WEEK 2: NURSING LESSONS

Day 1: Establish Rapport

Day 2 : Assessment for pain

Day 3 : Interview with a Nurse on Duty

Day 4 : Talking to a Doctor

Day 5 : Charting

How To Build Rapport With Your Patients

Specialist Language Courses

NURSES LEARN ABOUT THERAPEUTIC COMMUNICATION AND RELATIONSHIPS IN NURSING SCHOOL, BUT IN THE FAST-PACED, REAL WORLD OF NURSING, SOME THINGS FALL THROUGH THE CRACKS. MAKING POSITIVE CONNECTIONS WITH YOUR PATIENTS IS WORTH YOUR TIME. THE BENEFITS FOR THE PATIENT EXPERIENCE AND SAFER CARE ARE HUGE, AND YOU'LL PROBABLY FEEL BETTER ABOUT YOUR WORK, TOO!

INTRODUCE YOURSELF

INTRODUCING WHO YOU ARE AND YOUR ROLE ON THE CLINICAL TEAM IS IMPORTANT FOR BUILDING A POSITIVE NURSE-PATIENT RELATIONSHIP. IT SHOWS YOUR PATIENT THAT YOU WANT THEM TO KNOW EXACTLY WHO YOU ARE AND WHAT YOU'LL BE DOING TO CARE FOR THEM.

UNLESS YOUR PATIENT IS ASLEEP AND YOU DON'T WANT TO WAKE THEM UP, INTRODUCE YOURSELF IN A SIMPLE WAY. FOR EXAMPLE: "HI, MR. SMITH. MY NAME IS BETH BOYNTON AND I'LL BE YOUR NURSE FOR THE NEXT EIGHT HOURS. WHAT NAME DO YOU LIKE TO BE CALLED?"

REMEMBER, NURSES NATURALLY TOUCH PATIENTS AND DO THINGS IN THEIR PERSONAL SPACE. WE DO THINGS 'TO THEM', AND THIS CAN FEEL LIKE AN INVASION OF PRIVACY. CAN YOU IMAGINE HOW IT MIGHT FEEL FOR SOMEONE TO COME INTO YOUR ROOM AND START CHECKING YOUR BLOOD PRESSURE WITHOUT KNOWING WHO THEY ARE AND WHAT THEIR JOB IS?

LISTENING MEANS ASSESSING *AND* UNDERSTANDING

MOST OF US ARE EXPERTS AT LISTENING TO A PATIENT'S LUNG AND BOWEL SOUNDS, AS WELL AS THEIR ANSWERS TO OUR QUESTIONS ABOUT SYMPTOMS. BUT WE DON'T ALWAYS LISTEN IN A WAY THAT BUILDS OUR UNDERSTANDING OF WHERE OUR PATIENTS ARE COMING FROM OR WHAT'S TRULY ON THEIR MINDS.

AT SOME POINT DURING PATIENT CARE -- AND THE SOONER THE BETTER -- PUT DOWN YOUR PEN OR COMPUTER AND JUST LISTEN.

VALIDATE FEARS, DESIRES, OR OTHER CONCERNS

WHEN YOU VALIDATE WHAT YOUR PATIENT SAYS, YOU'RE TELLING THEM THAT YOU HEAR AND UNDERSTAND THEIR CONCERNS, BUT YOU'RE NOT TELLING THEM WHAT YOU THINK THEY SHOULD DO ABOUT IT.

A CLASSIC EXAMPLE COMES FROM WORKING WITH PATIENTS WITH DEMENTIA WHO FREQUENTLY SAY THINGS LIKE, "*I WANT TO GO HOME!*" RESPONDING WITH "*THIS IS YOUR HOME*" OR "*YOU CAN'T GO HOME*" OR "*HAVE SOME ICE CREAM*" ARE ALL INVALIDATING.

INSTEAD, SAY THINGS LIKE, "*YOU SEEM SAD THAT YOU'RE NOT HOME*" OR "*GOING HOME IS REALLY IMPORTANT TO YOU, ISN'T IT?*" BY DOING THIS, YOU'RE SHOWING THEM THAT YOU RESPECT HOW THEY FEEL, EVEN IF YOU CAN'T HELP THEM IN THE WAY THEY'D LIKE.

BY VALIDATING YOUR PATIENT'S FEELINGS, YOU OPEN THE DOOR TO LEARNING MORE ABOUT THEIR FEELINGS AND EXPERIENCE, AND THIS CAN IMPROVE CARE.

DO WHAT YOU SAY YOU'RE GOING TO DO

WE ALL KNOW THAT WAITING IS STRESSFUL, ESPECIALLY WHEN YOU FEEL VULNERABLE. BE HONEST WITH YOUR PATIENTS ABOUT WHEN YOU'LL BE BACK WITH PAIN MEDICINE OR TO PROVIDE ANYTHING ELSE THEY'VE ASKED FOR. IF A PATIENT CAN'T WAIT (FOR EXAMPLE URGENT TOILETING THAT REQUIRES A TWO-PERSON TRANSFER), LET YOUR SUPERVISOR KNOW THAT YOU NEED HELP RIGHT AWAY.

NEVER BE DEFENSIVE WITH PATIENTS ABOUT WHY YOU AREN'T MORE AVAILABLE, AND DEFINITELY DON'T COMPLAIN ABOUT STAFFING ISSUES TO THEM. YOUR CONCERNS ARE REAL, BUT YOU SHOULD SHARE THEM WITH YOUR SUPERVISOR, NOT YOUR PATIENTS.

LEARN ABOUT LIFE OUTSIDE THE HOSPITAL

NURSES ARE LUCKY TO MEET PEOPLE FROM EVERY WALK OF LIFE. ASK YOUR PATIENTS WHAT THEY DO IN THEIR REGULAR LIVES, WHAT THEIR INTERESTS ARE, AND WHERE THEY'RE FROM. THIS SHOWS YOUR PATIENTS THAT THEY'RE MORE TO YOU THAN JUST THE GALLBLADDER IN ROOM 222 OR THE NEW DIABETIC IN 14B.

TAKE A LITTLE EXTRA TIME TO CONNECT WITH YOUR PATIENTS IN POSITIVE WAYS AND BUILD TRUSTING RELATIONSHIPS. PATIENTS WILL FEEL CARED FOR AND BE MORE HONEST AND OPEN WITH YOU.

