2010

Clinical Exemplar

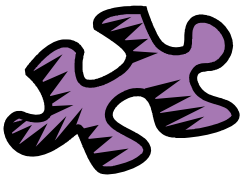
Sandy Boswell, BSN, RN, CAPA

Story

6

DOWN SYNDROME

Processing and assessing a patient on arrival in SPPU is like putting pieces of a puzzle together. Each piece of the puzzle helps admitting nurses have a clearer picture of a patient, who arrives as a stranger and becomes a distinct individual through our assessments. First, the nurse starts with the operating room schedule, which provides the initial pieces to the puzzle, the name, age, procedure, and doctor for the patient. If we are lucky, the patient's chart contains a history and physical to help with the upcoming assessment of our patient. This provides the nurse with real clues as to what challenges she will meet and what direction she will take which will enable her to best meet the needs of patients. For me, the most memorable admissions are ones where my patients have presented with needs, different from the norm.



Recently, as I read my patient's history and physical, I felt my adrenaline level rising as I realized my patient was going to be challenging and exciting. My patient was a 40 year Asian male with Down syndrome who would be undergoing laparoscopic cholecystectomy. Right away, my mind started racing with unanswered questions. What would the patient's maturity level be? Would I be able to get an iv in? Should I use EMLA cream as I would for a child? What support system did the patient have? How could I support the family? Would there be a language barrier? My first answers came when our aide, Lolo, presented me with vital signs that she had taken as she started the admissions process by bringing the patient in from the waiting room to a cubicle, giving him a patient gown and bags for clothing. Lolo is invaluable to me as a nurse, because her experience with patients allows her to help me with assessment. By the time I introduced myself, I already knew that the patient had a strong, family support system that spoke English, and that he was extremely cooperative.

Three women were with my patient; one was the patient's sister. I soon learned that the family was Vietnamese, but spoke English. My patient was non-verbal, but understood some things when his sister spoke to him in Vietnamese.

He did not appear scared and was extremely loving and affectionate with his sister. He would lay his head against her shoulder and she, in return, stayed very close to him, often touching him or holding his hand. His sister explained to me that cholecystitis had been diagnosed when the patient would grimace and place his hand over his right upper quadrant of the abdomen, leading the family to seek medical treatment. She also assured me that the patient was very cooperative and would have no trouble with IV insertion. She certainly was right, as I was able to insert an IV and use Lidocaine as the patient's sister held his hand.

The most poignant part of the admission was the patient's childlike love for his sister who reciprocated with gentle love and caring. After I admitted the patient, his sister spoke up and wanted to share with me how much his 82-year-old mother loved him. I told her that I had no doubt about how much his mother loved him since he was her baby, as all children are to their mothers. I felt that she was trying to validate for me his worth as a person and I found it very touching.

My patient loved helping us attach the sequential compression devices to his legs. Like playing with a toy, he helped us connect the blue attachments to the machine. I checked our operating room schedule where anesthesiologists are listed to see who would be performing anesthesia. I was really hoping that, because we were essentially dealing with a patient with the needs of a child, the anesthesiologist would consent to allow family to accompany our patient to the operating room for induction. Fortunately, the patient's anesthesiologist was most cooperative with this request. It is a wonderful help for patients and families because separation anxiety is reduced. The family member stays in the operating room only until the patient goes to sleep. After receiving permission from anesthesia, I checked with the patient's sister to ask if she would consider going to the OR with the patient for induction. I knew that the patient would be comforted by his sister's presence in the OR while he went to sleep, especially since this was his first operating room experience.

For me, the admission puzzle was complete when I saw my patient and his sister, right beside him, garbed in OR scrubs and a cap, waiting with her brother to accompany him to the operating room. With a cooperative patient, a supportive family, an accommodating anesthesiologist, and a surgeon who provided all the proper paperwork, the pieces fit together rather well, thus giving the patient a positive pre-operative experience.