Unfolding Case #2 Red Yoder
STAGES- Simulation Team Advancing Gerontologic Education Strategies
Educator's Toolkit

Overview
Red Yoder is an 80-year-old farmer who lives alone in the farmhouse he grew up in. It is located 20 miles outside of town. Red has been a widow for 10 years. His son Jon manages the farm now but Red is still involved in the decision making. Jon lives a few miles up the road and he or his wife stop by nearly every day.

In the introductory monologue, Red is awaiting a visit from the home health nurses. He relates that he is a newly insulin-dependent diabetic and has an open wound on his big toe that developed after walking in a new pair of shoes. When his daughter-in-law Judy saw the wound, she called the family doctor, who suggested a visit by the wound care nurse who works with the home health agency. Red says he agreed as long as his VA benefits cover the costs. Red is aware that his son and wife have concerns about him living alone, but Red insists that while he needs a little help from Jon and Judy at times, he is still capable of caring for himself.

A series of 3 simulation scenarios provide encounters with Red on three separate occasions.

Simulation Scenario 1 occurs in Red’s home during a visit by the nurses from the home health agency to assess the breakdown on his toe. During the assessment, Red reveals that he is having sleeping problems and some urgency incontinence. He also makes statements that should cue learners that further assessments are needed of his diet, medication, and alcohol use, and to rule out elder abuse. Concerns expressed by the daughter-in-law about his ability to care for himself should prompt learners to use the Katz Index of Independence in Activities of Daily Living assessment tool. Other assessment tools recommended for this scenario include SPICES: An Overall Assessment Tool of Older Adults, the Pittsburgh Sleep Quality Index (PSQI), the Elder Mistreatment Assessment and the Alcohol Use and Screening Assessment.

A second monologue occurs two weeks later. Red reveals that he is not going to town to meet his friends for coffee today and hopes his friends aren’t worried about him. He has a loss of appetite and his foot with the wound is red and swollen. Red reveals that he has been forgetting to take the antibiotic for the sore on his toe. He is questioning whether to take his insulin since he has not eaten, but his capillary blood glucose monitor reading is 203.

Simulation Scenario 2 takes place in the Emergency Room of the local hospital. Jon stopped by to check on Red after one of his friends from the VFW called to say that Red didn’t make it to town for coffee. When Jon arrived to check on his father he was surprised at how red and swollen his foot was. He saw that Red was weak and listless so he called the doctor who said he needed to be seen immediately at the local community hospital because the nearest VA hospital is over 100 miles away. The learner will encounter the older adult’s atypical presentation of sepsis. The assessment tool recommended for this scenario is the Confusion Assessment Method (CAM).
Simulation Scenario 3 occurs 5 days later when Red is scheduled for discharge from the hospital. Jon thinks that Red should move in with him for now, but Red is sure he is able to care for himself, and insists that his confusion was due to the fact that he did not have his glasses or hearing aids for the last week. Learners will need to determine how much, if any, functional decline has occurred while Red has been hospitalized. The risks and benefits of Red's living arrangements need to be analyzed in collaboration with Red, Jon, Judy and the healthcare team. Suggested tools for this scenario include the Katz Index of Independence in Activities of Daily Living (ADL) and/or the Lawton Instrumental Activities of Daily Living (IADL) Scale, and the Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults.

Finish the Story Assignment

The “Finish the Story” assignment is the same for all cases. Learners have seen the older adult at several snapshots in time. This last assignment in each of the cases calls for the student to “finish the story” and relate where they see the older adult or older couple about three months after their last encounter. This assignment should give faculty insight into what students have learned from the unfolding case.
Introductory Monologue

I understand you want to hear my story; well I’m not much for talking, but I can give you the highlights. There’s a lot that’s happened over my 80 years.
From the top. My name is Sherman Yoder, but I answer to “Red”. No one around here even remembers my real name. I was born in this house in the downstairs bedroom. Mom had already delivered 6 kids and there was no way I was waiting for Dad to finish feeding the hogs and get Mom to town before I come out. Mom used to love to tell that story. Dad bought this farmhouse and the first hundred acres right before he went off to WWI. The folks saw good times and bad in this ol’ place and so have I. All my brothers and sisters left the land as soon as they could. I was the only one of the lot to care about this place and want to carry on what Dad started. I really haven’t gone far from this spot in my entire life. The one time I got it in my head to try something different; I wound up in Korea with an Army uniform on. I was glad to get back to this place after that stint and here I’ve been ever since. Married the neighbor girl Bessie when I got back. Her dad wasn’t so sure that it would work out since she was 8 years younger than me and she intended to go off to the state college. We sure did prove him wrong; we celebrated our 50th anniversary the week before Bessie died. The ladies at the church had the hall all decorated up and we brought Bessie home from the hospital for the afternoon. She was bound and determined to live for that day; no way did she want her friends to go to that much work for her to not show up. I couldn’t believe it when the ladies had to prepare for the reception after we buried Bessie in that same hall one week later. We had such a good life together.
That was 10 years ago.
I don’t do much of the farm work anymore. Our son Jon takes care of the crops and the few animals we have. I still go out to the hen house every morning to collect the eggs. I’m a little stiff in the morning, but I get loosened up enough to walk out to gather some fresh eggs to go with my bacon for breakfast.
I get in to town at least once a week; on Monday morning me and my buddies meet at the VFW for our coffee and donut break. I get caught up on all the town gossip and we laugh and bellyache about what’s going on in the world.
Three weeks ago I celebrated my 80th birthday. My daughter in law, Judy, organized a big “to do” at the church after the Sunday service with cake and ice cream and all the fixings’ for my party. I had a big piece of cake but skipped the ice cream. Doc Baker was there and I knew he would scold me about too much sugar. Six months ago he told me I had diabetes and I started taking a pill for it, but a few weeks ago he put me on insulin. I figure I should be able to eat what I want; come on, I’m not going to live forever, and it was my favorite cake, German chocolate. I ate it in the kitchen so the Doc wouldn’t see me; wouldn’t you know, his office nurse Helen came in the kitchen with a load of dishes just as I was putting the last bite in my mouth. She just winked at me and smiled.
After the party I went out to the mall with Jon and the grandkids. I’m not one for shopping much, but I needed a new ink cartridge for my printer and the computer store is the one
place I like to look around in. Too bad we parked clear on the other end of the mall so the kids could go by their favorite stores for Grandpa to buy them a little something. Jon got real mad at me when I asked if I could sit and rest for a while, so I just kept walking. I guess my new shoes were a little tight; I didn’t feel anything but when I got home there was some blood on my sock, and then I saw a sore on my big toe. It must not be too bad since it’s not hurting except when I try to put my shoes on.

I showed the sore to Jon and Judy the other day and Judy said she would call the doctor to see what she should put on it. Jon gets so irritated when I need extra help; I hope I can just continue to soak my foot in hot water to clean it out. Judy was a nursing assistant out at the old folk’s home for many years; I’m hoping she will be able to help me with this. I like the idea of the home nurses coming out here as long as my VA benefits pay for it. That way they can see that I’m doing just fine living here on my own.

I was searching on the internet for the best way to treat this sore; there are so many sites that talk about foot sores if you’re a diabetic. Some of those pictures of toe sores are pretty scary; I can’t sleep at night thinking about what could happen if this doesn’t heal. Of course I haven’t slept through the night for years. Even the couple of beers I have at night when I’m on the computer don’t seem to be helping anymore. Bessie always gave the kids Benadryl to help them sleep so I’ve been taking a couple when I go to bed; they seem to help me sleep a little better.

As a matter of fact, I need to wrap this up now. I promised Jack, my grandson in college that I’d Skype him in a few minutes. He just started the agronomy program at the university. I love to hear about what he’s learning and give him encouragement to come back to the farm.

Red’s introductory monologue can be used in a variety of ways. Here are a few to consider:

- large class discussion
- small group discussion during class or clinical
- reflective journaling assignment
- web-based assignment: listen to the audio or read the script, then discuss and summarize the group’s conclusions.