WHEN YOU PRACTICE NURSING IN THIS WAY, YOU WON'T BE JUST ANOTHER NURSE. INSTEAD, YOU'LL BE A NURSE THEY'LL BE GRATEFUL TO FOR SHOWING THAT YOU ACTUALLY CARE ABOUT THEM AS HUMAN BEINGS.

7 WAYS TO BUILD RAPPORT WITH PATIENTS

1. Maintain Eye Contact

Maintaining eye contact communicates care and compassion. It can also show empathy and interest in your patient's situation. Eye contact and social touch connects you to your patients and communicates understanding.

2. Show Empathy

Empathy is the ability to understand the patient's situation, perspective and feelings. It allows you to deliver more personalized patient care. The empathetic nurse communicates and acts on their understanding of the patient.

3. Open Communication

One study found good communication to be a key factor in improving patient outcomes. Understanding your patient's communication preferences and state of mind will help build rapport. Informing your patient of new orders or changes in their condition is one way to do this.
Encouraging your patient to share their feelings with you is another. Open communication is one of the most essential nurse communication skills needed for success.

4. Make it Personal

Being a patient can be scary. To help ease their stay, take the time to get to know your patients. Ask about their friends and family, hobbies, and other important aspects of their life.

This communicates your desire to understand them as a person, not only as a patient. This is an easy way to learn how to build rapport with your patients.

5. Active Listening

Active listening is an essential holistic healthcare tool. It is a non-intrusive way of sharing a patient's thoughts and feelings. To practice active listening, follow these steps:

- Listen to what the patient is saying.
- Repeat what you heard to the patient.
- Check with the patient to ensure your reflection is correct.

The goal of active listening is to reflect the feeling or intent behind their words. You should listen to understand, not to respond. Practice active listening as one of several ways to build rapport.

