

vSim Health Assessment Case 8: Kim Johnson

Documentation Assignments

1. Document your findings and Kim Johnson's reactions related to the focused assessment of her neurologic and sensory motor status.

Several important observations were made during the focused assessment of Kim Johnson's neurologic and sensory-motor status. Kim, who was a 38-year-old female car occupant, had a complete thoracic spinal cord injury at T8 level; she complained of no sensation in her lower extremities. Nevertheless, she displayed accurate responses to pain and touch sensations in the upper limbs. She did not have any motor function in her lower extremities, and no purposeful movements were detected; muscle power in her lower limbs was also zero, and muscles were hypotonic. On the other hand, Kim had normal muscle tone of the upper limbs; she was able to move her upper limbs actively as demanded. Kim seemed worried about the absence of motion and sensation felt in the lower part of her legs, yet she was alert and participated in the assessment process. She also sought to become more fully informed about her condition and engaged in discussions about the process of rehabilitation that she was going to undergo.

2. Referring to your feedback log, document all nursing care provided and Kim Johnson's response to this care.

The following are some of the nursing care interventions that were done for Kim Johnson during her stay: Sensory and motor checks were conducted, with the findings indicating that Kim had no sensation and no movement in her lower limbs, but her upper limbs appeared to function appropriately. Application of the passive range-of-motion exercises for maintaining joint mobility to prevent the occurrence of contractures was addressed for Kim, and their response was positive, with increased comfort and comprehension of its benefits. I talked to Kim about the necessity to consume fiber-rich products since her condition due to spinal cord injury could lead to constipation as a result of inactivity. Kim agreed with all the advice and expressed adequate knowledge about the positive effects of changes in diets. Regarding catheter care, the nurse made sure that the process of catheterization was done under strict conditions to avoid infections, and Kim was taught how to wash her hands and handle her bladder. Kim positively responded to this education, suggesting she understood the doctors' advice and was willing to adhere to the recommended course of care. In general, Kim was motivated and enthusiastic about her rehabilitation and actively participated in the care process.

3. Document all patient teaching regarding assessments and safety issues provided to Kim Johnson, and her response to the teaching.

While Kim Johnson was a patient, teaching, and counseling were parts of her multiple care strategies aimed at facilitating her recovery and maintaining her well-being in the future. I acquired consent from the patient to demonstrate and explain the passive range of motion exercises involved in reducing overall joint flexion stiffness or contractures. Kim understood the exercises well and showed enthusiasm for the implementation of them. Support regarding the management of a high-fiber diet for constipation was also given, and Kim agreed to make necessary dietary changes as recommended by the healthcare team. I disclosed the dangers relating to catheter use, such as hand washing and using the right methods to reduce the occurrence of urinary system infections. Kim agreed with the practices and assured that she would uphold them with the utmost diligence. Also, Kim was informed of the possibility of aspiration and the necessity of physical and occupational therapy to make necessary changes to her home environment. She demonstrated engagement with these recommendations and mentioned her plans to organize therapy visits before discharge. In general, Kim's answers indicated her willingness to be an active participant in her care and follow through with the safety precautions being outlined.

4. Document your handoff report in the SBAR format to communicate Kim Johnson's future needs.

Situation: Kim Johnson is a 26-year-old female paralyzed due to a complete T8 thoracic spinal cord injury. She was admitted to our rehabilitation center this evening.

Background: The incident involved a low-velocity shot at her body in the back region. Kim does not feel her legs; in these regions, she does not experience pain. Her vital signs are currently stable, and she does not report any pain and has not had a bowel movement since admission. Her respiratory state changed for the better, and she was taken off the ventilator the day before.

Assessment:

Sensory and Motor Status: Fully developed and conscious paralysis with total anesthesia of the lower limbs; normal status of the upper limbs.

Bladder Management: There are no documented concerns; still uses a urinary catheter.

Constipation: Patient has not had bowel movements since arrival, has had a high fiber diet, and has been given stool softeners.

Recommendation:

Still continue to observe Kim's sensory and motor function and continue giving her ROM exercises. Closely monitor and encourage bladder care along with bowel evaluation and appropriate management. Coordinate for home adaptation and physical/occupational therapy to mitigate fall and safety hazards. I will establish a continuous learning process concerning her illness and precautions against complications.

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Guided Reflection Questions

Opening Questions:

How did you feel throughout the simulation experience?

During the simulation, I was engaged and concerned. There was also a need to focus more on the procedures of the assessment while at the same time bearing in mind some of Kim Johnson's emotional and physical needs. Just like the spinal cord injury that she was faced with, there really are issues in today's world that need to be discussed and handled with tact and thoughtfulness.

What do you think went well?