1. What are “Red’s” strengths?
2. What are your concerns for this patient?
3. What is the cause of your concern?
4. What information do you need?
5. What are you going to do about it?
6. What is “Red” experiencing?
B. Possible answers to questions:

1. What are “Red’s” strengths?
   Red has his son and daughter-in-law who live near and are active in his life. He has a close group of friends at the VFW and he has ties to his church. He is cognitively and physically active.

2. What are your concerns for this patient?
   Red’s sore on his big toe is concerning along with the fact that he has had this for 3 weeks without telling anyone. Several times he speaks of items he eats or drinks that are a concern due to high calorie and fat content (cake, bacon, beer, donuts). He also has a daily intake of alcohol and uses Benadryl to help sleep. Red made two statements about his son (“Jon got real mad”, “Jon gets so irritated”) that bear further assessment to rule out mistreatment.
   Does Red have adequate finances?

3. What is the cause of your concern?
   Red is trying to manage his wound on his own without consulting his family or doctor.
   He is experiencing sleep disturbance.
   Family dynamics may be the source of anxiety for Red.
   He also mentioned a concern about his VA benefits paying for the cost of the home care nurse.

4. What information do you need?
   How is Red managing his diabetes? More information is needed related to his diet, monitoring his blood glucose, and administration of insulin.
   What is his financial situation? Can he cover the cost of his living and medical costs?
   Red did not reveal any other difficulties related to incontinence or falls in the monologue. These should be assessed.

5. What are you going to do about it?
   Utilize the ACES Framework to guide assessments and actions.

6. What is “Red” experiencing?
   He is experiencing skin breakdown in which the healing processes is complicated by his diabetes. He wants to remain independent, living in his home.

The Essential Nursing Actions from the ACES Framework (see chart below) can serve as a guide to learners when deciding what interventions may be appropriate for the older adult in this situation.
ACES Framework

| Assess Function and Expectations | • Assess the older adult’s individual aging pattern and functional status using standardized assessment tools.  
• Use effective communication techniques to recognize, respond to, and respect an older adult’s strengths, wishes, and expectations.  
• Include findings of assessment of older adult’s cognition, mood, physical function, and comfort to fully assess the individual aging pattern. |
|----------------------------------|---------------------------------------------------------------------------------------------------------------|
| Coordinate and Manage Care       | • Manage chronic conditions, including atypical presentations, in daily life and during life transitions to maximize function and maintain independence.  
• Assist older adults and families/caregivers to access knowledge and evaluate resources.  
• Advocate during acute exacerbations of chronic conditions to prevent complications. |
| Use Evolving Knowledge           | • Understand geriatric syndromes and unique presentations of common diseases in older adults.  
• Access and use emerging information and research evidence about the special care needs of older adults and appropriate treatment options.  
• Interpret findings and evaluate clinical situations in order to provide high quality nursing care based on current knowledge and best practices. |
| Make Situational Decisions       | • Analyze risks and benefits of care decisions in collaboration with the interdisciplinary team and the older adult and family/caregivers.  
• Evaluate situations where standard treatment recommendations need to be modified to manage care in the context of the older adult’s needs and life transitions.  
• Consider the older adult’s wishes, expectations, resources, cultural traditions, and strengths when modifying care approaches. |

Simulation Scenario 1

This scenario takes place in Red’s home with the arrival of the home health nurses. They will assess Red’s physical and mental status as well as his home environment. They will notify the physician of their findings.

Second monologue: Occurs two weeks later.

“As much as I hate to miss it, I don’t think I’ll go into town today. I never miss Monday morning coffee at the VFW with my buddies. Sometimes my friends worry about me; they will probably wonder where I am. I know it’s only 20 miles, but I just haven’t felt like eating the last couple of days; maybe I’ve got the flu that’s going around. I’m not sure if I should take my insulin because I’m not eating, but my blood sugar was 203 when I poked my finger this morning. How can that be when I’m not eating? Wow! I just took of my sock to check on my sore and my whole foot is red and big. I haven’t looked at it for a few days; it was just a little pink the last time I checked it. I should have paid closer attention to those pills I was supposed to take, that antibiotic. The nurse
wanted to make sure I didn’t get an infection in that toe. She comes tomorrow to change the bandage; I’d better make sure to take the antibiotic today.”

Red’s second monologue can also be used in a variety of ways. Here are a few to consider:

- large class discussion
- small group discussion during class or clinical
- reflective journaling assignment
- web-based assignment: listen to the audio or read the script, then discuss and summarize the group’s conclusions.

Focused discussion and questions adapted from: (Benner, et al. 2010, p.133.)

1. What are “Red’s” strengths?
2. What are your concerns for this patient?
3. What is the cause of your concern?
4. What information do you need?
5. What are you going to do about it?
6. What is “Red” experiencing?

B. Possible answers to questions:

1. What are “Red’s” strengths?
   Red has assessed his wound and his blood glucose and is aware that there is a problem.

2. What are your concerns for this patient?
   Red’s foot is red and swollen and he has a loss of appetite.

3. What is the cause of your concern?
   Older adults may have an atypical presentation of sepsis. Red does not indicate that he is going to call his son or doctor to talk about how he is feeling and what his foot looks like.

4. What information do you need?
   There is a need to assess for signs and symptoms of infection, understanding that older adults may have an atypical presentation. There might be an absence of fever, absence of leukocytosis. Presentation of an infection in an older adult may be falls, decreased appetite or fluid intake, confusion, or change in functional status.

5. What are you going to do about it?
   Utilize the ACES Framework (above) to guide assessments and actions:

6. What is “Red” experiencing?
   From his assessment, there is a local and perhaps systemic infection occurring.
The **second simulation** takes place at the local hospital. Jon stopped by to check on Red after one of his friends from the VFW calls to say that Red didn’t make it for coffee. The nearest VA hospital is over 100 miles away and the doctor told him that Red needed to be seen immediately. He is admitted for possible sepsis. The focus of this simulation is an emphasis on the atypical presentation of sepsis in the older adult.

(See Simulation Template #2)

**Simulation Scenario 3** occurs 5 days later when Red is planning for discharge from the hospital. Jon thinks that Red should stay with him for now, but Red is sure he is able to care for himself at home as he has always done. Learners will need to determine how much, if any, functional decline has occurred while Red has been hospitalized. The risks and benefits of Red’s destination need to be analyzed in collaboration with Jon and Judy and the healthcare team.

(See Simulation Template #3)

**“Finish the Story” Assignment**

Learners have now seen Red at four snapshots in time. The last assignment calls for the student to “finish the story” and relate where they see Red about three months after their last encounter with him. This assignment should give faculty insight into what students have learned from the unfolding case.

The assignment may take on any the forms below:

- short paper
- reflective journal entry
- class discussion
- small group discussion
- online discussion
- student presentation using role playing

Whatever format you choose, encourage learners to indicate the reasoning behind their end of story, based on what they know about Red. They should consider his history and the risk factors and benefits they considered. The student should cite morbidity and mortality data to support their outcomes. They should relate their beliefs about the role of the nurse in his continued care and cite any community resources or referrals that might be needed.
Simulation Design Template- Sherman “Red” Yoder-Simulation #1

Date: 
Discipline:  Nursing
Expected Simulation Run Time: 
Location:  Simulated home environment

File Name: “Red” Yoder Simulation #1
Student Level: 
Guided Reflection Time: 20 minutes
Location for Reflection: classroom

Admission Date:

Today’s Date: 

Brief Description of Client 
Name: Sherman “Red” Yoder 

Gender: Male  Age: 80  Race: Caucasian
Weight: 109 kg  Height: 183 cm
Religion: Protestant
Phone: 869-555-3452
Allergies: no known allergies
Immunizations: Influenza last fall; tetanus 2007
Attending Physician/Team: Family Practice: Dr. Frank Baker
Past Medical History: Diabetes Type 2 diagnosed ______ (insert month that is six months prior)

History of Present illness: 
Developed an ulcer on his big toe 3 weeks ago. Has been soaking his foot to heal the wound; recently revealed the wound to his family who called Dr. Baker.

