Case 1: ATSP Re: Abdo pain

Thursday 2200, respiratory ward

43 year old female

Patient transferred from ITU 4/7 ago following RTA few days previously complicated with HAP

Nurse conversation

Info: Patient has been complaining of abdo pain intermittently for 2 days. Not seen by ward team for this. Currently uncomfortable, unable to sleep but otherwise well. Has been passing urine normally.

Obs: -Temp 36.5 -HR 90 -BP 122/84

-RR 18 -O_2 Sats 98%

Instructions: Get notes ready**,** Urine sample if possible then dipstick

---

On the ward

Initial assessment: Looks uncomfortable but well. Obs as above. Abdomen soft but generally tender. No rebound tenderness. Palpable large bowel . **PR- faecal loading**

On further questioning: Has had difficulty controlling her bowels for 5/7 only producing small amounts of liquid stools. No formed motions. Not mentioned it before on ward round.

Medical notes: Admitted to ITU after RTA. Developed HAP on ITU, otherwise has been recovering well.

Investigations: **Urine dipstick done on request**, NAD. Most recent bloods yesterday, all normal.

Kardex: Clexane, co-codamol 30/500 QDS, co-amoxiclav

Impression: Overflow diarrhoea with constipation

ΔΔ C. Diff

Plan:

1) Stool sample ?C.Diff (anyone with persistant loose stool)
2) Px Phosphate enema
3) Px Oral laxatives- E.g movicol and PRN Senna
4) Change co-codamol to PRN
5) IV fluids and ask for repeat bloods mane (particularly looking for low potassium)

Case 2: ATSP Re: Agitation and confusion

Tuesday 2345, respiratory ward.

86 yr old female admitted earlier with ?CAP via GP

Nurse conversation- Requesting sedation. Change in temperament and apparent confusion when giving night time meds this eve. Obs stable Temp 37.8. Currently keeping other patients on the ward from sleeping and has started wandering around the ward.

Instructions: Get notes/Kardex/ Obs chart together

On the ward

Initial assessment:

A B Talking nonsense, singing++volume. Localised crackles R base. RR18 Sat 97% 2L.

C HR 88, reg. BP 167/92, Fluid balance not recorded,

D Temp 37.8, **BM6.4, AMT 2/10** GCS 15

E No apparent injuries. Pt uncooperative with neuro exam but appears to have no asymmetry, weakness or deficit.

Medical notes: GP admission. Lives independently in warden controlled flat and normally copes well. Arthritis. No Hx dementia.

Investigations CXR confirms RLL CAP. Admission bloods: WCC 15.6, CRP 134

Medications omeprazole, naproxen, augmentin IV

Impression Delerium due to CAP- Pyrexial, infected

Plan:

1.) 2 hourly neuro obs

2.) Paracetamol 1g stat/PRN

3.) Nursed in well lit side room

4.) Zopiclone 3.75mg

Case 3: ATSP Re: Blood in catheter bag

Sunday 0200, Respiratory ward

68 yr old male, admitted 5/7 ago with CAP sepsis

Nurse conversation: Blood in catheter bag, confirmed by dipstick. Pt not in distress. No IV access as difficult veins. Pt on 8hrly obs.

Obs: RR 18 Sats 97% O/A

HR 84 BP 134/78 Temp 36.7

Instructions: Gather equipment together for cannula- green (minimum). Get notes, Kardex and fluid balance charts together.

On the ward

Initial assessment- Pt stable and pain free. No concerns. Hadn't noticed change in urine. 540ml blood stained urine in bag, no clots. No pain evident. Abdo S/NT No masses. **No postural drop.**

Medical Notes- Background IHD, CCF, COPD and permanent AF. No known urological pathology. Catheter passed for strict fluid balance monitoring with no complications. Latest bloods (from day before) consistent with resolving sepsis (Hb 13.4)

Fluid Balance +300ml (normal saline with K+ 10hrly bags)

Kardex - Aspirin, simvastatin, furosemide, ramipril, warfarin, mucodene, simbicort, salbutamol.

Impression: Haematuria ?cause

Plan:

1. Lying/Standing BP (no postural drop)
2. Bloods (including Xmatch, clotting) and IV access
3. Change catheter bag to monitor more accurately
4. Dipstick urine and treat infection if necessary
5. Regular obs (2-4 hrly) and continue with strict fluid balance
6. RV later with blood results

No need to recatheterise with 3 way at this stage ensuring it is still draining freely once bag changed.

