

VT

Mandeep work .docx

 My Files

 My Files

 University

Document Details

Submission ID

trn:oid::17268:88414738

Submission Date

Mar 28, 2025, 8:06 PM GMT+5:30

Download Date

Mar 28, 2025, 8:08 PM GMT+5:30

File Name

Mandeep work .docx

File Size

268.4 KB

14 Pages

2,776 Words

17,500 Characters

*% detected as AI

AI detection includes the possibility of false positives. Although some text in this submission is likely AI generated, scores below the 20% threshold are not surfaced because they have a higher likelihood of false positives.

Caution: Review required.

It is essential to understand the limitations of AI detection before making decisions about a student's work. We encourage you to learn more about Turnitin's AI detection capabilities before using the tool.

Disclaimer

Our AI writing assessment is designed to help educators identify text that might be prepared by a generative AI tool. Our AI writing assessment may not always be accurate (it may misidentify writing that is likely AI generated as AI generated and AI paraphrased or likely AI generated and AI paraphrased writing as only AI generated) so it should not be used as the sole basis for adverse actions against a student. It takes further scrutiny and human judgment in conjunction with an organization's application of its specific academic policies to determine whether any academic misconduct has occurred.

Frequently Asked Questions

How should I interpret Turnitin's AI writing percentage and false positives?

The percentage shown in the AI writing report is the amount of qualifying text within the submission that Turnitin's AI writing detection model determines was either likely AI-generated text from a large-language model or likely AI-generated text that was likely revised using an AI-paraphrase tool or word spinner.

False positives (incorrectly flagging human-written text as AI-generated) are a possibility in AI models.

AI detection scores under 20%, which we do not surface in new reports, have a higher likelihood of false positives. To reduce the likelihood of misinterpretation, no score or highlights are attributed and are indicated with an asterisk in the report (*%).

The AI writing percentage should not be the sole basis to determine whether misconduct has occurred. The reviewer/instructor should use the percentage as a means to start a formative conversation with their student and/or use it to examine the submitted assignment in accordance with their school's policies.

What does 'qualifying text' mean?

Our model only processes qualifying text in the form of long-form writing. Long-form writing means individual sentences contained in paragraphs that make up a longer piece of written work, such as an essay, a dissertation, or an article, etc. Qualifying text that has been determined to be likely AI-generated will be highlighted in cyan in the submission, and likely AI-generated and then likely AI-paraphrased will be highlighted purple.

Non-qualifying text, such as bullet points, annotated bibliographies, etc., will not be processed and can create disparity between the submission highlights and the percentage shown.



Introduction

Indigenous Australian Jarrah Wonga, 62, was recovering in hospital after undergoing two days of surgery. He received a total hip replacement due to osteoarthritis. Mr Wonga has since exhibited postoperative signs of acute confusion, agitation, and disorientation. Both the nursing staff and his family are concerned. This essay aims to explore the possible clinical issues contributing to Mr Wonga's sudden cognitive changes and identify appropriate nursing interventions using the Clinical Reasoning Cycle. Generative artificial intelligence (AI) will also be utilised to identify and prioritise two nursing concerns and the related interventions, as well as to review the AI-generated responses to these issues critically. Finally, discharge planning will be addressed in the essay by specifying two key nursing interventions focused on preventing future complications and promoting psychosocial well-being. This essay, through a structured and evidence-based approach, demonstrates that clinical reasoning is pivotal in developing culturally safe nursing care to facilitate optimal postoperative outcomes, particularly for patients with complex health needs and vulnerable backgrounds.

One potential clinical problem

One potential clinical problem in Mr Jarrah Wonga's case based on the clinical reasoning cycle (Levett-Jones, 2010) is **postoperative delirium (POD)** (Levett-Jones, 2010). Delirium is an acute, fluctuating disturbance of attention, cognition and arousal occurring in older adults after surgery. In Mr. Wonga's case, delirium is characterised by symptoms of confusion, restlessness, disorientation, rambling speech and fluctuating mood (Ho et al., 2021). This condition's pathophysiology appears to be multifactorial, and incomplete understanding. Although there is still no consensus opinion, it is thought to be associated not only with inflammatory and oxidative stress but also with acetylcholine deficiency and dopaminergic excess in the brain (Huang et al., 2021). After surgery, they associate increased

proinflammatory cytokines and surgical stress with altered cerebral metabolism and abnormal blood-brain barrier permeability in triggering acute cognitive dysfunction (Xiao et al., 2023).