Social History: 
Widower; his son Jon lives nearby

Primary Medical Diagnosis: 
Pressure ulcer right great toe

Surgeries/Procedures & Dates: 
L4-5 laminectomy 1976; Transurethral resection of 

Psychomotor Skills Required Prior to Simulation 
1. Basic health assessment 
2. Home environmental assessment 
3. Vital signs 
4. Blood glucose monitoring 
5. Wound assessment and care

Cognitive Activities Required prior to Simulation [i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]
Red’s introductory monologue. (R)

Review nursing management of the client with diabetes (activity, diet, monitoring of blood sugar, insulin administration, etc) (R)

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If you find this Simulation Design Template useful, we would appreciate hearing from you. Please send an email message with your comments to info@sirc.nln.org
### Nursing Diagnoses:
Alteration in tissue integrity; Risk for infection; Ineffective health maintenance
Simulation Design Template- Sherman “Red” Yoder-Simulation #1

Simulation Learning Objectives – for faculty

1. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tools. The suggested tools listed below can be found at http://consultgerirn.org/resources/?tt_request=issue04.pdf
   - SPICES: An Overall Assessment Tool of Older Adults
   - Katz Index of Independence in Activities of Daily Living (ADL)
   - The Pittsburgh Sleep Quality Index (PSQI)
   - Elder Mistreatment Assessment
   - Alcohol Use Screening and Assessment

1. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

2. The learner will use standardized communication tools to discuss the care of the client with other health care providers. Suggested tools: SBAR – call to Dr. Baker reporting status of wound and recommendation for treatment.

3. The learner will discuss pertinent assessment findings and what was found that was specific to the older adult patient.

4. The learner will implement appropriate interventions based on the assessment data collected. (wound care, education related to management of diabetes (capillary blood glucose measurement, nutrition, medication)

5. Learner will identify geriatric syndrome(s) evident in the simulation (sleep disturbance, skin breakdown)

Simulation Learning Objectives – for learners

1. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tool.

2. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

3. The learner will use standardized communication tools to discuss the care of the client with other health care provider.

4. The learner will discuss pertinent assessment findings and what was found that was specific to the older adult patient.

5. The learner will discuss pertinent assessment findings related to the patients diabetic status

7. The learner will implement appropriate interventions based on the assessment data collected.

8. Learner will identify geriatric syndrome(s) evident in the simulation.
Fidelity (choose all that apply to this simulation)

<table>
<thead>
<tr>
<th>Setting/Environment</th>
<th>Medications and Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER</td>
<td>IV Fluids:</td>
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<tr>
<td>Med-Surg</td>
<td>Oral Meds:</td>
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<td>Peds</td>
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<td>ICU</td>
<td>IVPB:</td>
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<td>OR / PACU</td>
<td>IV Push:</td>
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<td>Women’s Center</td>
<td>IM or SC:</td>
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<td>Behavioral Health</td>
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<td>Pre-Hospital</td>
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<td>Other: Home health</td>
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</tbody>
</table>

Simulator Manikin/s Needed:
Human patient simulator, or standardized patient

**Props:** Manikin dressed in street clothes, environment should look like the home; wound moulage: right great toe should have a wound that has some depth, has bright red tissue and slight redness around the wound. If available, may consider using the foot with the wound on the toe (Laerdal product) and cover the black part of the wound for the first simulation.

**Equipment attached to manikin:**
- IV tubing with primary line fluids running at mL/hr
- Secondary IV line running at mL/hr
- IV pump
- Foley catheter mL output
- PCA pump running
- IVPB with running at mL/hr
- 02
- Monitor attached
- ID band
- Other:

**Equipment available in room**
- Bedpan/Urinal
- Foley kit
- Straight Catheter Kit
- Incentive Spirometer
- Fluids

**Diagnostics Available**
- Labs
- X-rays (Images)
- 12-Lead EKG
- Other:

**Documentation Forms**
- Physician Orders
- Admit Orders
- Flow sheet
- Medication Administration Record
- Kardex
- Graphic Record
- Shift Assessment
- Triage Forms
- Code Record
- Anesthesia / PACU Record
- Standing (Protocol) Orders
- Transfer Orders
- Other:

**Recommended Mode for Simulation (i.e. manual, programmed, etc.)**
Manual; mechanism needed for transmission of the voice of the patient via manikin
## Simulation Design Template- Sherman “Red” Yoder-Simulation #1

<table>
<thead>
<tr>
<th>Medical Equipment</th>
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<tbody>
<tr>
<td>IV start kit</td>
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<tr>
<td>IV tubing</td>
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<tr>
<td>IVPB Tubing</td>
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<tr>
<td>IV Pump</td>
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<tr>
<td>Feeding Pump</td>
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<tr>
<td>Pressure Bag</td>
</tr>
<tr>
<td>02 delivery device (type)</td>
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<tr>
<td>Crash cart with airway devices and emergency medications</td>
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<tr>
<td>Defibrillator/Pacer</td>
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<tr>
<td>Suction</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

### Roles/Guidelines for Roles

- Primary Nurse
- Secondary Nurse
- Clinical Instructor
- Family Member #1
- Family Member #2
- Observer/s
- Recorder
- Physician/Advanced Practice Nurse
- Respiratory Therapy
- Anesthesia
- Pharmacy
- Lab
- Imaging
- Social Services
- Clergy
- Unlicensed Assistive Personnel
- Code Team
- Other:

### Important Information Related to Roles:

- Family member may be present. (daughter in law or son); they are supportive and want to learn how to care for the wound and how to help Red manage his diabetes.

### Significant Lab Values:

- No labs

### Physician Orders:

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### Student Information Needed Prior to Scenario:

- Has been oriented to simulator
- Understands guidelines /expectations for scenario
- Has accomplished all pre-simulation requirements
- All participants understand their assigned roles
- Has been given time frame expectations
- Other:

### Report Students Will Receive Before Simulation:

Red is an 80 year old farmer who lives by himself. He has had diabetes for about 6 months and recently began taking insulin. We (nurses from the home health agency) have been asked to see him to evaluate a wound he has from wearing a pair of shoes that were too tight. This wound happened about 3 weeks ago; Red has been treating it by soaking his foot in water. His daughter in law has also asked for an evaluation of his ability to live by himself. We know he is very independent, alert and oriented, drives himself into town at least once a week, and spends a lot of time on his computer.
Simulation Design Template- Sherman “Red” Yoder-Simulation #1

References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used For This Scenario

Reading and Resources:

You may wish to have your students review these resources in preparation for the first simulation scenario.

1. The following tools are available at ConsultgeriRN.org [http://www.consultgeriRN.com/resources]
   - SPICES: An Overall Assessment Tool of Older Adults
   - Katz Index of Independence in Activities of Daily Living (ADL) and/or The Lawton Instrumental Activities of Daily Living(IADL) Scale
   - The Pittsburgh Sleep Quality Index (PSQI)
   - Elder Mistreatment Assessment
   - Alcohol Use Screening and Assessment

2. This article reviews clinical practice guidelines. Standards of Medical Care in Diabetes—2010; Diabetes Care January 2010 vol. 33 no. Supplement 1 S11-S61; [http://care.diabetesjournals.org/content/33/Supplement_1/S3.full.pdf+html](http://care.diabetesjournals.org/content/33/Supplement_1/S3.full.pdf+html) (retrieved Aug 17, 2010)

3. This is the American Diabetes Association’s website that would be useful for both faculty and learners. [http://www.diabetes.org/](http://www.diabetes.org/)
## Scenario Progression Outline

