NRSG 366
Examination Scenarios
Semester 1, 2012
Scenario 1

Stanley is a 59 year old man who lives with his partner in a modest suburban home. Stanley has no chronic health problems other than a long history of diverticulitis and irritable bowel syndrome, which has progressively worsened over the past 2 years. Two weeks ago he developed a complete bowel obstruction and was hospitalised for an emergency bowel resection. Placement of a permanent sigmoid colostomy was necessary.

Stanley tolerated surgery well and his postoperative recovery was free of complications. However, he refused to learn about colostomy care and would not even look at the site. Fortunately, his partner Josephine was receptive to learning and quickly adapted to caring for Stanley’s colostomy. Stanley was discharged form hospital following his surgery with plans for follow- ups visits from the community nurse.

Upon the first visit to Stanley’s home, the nurse noticed Stanley was in the lounge room watching television in his bathrobe. As the nurse asked questions about his health history and surgery, Stanley let Josephine do all the talking. When asked if he had been changing the ostomy appliances, Stanley shook his head and looked away. Josephine added, ‘He still won’t look at it, and can’t put his clothes on because it keeps leaking. I don’t see how he will ever be able to go to work again.” Josephine leans towards the nurse and whispers, I can’t even leave the house because he wouldn’t know what to do if the bag fell off.”

Stanley works as an accountant and needs to return to work in time for income tax season, which is a month away.

When the nurse mentioned returning to work, Stanley admits that he is worried about “accidents’ and odour from the colostomy. ‘Maybe I should just take an early retirement”, he adds.
Questions
1) What can you infer about Stanley’s acceptance of his colostomy?

2) Considering his aversion to his colostomy, describe in five steps how you address Stanley’s knowledge deficit about his colostomy.

3) How would Stanley’s concern about the leakage and odour produced by his colostomy impact on him and his partner?

4) What would you discuss with Stanley in regards to his early retirement thoughts?

5) Discuss four resources that would be available in the community to support Stanley and Josephine in dealing with Stanley’s colostomy.

6) Design a care plan to teach Stanley how to take care of his own colostomy, taking into account his aversion to it.
Case Scenario 2

Jennifer Porter is a 42 year with Type 2 Diabetes Mellitus. She is a marketing manager for a large cosmetic company which involves travel and a dress code including high heels for most of her working day. She is responsible for establishing new clients which involves entertaining over restaurant meals. Jennifer loves her job despite the long hours and that it often takes over time she would spend with her family. She attempts to stay fit while on business trips by staying at hotels with a gym or pool but rarely uses them and has progressively gained weight since the birth of her daughter.

Jennifer has a partner, Gilbert, and a twelve year old daughter, Nadia. Jennifer developed gestational diabetes whilst she was pregnant. This resolved by the time Nadia was six weeks old. Jennifer was diagnosed with diabetes 18 months ago following a period of fatigue and recurrent urinary tract infections. Jennifer is reluctant to include Gilbert in any of the consultations regarding her health, and expresses minimal concern for her diabetes because she believes that her poor BSL control is just a hangover from her gestational diabetes, rather than a result of her Type 2 diabetes.

You are the practice nurse at Jennifer’s GP and will assess Jennifer prior to her seeing the doctor. As a result of your assessment, you have identified the following:

Jennifer is currently 75 kg in weight, a gain of 5 kilograms since her last visit. She is 164cm tall.

Her feet are showing signs of abrasion from her shoes.

Her random BGL is 10 mmol/L. Jennifer’s log book shows it has varied between 6mmol/L and 14mmol/L over a seven day period. Jennifer admits that she is not a reliable record keeper so it is hard to gain an accurate picture of her BSL.

Jennifer takes the oral contraceptive pill and regularly takes ibuprofen for stress headaches or after a long work dinner where plenty of alcohol was consumed.

Jennifer is experiencing visual changes at times but attributes these to long work hours and the stress headaches.
Question 1.
Identify five factors in Jennifer’s situation that would be concerning regarding her ongoing management.

Question 2.
Jennifer indicates that she is concerned about her increasing weight, however states that she has tried to diet but has had no success. Describe three strategies you could implement to assist Jennifer to get control of her weight.

Question 3.
Jennifer also indicates that she is experiencing some pins and needles in her hands and feet and wonders why that might be occurring. Describe what may be happening with Jennifer’s hands and feet.

Question 4.
Jennifer also tells you that she is finding that she feels ‘sick in the stomach a lot, particularly after she has dined out the previous evening. Describe the assessments you would do in relation to this comment.

Question 5.
Jennifer also tells you that she has noticed that Nadia is reporting a dry mouth and weight loss. Jennifer asks you what this could indicate as she is concerned that Nadia may be becoming anorexic. Describe what you think may be wrong with Nadia and how you would respond to Jennifer regarding this.

Question 6.
Plan an education session covering the forum main points to help Jennifer get control over her diabetes.
Scenario 3.

Geoff Wilson is a 35 year old diagnosed with multi-focal epilepsy. He was diagnosed 5 years ago and is stable and seizure free on a regime of two anti-convulsants. These are sodium valproate 600 mg nocte and phenytoin 300 mg daily.

