Case Study 4
Facilitator Card

CASE 4 (BGL)

- The important things to get across in this case are:
  - Glucose should be the first measure done if there is any change in mental state or alertness (including confusion/aggression/drowsiness)
  - If the patient is conscious they should receive glucose tablets and a drink
  - If unable to swallow IMI Glucagon could be administered
  - If the patient is unconscious they should receive IV glucose (need large vein to give concentrated glucose), thus IV access would be required
  - Oxygen should be applied
  - Aftercare after the initial bolus of glucose:
    - Ongoing BGL monitoring more frequently
    - Monitor oral intake
    - Reassess with medical staff the next scheduled dose of Hypoglycaemic medication.
  - If the patient proceeds to a seizure the important thing in this case is still glucose and oxygen

- Princeton is drowsy and disorientated. The cause for this an altered mental state is due to low BGL. Resulting from increased doses of his Gliclazide medication; also while not eating. Thus, needing glucose to be administered to rectify low BGL.

- Vital Signs
  - The change in the patient’s vital signs are reflective of the patients changing condition of decreased glucose delivery.
    - Increase in Sedation Score, Heart Rate and Respirations are symptomatic (or compensatory) changes in vital signs due to the hypoglycaemic event. BGL being the conclusive observation.
  - Med chart
    - Gliclazide – charted and given last evening in ED, despite patient not eating.
  - Patient history
    - Decreased intake and may have taken additional glicazide.
  - BGL chart
    - Commenced in ED, but trends not evident, due to limited admission time.
  - ABG – due to changes in RR and Saturations.
    - Essentially normal.
Case 4
Aim: To recognise a deteriorating medical patient

Group Objectives:
- Obtain adequate history
- Obtain vital signs as part of the assessment process
- Refer appropriately
- Communicate effectively
- Consider safety when caring for a confused patient

Equipment:
- Facilitator Card
- Player 1 Card – Patient
- Player 2 Card - Nurse
- IV Cannula
- Mini-jet of glucose/glucagon injection
- Medication Chart
- Blood Test results
- Observation chart
- Fluid balance chart not available
- Blood Glucose Monitoring Chart
- Communication Card
- Scribing Code Blue Form (Optional)

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

During the Scenario

The Nurse should seek help from nursing staff. If this does not occur prompt

If staff do not check BGL and initiate glucose the patient should become drowsier and have a seizure. The patient will

Scenario
Princeton Elvis
UR 1234510

Princeton Elvis is a 38-year-old patient who has been admitted to PSU for investigation of an acute psychotic episode.

Medical History: Type 2 Diabetes, ETOH.

He presented to ED yesterday, and was transferred to the mental health unit last evening.

This morning, the nurse is on morning rounds and seeing to princeton.

To start the scenario:
1. Assign roles to each player
2. Set up room with the patient in a chair or bed
3. Give the first player card to the player designated as the Patient
4. Give the Second player card to the player designated as the Nurse
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

Intern comes to review the patient:
1. What assessment would you do? (Prioritise)
   - Examination
   - BGL

2. What is your management plan for this patient?
   - Oxygen
be aware of this and you can initiate this by taping them on the shoulder. If they do ask for a BGL it is 1.2

If the Nurse needs prompting:
1. What are your first actions & who would you notify?
   - Patient Safety
   - Notify TL

   The Nurse should discuss the case face-to-face with the TL

   Communication should be clear, expressing concerns and what he/she would like the TL to do

If the RN needs prompting:

1. What observations are required?
   - Vital Signs
   - BGL

2. Who do you need to notify?
   - The RN should contact the intern
   - ? MET

Facilitator should place RN and Intern back-to-back to simulate phone conversation

In the phone call the RN should:
- Describe the patients history
- State what she would like the intern to do: i.e. come and review the patient

- IV
- Glucose IV 50 mls of 50 %
- IV maintenance
- BGL monitoring ½ hourly and repeat Glucose as necessary

Questions:
1. What are your next actions as a group?
   - Plan ongoing management
     - Diabetic education
     - Dietician
     - Medical

2. How often should observations be observed?
   - ½ hourly for 2 hour then hourly for 4 hours
   - BGL should be monitored with vital signs

To summarise

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

Take Home Messages Case 4
1. Always do a BGL if the pt is confused
2. Communication - SBAR
3. Full assessment & management
**Player 1**

**Consumer**

You are Princeton Elvis, a 58-year-old consumer. You are undergoing treatment for Schizophrenia.

You have poor eating habits, and you have not been taking your usual medications. Instead you have been stashing these tablets. Today, you impulsively consumed some of these tablets.

As a result you have become drowsy and disorientated.

*The nurse comes into your room to find you, but if the nurse interacts with you, you will not be able to respond appropriately.*

**Player 2**

**Nurse**

You are caring for Princeton Elvis, a 58-year-old consumer. He is undergoing treatment for Schizophrenia.

You enter Princeton’s room to find him drowsy and disorientated.

*What are your actions/interventions?*
You are caring for Princeton Elvis, a 58-year old consumer. He is undergoing treatment for Schizophrenia.

The nurse has contacted you regarding your patient.

The first item on your agenda:

You need to make sure the communication provided to you by the nurse is clear. Below is an ISBAR to utilise as a guide regarding the information you are being provided. You may need to prompt or ask questions of the nurse to obtain this information.

-------------------------------------------------------------------------------------------------------

At this point you should be satisfied with the information provided to you by the nurse.

You need to devise a management plan for this patient. However, if you are unsure you may contact the consultant for assistance!

The nurse will initiate a conversation, but you must ensure that you receive this information in accordance with ISBAR.

Use the questions/information below to guide the communication presented by the nurse. Hence, prompt or ask the nurse questions to enhance the communication utilising the ISBAR method of communication.

