CLINICAL REASONING IN NURSING

Assessment item 3 - Case Study–Clinical Reasoning & Nursing Assessment
Value: 50%
Due Date: Wednesday 30th April, 2025 2359 hr
Return Date: Thursday 22nd of May, 2025
Length: 1400
Submission method options: Turnitin assignment portal in subject Brightspace

SUBJECT LEARNING OUTCOMES
This assessment task will assess the following learning outcome/s:

- apply selected techniques and frameworks to assess the neurological, cardiovascular, respiratory and endocrine systems in a simulated environment.
- identify and demonstrate selected evidence-based nursing interventions to promote safety, healing and caring in practice in the management of neurological, cardiovascular, respiratory and endocrine health challenges in a simulated environment.
- apply the Clinical Reasoning Cycle to aid clinical decision-making and problem-solving in clinical and simulated scenarios.
- document assessment findings and appropriate nursing care in accordance with legal and professional requirements.

TASK:

This assessment task requires you to refer to the case study in the assessment 3 folder in the subject site.
You are asked to address the following four (4) stages of the Clinical Reasoning Cycle (CRC):

- Process and interpret;
- Establish goals;
- Take action; and
- Evaluate care.

For each section, please use the stage of the CRC as your subheading and address the following points while referring to, integrating and providing examples from the case study:

Processing & interpreting: Outline three (3) abnormal assessment findings and describe how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study. In-text referencing is required. (Suggested word count - approximately 450 words).

Establish goals: Formulate one (1) SMART goal relevant to the case study based on the nursing assessment. Make sure you use the SMART goal format subheadings in your response. No in-text referencing is required (Suggested word count - approximately 150 words).

Take action: Identify two (2) safe evidence-based nursing interventions that align with the SMART goal you have set. In-text referencing is required. (Suggested word count - approximately 400 words).

Evaluate care: Outline the process for evaluating the desired outcomes in this scenario and discuss the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. In-text referencing is required. (Suggested word count - approximately 400 words).

You <u>do not</u> need to provide an introduction or a conclusion. This assessment must be written using professional and academic language, be presented in structured paragraphs, and written in the third person.

The assessment needs to be adequately supported by at least six (6) current, reliable and purposeful peer reviewed and/or academic sources of information from journal articles, module readings, textbooks, and professional manuals. In-text citations and the reference list must be comprehensive according to APA 7th ed. style conventions. Sources should not be older than seven (7) years, that means they should be published after January 2018.

The presentation and formatting instructions for your assessment are available in the subject outline under the "My Subject" menu on BrightSpace.

A student template is available for use in the Assessment 3 module in the subject site. The template comes with pre-configured formatting, including margin size, font, headings, subheadings, and header and footer settings, if you choose to use it.

Criteria	High Distinction (85-100%)	Distinction (75-84.5%)	Credit (65-74.5%)	Pass (50-64.5%)	Fail (0-49.5%)	Mark
Processing & interpreting: Outline three (3) abnormal assessment findings and describe how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study.	You have outlined three abnormal assessment findings and analysed how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study. *(25.5 – 30 marks)*	You have outlined three abnormal assessment findings and examined how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study. (22.5 – 25 marks)	You have outlined three abnormal assessment findings and discussed how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study. (20 – 22 marks)	You have outlined three abnormal assessment findings and described how they link to the pathophysiology of the condition that has resulted in the hospital presentation as outlined in the case study. (15-19.5 marks)	You have not outlined three abnormal assessment findings and/or described how they link to the pathophysiology of the condition that has resulted in the hospital presentation and/or you have not adequately linked the case study in your answer. (0 – 14.5 marks)	/30
Establish goals: Formulate one (1) SMART goal relevant to the case study based on the nursing assessment. Make sure you use the SMART goal format subheadings in your response.	You have clearly and comprehensively formulated one appropriate goal to achieve a desired outcome which is relevant to the main patient problem previously identified. Each aspect of the SMART criteria has been clearly formulated to determine an appropriate goal for the patient. (8.5-10 marks)	You have clearly formulated one appropriate goal to achieve a desired outcome which is relevant to the main patient problem previously identified. Up to one aspect of the SMART criteria requires further development. (7.5-8 marks)	You have clearly formulated one appropriate goal to achieve a desired outcome which is relevant to the main patient problem previously identified. Two aspects of the SMART criteria require further development. (6.5-7 marks)	You have formulated one appropriate goal to achieve a desired outcome which is relevant to the main patient problem previously identified. Between 3 and 4 aspects of the SMART criteria require further development. (5-6 marks)	You have not formulated a desired goal which is relevant to the main patient problem previously identified. Each aspect of the SMART criteria requires further development. (0-4.5 marks)	/10