Case 4 ATSP Re: Decreased GCS

08.30 Sunday Orthopaedic ward

57 yr old female admitted with pathological #NOF 2/7 ago

Nurse conversation: Patient found to be drowsy when offered breakfast**. AVPU = V**. Not diabetic, No Hx trauma/fall/head injury/seizure. No chronic respiratory disease.

Obs: RR 10 Sats 96% O/A

HR 78 BP 108/78 T 35.8 .

Instructions: Ensure airway not compromised- reposition and put on high flow oxygen.

On the ward

Initial assessment:

A B. Airway is patent but pt slumped over, can hear some snoring noises.

Try Guedel airway- if tolerates they need senior help. If not and spits out/coughs etc then can proceed

Sats 100% on 15L. (94% O/A if they haven't asked for O2 already), RR 8. Chest clear and good a/e bilat. No wheeze ++ transmitted sounds.

- At this point they must ask for high flow oxygen and reposition the pt at least!! *If not done so already*

C. HR 78, reg and strong, BP 108/78 HS N, well perfused. CRT <2

D Pupils- equal but pin-point, **BM 5.6**, GCS: E 3, V4, M4 (tot = 11) temp 35.8

E. TD patch noticed on upper right arm. No evidence of bleeding. Wound dressing over hip clean, not oozing. Pt has green cannula in situ R ACF.

Medical notes: Long-term MS pt. admitted. Had hemiarthroplasty 1/7 ago but has since been experiencing a lot of pain. Documented in notes that FY1 called to see her x 2 overnight and he increased PRN oramorph for top up analgesia.

Kardex- see ppt

Impression: Opiate toxicity

Plan

1. 400mcg Naloxone/ 'Narcan' IV and continue until response.
2. Inform SPR ?Naloxone IVI
3. Reduce PRN oramorph dose (re-write)

NB communication with nurses is key!!

Case 5 ATSP Re: Dying patient

Gastro ward Wednesday 2230

70 yr old male admitted for general deterioration with metastatic pancreatic Ca

Nurse conversation- Requesting palliative meds, seems in distress. Patient deteriorated over past few hours, refused any PO intake past 24 hours.. Last obs done 4 hours ago, can't remember what they were.

Instructions: Gather all documentation together

On the ward

Initial assessment: (pt is shutting down so obs reflect this compared to last set 4hours ago)

A B. Patent and no added sounds. RR 10 regular, Sats 92% on 5L

C.HR 58 reg, weak. BP 108/62 Poorly hydrated, dry skin and mouth, CRT 3 seconds centrally

D GCS E2, V3, M5 (tot 10) temp 36.2. appears uncomfortable with grimacing facial expression, agitated.

E. Jaundiced with fresh excoriation marks on shoulders. Poor mouth care - v dry and crusty.

Medical notes Patient treated for CAP with augmentin IV since admission 3/7 ago but has made no improvement. Last entry in notes: *GCS 13 Obs stable, apyrexial, continue with care. DNAR.* No record of any d/w family. DNAR form attached and signed.

Investigations Admission bloods show deranged LFTs with obstructive jaundice pattern. Those from the afternoon show progressively worsening LFTs but no evidence of infection/acute changes.

*ABG may be useful if unsure about more investigations - can be relayed to senior and may help with decision-making depending on the situation

Kardex: Augmentin 1.2g IV TDS, Simvastatin 40mg ON, Ramipril 1.25mg OD

PRN: Paracetamol, ibuprofen, senna and metoclopramide.

Impression: Dying patient in obvious distress.

Problems:

1.) Poor hydration
2.) Poor oral care
3.) Distressed/agitated/in pain
4.) Itching from jaundice
5.) Family unaware of situation

Plan : DISCUSS WITH MOST SENIOR NURSE ON WARD

1.) IV access and fluids (slow bag e.g 12hrly N saline)
2.) Ask nurses to commence proper mouth care with wet sponges etc
3.) Prescribe PRN meds as per local guidance + stat dose of morphine
4.) Stat dose Chlorpheniramine plus PRN
5.) Inform family

Call family regardless of time esp if they are not expecting this. Sometimes pts can deteriorate v quickly and die unexpectedly. It may be the last chance they have to communicate with pt. CHECK medical and nursing notes while liasing with nursing staff before doing so to clarify overall situation.