Many risk factors make Mr. Wonga vulnerable to developing postoperative delirium. Advanced age, along with a history of mild cognitive changes evidenced by cases of forgetfulness, are predisposing factors (Bramley et al., 2021). Also, his history of Type 2 diabetes, hypertension, and osteoarthritis, requiring hip replacement, are all chronic diseases that are known risk factors for poor post-surgical recovery (Chaiwat et al., 2019). There may be a high degree of vulnerability to delirium from the very fact of the surgical procedure itself, its self-inducing anaesthesia and any associated stress response (Xiao et al., 2023). The fact that Mr Wonga had limited sleep postoperatively, unmanaged pain (grade 6/10), an elevated temperature (37.8°C) and hyperglycaemia (12.5 mmol/L), all of which added to the possibility of delirium, also had a role in the decision to administer antipsychotic medicine (Oh & Park; J., 2019).

Physiological stress and cognitive decline are the result of the administration of opioid analgesics such as oxycodone, which affects cognition in older adults associated with decreased oral intake and dehydration (dark urine and urine output) (Zhuang et al., 2022). Other cultural factors are also important; studies indicate that Aboriginal and Torres Strait Islander peoples may have higher levels of psychological distress associated with the delivery of health care in a healthcare setting due to systematic inequities, as well as communication barriers, which may compound confusion and agitation postoperatively (AIHW, 2023). Together, these factors demonstrate that postoperative delirium is an important clinical problem that needs immediate, culturally sensitive nursing intervention (Nolan-Isles et al., 2021).

It is important to recognise postoperative delirium early and treat it to prevent additional complications such as a fall, prolonged hospitalisation, worsening of functional status and increased morbidity. For Mr Wonga, timely and culturally appropriate nursing care is essential to his recovery, and the day-to-day activities of his life should be preserved (Swarbrick et al., 2022).

Critique of AI-generated responses

Most of the AI-generated responses are in response to answers to two priority nursing issues in Mr Jarrah Wonda's case; postoperative delirium and impaired mobility are also appropriate. This shows key nursing responsibilities in the Australian clinical setting. The interventions proposed are relevant to nursing practice as described by the Nursing and Midwifery Board of Australia (NMBA) (NMBA, 2024). The response correctly indicates cognitive reorientation and environmental control as appropriate strategies for treating Delirium. It also acknowledges the importance of supported ambulation and is appropriate for pain management to aid inclination and avoid complications (Vlisides & Avidan, 2019).

The high quality of the AI-generated response rested on its structure and clarity. All the nursing interventions are logical and clinically sound and based on fundamental nursing principles, including maintaining patient safety, early mobilisation and monitoring medication effects. Early mobilisation and collaboration with physiotherapists, although not entirely new, are well-established for debilitation and post-operative care (Igwe et al., 2024). The emphasis given to avoidance of sensory overload to promote sleep hygiene to minimise delirium reflects an understanding of non-pharmacological as a strategy for delirium management (Chaiwat et al., 2019).

The response, however, also has several drawbacks in-depth and cultural appropriateness. While acknowledging briefly that culturally sensitive care is required, it offers generic care strategies that are not suitable for the care of Indigenous Australian patients (Xiang et al., 2023). In terms of the Australian context, culturally safe care is imperative, particularly with Aboriginal and Torres Strait Islander peoples, when providing care in hospital settings that may result in fearful, mistrusting and communication barriers in hospitals as a result of past traumas and systemic inequities (Joye & Foran, 2023). There are specific interventions, including Aboriginal liaison officers, culturally appropriate communication methods, and involving family members in care planning that are absent and limit the depth and applicability of the response to Mr Wonga's unique psychosocial and cultural background (Igwe et al., 2024).

Furthermore, the response does not fully incorporate the patient's comorbid conditions into the nursing care plan. In the case study, for example, hyperglycaemia and dehydration (all well-known and frequently evaluated in such recovering patients) are noted (Bramley et al., 2021). Still, there is no monitoring of blood glucose levels, adjusting of diabetic medications, or assessment of fluid balance, all needed components of holistic care of a patient with type 2 diabetes recovering from surgery. Likewise, Mr Wonga's antihypertensive regimen and the risk of hypotension when mobilising were not considered (Chaiwat et al., 2019).

Therefore, the conclusion is that the AI-generated response provides a suitable baseline of appropriate and relevant nursing interventions but does not have the clinical detail or the cultural focus relevant to Australian nursing practice. Improving the response with more culturally safe, patient-centred and comorbidity-informed strategies would serve to improve the quality of response to truly holistic and evidence-based care for patients such as Mr Wonga.