<table>
<thead>
<tr>
<th>Timing (approximate)</th>
<th>Manikin Actions</th>
<th>Expected Interventions</th>
<th>May Use the Following Cues</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 minutes</td>
<td>Sitting comfortably in chair; alert and oriented; answers all questions. &quot;Judy told me you wanted to check in on me and make sure I’m still o.k. to live out here by myself” “Did you want to look at my foot?”</td>
<td>Wash hands</td>
<td>Role member providing cue: Patient Cue:</td>
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<tr>
<td></td>
<td></td>
<td>Introduce self</td>
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<td></td>
<td></td>
<td>Identify patient</td>
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<td></td>
<td>Begins general assessment</td>
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<tr>
<td>5-10 minutes</td>
<td>Answers to SPICES: Has trouble falling and staying asleep. Drinks a couple of beers (2) before bed to help him sleep. Takes 2 Benadryl recently to help sleep” Skin breakdown on right big toe. Answers to ADL/IADL: Bathes self uses shower chair if needs to sit. Judy does his laundry. He usually wears something easy to put on. Has fallen a couple of times when he gets up too fast. Has urgency with urination occasionally since TURP. Cooks simple meals. Judy brings over casseroles to get his through the week. Answers to PSQI: Goes to bed at 9:00; takes about an hour to fall asleep; gets up at 5:00 in the morning; gets 5 or 6 hours of sleep. Cannot get to sleep within 30</td>
<td>Advise Red that Benadryl should not be used to help him sleep. Discuss more healthy sleep habits. If statements related to his son Jon being angry during Red’s monologue are addressed, the Elder mistreatment tool can be used. Assess for orthostatic hypotension.</td>
<td>Role member providing cue: Judy Cue: Supportive, she should bring up issues to guide assessment if needed; i.e. “You take a few other medications don’t you?” “Did you say you are having trouble sleeping?” Or “When I got your groceries, you wanted more beer than you usually drink in a week” Or “Did you have bacon and eggs again for breakfast today?” (something to stimulate a discussion regarding his diet)</td>
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</table>
Simulation Design Template- Sherman “Red” Yoder-Simulation #1

8 minutes “once or twice a week”, wakes up in the middle of the night, have to get up to use the bathroom”

Rates sleep as “fairly bad”

Answers to Elder Mistreatment:
All answers indicate no mistreatment

Answers to Alcohol Use treatment: “Yes” to question – do you usually take a drink to relax or calm your nerves? All other answers “no”

Answers to nutrition screening:
“Breakfast every morning – bacon and eggs, 2 pieces of wheat toast with sugar free jelly
Lunch: bologna sandwich, glass of milk and bag of baked potato chips”

Blood glucose monitoring: “I prick my finger about once a week, or if I’m not feeling good” “It’s usually around 120-130”

Medication currently taking:
Tylenol for knee or back pain. One baby aspirin every day. Multivitamin every day.

10-20 minutes “The sore on my toe happened when I wore my new shoes too long. I can’t feel anything; it doesn’t hurt. If you show me how to take care of it, I can manage I think.”

Assesses wound wearing gloves.
Assess pain/sensation
Assess wound size including:
Color of wound tissue, wound margins, depth, color and temperature of foot; edema, odor, edema, odor,

Role member providing cue: Dr. Baker
Cue:
“Wet to damp saline soaked gauze to wound every day.
Home health nurse to monitor wound 2 times a week.”
<table>
<thead>
<tr>
<th>Simulation Design Template- Sherman “Red” Yoder-Simulation #1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Role member providing cue: Judy</td>
</tr>
<tr>
<td>Cue: Red, I'll go into town, fill the prescription and get the supplies for dressing the wound.</td>
</tr>
<tr>
<td>If time permits</td>
</tr>
<tr>
<td>Role member providing cue:</td>
</tr>
<tr>
<td>Cue:</td>
</tr>
</tbody>
</table>
Debriefing/Guided Reflection Questions for This Simulation
(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?

2. Describe the objectives you were able to achieve?

3. Which ones were you unable to achieve (if any)?

4. Did you have the knowledge and skills to meet objectives?

5. Were you satisfied with your ability to work through the simulation?

6. To Observer: Could the nurses have handled any aspects of the simulation differently?

7. If you were able to do this again, how could you have handled the situation differently?

8. What did the group do well?

9. What did the team feel was the primary nursing diagnosis?

10. What were the key assessments and interventions?

11. Is there anything else you would like to discuss?

12. How were you able to use the ACES Framework with Red’s situation? (Assess Function and Expectations, Coordinate and Manage Care, Use Evolving Knowledge, Make Situational Decisions)

Complexity – Simple to Complex

Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners

1. Focus and complexity of this simulation can be altered by changing the answers that the patient gives to any assessment.
Simulation Design Template- Sherman “Red” Yoder-Simulation #2

**Date:**

**File Name:** Sherman “Red” Yoder

**Discipline:** Nursing

**Student Level:**

**Expected Simulation Run Time:** 20 minutes

**Guided Reflection Time:** 20 minutes

**Location:** Simulated Emergency Room

**Location for Reflection:** classroom

<table>
<thead>
<tr>
<th>Admission Date:</th>
<th>Psychomotor Skills Required Prior to Simulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today’s Date:</td>
<td>1. General head to toe assessment including vital signs</td>
</tr>
<tr>
<td>Brief Description of Client</td>
<td>2. Focused assessment of circulatory and neurovascular status of foot, and wound</td>
</tr>
<tr>
<td>Name: Sherman “Red” Yoder</td>
<td>3. Specimen collection: Blood cultures, labs, wound</td>
</tr>
<tr>
<td>Gender: Male</td>
<td>4. Medication administration: IV, Subcutaneous</td>
</tr>
<tr>
<td>Age: 80</td>
<td>5. Oxygen administration</td>
</tr>
<tr>
<td>Race: Caucasian</td>
<td></td>
</tr>
<tr>
<td>Weight: 109 kg</td>
<td></td>
</tr>
<tr>
<td>Height: 183 cm</td>
<td></td>
</tr>
<tr>
<td>Religion: Protestant</td>
<td></td>
</tr>
<tr>
<td>Phone: 869-555-3452</td>
<td></td>
</tr>
<tr>
<td>Allergies: NKA</td>
<td></td>
</tr>
<tr>
<td>Immunizations: Influenza last fall; Tetanus 2007</td>
<td></td>
</tr>
<tr>
<td>Attending Physician/Team: Family Practice: Dr. Frank Baker</td>
<td></td>
</tr>
<tr>
<td>Past Medical History: Diabetes Type 2 diagnosed _______ (insert month that is six months prior)</td>
<td></td>
</tr>
<tr>
<td>History of Present illness: Developed an ulcer on his big toe 3 weeks ago. Currently treated with oral antibiotic and wet to moist saline soaked dressing daily. Home health nurse last assessed the foot 3 days ago.</td>
<td></td>
</tr>
<tr>
<td>Social History: Widower; Son (Jon) lives nearby</td>
<td></td>
</tr>
<tr>
<td>Primary Medical Diagnosis: R/O sepsis</td>
<td></td>
</tr>
<tr>
<td>Surgeries/Procedures &amp; Dates: L4-5 laminectomy 1976; Transurethral resection of the prostate 2005</td>
<td></td>
</tr>
</tbody>
</table>

**Cognitive Activities Required prior to Simulation [i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]**

- Study care of the client with an infection, specifically sepsis (R)
- Read atypical presentation of infection by older adults (R)
- Standardized hand off tool between health care team members (R)
- The Confusion Assessment Method (CAM) tool (R)

Tools in the *Try This:* ® and How to *Try This* Series, available at [www.ConsultGeriRN.org](http://www.ConsultGeriRN.org).
### Nursing Diagnoses:
- Infection
- Alteration in tissue integrity
- Risk for Shock
Simulation Design Template- Sherman “Red” Yoder-Simulation #2

Simulation Learning Objectives – for faculty

1. The learner will demonstrate a general head to toe assessment and a focused assessment of patient’s right foot.

2. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tools. Suggested tool: The Confusion Assessment Method (CAM)

3. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

4. The learner will use standardized communication tools to discuss the care of the client with other health care providers. Suggested tools: Standardized hand off tool (I PASS the BATON http://www.ahrq.gov/about/casestudies/ptsafety/ps2010a.htm)

5. The learner will discuss atypical assessment findings common in the older adult with sepsis.

6. The learner will implement appropriate interventions based on assessments and primary health care provider orders. (Specimen collection: blood culture, CBC, wound; application of oxygen, starting an IV, IV and subcutaneous medication administration)

Simulation Learning Objectives – for learners

1. The learner will demonstrate a general head to toe assessment and focused assessments as appropriate.

2. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tools.

3. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

4. The learner will use standardized communication tools to discuss the care of the client with other health care providers.