**Identifying**
Has the nurse introduced him/herself?
Has the nurse clarified who you are (and your name)?
Has the nurse identified the patient being discussed?

**Situation**
Has the nurse described the predicament or concern regarding this patient?
Has the nurse obtained vital signs?
If the nurse proceeds to inform you of the vital sign numerical values, interrupt as you are not interested in the values. Instead ask the nurse for their interpretation of these vital signs. A
good answer will consist of concerns around oxygen delivery, however you will also accept any information or concerns around failing physiology.

**Background**
As this patient's doctor, you are already aware of his background. However, you are happy to receive any additional information the nurse may provide.

**Assessment**
You seek the opinion of the nurse regarding what he/she thinks is wrong.
If the nurse has not conveyed what he/she thinks is wrong, ask for their opinion.

**Recommendation**
What does the nurse think or want done?
Or
What does the nurse want from you?

ISBAR (guide) – RMO to Consultant
My name is______.
Are you Dr.______?
I need to speak to you about Princeton Elvis.

Princeton was found in his room drowsy and disorientated. His vital signs show Tachypnoea and Tachycardia indicating a compensatory response attempting to maintain adequate oxygen delivery. His oxygen saturation remains uncompromised.

He has been compliant with his treatment regime.

However, he is at risk of further deterioration. Causation for his deterioration is currently unknown.

He may need to be transferred to an acute facility for further investigations.
Player 4
Consultant
You are caring for Princeton Elvis, a 58-year old male consumer. He is undergoing treatment for Schizophrenia.
He has a history of Type 2 Diabetes Mellitus.
-----------------------------------------------
You are involve in this scenario, because the RMO has contacted you seeking your advice.

Share with the group, your advice:
What you believe is the cause:
This patient is having a hypoglycaemic event secondary to an overdose of Glyclazide. He needs immediate administration of glucose.
The ongoing management for this consumer:
Supervision during the administration of medications.
Supervision at meal times.
Regular BGL monitoring.
Involvement in therapeutic sessions and support coinciding with the needs of the consumer.
## Case Study 4

### Blood Results

<table>
<thead>
<tr>
<th>ABG</th>
<th>Value</th>
<th>Normal range</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>7.42</td>
<td>7.35-7.45</td>
</tr>
<tr>
<td>PO2</td>
<td>105</td>
<td>80-100</td>
</tr>
<tr>
<td>PCO2</td>
<td>40</td>
<td>35-45</td>
</tr>
<tr>
<td>HCO3</td>
<td>23</td>
<td>22-26</td>
</tr>
<tr>
<td>BE</td>
<td>-3</td>
<td>-2.4+-2.3</td>
</tr>
<tr>
<td>SaO2</td>
<td>95</td>
<td>95-98%</td>
</tr>
<tr>
<td>Glucose</td>
<td>1.2</td>
<td>3.7-5.2</td>
</tr>
</tbody>
</table>
The Canberra Hospital
Diabetic Chart

Admission Insulin: ____________________________
OHA: ____________________________

Height (cm)  Weight (kg)  BMI  IBW (kg)

BP: Lying  Standing  Full Urinalysis

Princeton Elvis

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight Kg</th>
<th>Insulin/Tablet</th>
<th>Comments</th>
<th>Blood Glucose</th>
<th>Urine Glu</th>
<th>Ket</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**MEWS Escalation Table**

<table>
<thead>
<tr>
<th>MEWS</th>
<th>Note</th>
<th>Escalation</th>
<th>Observations</th>
<th>More hospital escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Vital signs:**
  - HR: 100-110 bpm
  - RR: 12-20
  - BP: 120/80

- **MEWS 5 - 7**
  - Consider MET if no improvement.

- **MEWS 4 - 5**
  - If no improvement, consider MET.

**MET Criteria**

- **Dial 88** 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

**Pain Scale**

0 = no pain – 10 = worst pain

- **Tick box if a variance applies**
- **Tick box if a variation is required**
- **Tick box if a variation is required**
- **Tick box if a variance applies**
- **Tick box if a variation is required**
- **Tick box if a variance applies**

**COMPASS©**

09/04/2018
## General Observation Chart - Adult

### 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 revised 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>Normal</th>
<th>Revised Accepted Range</th>
<th>Date</th>
<th>Time</th>
<th>Valid until</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
<td>&gt; 8</td>
<td>8-10</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Oxygen Saturation</td>
<td>&gt; 94</td>
<td>92-96</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>&gt; 8</td>
<td>60-120</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Systolic BP &gt; 180</td>
<td>Diastolic BP &gt; 110</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</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 a variance from the normal MET criteria document the revised 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. (EXAMPLE: accept BP down to 80 mmHg as long as alert, warm, passing urine and heart rate not greater than 100.)

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Normal</th>
<th>Revised Accepted Range</th>
<th>Date</th>
<th>Time</th>
<th>Valid until</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
<td>&gt; 8</td>
<td>8-10</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Oxygen Saturation</td>
<td>&gt; 94</td>
<td>92-96</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>&gt; 8</td>
<td>60-120</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Systolic BP &gt; 180</td>
<td>Diastolic BP &gt; 110</td>
<td>Date:</td>
<td>Time:</td>
<td>Valid until:</td>
</tr>
</tbody>
</table>

### Communication for MEWS ≥ 4

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Action/comments</th>
<th>Print name</th>
<th>Signature</th>
</tr>
</thead>
</table>

### Additional Observations

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Blood Glucose (mmol/L)</th>
<th>Weight (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### General Instructions

- Vital sign value must be recorded in the correct row as identified by its range.
- Observations must be represented graphically.
- For a vital sign in the extreme 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.