Discharge Planning

As two of the major nursing interventions that should be prioritised in planning Mr Jarrah Wonga's discharge, the nursing focus on the prevention of future complications and the psychosocial well-being of Mr Jarrah Wonga must be present first. Meant to help his recovery and promote an independent transition home to his home environment, considering his physical condition and his cultural background.

Primary nursing intervention for patients undergoing total hip replacement surgery should be the prevention of postoperative complications, particularly VTE risk and risk of fall, as both are common risks in recovering from total hip replacement surgery. Mr Wonga must be given a comprehensive mobility and home safety plan, and nurses should make sure that it is provided (Fontalis et al., 2021). They include educating the patient and his family about safe ambulation techniques, using mobility aids in the most appropriate ways and home amendments such as installing handrails or removing hazards. Physiotherapy should be arranged, and written instructions given to encourage mobility goals and reinforce the goals in the client's new environment (Kahn & Shivakumar, 2020).

In addition, since Mr Wonga was on enoxaparin for thromboprophylaxis in the hospital, there should also be included in discharge education the signs of VTE and the importance of maintaining mobility and hydration. In addition, he should have a specialised plan to manage pain so he does not require opioids to be able to participate fully in rehabilitation activities (Fontalis et al., 2021). This intervention not only decreases Mr Wonga's risk of falls, immobility, and thrombotic events but also allows for Mr Wonga's autonomy within a culturally safe and supportive environment (Kahn & Shivakumar, 2020).

The second nursing intervention also needs to be directed at the psychosocial effect of surgery, Mr Wonga's stated concern about losing independence and his confusion and agitation while in the hospital. After discharge, his mental and emotional welfare should be assessed, and this could be achieved by facilitating referrals to trained mental health and community support services that are culturally appropriate (Koizia et al., 2019). Encouraging an Aboriginal health worker or liaison officer to be involved in the discharge process, involves the communication being clear, culturally respectful and includes his family (Ma et al., 2021).

Mr Wonga and his family should also be educated regarding the recognition of recurrence of delirium or emotional distress and coping strategies with postoperative changes so that nurses can provide education on the matter. Social involvement in daily activities, family and community involvement, as well as community-based support can help reduce the feeling of isolation and anxiety (Changsuphan et al., 2018). This will also help Mr Wonga's psychosocial health throughout his recovery experience and decrease the likelihood of long-term and permanent emotional and cognitive decline (Ma et al., 2021). This evidence-related and responsive to the cultural needs of the nursing interventions ensures that the discharge plan addresses both the physical recovery and emotional resilience to the extent of adapting to the home setting and optimal post-surgical outcomes (Koizia et al., 2019).

Conclusion

This essay concluded by summarising the case of Mr Jarrah Wonga, where the problem of postoperative delirium was identified, and nursing interventions were documented based on evidence that can assist his recovery. Using the Clinical Reasoning Cycle, nursing issues of priority were captured, and nursing interventions were designed to address cognitive changes

and mobility limitations. Integration of cultural safety, clinical judgement and patient-specific factors was important for the development of AI-generated content, and the critique of AI-generated content highlighted the importance of integrating it for the production of care plans for patients. Special discharge refusal interventions were aimed at preventing complications and providing the psychosocial well-being of Mr Wonga. Clinical reasoning and evidence-based practice are key in making appropriate and safe nursing decisions for individualised care. Most of these elements serve to improve patient outcomes, especially in complex cases, and they enhance the professional nursing practice in diverse and rich cultural healthcare settings such as Australia.

AI Usage Statement

I acknowledge that I have used ChatGPT to complete this assignment. The AI was used specifically to answer part B of the assignment. All AI-generated content has been critically evaluated, appropriately referenced, and integrated into my work in accordance with academic integrity guidelines. I confirm that the analysis, interpretation, and conclusions presented in this assignment are my own and reflect my independent effort and understanding.

References

- Australian Institute of Health and Welfare. (2023). *Cultural safety in health care for Indigenous Australians: monitoring framework*. Retrieved from <https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework>
- Bramley, P., McArthur, K., Blayney, A., & McCullagh, I. (2021). Risk factors for postoperative delirium: An umbrella review of systematic reviews. *International Journal of Surgery*, 93, 106063. <https://doi.org/10.1016/j.ijisu.2021.106063>
- Chaiwat, O., Chanidnuan, M., Pancharoen, W., Vijitmala, K., Danpornprasert, P., Toadithep, P., & Thanakiattiwibun, C. (2019). Correction to: Postoperative delirium in critically ill surgical patients: incidence, risk factors, and predictive scores. *BMC Anesthesiology*, 19(1). <https://doi.org/10.1186/s12871-019-0732-8>
- Changsuphan, S., Kongvattananon, P., & Somprasert, C. (2018). Patient readiness for discharge after total hip replacement: An integrative review. *Journal of Health Research*, 32(2), 164-171. <https://doi.org/10.1108/jhr-01-2018-016>
- Fontalis, A., Berry, D. J., Shimmin, A., Slullitel, P. A., Buttaro, M. A., Li, C., Malchau, H., & Haddad, F. S. (2021). Prevention of early complications following total hip replacement. *SICOT-J*, 7, 61. <https://doi.org/10.1051/sicotj/2021060>