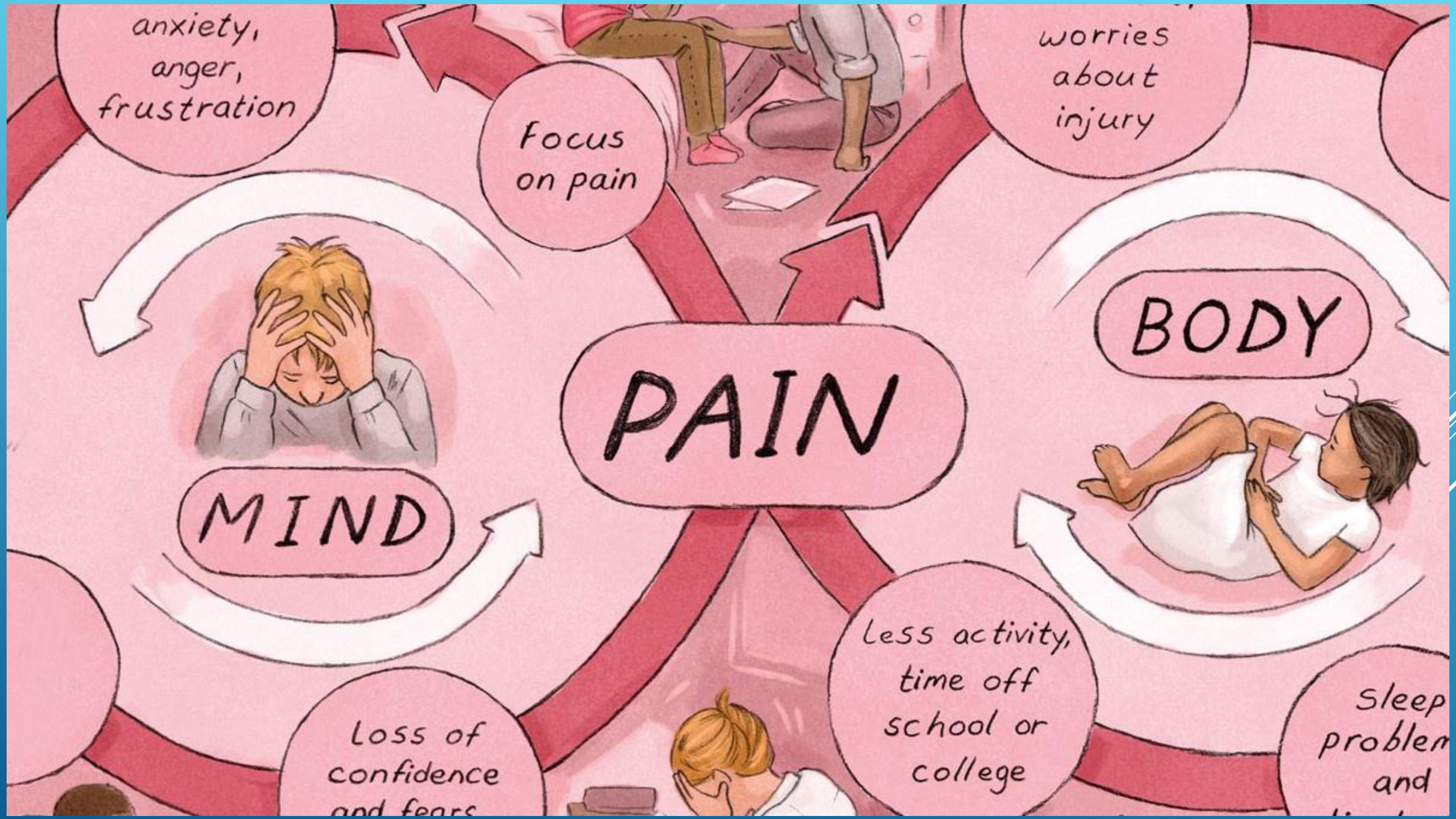
6. Practice Mirroring

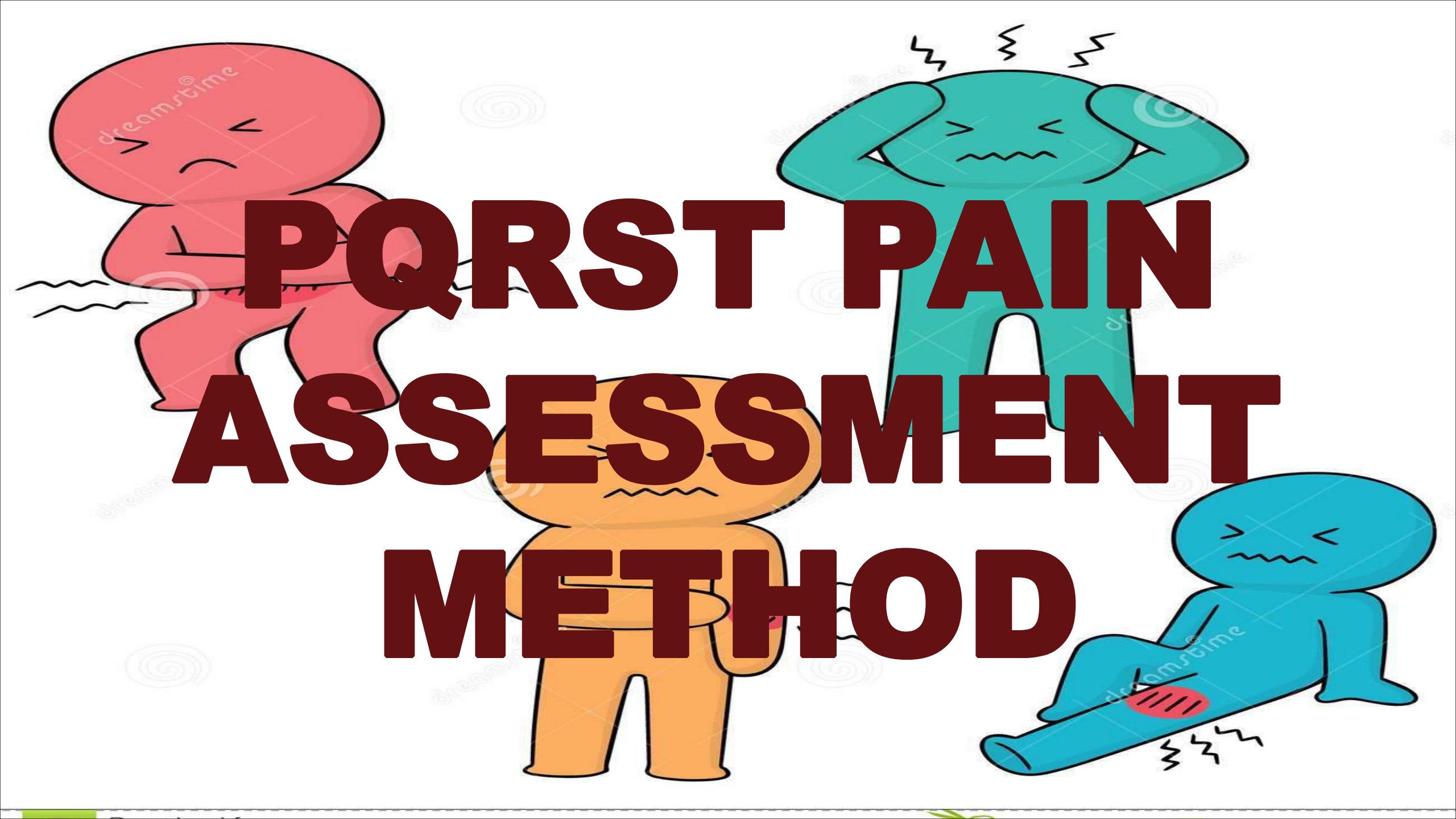
Matching the patient's demeanor, disposition, and rhythm quickly establishes rapport. This may even mean raising your voice to match a loud patient to create a synchronized bond.

Then, with a low voice and measured movements, lead the patient to a better place. Use mirroring to become attuned to the patient during difficult conversations.

7. Keep Your Word

Keeping your word is one of the most effective ways to build rapport with patients. If you tell them you will do something, do it. If your ability to complete a task changes, communicate this with the patient. Don't over-promise and under deliver. Keeping your word with patients not only builds rapport, it also builds trust.


anxiety, anger, frustration
Focus on pain
worries about injury
PAIN
MIND
BODY
Loss of confidence and fears
less activity, time off school or college
Sleep problem and


PQRST PAIN
ASSESSMENT
METHOD


GoAnimate
Go Make Your Own

PQRST PAIN ASSESSMENT METHOD

SINCE PAIN IS SUBJECTIVE, SELF-REPORT IS CONSIDERED THE GOLD STANDARD AND MOST ACCURATE MEASURE OF PAIN. THE PQRST METHOD OF ASSESSING PAIN IS A VALUABLE TOOL TO ACCURATELY DESCRIBE, ASSESS AND DOCUMENT A PATIENT'S PAIN.

P = PROVOCATION/PALLIATION

WHAT WERE YOU DOING WHEN THE PAIN STARTED? WHAT CAUSED IT? WHAT MAKES IT BETTER OR WORSE? WHAT SEEMS TO TRIGGER IT? STRESS? POSITION? CERTAIN ACTIVITIES?

WHAT RELIEVES IT? MEDICATIONS, MASSAGE, HEAT/COLD, CHANGING POSITION, BEING ACTIVE, RESTING?

WHAT AGGRAVATES IT? MOVEMENT, BENDING, LYING DOWN, WALKING, STANDING?

Q = QUALITY/QUANTITY

WHAT DOES IT FEEL LIKE? USE WORDS TO DESCRIBE THE PAIN SUCH AS SHARP, DULL, STABBING, BURNING, CRUSHING, THROBBING, NAUSEATING, SHOOTING, TWISTING OR STRETCHING.

R = REGION/RADIATION

WHERE IS THE PAIN LOCATED? DOES THE PAIN RADIATE? WHERE? DOES IT FEEL LIKE IT TRAVELS/MOVES AROUND? DID IT START ELSEWHERE AND IS NOW LOCALIZED TO ONE SPOT?

S = SEVERITY SCALE

HOW SEVERE IS THE PAIN ON A SCALE OF 0 TO 10, WITH ZERO BEING NO PAIN AND 10 BEING THE WORST PAIN EVER?
DOES IT INTERFERE WITH ACTIVITIES?
HOW BAD IS IT AT ITS WORST? DOES IT FORCE YOU TO SIT DOWN, LIE DOWN, SLOW DOWN? HOW LONG DOES AN EPISODE LAST?