5. The learner will discuss pertinent assessment findings and what was found that was specific to the older adult patient.

6. The learner will implement appropriate interventions based on the assessments and primary health care provider orders.
### Fidelity (choose all that apply to this simulation)

<table>
<thead>
<tr>
<th>Setting/Environment</th>
<th>Medications and Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ER</td>
<td>☐ IV Fluids: IV 0.9% NS 500 cc’s bolus, repeat X1</td>
</tr>
<tr>
<td>☐ Med-Surg</td>
<td>☐ Oral Meds:</td>
</tr>
<tr>
<td>☐ Peds</td>
<td></td>
</tr>
<tr>
<td>☐ ICU</td>
<td>☐ IVPB: Ceftazidime 1 gram IVPB q 8 hours</td>
</tr>
<tr>
<td>☐ OR / PACU</td>
<td>☐ IV Push:</td>
</tr>
<tr>
<td>☐ Women’s Center</td>
<td>☐ IM or SC:</td>
</tr>
<tr>
<td>☐ Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>☐ Pre-Hospital</td>
<td></td>
</tr>
<tr>
<td>☐ Other: Home health</td>
<td></td>
</tr>
</tbody>
</table>

### Simulator Manikin/s Needed:
Minimally, manikin with vital sign assessment capability, or standardized patient

### Props:
Wound moulage: right great toe should have a wound that has some depth, has bright red tissue with opaque drainage. If available, may consider using the foot with the wound on the toe (Laerdal product). Entire foot should be red.

### Equipment attached to manikin:
- ☐ IV tubing with primary line IV 0.9% NS fluids running at 500 cc’s bolus, repeat X1
- ☐ Secondary IV line running at mL/hr
- ☐ IV pump
- ☐ Foley catheter mL output
- ☐ PCA pump running
- ☐ IVPB with running at mL/hr
- ☐ 02
- ☐ Monitor attached
- ☐ ID band
- ☐ Other:

### Equipment available in room
- ☐ Bedpan/Urinal
- ☐ Foley kit
- ☐ Straight Catheter Kit
- ☐ Incentive Spirometer
- ☐ Fluids

### Diagnostics Available
- ☐ Labs
- ☐ X-rays (Images)
- ☐ 12-Lead EKG
- ☐ Other:

### Documentation Forms
- ☐ Physician Orders
- ☐ Admit Orders
- ☐ Flow sheet
- ☐ Medication Administration Record
- ☐ Kardex
- ☐ Graphic Record
- ☐ Shift Assessment
- ☐ Triage Forms
- ☐ Code Record
- ☐ Anesthesia / PACU Record
- ☐ Standing (Protocol) Orders
- ☐ Transfer Orders
- ☐ Other:

### Recommended Mode for Simulation (i.e. manual, programmed, etc.)
Manual or programmed; mechanism needed for transmission of the voice of the patient via manikin
Simulation Design Template- Sherman “Red” Yoder-Simulation #2

- IV start kit
- IV tubing
- IVPB Tubing
- IV Pump
- Feeding Pump
- Pressure Bag
- 02 delivery device (type)
- Crash cart with airway devices and emergency medications
- Defibrillator/Pacer
- Suction
- Other:

Roles/Guidelines for Roles
- Primary Nurse
- Secondary Nurse
- Clinical Instructor
- Family Member #1
- Family Member #2
- Observer/s
- Recorder
- Physician/Advanced Practice Nurse
- Respiratory Therapy
- Anesthesia
- Pharmacy
- Lab
- Imaging
- Social Services
- Clergy
- Unlicensed Assistive Personnel
- Code Team
- Other:

Student Information Needed Prior to Scenario:
1. Has been oriented to simulator
2. Understands guidelines /expectations for scenario
3. Has accomplished all pre-simulation requirements
4. All participants understand their assigned roles
5. Has been given time frame expectations
6. Knowledge of previous “Red” monologues and simulation

Important Information Related to Roles:
Family member may be present. (daughter in law or son to give history)

Significant Lab Values: (give to learner upon request after they have been drawn)

- WBC 11,000
- RBC 4.2
- Hgb 10.5
- HCT 45%
- NA 140
- K+ 4.4
- CL 99

Report Students Will Receive Before Simulation
Red Yoder is an 80 year old with a pressure ulcer on his right great toe which developed about 5 weeks ago. Has been treated at home with an oral antibiotic and wet to damp saline dressings daily. He will arrive here in the ER momentarily. Dr. Baker has written preliminary orders.
<table>
<thead>
<tr>
<th>BUN 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine 1.3</td>
</tr>
<tr>
<td>Glucose 210</td>
</tr>
</tbody>
</table>

**Physician Orders:**

Emergency Room orders:
- IV 0.9% NS 500mL bolus; may repeat x 1
- Labs: CBC, electrolytes, BUN and creatinine, arterial blood gases, blood culture x 2
- Wound culture and sensitivity
- Oxygen at 6 LPM per nasal cannula; titrate to keep SpO2 > 94%
- Insert urinary catheter
- Continuous ECG and Sp O2 monitoring
- Ceftazidime 1 gram IVPB every 8 hours
- Transfer to medical intensive care
References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used For This Scenario

Reading and Resources:

You may wish to have your students review these resources in preparation for the second simulation scenario.

1. Review medical-surgical nursing text related to care of the patient with sepsis.

2. Confusion Assessment Method Tool:  


## Scenario Progression Outline

<table>
<thead>
<tr>
<th>Timing (approximate)</th>
<th>Manikin Actions</th>
<th>Expected Interventions</th>
<th>May Use the Following Cues</th>
</tr>
</thead>
</table>
| 0-5 minutes           | Patient drowsy but easily aroused; has trouble keeping track of what's said. T: 38, HR 86; RR 28; BP 116/64 | Wash hands  
Introduce self  
Identify patient  
Head to toe assessment | Role member providing cue: Family member  
Cue: “Red is usually awake and alert. This is really a change for him” |
| 5-15 minutes          | Patient status remains the same. Able to answer most questions. Not able to focus attention. Rambles at times. VS unchanged. | Apply O2  
Draw labs  
Initiate IV fluid  
Begin IV antibiotic  
Insert Foley catheter and monitors urine output  
Assesses wound and takes culture gloves.  
Assess pain/sensation  
Assess wound size including: Color of wound tissue, wound margins, depth, color and temperature of foot; edema, odor, drainage, pulses  
Use CAM assessment tool | Role member providing cue: Family member  
Cue: “How come you said he has an infection? He hasn’t had a fever at home and he doesn’t have one now.” |
| 15-20 minutes         | Requests lab results. Gives report to the nurse in MICU using a standardized hand off tool |  | Role member providing cue: Family member  
Cue: Is he going to be o.k.? Can we go to the ICU with him? |
Debriefing/Guided Reflection Questions for This Simulation
(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?
2. Describe the objectives you were able to achieve?
3. Which ones were you unable to achieve (if any)?
4. Did you have the knowledge and skills to meet objectives?
5. Were you satisfied with your ability to work through the simulation?
6. To Observer: Could the nurses have handled any aspects of the simulation differently?
7. If you were able to do this again, how could you have handled the situation differently?
8. What did the group do well?
9. What did the team feel was the primary nursing diagnosis?
10. What were the key assessments and interventions?
11. Is there anything else you would like to discuss?
12. How were you able to use the ACES Framework now that Red has been hospitalized? (Assess Function and Expectations, Coordinate and Manage Care, Use Evolving Knowledge, Make Situational Decisions)

Complexity – Simple to Complex
Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners

1. Have student start IV, perform venipuncture to draw labs, administer IV medication, catheter insertion, ECG application. May have these things done and then have student interpret the data.
2. Include additional findings/information that will require more assessment, such as pressure ulcer, potential elder neglect, and financial concerns.
3. Students could begin to manage blood glucose. ABG’s could return showing ketoacidosis.
Simulation Design Template- Sherman “Red” Yoder-Simulation #3

Date:
Discipline: Nursing
Expected Simulation Run Time: 20 minutes
Location: Simulation lab

File Name: Sherman “Red” Yoder
Student Level:
Guided Reflection Time: 20 minutes
Location for Reflection: classroom

Admission Date:

Today’s Date:

Brief Description of Client
Name: Sherman “Red” Yoder

Gender: Male  Age: 80  Race: Caucasian
Weight: 109 kg  Height: 183 cm
Religion: Protestant
Phone: 869-555-3452
Allergies: NKA
Immunizations: Influenza last fall; Tetanus 2007
Attending Physician/Team:
Dr. Frank Baker

Past Medical History: Diabetes Type 2 diagnosed ______ (insert month that is six months prior)

History of Present illness:
Developed an ulcer on his big toe that was treated at home for 2 weeks. Son brought patient to ER 6 days ago and patient treated for sepsis with IV antibiotics.