Criteria	High Distinction (85-100%)	Distinction (75-84.5%)	Credit (65-74.5%)	Pass (50-64.5%)	Fail (0-49.5%)	Mark
Take action: Identify two (2) safe evidence-based nursing interventions that align with the SMART goal you have set.	You have identified two (2) safe evidence-based nursing interventions that align to the established SMART goal and provides a rationale for each. Evidence is analysed to consistently support rationales. (17 – 20 marks)	You have identified two (2) safe evidence-based nursing interventions align to the established SMART goal and provides a rationale for each. The rationales are explained by evidence and mostly provide specific explanations for the need for the intervention that include consideration of relevant best practice. (15 – 16.5 marks)	You have identified two (2) safe evidence-based nursing interventions that aligns to the established SMART goal and provides a rationale for each. The rationales are discussed by evidence, with some limited consideration of relevant best practice. (13 – 14.5 marks)	You have identified two (2) safe evidence nursing interventions that will address each SMART goal. The rationales are outlined by evidence that supports the need for the interventions. (10 – 12.5 marks)	You have not identified (2) safe evidence-based nursing interventions. You have not identified a rationale or the rationale is not supported by evidence. (0 – 9.5 marks)	/20
Evaluate care: Outline the process for evaluating the desired outcomes in this scenario and discuss the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions.	You have analysed the process for evaluating the desired outcomes in this scenario and analysed the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. (17 – 20 marks)	You have explained the process for evaluating the desired outcomes in this scenario and explained the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. (15 – 16.5 marks)	You have described the process for evaluating the desired outcomes in this scenario and described the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. (13 – 14.5 marks)	You have outlined the process for evaluating the desired outcomes in this scenario and discussed the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. (10 – 12.5 marks)	You have not outlined the process for evaluating the desired outcomes and/or did not discuss the importance of re-examining both objective and subjective data to assess the effectiveness of your nursing interventions. (0 – 9.5 marks)	/20

Criteria	High Distinction (85-100%)	Distinction (75-84.5%)
Communicates Professionally (Academic writing and presentation).	Language features and structures are used to convey meaning effectively, clearly, unambiguously, concisely, and in a formal academic style, with few spelling, grammatical, or punctuation errors. Presentation guidelines have been followed. **(8.5 – 10 marks)**	Language features and structures are used to convey meaning effectively, clearly, unambiguously, and in a formal academic style, with occasional minor spelling, grammatical, or punctuation errors. Presentation guidelines have been followed. **(7.5 – 8 marks)**
Uses evidence to support and build knowledge in practice (Academic referencing).	The assessment is supported by & related to a wide variety of peer reviewed references which include journal articles, professional manuals and documents, textbooks, and module readings. Referencing is comprehensive, demonstrates academic integrity, and is error free for the APA 7th ed. style conventions. **(8.5 – 10 marks)**	The assessment is supported by & related to a variety of peer reviewed references which include journal articles, professional manuals and documents, textbooks, and module readings. Referencing is comprehensive, demonstrates academic integrity, and conforms to APA 7th ed. style conventions, with one or two errors. **(7.5 – 8 marks)**

Marcus Jamieson, 52 years old, arrived at the emergency department this morning accompanied by his brother. Marcus appeared visibly anxious and was holding his chest. He described his intense chest pain as "a 9 out of 10, like a truck is sitting right here," as he pointed to the centre of his chest, which started about an hour into playing an early morning golf with his brothers. Marcus further characterised the pain as a sharp, crushing feeling in the center of his chest that radiated to his left arm. He added that he now feels very fatigued and short of breath.