T = TIMING

WHEN/AT WHAT TIME DID THE PAIN START? HOW LONG DID IT LAST? HOW OFTEN DOES IT OCCUR: HOURLY? DAILY? WEEKLY? MONTHLY? IS IT SUDDEN OR GRADUAL? WHAT WERE YOU DOING WHEN YOU FIRST EXPERIENCED IT? WHEN DO YOU USUALLY EXPERIENCE IT: DAYTIME? NIGHT? EARLY MORNING? ARE YOU EVER AWAKENED BY IT? DOES IT LEAD TO ANYTHING ELSE? IS IT ACCOMPANIED BY OTHER SIGNS AND SYMPTOMS? DOES IT EVER OCCUR BEFORE, DURING OR AFTER MEALS? DOES IT OCCUR SEASONALLY?

INTERVIEW WITH A NURSE ON DUTY

Put your possible Questions for the Interview here.

TALK TO A DOCTOR

Given a case study report to a doctor the case of your patient.

Watch the samples below.

Introduction

Situation

Background

Assessment

Recommendation

Introduction

Situation

Background

Assessment

Recommendation

SCENARIO:

MRS. GHUMAN IS A 56-YEAR-OLD WOMAN WHO WAS DIAGNOSED WITH HEART FAILURE 4 YEARS AGO. SHE HAS BEEN ADMITTED TO THE HOSPITAL FOR SHORTNESS OF BREATH (SOB). SHE STATES “I WAS TAKING A DIURETIC AT HOME BUT RAN OUT 2 DAYS AGO. 1 HAVE NOT BEEN ABLE TO REFILL MY PRESCRIPTION”. SHE COMPLAINS OF DIFFICULTY BREATHING AND HAS NOTICED SOME SWELLING IN HER FEET THAT SEEMED WORSE THAN USUAL. ON PHYSICAL EXAMINATION, YOU OBSERVE THAT SHE IS ALERT AND ORIENTED TO PERSON, PLACE, AND TIME. FOR RESPIRATORY ASSESSMENT, SHE HAS SOB ON EXERTION; OXYGEN SATURATION IS 89% ON ROOM AIR. ON AUSCULTATION, YOU HEAR FINE CRACKLES BILATERAL IN THE LOWER LOBES. WHEN ASSESSING HER LOWER EXTREMITIES, YOU FINE 2+ EDEMA BILATERALLY. VITAL SIGNS ARE: T- 37.0, BP – 130/85, P – 120, R- 35/MIN.

“You find that you want further guidance in what should be done next with your client. You decide to call a doctor in the unit next to yours, and consult with him on the situation. What do you tell him?

S C E N A R I O :

MRS. SINGH IS AN 80 YEAR OLD FEMALE WITH A LEFT CEREBROVASCULAR ACCIDENT (CVA) WHO HAS BEEN IN A LONG TERM CARE FACILITY FOR THE PAST10 YEARS. SHE IS IMMOBILE AND HAS TO BE TRANSFERRED WITH THE MECHANICAL LIFT. HER NUTRITIONAL NEEDS ARE MET WITH 6 CANS OF ISOSOURCE VIA G TUBE @ 50 MLS /HOUR. YOU ARE ASSIGNED TO MRS. SINGH ON THE EVENING SHIFT AND YOU PROVIDED HYGIENE CARE AND REPOSITIONED HER. MRS SINGH'S ROUTINE MEDICATIONS WERE ADMINISTERED AT 1800HR. HER G FEED (1 CAN ISOSOURCE) IS ALSO IN PROGRESS. AT 2000HR, WHEN YOU APPROACH MRS SINGH'S BED, YOU HEAR HER COUGHING, RESPIRATIONS ARE NOISY AND HER FACE IS FLUSHED. HER VITAL SIGNS ARE T39, 110 BPM, R 32 /MIN, BP 150/90 AND SP02-86% ON ROOM AIR.

"You find that you want further guidance in what should be done next with your client. You decide to call a doctor in the unit next to yours, and consult with him on the situation. What do you tell him?

INTRODUCTION	• State your name, designation, ward/unit • State the patient's name, age, sex and/or Admitting Doctor
SITUATION	• "I am calling about" - state the reason for the call or referral • Explain what happened to trigger this conversation • High stakes – medical emergency – time dependent • Articulate your concern
BACKGROUND	• State age sex and reason for admission • History of current problem • State any **relevant** medical, surgical or social background • A brief synopsis of treatment to date
ASSESSMENT	• State the patient's current vital signs and observations, outline what is recorded on the chart • Explain what you think the problem is or what possibilities you are considering • State what you have done for the patient so far
RECOMMENDATION / RESPONSE	• **SO WHAT? Or WHERE TO FROM HERE** • This can include your recommendation, or you can be refer to seeking the other persons recommendation. • State what you are looking for from the other person " I need you to review the patient" (PROVIDE A TIME FRAME) or " I need a management plan for this patient" • READ BACK OR REPEAT WHAT WAS SAID TO CONFIRM WHAT YOU HEARD


Charting for
Nurses
RNspeak.com

F-DAR CHARTING

IT IS A METHOD OF CHARTING NURSES USE, ALONG WITH OTHER DISCIPLINES, TO HELP FOCUS ON A SPECIFIC PATIENT PROBLEM, CONCERN, OR EVENT. IT IS GEARED TO SAVE TIME AND DECREASE DUPLICATE CHARTING. IT IS A GREAT CHARTING METHOD FOR NURSES WHO HAVE A LOT OF PATIENTS AND IS EASIER READ BY OTHER PROFESSIONALS. IT GIVES OTHER PROFESSIONALS A SNAPSHOT OF WHAT WENT ON DURING YOUR SHIFT IN A CONCISE MANNER

EXAMPLES

Date/Time	Focus	Progress Note
10/30/2015 0800 0900	Pain	D:) Patient requested pain medication for incisional pain in right groin. Patient is 1 day status post right heart cath. Rates pain 8 on 1-10 scale. A:) Administered Lortab 5/325 mg PO. R :) Patient now rates pain 2 on 1-10 scale.---------- ----------N. Nurse RN

WHAT DOES THE FDAR STAND FOR?