- Ho, M., Nealon, J., Igwe, E., Traynor, V., Chang, H. (., Chen, K., & Montayre, J. (2021). Postoperative delirium in older patients: A systematic review of assessment and incidence of postoperative delirium. *Worldviews on Evidence-Based Nursing*, 18(5), 290–301. <https://doi.org/10.1111/wvn.12536>
- Huang, H., Li, H., Zhang, X., Shi, G., Xu, M., Ru, X., Chen, Y., Patel, M. B., Ely, E. W., Lin, S., Zhang, G., & Zhou, J. (2021). Association of postoperative delirium with cognitive outcomes: A meta-analysis. *Journal of Clinical Anesthesia*, 75, 110496. <https://doi.org/10.1016/j.jclinane.2021.110496>
- Igwe, E. O., Nealon, J., O'Shaughnessy, P., Ormonde, C., & Traynor, V. (2024). Perioperative knowledge, self-efficacy and clinical practices related to postoperative delirium care in older people across geographical regions in Australia. *Australian Journal of Rural Health*, 32(2), 354–364. <https://doi.org/10.1111/ajr.13097>
- Joye, M., & Foran, P. (2023). Strategies to optimise culturally appropriate perioperative care for Aboriginal and Torres Strait Islander peoples: A discussion paper. *Journal of Perioperative Nursing*, 36(1). <https://doi.org/10.26550/2209-1092.1247>
- Kahn, S. R., & Shivakumar, S. (2020). What's new in VTE risk and prevention in orthopedic surgery. *Research and Practice in Thrombosis and Haemostasis*, 4(3), 366–376. <https://doi.org/10.1002/rth2.12323>

- Koizia, L. J., Wilson, F., Reilly, P., & Fertleman, M. B. (2019). Delirium after emergency hip surgery – common and serious, but rarely consented for. *World Journal of Orthopedics*, *10*(6), 228–234. <https://doi.org/10.5312/wjo.v10.i6.228>
- Ma, J., Li, C., Zhang, W., Zhou, L., Shu, S., Wang, S., Wang, D., & Chai, X. (2021). Preoperative anxiety predicted the incidence of postoperative delirium in patients undergoing total hip arthroplasty: A prospective cohort study. *BMC Anesthesiology*, *21*(1). <https://doi.org/10.1186/s12871-021-01271-3>
- Nolan-Isles, D., Macniven, R., Hunter, K., Gwynn, J., Lincoln, M., Moir, R., Dimitropoulos, Y., Taylor, D., Agius, T., Finlayson, H., Martin, R., Ward, K., Tobin, S., & Gwynne, K. (2021). Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia. *International journal of environmental research and public health*, *18*(6), 3014. <https://doi.org/10.3390/ijerph18063014>
- Nursing and Midwifery Board of Australia. (2024). *Fact sheet: Scope of practice and capabilities of nurses*. <https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-scope-of-practice-and-capabilities-of-nurses.aspx>
- Oh, S., & Park, J. Y. (2019). Postoperative delirium. *Korean Journal of Anesthesiology*, *72*(1), 4-12. <https://doi.org/10.4097/kja.d.18.00073.1>
- Swarbrick, C. J., & Partridge, J. S. (2022). Evidence-based strategies to reduce the incidence of postoperative delirium: A narrative review. *Anaesthesia*, *77*(S1), 92–101. <https://doi.org/10.1111/anae.15607>

Vlisides, P., & Avidan, M. (2019). Recent advances in preventing and managing postoperative delirium. *F1000Research*, 8, 607. <https://doi.org/10.12688/f1000research.16780.1>

Xiao, M. Z., Liu, C. X., Zhou, L. G., Yang, Y., & Wang, Y. (2023). Postoperative delirium, neuroinflammation, and influencing factors of postoperative delirium: A review. *Medicine*, 102(8), e32991. <https://doi.org/10.1097/md.00000000000032991>

Xiang, P. Y., Boyle, L., Short, T. G., Deng, C., & Campbell, D. (2023). Incidence of postoperative delirium in surgical patients: An observational retrospective cohort study. *Anaesthesia and Intensive Care*, 51(4), 260–267. <https://doi.org/10.1177/0310057x231156459>