Triage Observations at 0715 hr

Airway: Patent, own, RR: 33 $Sp0_2$: 96% on Room Air (RA)

BP: 170/86

HR: 130, regular

T: 37.1 °C

Pain 9/10. The patient reports "a 9 out of 10 central chest pain, heavy and sharp, crushing feeling in the center of his chest that radiated to his left arm.

GCS 15

BSL: 7.5 mmol/L

Medical History

Nil known allergies

Appendicectomy

Not on regular medication

Drinks 4 stubbies / week (stubby of beer=375mL; 4.9% alcohol)

ED Investigations

CXR: Pending

ECG: Non-ST elevated myocardial infarction (NSTEMI) with widespread T wave inversion most prominent in the lateral leads

Troponin: Results pending

FBC, UEC, Lipid profile: Results pending

In the ED, the patient was commenced on Pathway for Acute Coronary Syndrome (PACSA) for high-risk NSTEMI. Marcus received aspirin 300mg PO, a glyceryl trinitrate (GTN) sublingual tablet of 300 micrograms, and enoxaparin 100mg via subcutaneous injection. Marcus has been admitted to the medical ward for cardiac monitoring via telemetry and has been added to the cardiac catheterisation list this evening for an angiogram.

You are the registered nurse (RN) in the medical ward, and you assume care of Marcus during this afternoon shift. Marcus appears anxious and is rubbing his left arm. You approach Marcus to introduce yourself and proceed to conduct your primary and secondary assessment.

Your response to the assessment questions should be based on your assessment in this shift.

Primary Assessment		Data Collected at 1500hrs by yourself as the Patient's RN
Airway		Patent, maintaining own airway
Breathing		Talking in sentences. Rapid breathing.
Circulation		Warm to touch
Disability		Alert Anxious and rubbing left arm
Exposure/environment		Nil abnormalities detected (NAD)
Secondary Survey		
Full set of vitals (Please refer to the Standard Adult Observation Chart next page)	RR	36 breaths per minute
	Sp02	97% on room air (RA)
	HR	140 beats per minute
	BP	BP 168/75mmHg
	Temp	37 °C
	Pain score /10	Provoking/Relieving Factors: Constant pain even when at rest and gets worse on movement. Quality: Sharp, heavy and crushing pain Region: Central chest and on the left arm Severity: Increasing to 9/10 on movement. 5/10 at rest. Time: "All started early this morning while playing golf. It went away after some meds this morning in ED. And it came back again after walking to the bin just before you arrived. I just wanted to clear the rubbish from my table."
Fluids in & out		Fasting for angiogram. Scheduled for later this evening. Voiding (urinal bottle present at the bedside). Currently not on Fluid Balance Chart.
Glucose		Random daily BSL: 7.5 mmols/L
History	**A** Allergies	NKDA
	M Medications	Not on regular medications prior to admission
	P Past medical History	Drinks 4 stubbies/week Appendicectomy
	L Last oral intake	Drank tea and lemonade at the golf resort this morning. Nothing since.
	E Events leading up to the presentation	Pain on exertion (during golf) Intermittent indigestion-type pain in the past couple of nights
Head to toe	Head/neck/face	NAD
	Chest	Equal rise and fall of chest. Good air entry on auscultation
	Abdomen/back	NAD. Bowels opened this morning at home. Normal stool.
	Pelvis	NAD
	Extremities	Peripheral pulses are present, regular and strong CR 2 seconds

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction/Type/Date	Initials
NKDA		

Sign. JJ Print. Jones Date Today

FAMILY NAME Jamieson	MRN 456789
GIVEN NAME Marcus	☐ MALE ☐ FEMALE
D.O.B. 04 /02 /1973	M.O. Jones
ADDRESS 1 Pear Tree Close Sydney 2000	
LOCATION Medical Ward, Charles Sturt University Hospital	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber **to Print Patient Name and Check Label Correct:** Marcus Jamieson Weight(kg):..... Height(cm):.....

