The Hospital Rotation

Student Data:
Date: Use today’s date
Hospital: Anytown Regional Medical Center
Shift: 2300-0700
Preceptor Name & Level: Jane Doe, RN

It is 2300 hours and you just got off an ambulance rotation one hour ago. You are doing a hospital clinical tonight because you have a tight schedule and need to complete your hospital hours before the end of the semester. You arrive on time at 2300, report to the RN on duty and begin your shift. The RN remembers you had brought in a patient earlier that evening and she asks you if you want to follow-up on his condition and treatment. You tell her yes and she assigns you to assist with the patient.

In Treatment Room One, you observe a 58-year-old male patient whose chief complaint was abdominal pain several hours ago at approximately 1830 hours. You are going to do the complete follow-up assessment (you have on your BSI) and you approach the patient and reintroduce yourself. The patient remembers you and he is still AOX4. You explain that you would like to do a follow-up on him with his permission (which he grants) and you begin your history-taking interview and assessment. First, you re-establish the chief complaint, which he states is abdominal pain that began about six hours ago. The patient has experienced this type of pain before especially after eating spicy foods. The patient states he weights approx. 212 lbs. Vital signs at 2315 hours reveal:

- RR: 12, regular, non-labored;
- P: 102, strong, and regular;
- B/P: 138/82;
- Skin: pink, warm and dry;
- GCS: 15

Other information obtained reveals the patient has a past medical history of HTN, and non-insulin dependent diabetes. The patient takes ZOCOR medication for high cholesterol and tries to regulate his diet (sometimes) consistent with his doctor's instructions to control the diabetes. The patient denies allergies to medication, iodine, or shellfish. The patient’s family medical history is HTN, high cholesterol, and diabetes. Social HX reveals

- ETOH: denies,
- DRUGS: denies,
- TOBACCO: 1/2 pack per day,
- OTHER: none.

The patient’s current health status is generally good to fair depending on diet and medication compliance.
You decide to obtain a SAMPLE HX in the meantime:

- **S**: progressive onset of right-sided abdominal pain;
- **A**: NKDA;
- **M**: high cholesterol meds, name ZOCOR;
- **P**: HTN and diabetes, denies prior surgeries;
- **L**: 6.5 hours ago;
- **E**: Watching TV and his stomach started to burn and hurt.

You continue your assessment. The patient’s pupils are PEARL at 3mm. Breath sounds are clear and equal bilaterally; there is equal rise and fall of the chest and no trauma noted. The abdomen is soft, tender, and non-distended with the pain palliated (gone) due to the morphine administered by the ED RN; the quality is dull and non-radiating, and the timing is only mildly intermittent. His temperature is 97.6 degrees F, SaO2=98% on room air and CO2 is 28. Bowel sounds are inactive in all four quadrants to auscultation with your stethoscope. You have time to check the treatment performed and notice that a full blood draw was performed as well as an IV established in the left arm. A 1000cc bag of normal saline fluid was administered. The lab results indicated a BGL of 122mg/dl and normal values for all other lab tests. A 12 LEAD EKG was being performed while you were doing the assessment.

You elect at 2355 hours (wise choice) to do a second set of vitals and they reveal a

- **GCS**: 15;
- **RR**: 12, regular, non-labored;
- **P**: 104, strong, and regular;
- **B/P**: 136/80;
- **S**: pink, warm and dry.

After you complete your assessment you ask the RN to help you identify a differential diagnosis. She tells you that his medical condition is called cholecystitis (gall bladder disease) and appendicitis, diverticulitis, and possible gastritis is being ruled out. Your full assessment of this patient revealed no other injury or illness (or trauma) and the patient remained in the Emergency Center to receive further evaluation and treatment.

Follow the instructions on the cover sheet and document this patient. Complete all the information required on Page 2. Fill in any missing information as needed.