F (FOCUS): THIS IS THE SUBJECT/PURPOSE FOR THE NOTE. THE FOCUS CAN BE:

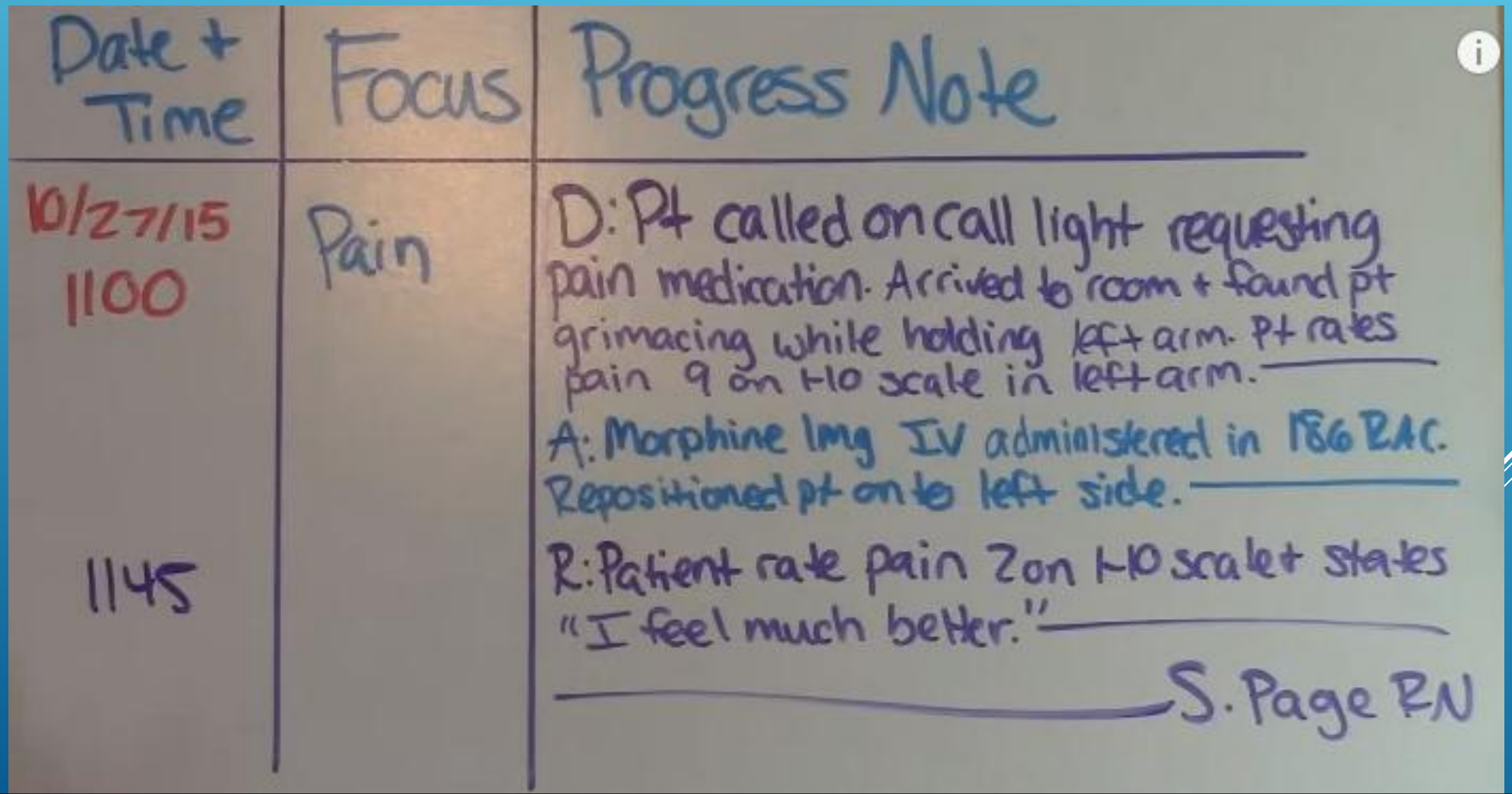
- NURSING DIAGNOSIS
- EVENT (ADMISSION, TRANSFER, DISCHARGE TEACHING ETC.)
- PATIENT EVENT OR CONCERN (CODE BLUE, VOMITING, COUGHING)

D (DATA): THIS IS WRITTEN IN THE NARRATIVE AND CONTAINS ONLY SUBJECTIVE (WHAT THE PATIENT SAYS AND THINGS THAT ARE NOT MEASURABLE) & OBJECTIVE DATA (WHAT YOU ASSESS/FINDINGS, VITAL SIGNS AND THINGS THAT ARE MEASURABLE). THIS LAYS THE SUPPORTING EVIDENCE FOR WHY YOU ARE WRITING THE NOTE. YOU ARE LETTING THE READER KNOW "THIS IS WHAT THE PATIENT IS SAYING AND WHAT I'M SEEING".

A (ACTION): THIS IS THE "VERB" AREA. IN THIS SECTION, YOU ARE GOING TO WRITE HERE WHAT YOU DID ABOUT THE FINDINGS YOU FOUND IN THE DATA PART OF THE NOTE. THIS INCLUDES YOUR NURSING INTERVENTIONS (CALLING THE DOCTOR, REPOSITIONING, ADMINISTERING PAIN MEDICATION ETC.)

