Upper Abdominal Pain

Points to hit on (upper abd pain, abd assessment, blood draw, IV insertion)

Presenting patient with clothes on

56 year old male, comes alone – no family

Volunteers no history, presents moaning

Complaining of 9/10 abd pain, x10 hours, vomiting, wave-like, sharp, epigastrum/upper mid abdomen

Had one episode before, did not seek medical attention

Admits to drinking heavily over weekend.

T 37.2 HR 96 RR 20 BP 166/94 SpO2 94%

Past medical history: 1 previous similar episode, smoker, ‘stomach problems’

NKA

Upon further probing, admits to drinking 2 drinks per day.

Abd assessment: abdomen tense, bowel sounds present, no radiation of pain, no pin point tenderness upon light palpation.

OPQRST –

Nurse to complete ABCD, abd assessment, initiate medical directive: labs and IV start.

Patient repeatedly asking for pain control, retching, restless -----hopefully prompting nurse to approach MD asking for antiemetic and pain relief.

**Observer 1 Checklist: Upper Abdominal Pain**

Learning Objectives:

1. Complete ABCD, abdominal assessment & OPQRST pain assessment in patient with abdominal pain
2. Recognize criteria and initiate Lab draw/Initiate IV medical directive when appropriate
3. Collaborate with other providers when indicated in timely fashion

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y** | **N** | **Comments** |
| Hand hygiene |  |  |  |
| Introduced self; undressed patient |  |  |  |
| Completed full set of vital signs  Attached pulse oximetry |  |  |  |
| Took patient history |  |  |  |
| ABCD assessment |  |  |  |
| Abdominal assessment |  |  |  |
| Pain assessment: OPQRST |  |  |  |
| Identified need to initiate medical directive (Lab draw/IV insertion) |  |  |  |
| Notified MD |  |  |  |
| Other observations |  |  |  |

**Observer 2: Team Communication Checklist**

Objectives:

1. Demonstrates clear communication with team members including closed loop communication
2. Demonstrates understanding and use of team resources

|  |  |  |  |
| --- | --- | --- | --- |
| **Team Members** | **Y** | **N** | **Comments** |
| Communication is concise, clear and specific |  |  |  |
| Seeks information from all resources |  |  |  |
| Verifies that information is correct |  |  |  |
| Notified MD and was able to give report of patient using SBAR tool: |  |  |  |
| Situation |  |  |  |
| Background |  |  |  |
| Assessment |  |  |  |
| Recommendations  Requested: analgesia and antiemetic |  |  |  |
| Additional observations |  |  |  |

**Observer 3: Team dynamics**

1. List examples of effective communication you observed during this scenario (including closed loop communication).
2. Have you observed times in which communication was unclear and you did not observe closed-loop communication? If so, provide examples and explained how the closed loop communication would have improved the scenario.
3. Were appropriate care providers notified in a timely fashion and was the nurse able to provide a history of patient presentation and events occurring in the ED?

Was the SBAR tool implemented?

**Observer 4: Assessment Observations of RN 1**

1. Were key assessment and interventions organized and prioritized appropriately?
2. Describe collaboration efforts of RN 1 with RN 2
3. Describe reassessment completed when patient had episode of pain/hypotension
4. Describe communication between RN 1 and MD upon deterioration of patient.