Hospital Nursing Guided Practice: Shift Assessment Navigator

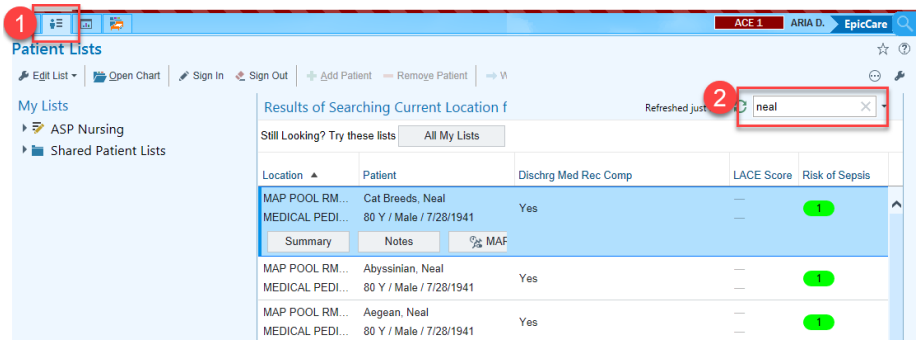
Exercise

To complete Guided Practice outside of class:

- Refer to your tent card for the User ID and password for Inpatient Nurse **Aria**.
- Refer to your tent card for your patient's name.

Section A: Neal is an 80-year-old male who was admitted yesterday for Pneumonia. It is time to do your shift assessment on him.

1. Find your Neal patient by clicking the patient list mini tab and typing his name in the search field on the top right side of your screen.



2. Click on the **Navigators** activity.
3. Click on the **Shift Assessment** tab.
4. Review any BPA's if they appear.
5. The LDA Avatar section is a great reminder to review the age of your lines and determine if they need to be changed or removed.
6. If you had any signed/held orders, you would review and release them now.
7. Start by documenting a set of vitals on your patient:
    - **Temperature** – 101.0 taken orally.
    - **Pulse** – 110 taken with a monitor.
    - **Respirations** – 22
    - **BP** – 110/72 taken on his right upper arm automatically while he is lying in bed.
    - **Sp02** – 93%. Oximetry type is intermittent, taken while the patient is at rest.
    - **O2 Delivery Method** – Nasal cannula running at a rate of 2L/min
8. You do a pain assessment on your patient. He is reporting pain of a **5** on a **0-10** scale.

9. His pain is located in his **Upper Chest**.
10. He describes the pain as **burning** when he coughs.
11. The pain is **acute** and has been ongoing since yesterday.
12. To intervene, you have given him **Medications** and provided **Emotional support**.

Section B: Next, let's start our patient assessment.

1. Click on **Head to Toe**.
    - Document that your patient has a **Serious infection** in the 1-point DVT Risk Factor section. Which leaves him at a low risk.
2. Neurologically, the patient is still **Within Defined Limits (WDL).**
3. Your patient has **not received any sedation**.
4. HEENT has **exceptions**. The patient has:
    - **Dry - Lips**
    - **Dry - Tongue**
    - **Dry - Mucous Membrane(s)**
5. Psychosocial has **exceptions.** The patient is **anxious** due to the fact that he is uninsured and concerned about his **rising medical bills**.
6. Respiratory has **exceptions**. The patient's right breath sounds have **inspiratory wheezes**.
7. Respiratory Therapy has been completed. The patient has been given a **nebulizer** treatment.
8. Cardiac has **exceptions**. Indicate that:
    - Cardiac Rhythm is **NSR** and **Intermittently Tachycardic**
    - Cardiac Symptoms – **None**
    - Telemetry Monitor On – **Yes**
9. Peripheral Vascular is **WDL**.
10. Musculoskeletal has **exceptions**. The patient has:
    - RLE – **Limited Movement; Weakness**
    - LLE – **Limited Movement; Weakness**
11. Integumentary is **WDL**
12. Document the following in the Braden Scale (Be sure to document interventions):
    - Sensory Perceptions – **3 Slightly limited**
    - Moisture – **4 Rarely moist**
    - Activity – **3 Walks occasionally**
    - Mobility – **3 Slightly limited**

- Nutrition – **2 Probably inadequate**
- Friction and Shear – **2 Potential problem**

13. Gastrointestinal is **WDL**.
14. Genitourinary is **WDL**.

Section C: SKIP THE FALLS SECTION!!

Section D: Document the patient's Cares/Safety information.

1. Click on **Cares/Safety**.
2. Indicate in the Precautions section that your patient is a **Fall Risk and on Isolation for Droplet Precautions**.
3. Safe environment is **WDL**.
4. The patient's family is **visiting**.
5. Document in the mobility section that:
   - Activity – **Resting in bed**
   - Level of Assistance – **Independent**
   - Positioning frequency – **Every 2 hours**
   - Head of Bed elevated – **45 degrees**
6. In the nutrition section, document that your patient is currently on a **General** Diet.
7. Document that the patient has had a **gown change** and a **linen change**.

Section E: Next, let's document in the I & O section.

1. Patient has **200 mL** of **amber** colored, **clear**, urine in his urinal.
2. Patient became sick after lunch and vomited twice. We were unable to measure the amounts.

This completes your Shift Assessment Practice Session. This is not all inclusive of a typical workflow; it only highlights specific portions of the medical record.