Social History: Widower; Son (Jon) lives nearby

Primary Medical Diagnosis:
Sepsis

Surgeries/Procedures & Dates: L4-5 laminectomy 1976; Transurethral resection of the prostate 2005

Psychomotor Skills Required Prior to Simulation
1. Basic head to toe assessment.
2. Assisting a patient with ambulation.
3. Wound assessment and wet to damp dressing change.

Cognitive Activities Required prior to Simulation [i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]
Knowledge related to functional decline in the hospitalized older adult (R)
ConsultGeriRN.org Try This:® Series (R)
Nursing Diagnoses: Potential Impaired Home Maintenance; Infection; Alteration in tissue integrity
Simulation Learning Objectives – for faculty

1. The learner will demonstrate a general head to toe assessment and a focused assessment of patient’s right foot.

2. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tools. Suggested tool: Katz Index of Independence in Activities of Daily Living (ADL), and the Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults

3. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

4. The learner will use standardized communication tools to discuss the care of the client with other health care providers. Suggested tools: Standardized hand off tool (I PASS the BATON http://www.ahrq.gov/about/casestudies/ptsafety/ps2010a.htm )

5. The learner will discuss functional decline of the hospitalized older adult.

6. The learner will implement appropriate interventions based on assessments and primary health care provider orders. (Discharge planning)

Simulation Learning Objectives – for learners

1. The learner will demonstrate a general head to toe assessment and focused assessments as appropriate.

2. The learner will assess the patient’s individual aging pattern and functional status using standardized assessment tools.

3. The learner will use communication techniques to recognize, respond to and respect an older adult’s strengths, wishes and expectations.

4. The learner will use standardized communication tools to discuss the care of the client with other health care providers.

5. The learner will discuss pertinent assessment findings and what was found that was specific to the older adult patient.

6. The learner will implement appropriate interventions based on the assessments and primary health care provider orders.
**Fidelity (choose all that apply to this simulation)**

<table>
<thead>
<tr>
<th>Setting/Environment</th>
<th>Medications and Fluids</th>
<th>Diagnostics Available</th>
<th>Documentation Forms</th>
<th>Recommended Mode for Simulation (i.e. manual, programmed, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ER</td>
<td>- IV Fluids:</td>
<td>- Labs</td>
<td>- Physician Orders</td>
<td>Manual or programmed; mechanism needed for</td>
</tr>
<tr>
<td>- Med-Surg</td>
<td>- Oral meds:</td>
<td>- X-rays (Images)</td>
<td>- Admit Orders</td>
<td>transmission of the voice of the patient via manikin</td>
</tr>
<tr>
<td>- Peds</td>
<td>- IVPB:</td>
<td>- 12-Lead EKG</td>
<td>- Flow sheet</td>
<td></td>
</tr>
<tr>
<td>- ICU</td>
<td>- IV Push:</td>
<td>- Other:</td>
<td>- Medication Administration Record</td>
<td></td>
</tr>
<tr>
<td>- OR / PACU</td>
<td>- IM or SC:</td>
<td></td>
<td>- Kardex</td>
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<td>- Pre-Hospital</td>
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<tr>
<td>- Other: Home health</td>
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<td></td>
<td>- Code Record</td>
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<tr>
<td></td>
<td></td>
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<td>- Anesthesia / PACU Record</td>
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<td>- Transfer Orders</td>
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<td></td>
<td></td>
<td></td>
<td>- Other:</td>
<td></td>
</tr>
</tbody>
</table>

**Simulator Manikin/s Needed:**
Any simulator can be used. A standardized patient (or student playing the role) would facilitate a mobility assessment.

**Props:** Patient will still have a wound on right great toe. Foot no longer red and swollen.

**Equipment attached to manikin:**
- IV tubing with primary line fluids running at mL/hr
- Secondary IV line running at mL/hr
- IV pump
- Foley catheter mL output
- PCA pump running
- IVPB with running at mL/hr
- Monitor attached
- ID band
- Other:

**Equipment available in room**
- Bedpan/Urinal
- Foley kit
- Straight Catheter Kit
- Incentive Spirometer
- Fluids
- IV start kit
- IV tubing
- IVPB Tubing
- IV Pump
- Feeding Pump
<table>
<thead>
<tr>
<th>Pressure Bag</th>
<th>02 delivery device (type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crash cart with airway devices and emergency medications</td>
<td>Defibrillator/Pacer</td>
</tr>
<tr>
<td>Suction</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**Roles/Guidelines for Roles**

- Primary Nurse
- Secondary Nurse
- Clinical Instructor
- Family Member #1
- Family Member #2
- Observer/s
- Recorder
- Physician/Advanced Practice Nurse
- Respiratory Therapy
- Anesthesia
- Pharmacy
- Lab
- Imaging
- Social Services
- Clergy
- Unlicensed Assistive Personnel
- Code Team
- Other:

**Important Information Related to Roles:**

Family member may be present. (daughter in law or son to discuss concerns about going home)

**Significant Lab Values:** No new labs drawn

**Physician Orders:**

Discharge tomorrow.

**Student Information Needed Prior to Scenario:**

1. Has been oriented to simulator
2. Understands guidelines /expectations for scenario.
3. Has accomplished all pre-simulation requirements
4. All participants understand their assigned roles
5. Has been given time frame expectations

**Report Students Will Receive Before Simulation**

Morning report: Patient is alert and oriented; vital signs stable. Fasting blood sugar this morning is 118. Red had his usual night of sleep. He was up several times to go to the bathroom. Since his catheter was removed yesterday he has urge incontinency. He is able to ambulate to the bathroom, but it is slow and he is weak. Need to discuss where he is being discharged to. He had been living at home with help from his son and daughter in law.
References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used For This Scenario

Reading and Resources:

You may wish to have your students review these resources in preparation for the second simulation scenario.


### Scenario Progression Outline

<table>
<thead>
<tr>
<th>Timing (approximate)</th>
<th>Manikin Actions</th>
<th>Expected Interventions</th>
<th>May Use the Following Cues</th>
</tr>
</thead>
</table>
| 0-5 minutes          | Patient alert, oriented VS within normal limits  
“I want to go back to my **own** house”  
“Of course I was confused there for a while. No one gave me my glasses or hearing aids”  
“I think I can get up and walk around” | Wash hands  
Introduce self  
Identify patient  
Head to toe assessment  
Begins discussion related to the discharge order that has been written for tomorrow. | **Role member providing cue:** Family member  
**Cue:** “Red you haven’t been up and walking. How will you make it to the bathroom?” |
| 5-15 minutes         | If using a standardized patient, Red should ambulate slowly and with hesitation. After walking a short distance say “I’m really tired; I used to walk about all day long with no problems”  
“At this rate I will wet myself every time I need to get to the bathroom. Can I take a urinal home with me?”  
“I’ve been taking more medicine since I’ve been in the hospital. It seems very complicated. Can you tell Judy and I what we are supposed to do?” | Administers standardized tool to assess Red’s level of function.  
If using a standardized patient, learner should ambulate to assess Red’s mobility.  
Assess pain/sensation  
Assess wound size including: Color of wound tissue, wound margins, depth, color and temperature of foot; edema, odor, drainage, pulses | **Role member providing cue:** Family member  
**Cue:** “Red, at least come and live with us until you get your strength back”  
“We can get your medication set up and get you used to the new stuff at our house.” |
| 15-20 minutes        | Calls to give hand off to home health agency for follow up care | **Role member providing cue:** Family member  
**Cue:** (if learner does not talk about how the home health nurse will follow up)  
“How will the nurses that come out to the house know what’s going on now”  
“We don’t want Red to end up in the hospital again.” |
Debriefing/Guided Reflection Questions for This Simulation
(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?
2. Describe the objectives you were able to achieve?
3. Which ones were you unable to achieve (if any)?
4. Did you have the knowledge and skills to meet objectives?
5. Were you satisfied with your ability to work through the simulation?
6. To Observer: Could the nurses have handled any aspects of the simulation differently?
7. If you were able to do this again, how could you have handled the situation differently?
8. What did the group do well?
9. What did the team feel was the primary nursing diagnosis?
10. What were the key assessments and interventions?
11. Is there anything else you would like to discuss?
12. What are the risks and benefits of Red’s transition from the hospital to his home? Use the ACES Framework to assess and evaluate this situation. (Assess Function and Expectations, Coordinate and Manage Care, Use Evolving Knowledge, Make Situational Decisions)

