- Obtain appropriate vital signs
- Refer appropriately
- Communicate effectively

Equipment:
- Facilitator Card
- Player 1 Card – Patient
- Player 2 Card - RN
- IV Cannula
- Medication Chart
- Blood Test results
- Observation chart
- Communication Card
- Scribing Code Blue Form (Optional)

Roles in the scenario
1. Patient
2. Registered Nurse
3. Intern
4. Surgical Registrar
5. Optional extras:
   a. Additional Nurses
   b. Consultant
   c. Relative
   d. Relative

Scenario
Mr. Eastwood
UR 123412

Mr Eastwood is a 46y.o. male who has been in the unit for three days. He is scheduled, and under suicide watch. He has a history of self harm.

His temperament has been frustrating for the staff, as he hangs out in the corridor, being loud and obstructive.

Today, he is in the corridor complaining as usual, however has now returned to his room and is unusually quiet.

To start the scenario:
1. Assign roles to each player
2. Give the first player card to the player designated as the Patient
3. Give the Second player card to the player designated as the RN
4. When the RN Phones the Intern place the two players (RN & Intern) back to back to simulate communication via the phone.
5. Allow the scenario to build on itself prompting other players to enter as called for or prompt if necessary
6. Supply players with further information such as medication charts, observations or blood results when asked
During the scenario:
If the RN needs prompting:
1. What questions/assessments would you conduct?
   • Establish what the patient is complaining about.
   • Conduct Vital Signs
   • What is your general assessment – pale, diaphoretic etc.
2. Who would you notify? Why?
   • Minimum escalation according to MEWS
   • A higher escalation may be reasonable

Facilitator should place RN and Medical Officer back-to-back to simulate phone conversation
In the phone call the RN should:
   • ISBAR

Medical Officer comes to review the patient:
1. What information do you require from the RN?
   • Vital Signs
   • Information that has been gathered, including patients history
2. What assessment would you do? (Prioritise)
   • DR ABCD
   • Abdominal Assessment (Inspect, Auscultate, Palpate, Percuss)
   • Bloods
3. What is your management plan for this patient?
   • Oxygen
   • Pressure on abdominal wound
   • IV access
   • IVT
   • Pain relief
   • Investigations
   • Escalation and transfer out for investigations

4. Who will you notify?
   • Consultant
   • Canberra Hospital Admitting Officer

Questions:
1. What are your next actions as a group?
   • Notify
   • Prepare for transport

2. How often should observations be observed?
   • ½ hourly for 1 hour then hourly for 4 hours

To summarise

Ask the group:
1. What they thought went well?
2. What suggestions would they make to improve their roles?
**Case Study 2**

**Player 1 Card**

**Patient**

You are Mr. Eastwood a 46y.o. male. You have been scheduled and, under suicide watch, with a history of self harm.

Unbeknown to the nurses you have managed to stab yourself in the stomach with a paddle pop stick used by another patient for their coffee. You have removed the paddle pop stick, which reveals little evidence of a puncture wound.

You have been loud and obstructive this admission, and now complain of abdominal pain to the nurse while in the corridor, where you hang out. You have gone back to your room feeling lightheaded and are now very quiet.

**Case Study 2**

**Player 2 Card**

**RN**

You are working in the secure mental health unit. One of the patient’s Clint Eastwood, has been in the unit for 3 days. He has been scheduled, and is on suicide watch. His temperament has been frustrating for the nurses, as he hangs out in the corridor, being loud and obstructive.

Today, he was in the corridor complaining as usual. But he has now gone to his room and is quiet.
Case Study 2

Blood Results

<table>
<thead>
<tr>
<th>Blood Test</th>
<th>Admission</th>
<th>Day 3</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb</td>
<td>138</td>
<td>105</td>
<td>115-160</td>
</tr>
<tr>
<td>Hct</td>
<td>0.44</td>
<td>0.31</td>
<td>0.32-0.47</td>
</tr>
<tr>
<td>WCC</td>
<td>5.6</td>
<td>10.0</td>
<td>4.0-11.0</td>
</tr>
<tr>
<td>Na</td>
<td>142</td>
<td>142</td>
<td>137-145</td>
</tr>
<tr>
<td>K</td>
<td>4.0</td>
<td>4.0</td>
<td>3.5-5.0</td>
</tr>
<tr>
<td>Urea</td>
<td>5.3</td>
<td>10</td>
<td>2.5-7.5</td>
</tr>
<tr>
<td>Creatinine</td>
<td>75</td>
<td>130</td>
<td>60-110</td>
</tr>
</tbody>
</table>
# THE CANBERRA HOSPITAL

