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| **Patient-Centered Case Study for Health and Illness in Undergraduate Program**  Presentation material is due at 11:59 PM the evening before Presentation Day    **Purpose:** The purpose of using a case study in class is to assist students to develop analytic skills in problem solving and decision making in complex situations. This case study is about the patient living with multi-problems (both physical and psychological). As a result, this case study will facilitate you to develop coping skills with ambiguities.  **Instruction:**   1. Review case study guidelines and create a PowerPoint Presentation 2. Answer the case study questions and key points 3. Develop three interactive activities (e.g., NCLEX/NextGen style questions, Games, Video Quizzes, etc.) for the class 4. List a rationale for each question must include sources and evidence to support response **(noted as citations within the answe**r**).** A reference list is required with the minimum of 3 professional, reliable sources. In APA format. 5. From the PowerPoint, all members of the group will develop a case study presentation to present to the entire class. You will have 15 minutes to highlight your PPT case study presentation. You can use (SBAR; Situation, Background, Assessment, and recommendation) technique or others as a communication tool to highlight your PPT case study. | |
| Betty is a 50-year-old Hispanic woman, came to this country from Cuba with her parents when she was 7 years old. The family members worked as migrant farm workers until they had enough money to open a restaurant. Betty married young. She and her husband Ralph worked in the family restaurant and eventually bought it from the parents. They raised seven children, all grown and living on their own. Betty and Ralph live in a mobile home close to the restaurant. She does not work in the family restaurant anymore because she worries excessively about doing a poor job. Betty no longer goes out if she can help it. She stays at home worrying about how she looks, what people think or say, the weather or road conditions, and many other things. She keeps her clothing and belongings in perfect order while claiming she is doing a poor job of it. She does not prepare large family dinners anymore, though she still cooks the daily meals; one daughter has taken over the family dinner. This daughter has become concerned about Betty being isolated at home and worrying excessively and calls the community mental health center for an appointment for Betty.  Betty presents at the local health center accompanied by her husband, her children and their spouses, several grandchildren, and a few cousins. When Betty’s name is called, she frowns and says “What will I say? I don’t know what to say. I think my slip is showing. My hem isn’t straight.” Betty wants her whole family to go in to see the nurse with her. The nurse notices that she is extremely well groomed and dressed in spite of concerns she has been voicing about her appearance. Her daughter says that Betty “worries all the time.” Although she has always been known to be a worrier, the worrying has become worse over the past 6-8 months. Ralph shares that his wife is keeping him awake at night with her inability to get to sleep or stay asleep.  During an interview, the nurse notices that Betty casts her eyes downward, speaks in a soft voice, does not smile, and seems restless as she taps her foot on the floor, drums her fingers on the table, and seems on the verge of getting out of her chair. Themes in the interview include: being tired, not being able to concentrate, not getting work done, trouble sleeping, worrying about whether her husband lovers her anymore and whether she and her husband have enough money, and not having the energy to attend to the housework or her clothing.  The psychiatrist examines Betty and after a thorough physical examination and lab studies, finds nothing to explain her fatigue and difficulty sleeping other than anxiety. The psychiatrist got Betty’s report from family health care provider, and Betty has no medical diagnosis indicating that she suffers from anxiety. The psychiatrist prescribes buspirone (BuSpar) for her.  2 weeks later, during a home visit to Betty, the nurse learns that Betty is upset with Ralph for loaning all their savings to the daughter to build a new home while they continue to live in an older mobile home. At the end of the home visit, Betty’s daughter wonders if Betty is making any progress. Betty also worries she is not getting better and asks the nurse about taking herbal medicines containing Kava and Passaflora. Her sister wants to take her to see the folk healer to cure the evil eye that was placed on Betty and made her sick.   1. What are some cultural considerations to consider when providing care to Betty? What behaviors does Betty have that match the criteria for a diagnosis of Generalized Anxiety Disorder (GAD)? 2. How common is the diagnosis of GAD? Is it common for clients with GAD to have comorbidity, and should the client be assessed for any particular condition? 