**STARL and ISBAR**

**Part 1: STARL reflection model**

Situation: I took part in the stipulated activity in the course of my studies as a student. Notably, it was a school environment and most of the people within my scope of reach were either students or tutors within the school environment.

Task: My role was to act as a nurse who had a responsibility of undertaking a general survey health assessment on a patient. I was required to ask a range of questions which were to enable me to develop a diagnosis of what the patient might be ailing from (Estes, 2016). I did not necessarily have to rely on the information that the patient provided; however, I was to rely on my professional competencies so that I am capable of recognizing any strange behaviors in the individual and deducing the most appropriate way to describe the condition.

Action: I carried out a survey as per the requirements of the nursing discipline. The questions were divided into five sections. They include physical presence, psychological presence, distress observation, pain assessment and vital signs assessment. Under physical presence, I gave the patient an opportunity to introduce himself.  I took this step because nursing entails the extension of care to patients (Crisp at al., 2016). An introductory session marks the first step showing care towards the patients and builds a rapport. I then observed the general appearance of patients to determine frailties in their physical system. I used observation skills and analytical skills to recognize and deduce any kind of abnormal behavior in the patient. I also incorporated good communication skills while engaging the patient to ensure that he heard the questions clearly and responded to them expectedly. All of the survey questions I addressed at this stage were vital in the need to make a diagnosis.

Result: The patient responded accordingly. I was capable of deriving responses that would enable me to execute my clinical duties. The responses were appropriate for making a diagnosis or finding out the health status of the patient.

Learning: I learnt that is always easy to get effective and comprehensive results when you have the right skills for the task.

**Part 2: the ISBAR format**

**Introduction**

 This Patient is called Courtney Sanders. She is 54 years old. Her height is 154cm and she weighs 70kg.

**Situation**

I have been assessing the health status of Courtney Sanders. I carried out a general survey on health assessment of the patient by asking a range of questions so as to determine her health status. The patient came for check up because she had a dry mouth, sore throat and was coughing intermittently.

**Background**

The patient exhibited a number of suggestive symptoms in regards to her health status. She normally coughs while making signs that indicate she is going through pain developing from the epigastric region. The patient makes a lot of facial expressions that indicate pain when coughing. She normally holds the epigastric area for support. Her medical records show that the patient yawns and looks tired all the time. She also has a posture of leaning forward while clutching the abdomen. Furthermore, she gaits when entering and bends forward when leaving. She also clutches the abdomen to prevent the gait from being fluid and normal. The background information about the health status of the patient guided me in my selection of tests that I was to perform on her.

**Assessment**

There are a number of issues that I derived from the health assessment exercise on the patient. Under physical examination, I noted that patient’s mouth was dry. Consequently, I requested the patient to inform me on what had transpired. The patient reported the dryness of her mouth and the appearance of her eyes which are also sore. She had a moist cough for five days and her mucus was yellow for the past three days. The patient’s throat is sore and she experienced a running nose in the past two days. However, the running nose had momentarily stopped. For a normal person, the mouth should not be dry, mucus should be colorless and the throat should be soft.

To assess the psychological presence of the patient during times of treatment, I observed her dressing, grooming and personal hygiene. Furthermore, I observed the manner and mode of behavior the patient before asking her how she felt. The patient feels tired and exhausted. She also has crumpled clothes and attributes this state to her incapability to iron. In most cases, she appears not only restless but also anxious. I asked the patient about her sleeping patterns, of which the patient affirmed that her sleep is normally interrupted by coughing. I asked the patient to explain her state of worry after noticing it from her speech and facial expressions (Ramasubbu et al., 2017). Sander explained that the source of her worries is in regards to job insecurity. She is not sure of the payments in spite of his devotion to the work as a computer programmer. She also worries about her health because she drinks a lot of water to compensate for her dry mouth but she does not each much. Additionally, the patient has a severe abdominal pain as she coughs day and night. Healthy people do not feel tired all the  time, have normal sleeping patterns, eat and drink normally, and do not feel any abdominal pain.

I also observed the patient to find out if there are instances of distress in the patient’s life. I made observations for labors breathing and speech, facial expressions exhibiting pain and misery, visible signs of attempts of protecting painful areas, life threatening occurrences, and anxiety. I noticed that the patient coughed intermittently during the interview, made facial expressions of pain when coughing, she also held the epigastric areas, yawned and looked tired. I then undertook a pain assessment exercise with the help of the PQRST mnemonic test to determine the severity of the conditions. Coughing was the main provoking factor as it caused an increase in pain. I described the quality of the pain as a dull ache that intensified during coughing. She had taken panadol as a relieving factor but it failed. Pain was dominant in the epigastric region. The patient gave the severity of the state 7 out of 10. She has experienced pain while coughing for roughly 2 days. Healthy people should be free from pain and distress.

**Recommendation**

Courtney coughs intermittently and produces yellow mucus. Notably, she is suffering from Tuberculosis. My recommendation after realizing the condition of the patient will be to undertake a preventive therapy program to kill germs that are likely to cause more damage in the future. I would also ensure that the patient sticks to the treatment program through a directly observed therapy strategy. As a health care work, I would recommend administering medication so as to avoid chances of skipping medication. Skipping doses or stopping treatment allows bacteria to become resistant to drugs, making the condition more dangerous and difficult to handle (Sylvia, 2017).

**References**

Crisp, J., Clint, D., Rebeiro, G., & Waters, D. (2016). *Potter and Perry’s Fundamentals of Nursing, Australian and New Zealand Edition*. Chatswood: Elsevier Australia.

Estes, M., Calleja P., Theobald, K. & Harvey, T. (2016). *Health Assessment and Physical Examination*. South Melbourne, VIC: Cengage Learning Australia.

Ramasubbu, B., Stewart, E. & Spiritoso, R. (2017). Introduction of the identification, situation, background, assessment, recommendations tool to improve the quality of information transfer during medical handover in intensive care. *Journal of the Intensive Care Society*, *18*(1), 17-23.

Sylvia, S., Xue, H., Zhou, C., Shi, Y., Yi, H., Zhou, H., Rozelle, S., Pai, M.., & Das, J. (2017).Tuberculosis detection and the challenges of integrated care in rural China: A cross-sectional standardized patient study. *PLoS Med, 14*(10).