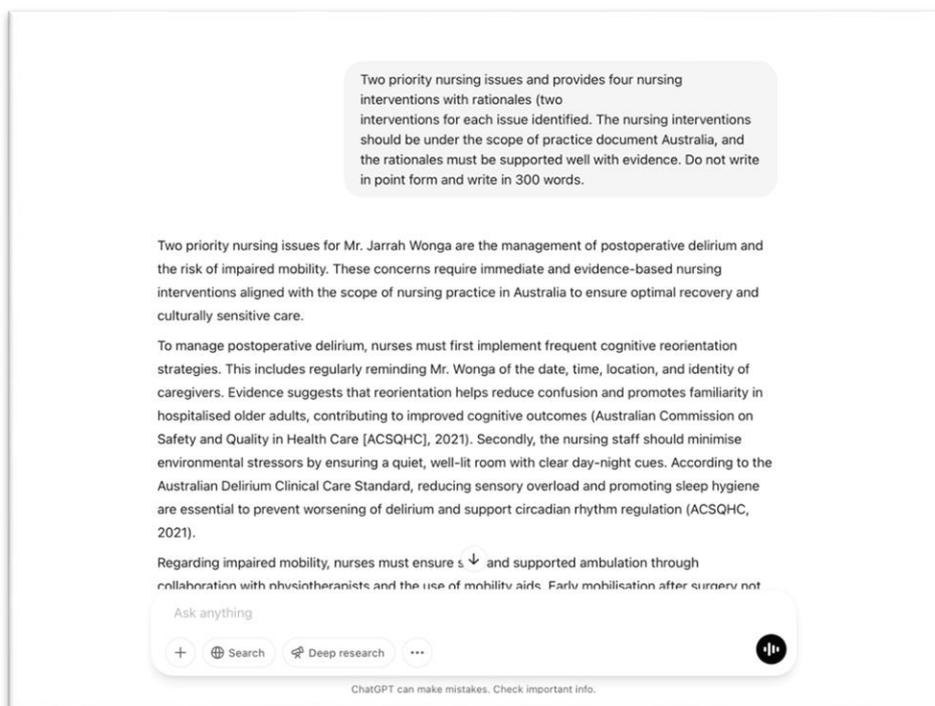
Zhuang, X., He, Y., Liu, Y., Li, J., & Ma, W. (2022). The effects of anesthesia methods and anesthetics on postoperative delirium in the elderly patients: A systematic review and network meta-analysis. *Frontiers in Aging Neuroscience*, 14. <https://doi.org/10.3389/fnagi.2022.935716>

Appendix

Part B

Step 2

The



generative tool used was Chatgpt.

As prompts, the entire case study was copied first, followed by a prompt to give two major nursing problems and related nursing interventions.

AI response

Two priority nursing issues for Mr. Jarrah Wonga are the management of postoperative delirium and the risk of impaired mobility. These concerns require immediate and evidence-based nursing interventions aligned with the scope of nursing practice in Australia to ensure optimal recovery and culturally sensitive care.

To manage postoperative delirium, nurses must first implement frequent cognitive reorientation strategies. This includes regularly reminding Mr. Wonga of the date, time, location, and identity of caregivers. Evidence suggests that reorientation helps reduce confusion and promotes familiarity in hospitalised older adults, contributing to improved cognitive outcomes (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2021). Secondly, the nursing staff should minimise environmental stressors by ensuring a quiet, well-lit room with clear day-night cues. According to the Australian Delirium Clinical Care Standard, reducing sensory overload and promoting sleep hygiene are essential to prevent worsening of delirium and support circadian rhythm regulation (ACSQHC, 2021).

Regarding impaired mobility, nurses must ensure safe and supported ambulation through collaboration with physiotherapists and the use of mobility aids. Early mobilisation after surgery not only improves functional recovery but also reduces the risk of complications such as pressure injuries and deep vein thrombosis (NSQHS Standards, 2021). Nurses should also provide pain management tailored to Mr. Wonga's needs, balancing effective analgesia with minimised cognitive side effects. For instance, using regular paracetamol and reviewing the frequency of oxycodone can help maintain comfort while reducing opioid-induced delirium. The Nursing and Midwifery Board of Australia (NMBA) standards emphasise that nurses are accountable for monitoring medication effects and advocating for adjustments in collaboration with the healthcare team.

By addressing these two nursing priorities—cognitive impairment and mobility limitation—nurses can promote Mr Wonga's safety, preserve his autonomy, and support a culturally safe and holistic recovery process.