3. What does the nurse need to know about buspirone? What teaching needs to be done with Betty with regard to buspirone? What other medications (include effectiveness) are being used in the treatment of GAD? 4. What are some of the interventions, in addition to antianxiety drugs, being used with clients who have GAD?   Later in the evening Betty gets ready for bed and wishes Ralph a good night at approximately 2300. The next morning at 0530, the alarm clock goes off, Ralph gets up. He notices that Betty did not wake up. “Good morning, Betty, rise and shine.” No response from Betty. He nudges her and no response. A few minutes later, Betty opens her eyes, but has slurred speech and unable to get up out of bed. Ralph immediately calls 911. Local EMS arrive within 15 minutes, recognize Betty is exhibiting S/S of a Stroke. Initial NIH Stroke Scale (NIHSS)= 9 **(see additional Word document for NIHSS on Betty)**. VS= T-98.9 P-105 R-24 BP-168/90. EMS transports Betty to the ER, in route notifying the ED of a suspected stroke. The ED prepares for Betty’s arrival and initiate a Stroke Alert. EMS asks Ralph about Betty’s health history as Betty is having difficulty with her speech, slurred words, and rather anxious. Upon arrival to the ED, EMS hands off report to the ED RN. | |
| **HEALTH HISTORY**  Past Medical History (PMH)   * Hypertension (HTN) * Hypercholesterolemia * Vertigo * Generalized Anxiety Disorder (GAD)   Past Surgical History   * Caesarean with last 2 children   Family History   * Father has HTN and Diabetes Mellitus 2 (DM2) * Mother well no apparent problems * Brother smoke and depression * Daughter DVT and PE | **SOCIAL HISTORY**   * Married x 33 years * Non-smoker, but Husband smokes * Alcohol- 1-2 glasses of wine for special occasions * Drugs- never * Caffeine- 1 pot of coffee daily   Allergies   * No Known Drug Allergies (NKDA)   Medications   * Atorvastatin for elevated cholesterol at bedtime * Labetalol for HTN twice daily * Buspar for GAD * Multivitamin 1 tab PO daily * Aspirin 81 mg (baby aspirin) chewable 1 daily |
| It is now 0615 (See the additional document for NIH Stroke Scale). The stroke team is present beginning to execute the Stroke Protocol. The nurse is performing NIHSS, physician is asking questions to Betty and Ralph, lab tech is drawing blood, and ED tech is obtaining VS and 12 lead EKG. CT calls to notify they are ready for Betty; Betty is brought to CT for a CT scan without contrast and CT angiography (CTA). During the meantime, the ED physician is speaking with the on-call neurologist about Betty’s condition.   1. What information is essential to determine whether Betty is a candidate for treatment with tPA? Provide this information in SBAR format. Include rationale.   *Situation*  *Background*  *Assessment*  *Recommendation*  CTA reveals an occlusion of the left middle cerebral artery (MCA) stem. She is taken emergently to the OR where the neurosurgeon performs a thrombectomy and thrombolysis to gain revascularization. Upon completion of the procedure, Betty is brought to the ICU to recover. VS= T-99.1 P-110 R-22 BP-173/95 Pox- 95% 4L nasal cannula.   1. Upon Betty’s arrival to the ICU what are the nursing priorities? Provide rationale. Does Betty have any risk factors for a stroke? If so, what are they?   As the nurse, you perform a neurological assessment including NIHSS. Betty is drowsy, but easily arousable. She states the correct month and she is 50 years old. She is able to open and close her eyes. She squeezes your fingers upon command. Betty is able to follow your finger in all visual fields. She is able to state which visual field you are holding your finger and how many you are holding up. Upon smiling there is some asymmetry with right sided facial droop, but is able to raise eyebrows symmetrically and close eyes shut. She raises each extremity at time to hold in the air. RUE: not able to hold up for 10 seconds and begins to drift down to the bed. LUE: no drift noted and holds up for full 10 seconds. RLE: begins to fall by the end of 5 seconds but does not hit the bed. LLE: No drift noted. Betty performs the finger-nose-finger test without difficulty as well as the heel-shin test. No noted sensory loss with the pinprick test. Speech is slurred at times, but is able to respond appropriately. You are able to understand what Betty says. Betty is able to make a distinction between her right versus left side of body as well as to what parts of the body encounter tactile stimuli.   1. As Betty’s ICU RN, you are trained and qualified to complete NIHSS. Why is it important to continue NIHSS assessments on Betty? According to the information provided what is Betty’s current NIHSS score? 2. The physician ordered the following orders: ECHO, aPTT/ INR, Carotid Ultrasound, MRI in am, Speech therapy, Sequential Compression Devices (SCDs) to BLE, and PT/OT. Why were these ordered and what is the rationale? Be specific. 3. 2 days later, the physician writes discharge orders for Betty. What sort of discharge teaching would you provide Betty and her family in regard to Strokes, S/S to be aware of, risk factors, prevention, etc? Provide rationale. Would you provide patient teaching and education differently for someone who has GAD? What sort of resources are available in the community? 4. Provide 3 questions/activities the team will use to engage and interact with the audience.   References | |