Case 6 ATSP Re Fall / collapse

Saturday 1500, Rehab ward

82 yr old female simple fall on ward. Admitted 2/52 with urosepsis.

Nurse conversation: Unwitnessed, staff heard thud and found her on the floor thinks she may have banged her head from the sound. Doesn't know obs, not with her. Pt sat in chair now, reading paper. Nurse would like her checked over.

Instructions: Gather documentation together, ask for L/S BPs to be done

---

On the ward

Initial assessment:

A B.Patent, no added sounds. RR 18, Sats 98% OA. Talking coherently.

C.HR 88reg, strong. **BP L- 138/62 S- 142/68** looks well hydrated.

D Orientated TPP, GCS 15, BM8.3, PEARLA, CN normal and neurologically intact, able to mobilise with normal gait (unsteady), no asymmetry.

E. hips symmetrical, tender around ant/lat aspect right. FROM.Able to WB but uncomfortable. Small swelling to right forehead in hairline. NO broken skin, no boggyness. No other signs of trauma.

History consistent with mechanical fall, remembers whole event, no vomiting, no seizure Sx, no cardiac sounding Sx.

Medical notes Admitted 2/52 ago with urosepsis. Recovered well but unsafe to D/C due to frailty and no social support in place. Transferred to rehab ward 8/7 ago. Unsteady on feet around ward and has fallen once before a couple of days ago. Suffers from Osteoporosis and IDDM.

Kardex Adcal D3, Calcichew, lisinopril, insulin, aspirin, simvastatin

Impression mechanical fall with minor head injury.

Plan

1.) Neuro obs 4hrly

2.) XR hips – elderly osteoporotic lady even if no signs/symptoms of trauma

3.) Documentation of head injury

Case 7: ATSP Re coffee ground vomit

Tuesday 1900 respiratory ward.

63 yr old male admitted yday evening with Inf. Exac. COPD

Nurse conversation –50ml coffee ground vomit. Dipstick B++++. Will perform new set of obs before you get there, last ones 90mins previously were stable. IV access with blue cannula for IVs.

Instructions: Gather notes and cannulation equipment with green cannula (or ask if someone else can do it)

On the ward

Initial assessment:

A B. RR 18, Sats 93% on 28%venturi.

C. HR 96, reg and strong. BP 136/78 CRT <2 peripherally. **(no significant postural drop)**

D E. T 36.8 Abdo soft, mildy tender epigastrium. No guarding/rigidity. BS N. **PR NAD.**

Medical notes- Background: NIDDM, HTN, high cholesterol. No other vomiting. BO today as N. No malena/fresh bleeds. No Hx alcohol abuse/PU/GOR.

Admission bloods: WCC 14.6 with neutrophilia, CRP 245, U/E NAD.

Kardex Augmentin 1.2g IV TDS, Salbutamol 5mg ned QDS, Atrovent neb 500mcg QDS, tiotropium, carbocisteine, metformin BD, Aspirin, Simvastatin, Ramipril.

Impression: Small UGI bleed ?cause

Plan

Patient is stable given history and exam. Inclined to give benefit of the doubt and treat conservatively. To be **safe**:

1. IV access with green+ cannula (even if has one already for IVs)
2. Bloods inc G/S, clotting, FBC, U/Es.
3. Recheck obs in 1hr then 2hrly thereafter. No need for fluid at this point.
4. Omeprazole 40mg IV
5. Hold am dose of aspirin
6. Keep NBM (will miss evening meal but keep on the safe side and see if any further vomits)
7. Review fully in 2-4hrs with blood results. If no further vomits, bloods normal and patient stable, can eat and drink. Otherwise keep NBM and commence IV fluids.

Case 8. ATSP Re: Haematemesis

Saturday 0900, gastro ward

56 yr old female admitted for alcohol withdrawal seizures

Nurse conversation: 300ml-fresh blood stained vomit- 3rd episode in 4 hours. Nurse asking if night staff handed-over but this hasn't happened. Has been seen previously, bloods sent inc X-match. IV access with Pink cannula.