NSW GOVERNMENT Health

Facility/Service: _____

Ward/Unit:.....

MEDICATION Chart No. _____ **of** _____

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Other
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Prescriber/Nurse Initiator (NI) Print Your Name	Given by	Time Given	Pharmacy
Today	Aspirin	po	300mg	STAT	JJ	Jones	LM	0730	
Today	Glyceryl Trinitrate	sublingual	300 micrograms	STAT	JJ	Jones	LM	0730	

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1 / Nr 2		Prescriber Name	Prescriber Sign.	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken Prior to Presentation to Hospital (Prescribed, over the counter, complementary) Own medications brought in? ☐ Y ☐ N Administration Aid (Specify).....

Medication	Dose & Frequency	Duration	Medication	Dose & Frequency	Duration

GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

Check if patient has another Medication Chart

SMR130001

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH606207 National Medication Chart - 04/2014 - © Commonwealth of Australia 2005 - As amended - 311019

MEDICATION CHART (MR71) SMR130.001

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20____

FAMILY NAME Jamieson	MRN 456789
GIVEN NAME Marcus	☒ MALE ☐ FEMALE
D.O.B. 04 / 02 / 1973	M.O.
ADDRESS 1 Pear Tree Close Sydney 2000	
LOCATION Medical Ward, Charles Sturt University Hospital	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber **to Print Patient Name and Check Label Correct:** .....

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date			
Today	Glyceryl trinitrate				Today	Today	Today
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time	0740	0810	0830
Sublingual	300 micrograms		1800 micrograms				
Indication	every 5 min PRN	Pharmacy		Dose	300 mcg	300 mcg	300 mcg
C/P if SBP >100mmHg				Route	subling	subling	subling
Prescriber Signature	Print Your Name		Contact	Sign	LM	LM	LM
JJ	Jones						

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Today	Morphine			
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
IV	2.5-5 mg if required repeat after 5 minutes		10 mg	
Indication	Pharmacy			Dose
ACS C/P				Route
Prescriber Signature	Print Your Name		Contact	Sign
JJ	Jones			

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Today	Fentanyl			
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
IV	25-50 micrograms Repeat after 5 minutes PRN		100 micrograms	
Indication	Pharmacy			Dose
ACS C/P				Route
Prescriber Signature	Print Your Name		Contact	Sign
JJ	Jones			

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Today	Metoclopramide			
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
IV	10 mg TDS			
Indication	Pharmacy			Dose
N&V				Route
Prescriber Signature	Print Your Name		Contact	Sign
JJ	Jones			

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Today	Ondansetron			
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
IV	4-8 mg TDS			
Indication	Pharmacy			Dose
N&V				Route
Prescriber Signature	Print Your Name		Contact	Sign
JJ	Jones			

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Today	Paracetamol			
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
PO	1000mg QID			
Indication	Pharmacy			Dose
pain				Route
Prescriber Signature	Print Your Name		Contact	Sign
JJ	Jones			

Date	Medication (Print Generic Name)		Max PRN dose/24 hrs	Date
Route	Dose & Hourly Frequency	PRN	Max PRN dose/24 hrs	Time
Indication	Pharmacy			Dose
				Route
Prescriber Signature	Print Your Name		Contact	Sign

Continue on discharge? Yes / No
Dispense? Yes / No
Duration ..... days/Qty .....

Date .....
Pharmacist .....
Print Name: .....
Contact: .....
Prescriber's Signature: .....

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

SMR130001

Check if patient has another Medication Chart

NOT A VALID ORDER UNLESS LEGIBLE

End of Scenario: Write your case analysis as the medical nurse considering all vital signs and information provided to you in this document. Refer to the Assessment Task in your subject outline to address assessment criteria.