**MEDICATION CHART 1-2-3-4-5 OF 1-2-3-4-5**

**AS REQUIRED**  
**PRN**  
**MEDIICATIONS**

**Attach ADR Sticker**  
See front page for details.

**Year**  
2011

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Route</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOT FOR ADMINISTRATION**

**Community Pharmacy:**  
**Dispenser:**  
**Date:**  
**Medication actually administered by:**

CHECK if patient has another Medication Chart.
### MEWS Escalation Table

<table>
<thead>
<tr>
<th>MEWS</th>
<th>Notify</th>
<th>Escalate</th>
<th>Observations</th>
<th>Intra hospital escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEWS 4 - 5</td>
<td>Team Leader</td>
<td>Respiratory Zone (RMO) to review within 30 mins</td>
<td>After 60 minutes if resuscitation or intubation escalation per MEWS 4 - 5</td>
<td>Vital signs: 3 hourly to 1 hour</td>
</tr>
<tr>
<td>MEWS 6 - 7</td>
<td>Team Leader</td>
<td>Respiratory Zone (RMO) to review within 30 mins</td>
<td>After 60 minutes if resuscitation or intubation escalation per MEWS 6 - 7</td>
<td>Commercial Fluid balance chart</td>
</tr>
<tr>
<td>MEWS 8</td>
<td>Team Leader</td>
<td>Respiratory Zone (RMO) to review immediately</td>
<td>Consider MEWS if resuscitation or intubation escalation per MEWS 8</td>
<td>Hourly for 4 hours</td>
</tr>
</tbody>
</table>

**Respiratory Rate:**
- Normal: 12-20
- Tachypnea: >20
- Bradypnea: <12

**Oxygen Saturation:**
- Normal: 90-100%
- <90%

**Blood Pressure:**
- Normal: 90-140/60-90
- Hypotension: <90/60
- Hypertension: >140/90

**Heart Rate:**
- Normal: 60-100
- Tachycardia: >100
- Bradycardia: <60

**Temperature:**
- Normal: 36.5 - 38.5
- Fever: >38.5
- Hypothermia: <36.5

**Sedation Score:**
- Awake: 1
- Confused: 2
- Unconscious: 3

**Pain Scale:**
- 0 = no pain
- 10 = worst pain

---

**MET Criteria**

Dial “8” or use Code Blue Button
- Any observation in the 4MET zone
- Sudden drop in level of consciousness
- Airway threat
- Respiratory or cardiac arrest
- Any patient you are worried about that does not fit the above criteria

**4MET**

- Modified Early Warning Scores
- 0
- 1
- 2
- 3
- 4MET

---

**Tick box if variances apply**
- Pain
- Sedation

---

**Tick box if variances apply**
- Frequency of observations apply
**Case 2**

**UR Number:** 123 412
**Family name:** EASTWOOD
**Given name:** CINT

**Date/Time:**

**Frequency required:**

**Medical officer name:**

**Signature:**

### Variance to MEWS in Patients with a Chronic Condition:

Where a patient has a pre-existing chronic condition that may require variance from the normal scoring of MEWS document the reason accepted range for the adjusted vital sign below. Agreement with the admitting Consultant or Registrar is required. Variance must also include a “valid until” date.

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>MEWS</th>
<th>Acceptable Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen Saturation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Variance to MET in Patients with a Chronic Condition:**

Where a patient has a pre-existing chronic condition that may require variance from the normal MET criteria document the revised accepted MET criteria for the adjusted vital sign below. Agreement with the admitting Consultant or Registrar is required. Variance must also include a “valid until” date.

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>MET</th>
<th>Acceptable Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
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<td></td>
</tr>
<tr>
<td>Heart Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Communication for MEWS ≥ 4

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Actions/Comments</th>
<th>Print name</th>
<th>Signature</th>
</tr>
</thead>
</table>

**Additional Observations**

**Date:**

**Time:**

**Blood Glucose Level (mmol/L):**

**Weight (kg):**

**Blood Pressure:**

**General Instructions:**
- Vital sign values must be recorded in the correct row as identified by its range.
- Observations must be represented graphically.
- For a vital sign in the extremes of a range i.e. RR ≥ 36, write the number.
- If vital sign falls in coloured area refer to MEWS legend to determine score.
- Add all scores to calculate Total MEWS.
- For MEWS ≥ 4 refer to MEWS Escalation Table.