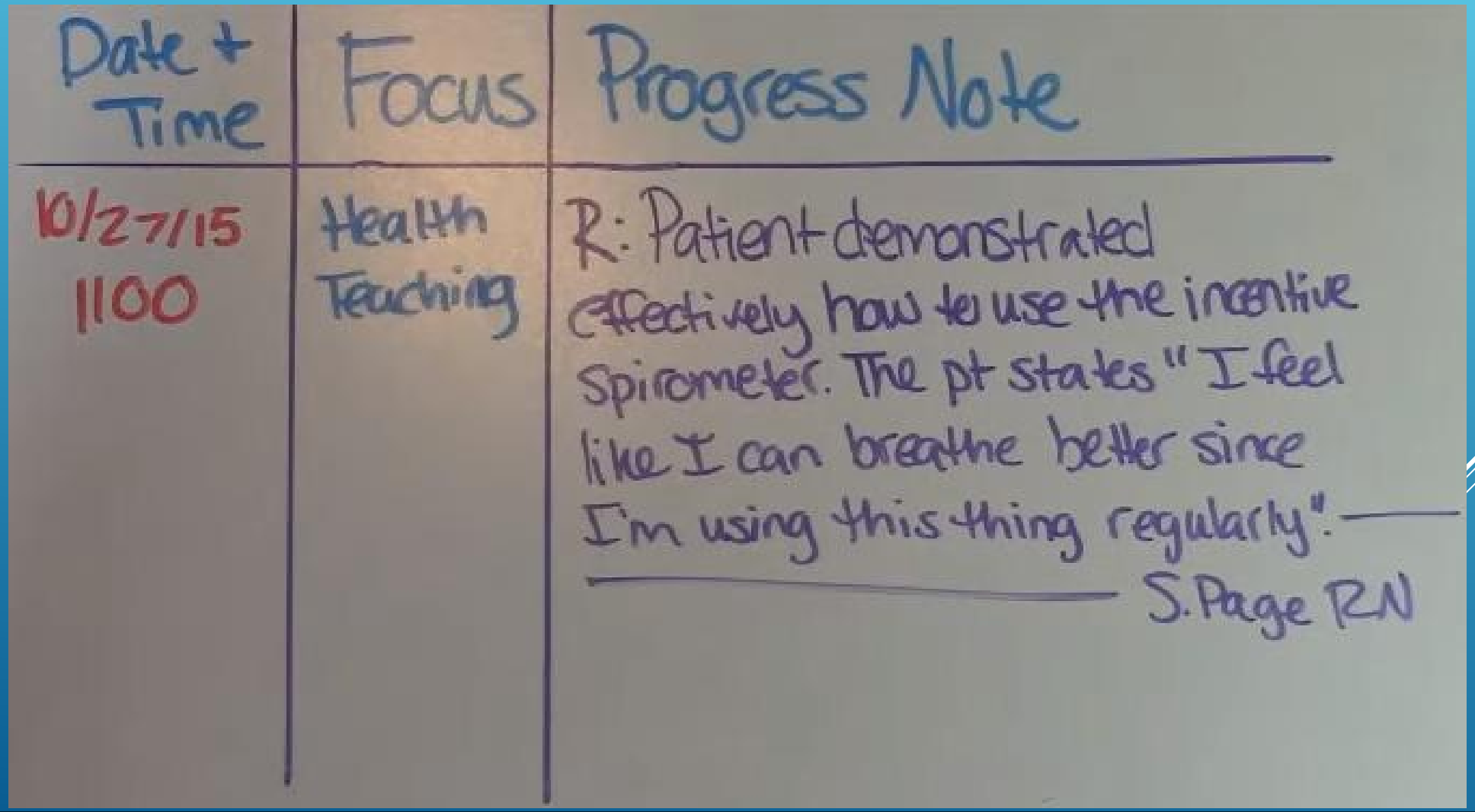
R (RESPONSE): THIS IS WHERE YOU WRITE HOW THE PATIENT RESPONDED TO YOUR ACTION. SOMETIMES, YOU WON'T CHART THE RESPONSE FOR *SEVERAL MINUTES OR HOURS LATER*.

EXAMPLE 1: THIS IS WHAT IT WOULD LOOK LIKE IF YOU ARE CHARTING A DAR FORMAT AND THE RESPONSE IS WRITTEN LATER. NOTE HOW THE NOTE WAS FIRST WRITTEN AT 1100 AND THE RESPONSE WAS WRITTEN LATER AT 1145.

