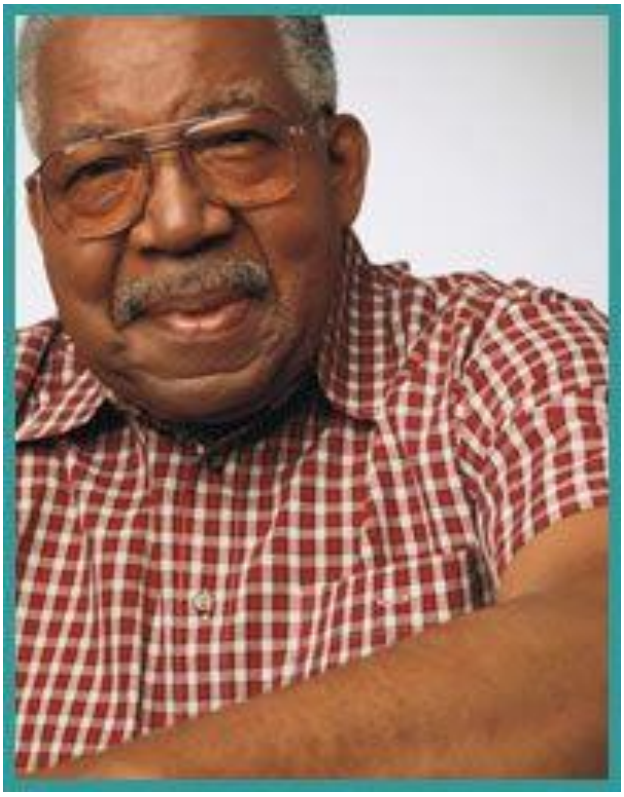
Part I: Emergency Department (ED)

SKINNY Reasoning



John Taylor, 68 years old

Primary Concept			
Infection/Immunity			
Interrelated Concepts (In order of emphasis)			
• Clinical judgment			
NCLEX Client Need Categories	**Covered in Case Study**	**NCSBN Clinical Judgment Model**	**Covered in Case Study**
Safe and Effective Care Environment		Step 1: Recognize Cues	✓
• Management of Care	✓	Step 2: Analyze Cues	✓
• Safety and Infection Control		Step 3: Prioritize Hypotheses	✓
Health Promotion and Maintenance	✓	Step 4: Generate Solutions	✓
Psychosocial Integrity	✓	Step 5: Take Action	✓
Physiological Integrity		Step 6: Evaluate Outcomes	✓
• Basic Care and Comfort	✓		
• Pharmacological and Parenteral Therapies	✓		
• Reduction of Risk Potential	✓		
• Physiological Adaptation	✓		

Initial Triage Assessment in ED

Present Problem:

John Taylor is a 68-year-old African-American male with a history of type II diabetes and hypertension who came to the emergency department (ED) triage window because he felt crummy; complaining of a headache, runny nose, feeling more weak, "achy all over" and hot to the touch and sweaty the past two days. When he woke up this morning, he no longer felt hot but began to develop a persistent "nagging cough" that continued to worsen throughout the day. He has difficulty "catching his breath" when he gets up to go the bathroom. John is visibly anxious and asks, "Do I have that killer virus that I hear about on the news?"

Personal/Social History:

John lives in a large metropolitan area that has had over three thousand confirmed cases of COVID-19. He has been married to Maxine, his wife of 45 years and is retired police officer and active in his local church.

1. ***What data from the histories are RELEVANT and must be NOTICED as clinically significant by the nurse?***
   (NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential)

RELEVANT Data from Present Problem:	**Clinical Significance:**
RELEVANT Data from Social History:	**Clinical Significance:**

2. ***What additional clarifying questions does the triage nurse need to ask John to determine if his cluster of physical symptoms are consistent with COVID-19?***

3. ***Based on the clinical data collected, identify what measures need to be immediately implemented using the following clinical pathway.***

4. What type of isolation precautions does the nurse need to implement if COVID-19 is suspected? What specific measures must be implemented to prevent transmission?

Type of Isolation:	**Implementation Components:**

5. What are the six steps in the chain of infection? Apply what is known about COVID-19 to each step.

Six Steps:	**Coronavirus COVID-19:**
1.	
2.	
3.	
4.	
5.	
6.	

6. Is this patient a susceptible host? What step in the chain of infection does proper isolation precautions impact? Why?

Patient Care Begins:

John is brought back to a room. As the nurse responsible for his care, you collect the following clinical data:

Current VS:	**P-Q-R-S-T Pain Assessment:**	
T: 100.3 F/38.8 C (oral)	**P**rovoking/Palliative:	"moving makes it worse"
P: 118 **(**regular)	**Q**uality:	"achy"
R: 20 (regular)	**R**egion/Radiation:	"all over"
BP: 164/88 **MAP**: 113	**S**everity:	5/10
O2 sat: 92% room air	**T**iming:	continuous

1. What VS data are RELEVANT and must be NOTICED as clinically significant by the nurse?

(NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	**Clinical Significance:**

2. What body system(s) will you assess most thoroughly performing a FOCUSED assessment based on the primary/priority problem? Identify correlating specific nursing assessments.

(NCLEX: Reduction of Risk Potential/Physiologic Adaptation)

PRIORITY Body System:	**PRIORITY Nursing Assessments:**

Current FOCUSED Nursing Assessment:	
GENERAL SURVEY:	Appears anxious, body tense
NEUROLOGICAL:	Alert & oriented to person, place, time, and situation (x4), generalized weakness
HEENT:	Head normocephalic with symmetry of all facial features. Lips, tongue, and oral mucosa pink and moist.
RESPIRATORY:	Breath sounds fine dry crackles bilat. with diminished aeration on inspiration and expiration in all lobes anteriorly, posteriorly, and laterally, non-labored respiratory effort, episodic non-productive cough
CARDIAC:	No edema, heart sounds regular, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks, brisk cap refill. Heart tones audible and regular, S1 and S2 noted over A-P-T-M cardiac landmarks with no abnormal beats or murmurs. No JVD noted at 30-45 degrees.
ABDOMEN:	Deferred
GU:	Deferred
INTEGUMENTARY:	Skin hot, dry, intact, normal color for ethnicity. Skin integrity intact, skin turgor elastic, no tenting present.

3. What assessment data is RELEVANT and must be NOTICED as clinically significant by the nurse?

(NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential Reduction of Risk Potential/Health Promotion & Maintenance)

RELEVANT Assessment Data:	**Clinical Significance:**

4. ***Interpreting clinical data collected, what problems are possible? Which problem is the PRIORITY? Why?*** *(NCSBN: Step 2: Analyze cues/Step 3: Prioritize hypotheses/NCLEX: Management of Care)*

Problems:	**Priority Problem:**	**Rationale:**

5. ***What nursing priority(ies) and goal will guide how the nurse RESPONDS to formulate a plan of care?*** *(NCSBN: Step 4 Generate solutions/Step 5: Take action/NCLEX: Management of Care)*

Nursing PRIORITY:		
GOAL of Care:		
Nursing Interventions:	**Rationale:**	**Expected Outcome:**

Caring and the "Art" of Nursing

6. ***What is the patient likely experiencing/feeling right now in this situation? What can you do to engage yourself with this patient's experience, and show that they matter to you as a person?*** (*NCLEX: Psychosocial Integrity)*

What Patient is Experiencing:	**How to Engage:**