Geoff lives with his wife of 15 years, Gemma and their 5 year old daughter, Nessa. As the community nurse, you have been seeing Gemma to support her with her new diagnosis of Diabetes Mellitus Type 1. You have a good relationship with both Nessa and Gemma.

Geoff had a grand-mal seizure this morning as you arrived and it was witnessed by Nessa. This is the first seizure that Nessa has witnessed.

Geoff is now asleep and Nessa tells you about her father’s seizure and asks you if he will be all right.
Question 1
Nita asks you whether her father will be alright. Describe the elements you would consider when you think about how you will respond to Nita.

Question 2
Nita remains concerned about her father and appears quite scared by what she has witnessed this morning. Nita wants to know whether her father will have any further seizures. Describe what information you would give Nita and how you would do it.

Question 3.
Gemma is unsure about her diabetes and appears unsure as to why she has now been started on insulin and how long she will need to have these injections. Describe the elements you would need to cover in an educational session to respond to Gemma’s uncertainties.

Question 4.
On your next visit, Gemma that she wants to learn how to give herself insulin injections. Describe how you would assess Gemma’s ability and readiness to do this and what skills she will need to develop to do this safely.

Question 5.
On your next visit, Gemma tells you that Nita remains concerned about her father’s seizure and talks about it constantly. Gemma asks you what she could do about this as she is worried about the impact on Nita. Describe three options that would be available to Gemma identifying the advantages and disadvantages of each option.
Scenario 4

You are working with a community health nurse. Included on your case load is Mrs Clarissa Koutas. Clarissa is 72 years old woman who migrated from Croatia with her husband. Approximately seven months ago, Clarissa’s husband of 40 years died. Clarissa’s husband was her main carer. Clarissa now lives alone in their four bedroom single story home.

Clarissa is diagnosed with Diabetes Mellitus Type 2 and hypertension that is controlled with oral medications. Her feet have started to burn and the pain keeps her up at night. You haven’t seen Clarissa for three or four weeks. On your visit today, you noticed there are dirty dishes in the kitchen sink and clothes on the floor in the bathroom and corridor. She tells you that her "arthritis is really acting up and her knees ache all the time."

When you ask her what her doctor has said about her pain, she states, "Well, he thinks it is just a part of getting old and tells me to take paracetamol when my knees or feet hurt. He tells me to do what I can and continue to try to stay active. He doesn't want to give me stronger pain medications because of my age. The pain is so bad, though, that I can't do much. When I go into the doctor's office, they ask me about my pain and I tell them it's a 6 on their pain scale. However, they don't seem to ever do anything about it. Don't you think there is something better that I can take for the pain? I'd give anything to get a decent night's sleep."
Question 1.
Describe four types of assessment you would undertake in this situation.

Question 2.
Describe two strategies from each of your assessments that would support Clarissa at home.

Question 3.
Identify and discuss three factors that would impact on Clarissa’s level of independence in her home.

Question 4.
Identify how you would assess the impact of pain on Clarissa’s functioning and quality of life.

Question 5.
Develop a plan of care for managing Clarissa’s pain, including possible medications the GP could prescribe, providing rationales for your choices.

Question 6.
Describe three external support services that may be available to assist in supporting Clarissa’s independence at home?
Scenario Five
Jack Williams is a 45 year old who lives in his own home. He has been recently diagnosed with acute renal failure secondary to a streptococcus infection. Jack also has a current right leg ulcer as a result of peripheral vascular disease. Jack is a newspaper journalist and is reliant on being able to get to work on a regular basis. He is able to work from home on occasions, however needs to be able to get out to research stories for publication. You are the community nurse who is visiting Jack at home for the first time.

He has been experiencing the following symptoms:
- anuria
- swollen lower limbs
- swollen face
- bilateral loin pain
- wheezy breathing
- shortness of breath on exertion
- pins and needles in both feet

Jack has discharged himself from hospital against medical advice, and the hospital has requested the community nurse to visit to assess Jack’s overall situation.
Question 1.
Jack asks why he is experiencing the symptoms that he is experiencing, commenting ‘it’s only my kidney’s that are the problem. I can’t see what all the fuss is about’. Provide a rationale for each of the symptoms that Jack is experiencing.

Question 2.
Describe the assessments you would undertake in assessing the severity of Jack’s symptoms.

Question 3.
At your second visit, you note that Jack’s breathing appears to be more laboured and he is having difficulty speaking for long periods of time. What assessments would you undertake providing a rationale for each of the assessments you would use.

Question 4.
At this visit, Jack asks you to have a look at his leg ulcer as it has been really painful over the last few days. Outline the characteristics of the wound you would assess.

Question 5.
You note that Jack has a few empty potato crisp bags on his coffee table. You ask him about his diet and what he has been eating whilst he has been off work. Jack indicates that he has not been eating well and has only been eating snacky type foods as his feet have been too painful for him to walk around the supermarket. He asks what type of foods you would suggest that he eat. Provide a rationale for your responses.