Complexity – Simple to Complex
Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners

1. Learner could reinforce teaching related to management of patient’s diabetes (diet, assessing his blood glucose, insulin administration)
2. Learner could administer morning medication (e.g. insulin, oral antibiotic) and perform a.m. cares (which would be a good way to assess Red’s ability to perform his ADL’s)
3. Red’s responses to the functional assessment can be altered and the destination for his discharge changed. He could have very little functional decline, or he could have so much decline that his family is unable to care for him at home.
Physician’s Orders

Allergies: NKA

<table>
<thead>
<tr>
<th>Date/Time: (insert current day and time)</th>
<th>Emergency Room orders:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IV 0.9% NS 500mL bolus; may repeat x 1</td>
</tr>
<tr>
<td></td>
<td>Labs: CBC, electrolytes, BUN and creatinine, arterial blood gases, blood culture x2</td>
</tr>
<tr>
<td></td>
<td>Wound culture and sensitivity</td>
</tr>
<tr>
<td></td>
<td>Oxygen at 4 liter per nasal cannula; titrate to keep SpO2 &gt; 94%</td>
</tr>
<tr>
<td></td>
<td>Insert urinary catheter</td>
</tr>
<tr>
<td></td>
<td>Continuous ECG and Sp O2 monitoring</td>
</tr>
<tr>
<td></td>
<td>Ceftazidime 1 gram IVPB every 8 hours</td>
</tr>
<tr>
<td></td>
<td>Transfer to medical intensive care</td>
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Dr. Frank Baker
Physician Progress Notes

Allergies:

<table>
<thead>
<tr>
<th>Date/Time:</th>
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<tbody>
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</tbody>
</table>
NURSING NOTES

Date:

Patient was admitted via emergency room earlier today. He has a history of diabetic wound; we don’t know how well he has been taking care of himself as he is confused.

Nurse signatures

<table>
<thead>
<tr>
<th>Initial</th>
<th>Nurse Signature</th>
<th>Initial</th>
<th>Nurse Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
## Medication Administration Record

### Allergies:

<table>
<thead>
<tr>
<th>Date of order</th>
<th>Medication •Dosage •Route • Frequency</th>
<th>Hours to be Given</th>
<th>Dates given</th>
</tr>
</thead>
<tbody>
<tr>
<td>(insert)</td>
<td>Ceftazidime 1 gram IVPB every 8 hours</td>
<td>(insert to fit simulation timing)</td>
<td>/ / /</td>
</tr>
</tbody>
</table>

### Intravenous Therapy

<table>
<thead>
<tr>
<th>Date of order</th>
<th>IV solution, Rate ordered</th>
<th>Date/Time hung</th>
</tr>
</thead>
<tbody>
<tr>
<td>(insert)</td>
<td>0.9% NS 500mL</td>
<td></td>
</tr>
</tbody>
</table>

### Nurse signatures

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Medication Administration Record

### Allergies:

<table>
<thead>
<tr>
<th>Intramuscular legend:</th>
<th>Subcutaneous site code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A=RUQ ventrogluteal</td>
<td>1=RUQ abdomen</td>
</tr>
<tr>
<td>B=LUQQ ventrogluteal</td>
<td>2=LUQ abdomen</td>
</tr>
<tr>
<td>C=R Deltoid</td>
<td>3=RLQ abdomen</td>
</tr>
<tr>
<td>D=L Deltoid</td>
<td>4=LLQ abdomen</td>
</tr>
<tr>
<td>E=R Thigh Lateral</td>
<td>5=RU arm</td>
</tr>
<tr>
<td>F=L Thigh Lateral</td>
<td>6=LU arm</td>
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</table>

<table>
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<tr>
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<tbody>
<tr>
<td>Date of order</td>
</tr>
<tr>
<td>Medication • Dosage • Route • Frequency</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Date</td>
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<tr>
<td>Date</td>
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</tbody>
</table>

### INSULIN ADMINISTRATION

| Date | Time | Site | GMR | Initials |
| Date | Time | Site | GMR | Initials |
| Date | Time | Site | GMR | Initials |

### Nurse signatures

<table>
<thead>
<tr>
<th>Initial</th>
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<th>Initial</th>
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</thead>
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## Vital Signs Record

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<th>1600</th>
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<th>0800</th>
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### Temperature

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### BP

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### Pulse

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### O₂ Saturation

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### Weight

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### Respirations

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### GMR

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### Nurse Initials

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</table>
**Intake & Output Bedside Worksheet**

<table>
<thead>
<tr>
<th>ORAL</th>
<th>TUBE FEED</th>
<th>IV</th>
<th>IVPB</th>
<th>OTHER</th>
<th>URINE</th>
<th>Emesis</th>
<th>NG</th>
<th>Drains Type:</th>
<th>Other</th>
</tr>
</thead>
</table>

Total Intake this shift:  
Total Output this shift:  

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

**Fluid Measurements**

- 1 ml = 1 cc
- 1 ounce = 30 cc
- 8 ounces = 240 cc
- 1 cup = 8 ounces = 240 cc
- 4 cups = 32 ounces = 1 quart or liter = 1000 cc