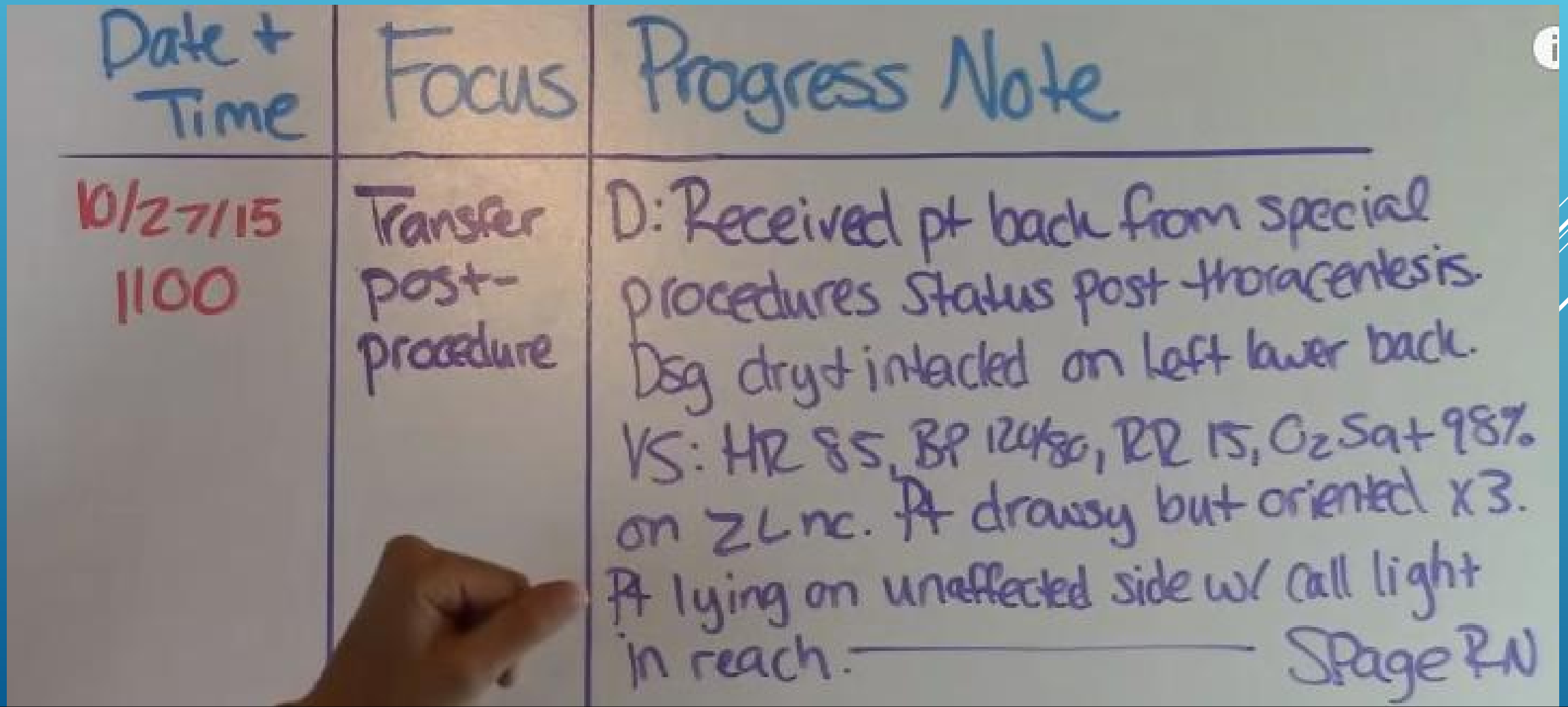


Date + Time	Focus	Progress Note
10/27/15 1100	Pain	D: Pt called on call light requesting pain medication. Arrived to room + found pt grimacing while holding left arm. Pt rates pain 9 on 1-10 scale in left arm. A: Morphine 1mg IV administered in R86 RAC. Repositioned pt onto left side. R: Patient rate pain 2 on 1-10 scale + states "I feel much better." S. Page RN
1145		

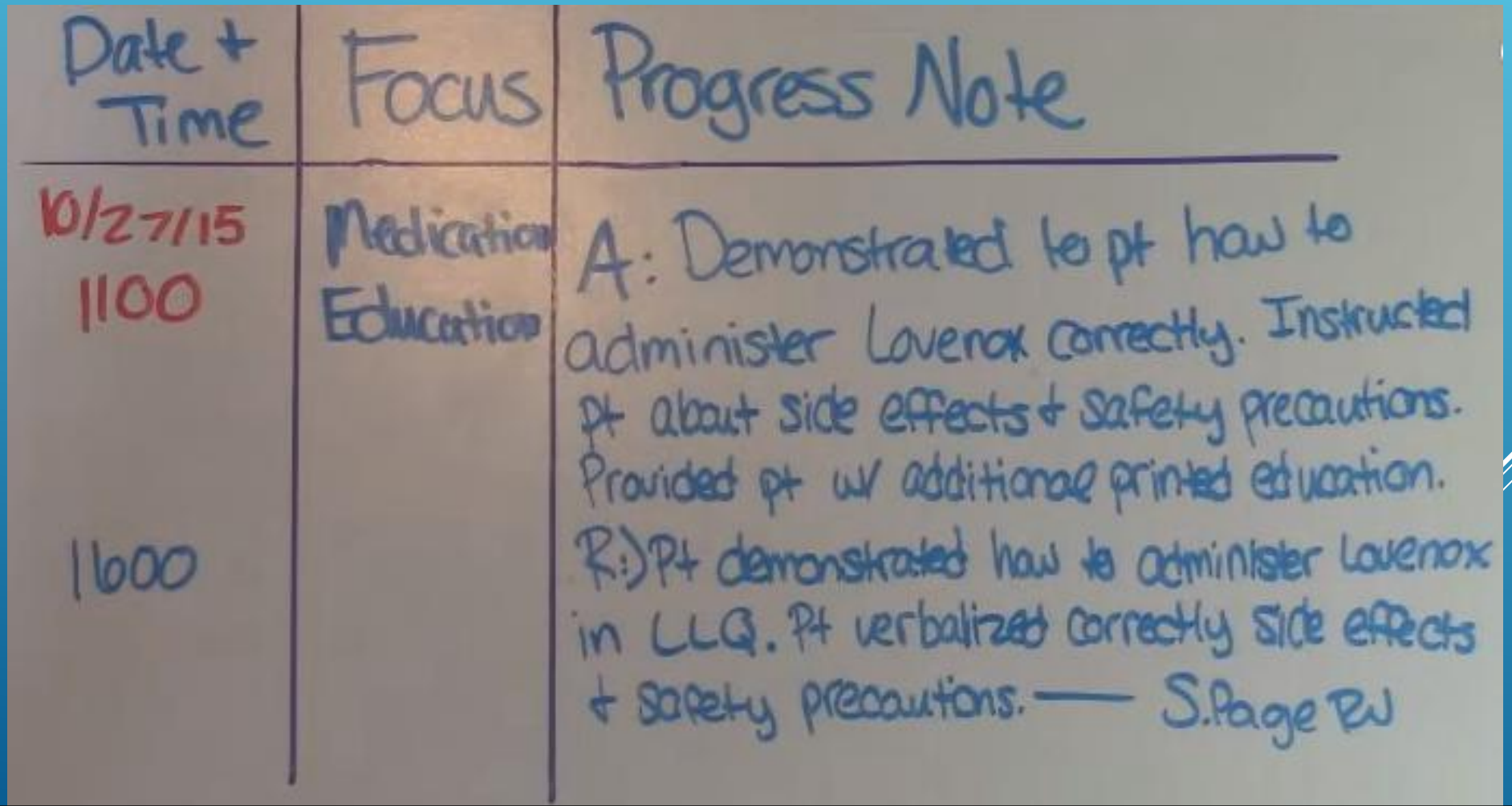
EXAMPLE 2: IN THIS EXAMPLE, I SHOW HOW YOU CAN HAVE JUST AN R (RESPONSE). FOR EXAMPLE, SAY THE PATIENT HAS MET A GOAL ON THE CARE PLAN ON DEMONSTRATING HOW TO PROPERLY USE THE INCENTIVE SPIROMETER. YOU WOULD DOCUMENT JUST THE R (CHARTING THE D AND A WOULD BE REDUNDANT AND POINTLESS)



EXAMPLE 3: IN THIS EXAMPLE, I SHOW HOW YOU CAN CHART JUST A D (DATA). THIS IS USED FOR WHEN YOU DON'T HAVE A FLOW SHEET TO DOCUMENT SOMETHING LIKE A TRANSFER, PROCEDURE, ADMISSION, OR SOMETHING TO THE EQUIVALENT THAT NEEDS TO BE CHARTED. FOR INSTANCES, SAY YOU RECEIVED A PATIENT BACK FROM A THORACENTESIS AND THERE IS NO FLOW SHEET FOR YOU TO DOCUMENT ABOUT RECEIVING THE PATIENT BACK FROM THE PROCEDURE, HERE IS HOW YOU COULD CHART IT.



