Evidence-based practice case study

Task description: This assessment requires you to choose one (1) priority problem.
Then use the two (2) case studies to apply your knowledge of evidence-based nursing practice and the clinical reasoning cycle to demonstrate your understanding of how to plan and evaluate person centered care for each person.

What you need to do:
Step One
Select one (1) priority problem from this list:
1. Potential for impaired safety: increased falls risk
2. Potential for impaired skin integrity
3. Impaired hydration

Step Two
Thoroughly read and compare the two (2) case studies (see the end of the task description).

Step Three
Use the following headings (tasks i-iv) and address points in relation to your chosen problem and the two (2) case studies. Support your responses using peer reviewed, current and relevant literature

i. Interpretation of Assessment Data
Explain what pathophysiological changes have occurred for the two cases to experience the chosen problem.
Identify and discuss the similarities and differences between the presenting assessment data related to the chosen problem for each case. In you discussion you must demonstrate your understanding of age and developmental based differences between the cases and the presentation of assessment data relevant to the chosen problem.

ii. Development of Goal for Care using SMART Framework
From the position of your chosen problem, use the SMART framework to write a goal for care for each case (i.e. there will be two goals). The goal for care should consider the uniqueness of each case. The SMART framework headings MUST be used to present your goal. Supporting evidence is NOT required for task (ii).

iii. Evidence-Based and Person-Centred Interventions to Address the Goal for Care:
Choose two (2) evidence-based interventions (at least one must be nurse initiated) to address the goal of care.
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Justify your choice of intervention and discuss how the two (2) interventions need to be modified to meet the unique needs of the cases based on their age and developmental differences.
Note: The same two interventions will be recommended for both cases, but you need to discuss how these would be modified to suit the needs of the individual.

iv. Evaluation of the Efficacy of Interventions:

Discuss how a nurse would evaluate the efficacy of the two interventions and the similarities and differences in the approach to evaluating the cases based on their age and developmental differences.
For each case identify the expected positive changes in assessment data indicating the intervention was effective. This is an individual assessment

Length: 1500 words +/-10% (word length includes in-text referencing and excludes your reference list)
Estimated time to complete task: Approximately 25-30 hours
Weighting: 50%
How will I be assessed: +/- 7 point grading scale using a rubric
Due date: This assignment is to be submitted 20 September 2022 (week 9) by 11:59pm.
Assessments are to be submitted via Turnitin in your NSB132 Blackboard site. More information about Turnitin is available on the FAQs about Turnitin page.
Requirements:
There are four (4) parts to this assessment. Headings can be used to structure your responses.
Your assignment must be written in:
• Double-spaced text
• Use font, such as Times New Roman, Arial or Calibri; font size 12
• Use of appendices, figures or tables, and dot points are NOT acceptable

Case Study 1
Introduction: Sam is a three-year-old boy admitted to the Children's Hospital emergency department (ED).
Situation: Sam was brought to the ED by his mother because he has been vomiting and had diarrhoea for 2 days and he has become increasingly irritable today.
Background: Sam is usually a well and active three-year-old who attends day care where there has been an outbreak of norovirus. Sam started vomiting two days ago and has had diarrhea.
Assessment:
Weight: 15kg
Medical History: Nil significant; Nil allergies; up to date with all current vaccinations
Current medications: 225mg Paracetamol oral given on admission (1 hour ago)
Nutrition & Elimination: Nil orally since arriving at ED and decreased intake for the past two days. Complaints of feeling thirsty but take small sips of water only – estimate 150mls in 24 hours. Mother reports Sam last vomited 8 hours ago and had a large BO Type 7 while in the ED and soiled himself. Usually is toilet trained and does not have any special nutrition or hydration considerations.
Vital signs: Temperature 37.9 degree Celsius; Blood pressure 95/54; Pulse rate 124, Respiratory rate 32, SPO2 100% on room air.
Oral mucous membranes are dry, skin turgor less than 2 seconds, last voided 6 hours ago and no palpable bladder. Extremities are cool to touch.
Neurological: V; cries and is irritable when woken, sitting on mother's lap or in cot.
Pain: 5/10 (FLACC scale), occasional grimace and cries when awake and difficult to console; states 'my tummy hurts'.

Recommendations: Sam will be observed for the next 8-hours in hospital where you need to conduct the appropriate assessments and provide care. His doctors have stated that intravenous fluid therapy (IVT) is not necessary at present.

Case study 2
Introduction: Sandra is an 83-year-old woman admitted to the Emergency Department (ED)
Situation: Sandra was brought to the ED by her daughter because she has been vomiting and has had diarrhoea for two days and she has become increasingly drowsy and disoriented today.
Background: Sandra lives alone and is usually able to manage independently with occasional assistance from her daughter who lives in the next suburb. Her daughter's children had norovirus 4 days ago and Sandra started vomiting and having diarrhoea 2 days ago.
Assessment:
Weight: 70kg
Medical History: Nil significant, Nil allergies; up to date with all current vaccinations
Current medications: 1G Paracetamol oral given on admission (1 hour ago)
Nutrition & Elimination: Nil orally since arriving at ED and reduced intake for 2 days.
Taking sips of water only – estimate 300mls in 24 hours. Last vomited 6 hours ago and had a large BO Type 7 while in the ED and was incontinent. Is usually continent for urine and faeces and does not have any special nutrition or hydration considerations.
Vital signs: Temperature 37.3 degree Celsius; Blood pressure 105/80 (lying); 95/54 (standing); Pulse rate 98, Respiratory rate 18, SPO2 99% on room air.
Oral mucous membranes are dry, skin turgor greater than 2 seconds, last voided 6 hours ago and no palpable bladder. Extremities are cool to touch.
Neurological: V; GCS - 14; 4AT - 8 – drowsy and disoriented to time.
Pain: 7/10 (Abbey pain scale); states she has abdominal cramps.
Recommendations: Sandra will be observed for the next 8-hours in hospital where you need to conduct the appropriate assessments and provide care. Her doctors have stated that intravenous fluid therapy (IVT) is not necessary at present.