**Sample Measurements**

- Coffee cup = 200 cc
- Clear glass = 240 cc
- Milk carton = 240 cc
- Small milk carton = 120 cc
- Juice, gelatin or ice cream cup = 120 cc
- Soup bowl = 160 cc
- Popsicle half = 40 cc
<table>
<thead>
<tr>
<th>Section</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL APPEARANCE</td>
<td>male, female, DOB:__________</td>
</tr>
<tr>
<td></td>
<td>Occupation, Religion, Age, Ethnicity</td>
</tr>
<tr>
<td>SKIN</td>
<td>[ ] See wound care sheet, [ ] see nursing notes</td>
</tr>
<tr>
<td>Braden scale score:</td>
<td>[ ] Risk skin breakdown, [ ] see nursing notes</td>
</tr>
<tr>
<td>COLOR</td>
<td>[ ] Acyanotic, [ ] Pale, [ ] Ruddy, [ ] Jaundiced, [ ] Cyanotic</td>
</tr>
<tr>
<td>TEMP</td>
<td>[ ] Warm/dry, [ ] Hot, [ ] Cool, [ ] Cold, [ ] Clammy, [ ] Diaphoretic</td>
</tr>
<tr>
<td>TURGOR</td>
<td>[ ] &lt; 3 sec, [ ] &gt; 3 sec, [ ] See nursing notes</td>
</tr>
<tr>
<td>HAIR</td>
<td>[ ] Shiny, [ ] Dry/FAKING, [ ] Balding, [ ] Lesions, [ ] Lice</td>
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<tr>
<td>MUSCULOSKELETAL</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>GAIT</td>
<td>[ ] Steady, [ ] Unsteady, [ ] Non-ambulatory</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>[ ] Up ad lib, [ ] Walker, [ ] Cane, [ ] Crutches, [ ] Wheelchair</td>
</tr>
<tr>
<td>HAND GRIPS</td>
<td>[ ] Amputation, [ ] Right, [ ] Left, [ ] Location, [ ] Location</td>
</tr>
<tr>
<td>ROM</td>
<td>[ ] Arms: [ ] Full, [ ] Weak, [ ] Flaccid, [ ] Contractures</td>
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<tr>
<td></td>
<td>[ ] Legs: [ ] Full, [ ] Weak, [ ] Flaccid, [ ] Contractures</td>
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<tr>
<td>AMPUTATION</td>
<td>[ ] Right, [ ] Left, [ ] BKA, [ ] AKA, [ ] Other</td>
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<tr>
<td>SPINE</td>
<td>[ ] Kyphosis, [ ] Scoliosis, [ ] Osteoporosis</td>
</tr>
<tr>
<td></td>
<td>[ ] Cast location, [ ] Traction</td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>RESPIRATIONS</td>
<td>Rate: O2, SPO2%</td>
</tr>
<tr>
<td>BREATH SOUNDS</td>
<td>[ ] Clear, [ ] Irate, [ ] Labored, [ ] Uses accessory muscles, [ ] Cough</td>
</tr>
<tr>
<td>HEART SOUNDS</td>
<td>[ ] Normal S1-S2, [ ] Abnormal S1-S4, [ ] Murmur</td>
</tr>
<tr>
<td>PULSE</td>
<td>[ ] APICAL: [ ] Reg, [ ] Irreg, [ ] Strong, [ ] Faint</td>
</tr>
<tr>
<td>RADIAL</td>
<td>[ ] Reg, [ ] Irreg, [ ] Strong, [ ] Faint, [ ] Nonpalpable</td>
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<td>EXTREMITY COLOR &amp; TEMP</td>
<td>[ ] Warm, [ ] Cool, [ ] Cold, [ ] Acyanotic, [ ] Cyanotic, [ ] Discolor</td>
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<tr>
<td>EDEMA</td>
<td>[ ] None, [ ] Generalized (anasarca), [ ] See nursing notes</td>
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<tr>
<td>Site #1</td>
<td>[ ] Pitting, [ ] 1+ to 2+, [ ] 3+, [ ] 4+, [ ] Non-pitting</td>
</tr>
<tr>
<td>Site #2</td>
<td>[ ] Pitting, [ ] 1+ to 2+, [ ] 3+, [ ] 4+, [ ] Non-pitting</td>
</tr>
<tr>
<td>CAPILLARY REFILL</td>
<td>[ ] Fingers: [ ] Brisk, [ ] Slow, [ ] Pacemaker</td>
</tr>
<tr>
<td></td>
<td>[ ] HTN, [ ] CAD, [ ] CHF, [ ] PVD, [ ] Other</td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>PAIN</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>/general appearance</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>RESPIRATIONS</td>
<td>Rate, O2, SPO2%</td>
</tr>
<tr>
<td>GASTROINTESTINAL/NUTRITION</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>APPEARANCE</td>
<td>[ ] Flat, [ ] Round, [ ] Obese, [ ] Soft, [ ] Gravid</td>
</tr>
<tr>
<td>BOWEL SOUNDS</td>
<td>[ ] Active, [ ] Hypoactive, [ ] Hyperactive, [ ] Absent</td>
</tr>
<tr>
<td>PALPATION</td>
<td>[ ] Non-tender, [ ] Tender (location), [ ] Mass (location)</td>
</tr>
<tr>
<td>LAST BM</td>
<td>[ ] Incontinent, [ ] Stoma, [ ] Constipation, [ ] Diarrhea, [ ] Mucous, [ ] Blood</td>
</tr>
<tr>
<td>DIET</td>
<td>[ ] Impaired swallowing, [ ] Choking</td>
</tr>
<tr>
<td>GENITOURINARY</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>APPEARANCE OF URINE</td>
<td>[ ] Clear, [ ] Light Yellow, [ ] Amber, [ ] Brown</td>
</tr>
<tr>
<td>BLADDER</td>
<td>[ ] Cloudy, [ ] Sediment, [ ] Red/Wine, [ ] Clots</td>
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<tr>
<td>FEMALES</td>
<td>[ ] LMP, [ ] WNL, [ ] Dysmenorrhea</td>
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<td>SEXUALITY</td>
<td>[ ] Sexually Active, [ ] Safe Sex</td>
</tr>
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<td>MENTAL HEALTH</td>
<td>[ ] Urinary retention, [ ] BP, [ ] Frequent UTI</td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>[ ] See nursing notes</td>
</tr>
<tr>
<td>PAIN</td>
<td>[ ] See nursing notes</td>
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<tr>
<td>RESPIRATIONS</td>
<td>Rate, O2, SPO2%</td>
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<td>[ ] See nursing notes</td>
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<tr>
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<td>[ ] Incontinent, [ ] Stoma, [ ] Constipation, [ ] Diarrhea, [ ] Mucous, [ ] Blood</td>
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<tr>
<td>DIET</td>
<td>[ ] Impaired swallowing, [ ] Choking</td>
</tr>
<tr>
<td>PATIENT INFORMATION</td>
<td>Patient Name: Sherman Yoder, Rm# 16, Date Admit: Dr. Baker, Frank</td>
</tr>
<tr>
<td>Date Admit</td>
<td>1930, Age 80, Dr. Baker, Frank</td>
</tr>
<tr>
<td>MRN</td>
<td>000-555-555, 16, Frank</td>
</tr>
</tbody>
</table>

---

**NURSE SIGNATURE**: Time completed:__________

**REASSESSMENT**: Time ________ [ ] No change, [ ] See nurses notes, [ ] Initials

**TYPE OF LEARNER**: [ ] Visual, [ ] Auditory, [ ] Kinesthetic

**EDUCATIONAL LEVEL**: Family present: [ ] Y, [ ] N

---

**FLUID BALANCE**: [ ] See nursing notes

**INTAKE**: [ ] PO, [ ] IV, Solution, [ ] Rate, [ ] mL/hr

**SITE LOCATION**: [ ] Clean, [ ] Patent, [ ] Redness, [ ] Swelling, [ ] Cool, [ ] Hot, [ ] Pain, [ ] Tubing change, [ ] Dressing change

**MUCOUS MEMBRANES**: [ ] Moist, [ ] Pink, [ ] Dry, [ ] Sticky, [ ] Coated

**Today’s wt**:__________, [ ] Yesterday’s wt:__________
<table>
<thead>
<tr>
<th>Date: Braden Scale Score:</th>
<th>Date: Braden Scale Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Hourly</td>
<td>Fall Risk Score:</td>
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</table>

**Pain Assessment**
- Intensity (1-10/10)
- Pain Type (see legend)
- Intervention (see legend)

**Patient Position**

**PO Fluids (ml)**

**IV Site/Rate Checked**

**Patient Hygiene**

**Wound Assessment**

**Wound Bed**

**Wound Drainage**

**Wound Care**

Nurse Initials

<table>
<thead>
<tr>
<th>Initial</th>
<th>Nurse Signature</th>
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**Legend:** *= see nursing notes

**Pain Type:**
- A - aching
- ST - stabbing
- SH - shooting

**Pain Interventions:**
- 1 - Relaxation/Imagery
- 2 - Distraction
- 3 - Reposition
- 4 - Medication

**Positioning:**
- B - back
- R - right
- L - left
- C - chair
- A - ambulatory

**PT. Hygiene:**
- b - bedbath
- a - assist bath
- p - partial bath
- sh - shower
- g - grooming
- m - mouth care
- f - foot care
- n - nail care

**Wound Assessment**
- # 1-4 - Pressure Ulcer stage
- I - Incision
- R - Rash
- SK - skin tear
- E - Echymosis
- A - Abrasion

**Wound Bed:**
- D - Dry & intact
- S - Sutures/ staples
- G - Granulation tissue
- P - Pale
- Y - Yellow
- B - Black

**Wound Drainage:**
- 0 - none
- S - Serous
- P - Purlulent
- S - Serosanguinous
- B - Bright red blood
- D - Dark old blood

**Wound Care:**
- C - Cleaned with NS
- G - Gauze dressing
- W - Gauze wrap
- A - ABD pad
- M - Medication
- O - other **
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