EXAMPLE 4: IN THIS EXAMPLE, I SHOW HOW YOU COULD CHART BY STARTING WITH ACTION (A) AND RESPONSE (R). YOU WOULD DO THIS IF IT IS UNNECESSARY TO REPEAT THE OBJECTIVE AND SUBJECTIVE DATA AND/OR YOUR INTERACTION WITH THE PATIENT BEGAN WITH AN ACTION. FOR EXAMPLE, THIS IS WHAT YOU WOULD USE FOR DISCHARGE TEACHING OR PATIENT EDUCATION. NOTE HOW THE RESPONSE WAS WRITTEN LATER (AT 1600) WHEN THE PATIENT ACTUALLY DEMONSTRATED THE INJECTION.



Date + Time	Focus	Progress Note
10/27/15 1100	Medication Education	A: Demonstrated to pt how to administer Lovenox correctly. Instructed pt about side effects & safety precautions. Provided pt w/ additional printed education.
1600		R:) Pt demonstrated how to administer Lovenox in LLQ. Pt verbalized correctly side effects & safety precautions. —— S. Page RN

SOAPI NOTE

SUBJECTIVE

SUBJECTIVE REFERS TO THINGS THE PATIENT CAN TELL YOU, AND OFTEN INCLUDES PAIN LEVEL AND FEELINGS OR CONCERNS. IT CAN ALSO REFER TO THINGS A PATIENT'S FAMILY MEMBERS TELL YOU.

OBJECTIVE

OBJECTIVE REFERS TO HARD DATA YOU COLLECT REGARDING THE PATIENT. THIS CAN INCLUDE VITAL SIGNS, LABORATORY RESULTS, OBSERVABLE SIGNS AND SYMPTOMS, AND YOUR PHYSICAL ASSESSMENT FINDINGS.

ASSESSMENT

ASSESSMENT REFERS TO YOUR OVERALL INTERPRETATION OF THE SUBJECTIVE AND ASSESSMENT. IS THE PATIENT IMPROVED SINCE ADMISSION? ARE THERE NEW ISSUES THAT YOU ARE OBSERVING THAT NEED TO BE ADDRESSED? ALL OF THESE THINGS BELONG IN THE ASSESSMENT.

PLAN

PLAN REFERS TO THE PATIENT'S PLAN OF CARE. HOW IS THE MEDICAL TEAM ADDRESSING THE PATIENT'S HEALTH PROBLEMS? ARE THERE UPCOMING TESTS OR BLOOD DRAWS? IS THE PATIENT ON MEDICATIONS TO TREAT A PROBLEM THAT YOU ARE MONITORING A RESPONSE TO? THESE ARE EXAMPLES THAT FALL UNDER THE PLAN.

INTERVENTIONS

INTERVENTION REFERS TO THE THINGS WE ARE DOING FOR THE PATIENT. EXAMPLES OF INTERVENTION CAN INCLUDE TREATMENTS AND MEDICATIONS, AS WELL AS EDUCATION PROVIDED TO THE PATIENT ON YOUR SHIFT.

“S – MR. SMITH IS AN 88 YEAR OLD MALE WITH DIAGNOSIS OF CONGESTIVE HEART FAILURE. THE PATIENT IS ALERT AND ORIENTED X 1 BUT PLEASANTLY CONFUSED. HE DID HAVE COMPLAINTS OF SHORTNESS OF BREATH ON THIS SHIFT AND STATES THE 2 LITERS OF OXYGEN MADE HIM FEEL BETTER. HE VERBALLY DENIED PAIN AND HIS NONVERBAL PAIN SCORE WAS 0. HIS DAUGHTER VISITED TODAY AND ADVISED THAT HE WAS TRYING TO CLIMB OUT OF BED TO GO TO THE BATHROOM BECAUSE OF HIS CONFUSION. SHE STATED HE “FORGOT HE WAS IN THE HOSPITAL.”

O – PATIENT’S VITAL SIGNS TODAY WERE AS FOLLOWS: BP 162/82, PULSE 64 AND REGULAR, RESPIRATIONS 20 PER MINUTE AND PULSE OX 98% ON 2L OXYGEN VIA NASAL CANNULA. HIS LUNGS ARE DIMINISHED WITH SCATTERED CRACKLES. BOWEL SOUNDS ARE ACTIVE AND PATIENT HAD A BOWEL MOVEMENT X 2 TODAY, BOTH SOFT. INCONTINENT OF URINE AND WEARING A DIAPER. SKIN INTACT AT THIS TIME. SKIN COLOR IS PALE. 2+ NON-PITTING EDEMA NOTED IN BILATERAL CALVES AND ANKLES. BNP WAS GREATER THAN 20,000 TODAY.

A – PATIENT’S STATUS IS IMPROVING, AND HE IS LESS SHORT OF BREATH THAN IN PREVIOUS DAYS. HE CONTINUES WITH EDEMA. CURRENTLY THE PATIENT IS AT RISK FOR FALLS DUE TO CONFUSION AND WILL NEED FALL PRECAUTIONS ENFORCED.

P – INITIATE FALL PRECAUTIONS WITH A BED ALARM/BODY ALARM. CONTINUE WITH LASIX FOR DIURESIS. AWAITING CARDIOLOGY CONSULT TOMORROW. PT HAD AN ECHOCARDIOGRAM TODAY AND RESULTS ARE PENDING.

I – ASSESSED PATIENT AND RECONCILED MEDICATIONS. SPOKE WITH DAUGHTER, PT’S POWER OF ATTORNEY, TO PROVIDE UPDATE AND EDUCATION ON PATIENT’S CONDITION. LABORATORY OBTAINED MORNING LABS WITHOUT PROBLEM AND VASCULAR THERAPY PLACED A NEW 18G PERIPHERAL IV AS PREVIOUS ONE WAS DUE FOR A CHANGE. PT TOOK ALL MORNING MEDS WITHOUT PROBLEM. REORIENTED PATIENT AND PROVIDED OPPORTUNITIES FOR TOILETING AND FOR MAKING NEEDS KNOWN EVERY 1-2 HOURS TODAY TO LESSEN RISK OF FALL.”


xtranormal

Communication Techniques

Evaluate these two vignettes for different therapeutic techniques and communication barriers. Consider the patient's response to each encounter.