Obs RR 22, Sat 96% O/A

HR 107, BP 103/70 T 36.5.

Instructions: Order blood, Cannulation equipment- x2 Green, run through 500ml saline stat.

On the ward

Initial assessment:

A B. Chest clear, no respiratory distress

C. CRT <2 centrally

D GCS 15/15, temp 36.5, BM 6.2 **Abdo**: soft but tender epigastium with guarding. BS present, no masses. **PR:** pt has episode of malena while being examined, approx 100ml

E. jaundiced, looks unwell.

At this point they should recognise they need senior input and ask a nurse to bleep SHO or SPR. Should stay with the patient and ask for notes etc to be brought to them. SHO and SPR are both busy but one will come shortly. Meanwhile Pt needs to be stabilised.

Medical notes Powerpoint

Investigations Bloods from 0500: Hb 9.5, WCC 11.4, Plts 135, MCV 105, INR 1.6, Albumin 22, Urea 9.6, Creatinine 101.

Kardex- Thiamine, Vit B co-strong, omeprazole

Impression UGI bleed ?varices or perf PU

Plan

1. IV access with x2 large cannulas
2. Bloods inc LFTs (no need to redo x match).
3. Fluids- saline 500ml stat.
4. ABG
5. Erect CXR to be ordered (portable)
6. NBM
7. catheterise (most nurses will be able to do this while you are examining etc)

Med reg appears, reviews management and is satisfied patient has been stabilised. He then reassess the situation, prescribes terlipressin and feels this lady needs an urgent OGD. Pat on the back.

Case 9 ATSP re: High EWS

2300 Wednesday, uGI surgical ward 68 year old lady, 1/7 post oesophagectomy BG: oesophageal Ca

Nurse conversation

Info: Patient is becoming increasingly short of breath. She looks unwell. Not been seen by consultant today. Just taken obs**: Scoring EWS 7**

Obs: -Temp 38.2 -HR 115 -BP 120/84

-RR 26 -O_2 Sats 88%

Instructions: Get notes ready, bleep for ECG, IV access, send bloods and cultures, bleep for portable CXR, high flow oxygen

On the ward

Initial assessment: Looks unwell but is speaking and alert.

A - Speaking in full sentences

B - Obs as above. Widespread crackles and wheeze over right side chest with poor A/E

C - Obs as above. Heart sounds normal and regular

D – BM 6.5, orientated to time and place

Medical notes: Uncomplicated oesophagectomy 1/7 ago. Has been well since, nil else of note.

Kardex: Oramorph, clexane, thyroxine

Investigations: Last bloods done yday, WCC 13, otherwise normal.

Impression: ?HAP, Aspiration pneumonia, anastamotic leak/perf, PE

Plan:

ABG, initial, then repeat

1) CXR (even if done recently) – portable
2) ECG
3) Bloods, including cultures
4) Antibiotics – Check trust policy, e.g. Tazocin
5) Paracetamol, preferably I.V
6) IV fluids
7) Senior must be informed

Case 10 ATSP re: Hyperkalaemia

1300, Saturday Stroke Ward

80 year old man, admitted with stroke.

Nurse conversation

Info: Potassium 6.8. Patient otherwise well. Other bloods normal. Patient on IV fluids. Eating and drinking normally.

Obs: -Temp 37.2 -HR 88 -BP 124/82

-RR 18 -O_2 Sats 98%

Instructions: Get notes ready, bleep for ECG

On the ward

Initial assessment: Looks well, bright and alert. R sided hemiplegia, otherwise exam unremarkable.

Medical notes:. . BG: Hypertension, left ventricular failure, previous stroke

Admitted 5/7 ago. NBM for 2 days following this then assessed by SALT, safe to swallow.

Kardex: : Aspirin, clopidogrel, ramipril, simvastatin, metformin, sando-K, spironolactone

Investigations: Last potassium done 4 days ago, 2.8. Other bloods all normal

IV fluid chart:

- 2 L Normal saline / 16 hours, each with 40mmol K^+
- 1 L 5% glucose / 8 hours
- Above regimen has been used for 5 days

Plan:

1) ECG (done on ward, NSR 80bpm)
2) Insulin-dextrose IVI (Trust protocol)
3) Withhold relevant meds (stop sando K)
4) Stop fluids
5) Repeat bloods (give a time approx 4hours later) then BD until stable

Case 11 ATSP re: Low urine output

2000, Thursday LGI surgical ward

52 year old man, elective admission for hemicolectomy. 4 hours post op.

