MANAGEMENT OF A DIABETIC PATIENT SCENARIO

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| **SCENARIO TITLE** |
| Management of a Diabetic Patient  |
| **AUTHOR** |
| Peta Niblett (created June 2013). |
| **TARGET GROUP** |
| * Third Year Undergraduate Nursing Students.
* Graduate Year Nurses
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| **PREREQUISTE KNOWLEDGE** |
| * Theory provided by the affiliated University.
* Attended Lab sessions in regards to Diabetic patients
* Relevant PROMPT guidelines.
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| **OBJECTIVES** |
| * Hand Hygiene
* To recognise clinical deterioration – Hypoglycaemia.
* To assess and initiate care for a hypoglycaemic patient.
* To document appropriately accordingly.
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| **STAFF ROLES** |
| Patient Simulator/Actor (SP) – Diabetic patient.* **Nurse (1)** – Gives handover from the night shift to day shift using ISBAR principles.
* **Nurse (2)** - Caring for the patient on the day shift, takes handover.
* Facilitator/ANUM – In charge of the morning shift

– Provides a brief of the environment/setting/equipment available, overview of the scenario.* Medical Registrar/Actor (Endo Unit) – Answers phone call from the primary nurse in regards to the patients clinical deterioration/hypoglycaemic episode. After further questioning agrees to come and R/V the patient.
* **Observers:** Staff/students can take an observer role. Encourage to take notes during the scenario to allow for involvement in the debriefing.
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| **PATIENT SIMULATOR/TASK TRAINER** |
| * Patient Simulator (SP) – Diabetic patient.
* Mega Code Kellie – Sim Pad, voice over/ear phones.
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| **PATIENT CHARATERISTICS/VITAL SIGNS** |
| Mrs. Dorothy Smith is a65 year old lady who has a past medical history of type 1 Diabetes (IDDM), Hypertension and high cholesterol. She is currently admitted to your ward with unstable diabetes secondary to recent gastroenteritis experienced 48/24 previously. She has not had any further gastro symptoms since being admitted to the ward. |
| **ENVIRONMENT/SETTING/LOCATION** |
| Admitted Medical ward patient  |
| **EQUIPMENT REQUIRED** |
| * Patient simulator/actor or Mega Code Kellie on a ward bed
* BSL Machine – (Use mock BSL handed to the staff/student when the observation is taken).
* Vital sign equipment – stethoscope, tympanic thermometer, sphygmomanometer.
* Lucozade - Cup
* Patient charts – Medication Chart (MR21) x 1, Observation chart x 1, progress notes.
* ID Bands x 2 (red).
* Telephone (identified phone number).
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| **STUDENT BRIEF (INCLUDING RELEVANT PMH/HPI/SOCIAL Hx/FH)** |
| Mrs. Dorothy Smith is a65 year old lady who has a past medical history of type 1 Diabetes (IDDM), Hypertension and high cholesterol. She is currently admitted to your ward with unstable diabetes secondary to recent gastroenteritis experienced 48/24 previously. She has not had any further gastro symptoms since being admitted to the ward.You are working on a morning shift and have been assigned the care of Mrs. Smith. You receive handover from the nurse caring for the patient on the night shift.Handover using ISBAR about the patient’s clinical condition (Nurse 1) to (Nurse 2).(ISBAR handover tool) – provided in resource pack). |
| **MEDICATIONS/ALLERGIES** |
| Drug Allergies ; PenicillinInsulin: Lantus/Novorapid – Mane/NoctePerindopril 5mg: DailyAtorvastatin: BD |
| **ACTOR ROLES** |
| * Patient Simulator/Actor – Patient becomes dizzy, pale and nauseated – Hypoglycaemic episode.
* Mega Code Kellie – Could be used instead of a SP using a voice over/Sim Pad.
* Medical Unit Registrar (Endo) – Communicates with the student over the phone receiving handover in an ISBAR form in regards to the patients current clinical condition.
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| **SCENARIO EVENTS** | **EXPECTED ACTIONS** |
| * Nurse (1) gives nursing handover to the am staff to Nurse (2).
* Nurse (2) introduces themselves to the patient and begins a patient assessment.

 * SP: Begins to feel unwell stating “she hasn’t eaten for hours”.
* SP: States “Feeling dizzy and light headed, nauseated.”

*“I didn’t eat my dinner last night as I didn’t feel well and didn’t tell anyone as I didn’t want to be a burden.”** Facilitator/ANUM: Asks the nurse to describe to them what symptoms the patient is displaying.
* Facilitator/ANUM: Decision made to give Lucozade if not already given by Nurse (2).
* SP: Questions Nurse (2) as to “how long will the doctor be?”
* Facilitator/ANUM asks Nurse (2) what the next course of action will be and if there is anyone else who needs to be contacted (Phone call to Endo team).
* Medical doctor questions Nurse (2) for specific information if not given over the phone adhering to ISBAR principles.
* SP: States “I feel a lot better now.”

**Facilitator: End of the scenario the scenario, commence debriefing.** | * ISBAR is used to communicate handover from night shift to the morning shift.
* Hand Hygiene
* Takes a set of baseline vital signs – GCS, HR BP, RR, temperature.
* Asks the patient how they are feeling?
* Checks the patient charts and documents accordingly.
* Nurse (2): Asks the patient what symptoms they are experiencing.
* Nurse (2): Checks patient charts – Recognises no observations were taken at 0600hrs. The patient was given their nocte insulin and didn’t have any dinner (as stated by the SP).
* Initiates taking a BSL reading.
* Recognises clinical deterioration (low reading – 2.1mmol/L).
* Effectively communicates with the ANUM that the patient’s condition has changed.
* Provides re-assurance to the patient that they will get assistance, alerting the ANUM.
* Nurse (2): Gives the patients clinical condition using ISBAR principles and highlights the current low BSL reading.
* Initiates the need for administration of Lucozade in the interim.
* 150mls of Lucozade given to the patient.
* Re-assurance is given to the patient that the admitting medical team will be contacted immediately in regards to their clinical condition.
* Nurse (2): Telephones the medical team (Endo – dedicated phone no.) to notify them of the patient’s clinical deterioration and current hypoglycaemic state.
* Nurse (2): Uses ISBAR to communicate effectively and provide accurate patient information.
* Re-assesses the patient whilst awaiting medical review and post Lucozade administration (15mins).

(As per current PROMPT guideline).* Observations
* Re-check BSL (Increased to 4.0mmol/L).
* Nurse (2): Provides re-assurance to the patient.
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| **DISCUSSION/DEBRIEFING POINTS FOR FACILITATOR (Learning Points)** |
| * Hand Hygiene (5 moments)
* ISBAR – Effective communication
* Patient assessment
* Identification of clinical deterioration.
* Escalation process (Hospital policy)
* Documentation
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