The neurological and sensory-motor examination was effectively set and performed on Kim Johnson, and the patient education was taken well. Some of the positive aspects included the ability to perform range-of-motion exercises effectively and the ability to communicate with the patient about catheter care clearly to the patient. Other remaining positive results include Kim's comprehension of her care plan and comprehensive participation in its implementation.

Reflecting on Kim Johnson's case, were there any actions you performed differently when repeating the scenario, or that you would do differently if you were to repeat it? If so, how did/would your patient care change and what differences, if any, did you or would you expect in Kim Johnson's outcomes?

If I were to repeat this scenario, I would pay a lot more attention to patient counseling on the effects of their injury in the long run and where and when to seek treatment when complications arise. I would also emphasize communication with the supporting interdisciplinary team to close any gap that may exist in the care plan. It could lead to enhanced patient experiences, increased focus on her post-surgery complications, and the overall need for rehabilitation.

Scenario Analysis Questions*

PCC What should your focused neurological assessment of Kim Johnson include?

The neurological assessment of Kim Johnson should involve investigating her mental state, including her level of consciousness as well as her orientation. It should evaluate whether or not she has feelings in specific parts of her body, muscle strength, and coordination. Special emphasis should be placed on the alteration of the patient's perception of pain or touch, as well as muscle stiffness or tonic reflex response.

T&C Given the above findings, develop your SBAR report to the charge nurse.

Situation: Kim Johnson is a 26-year-old female with paraplegia due to a T8 complete spinal cord injury. She was brought to the facility this evening, though she had been transferred from our office earlier today.

Background: The wound was a low-velocity gunshot wound without documented involvement of any visceral organ. She currently does not have any deliberate mobility in either of her legs, and the muscles in these regions are hypotonic.

Assessment: The patient is confused and cannot identify the location of their hospital or the date and only has diminished sensation in the upper limbs. She stated that she does not feel any pain but cannot feel her lower limbs. She has recently gotten off the ventilator and has shown improvement in her respiratory function.

Recommendation: Continue to repeat exercises for a range of movements, observe for any adverse effects, and make sure a high-fiber diet is adopted. Follow-up and monitoring shall be done to assess the effectiveness of the interventions and revise them accordingly. Have interprofessional patient care collaboration meetings at least on a weekly basis to facilitate better patient care.

T&C What potential complications (assessment findings) could occur if both active and passive range-of-motion exercises were not included in Kim Johnson's plan of care?

Some of the possible adverse effects of leaving out a range of motion exercises include Contractures, muscle wastage, and limited joint flexibility. Moreover, it is possible that Kim is at higher risk for pressure ulcers since the individual has to spend most of the time in bed and armchair with poor blood circulation to the lower limbs. Failure to address these aspects might result in further functional impairment and a deterioration in the quality of life.

T&C What other health care provider should the nurse collaborate with regarding range-of-motion exercises?

The nurse should consult with physical and occupational therapists regarding the range of motion exercises. These specialists can then give Kim individual workout instructions on the frequency of check-ups and adapt the care plan if necessary to help her regain more functional use of her body and avoid potential adverse outcomes.

PCC/S When performing an assessment of Kim Johnson's home, what changes might need to be made to assist with patient care in the home?

There may be changes that are recommended for Kim Johnson's home, e.g., alterations for easy mobility and safety. This may involve placing grab bars in the bathroom, ensuring that every part of the house is easily accessible via a wheelchair, and repositioning furniture to create easy traffic paths within the home. Moreover, if she will require assistance in activities of daily living, adaptive equipment for DLA and changes in the bed and seating positions, might be required.

- I Where might you find information regarding Americans with Disabilities Act (ADA) guidelines for paraplegics?

Concerning the ADA guidelines for paraplegics, information was retrieved from the official ADA website, www.ada.gov, or from sites such as the National Spinal Cord Injury Association or the Christopher and Dana Reeve Foundation. These resources provide bulk information on accessibility standards, civil liberties, and other accommodations for disabled individuals.

Concluding Questions

Describe how you would apply the knowledge and skills that you acquired in Kim Johnson's case to an actual patient care situation.

With reference to Kim Johnson's case, I would describe the areas of practical knowledge and skills that I have acquired and elaborate on the ways in which these components can be applied to patient assessment and education. This entails comprehensive neuropsychiatric and sensory-motor neurological assessments, early identification of possible complications and interventions, and adequate counseling of the patients on rehabilitation and home care. In this scenario, it will be important to work with a team of other practitioners and integrate EBP into clinical practice.

What opportunities for improvement should you address?

There is room for improvement concerning patient education regarding long-term management strategies, particularly in the integration with other team members. It would also be helpful to enhance the communication with the patient and his/her family concerning the expectations as well as the available possibilities for further treatment. Indeed, changes in care plans regarding patient progress and feedback are crucial to guaranteeing the proper outcomes and means of care.