Nurse conversation

Info: Came back from theatre 4 hours ago. Urine output 10mls per hour. Tired but otherwise well.

Obs: -Temp 36.8 -HR 98 -BP 116/76

-RR 20 -O_2 Sats 94% on 4L

Instructions: Get notes readyCheck catheter is patent- flush

On the ward

Initial assessment: Looks tired but well.

A – speaking full sentences

B – Obs as above. Chest clear

C – Obs as above. JVP normal, no oedema

D – Orientated to time and place

E – Abdo dressed in bandages. No masses. Drains working. Catheter draining small amounts of clear urine

Fluid balance:

IN: 500mls **OUT:** Urine 30mls

Stoma 400mls

Insensible losses 200mls

Medical notes: Elective admission for hemicolectomy. Operation went well. Nil else of note.

Kardex: Clexane, Co-codamol PRN

Plan:

1) Fluid challenge, 500 ml stat
2) Recheck urine output in 1 hour - maintain at 0.5ml/kg/hour
3) Repeat bloods to check renal function
4) Prescribe fluids for next 24 hours e.g. 3 litres (depending on patient's size)

Case 12 ATSP re: SOB

Wednesday 2100, Respiratory ward, 58 year old male. Background COPD

Nurse conversation

Info: Admitted today, transferred from MAU 2 hours ago. Has been SOB since arrival on the ward but seems to be getting worse. Currently on 24% oxygen via venturi mask. EWS 3

Obs: -Temp 37.1 -HR 96 -BP 140/92

-RR 28 -O_2 Sats 78%

Instructions: Get notes ready

On the ward

Initial assessment: Looks SOB

A – Speaking in full sentences

B – Obs as above. Working hard. Centrally cyanosed, slight crackles and wheeze on chest.

C – Obs as above. Heart sounds normal and regular.

D/E- calves S/NT. No evidence DVT.

Medical notes: Clerk in is the only thing in notes, quick review by MAU consultant who advised transfer to respiratory ward. Nil else.

Investigations: Bloods done in A&E. WCC 14, otherwise normal.

CXR today showed chronic COPD changes and bronchopneumonia

ABG on admission: pH 7.4 pCO_2 6.7 BE -4

PaO_2 8.3 HCO_3 28

Kardex: Salbutamol nebs, ipratropium nebs, co-amoxiclav IV, ramipril, allopurinol

Plan:

1) Repeat ABG

   pH 7.4 pCO_2 6.8 BE -4

   PaO_2 6.3 HCO_3 28

2) Salbutamol nebs with air
3) Increase oxygen to 35% via venturi
4) Repeat ABG again in 15-30 minutes (most respiratory nurses will do CBG if asked)
5) Discuss with senior about escalation of care in case patient worsening

Case 13 ATSP re: Tachycardia

20.45 Tuesday, General medical ward

65 year old man

Admitted with cellulitis

Nurse conversation

Info: Patient looks better than he did on admission. Just done routine obs, as below.

Obs: -Temp 37.6 -HR 110 -BP 109/78

-RR 14 -O_2 Sats 98% on air

Instructions: Get notes ready

Bleep for ECG

On the ward

Initial assessment:

A – Speaking in full sentences, alert

B – Obs as above. Chest clear. Patient denies SOB.

C – Obs as above. Pulse irregularly irregular, JVP not seen. CVS exam otherwise normal. Patient denies chest pain / palpitations.

Medical notes: BG: hypertension. No previous mention of AF. ECG on admission showed sinus rhythm

Investigations: Bloods including cultures sent this afternoon, not checked yet.

Kardex: Co-amoxiclav, ramipril

ECG done on request: No P waves (Fast AF or AF with rapid ventricular response)

Plan:

1) IV fluids - 500ml saline stat

2) Add electrolytes to bloods (Ca, Mg, and check K once back)

3) Review in 1 hour

If HR settles then observe reg nursing obs.

If still tachy/AF then D/W senior Re rate control

NB For fast AF or any new arrhythmia: involve senior help