NURS 3132: Integration II Simulation Day 1
Clinical Education Center and Simulation

Learning Activities

<table>
<thead>
<tr>
<th>Clinical Education Center – 3rd Floor</th>
<th>Simulation Center – 5th Floor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome, Attendance and Questions/Answers</td>
<td>Welcome, Attendance and Questions/Answers</td>
</tr>
<tr>
<td>12 students</td>
<td>12 students</td>
</tr>
<tr>
<td>1 hour and 45 minutes</td>
<td>2 hours</td>
</tr>
<tr>
<td><strong>Activity #1</strong></td>
<td><strong>Simulation #1 - Room 3</strong></td>
</tr>
<tr>
<td>Wound Vac</td>
<td>p. 19</td>
</tr>
<tr>
<td>Scenario #1- New Admission to Observation Unit @ 2330</td>
<td></td>
</tr>
<tr>
<td><strong>Activity #2</strong></td>
<td><strong>Simulation #2 - Room 3</strong></td>
</tr>
<tr>
<td>Trach Care and Suctioning</td>
<td>Scenario #2 30 minutes after admission @ MN p. 19</td>
</tr>
<tr>
<td><strong>Activity #3</strong></td>
<td><strong>Simulation #3 - Room 2</strong></td>
</tr>
<tr>
<td>Communication Tools</td>
<td>Scenario #3- Wound Vac in place @ 0630 p. 22</td>
</tr>
<tr>
<td><strong>Activity #4</strong></td>
<td><strong>Simulation #4 - Room 2</strong></td>
</tr>
<tr>
<td>Developing a Nursing Plan of Care</td>
<td>Scenario #4- Transferring to Pulmonary Unit @ 0700 p. 22</td>
</tr>
</tbody>
</table>

- The Clinical Education Center is packed with new clinical content and nursing application
- Please prepare for the simulation scenarios as you would for a clinical day.
- Be prepared to provide knowledgeable, effective, and safe patient care in each of the simulation scenarios today. You will need to prepare for simulation in advance.

Please prepare before this experience:
- Complete the Nursing Care Plan tool utilizing the patient data for simulation patient Dorothy Dix provided in this workbook.
- You will be responsible for pages 1-3 for simulation experience #1 and pages 4 – 10 for simulation experience #2.

Please read before this experience:
- This workbook
- Selected procedures

Please bring to this experience:
- This workbook, please review the simulation in detail. You should be familiar with the patient’s PMH, admitting diagnosis, possible interventions which include medications
- Completed Care Plan
- Stethoscope
- Clinical resources i.e. pen, penlight, clipboard
- Davis Drug book
- Eagerness and the appetite to explore the nursing vanguard 😊
Clinical Education Center

Activity #1
Wound Vac-Negative Pressure Wound Therapy

30 minutes
Your role as a student nurse:
Review Craven, Applying a Negative-Pressure Wound Therapy Dressing, Procedure 29-4 p. 972 and also p 955
Review Lewis, Dirksen, Heitkemper, Bucher& Camera (2011) Inflammation and Wound Healing, Chapter 13 p. 197

Critical Thinking Exercise:
- You are assigned to care for a patient with a stage 4 pressure ulcer that has been successfully debrided. Apply a negative-pressure wound therapy dressing and connect the canister tubing to the negative-pressure therapy unit. Please provide patient education and perform an assessment to ensure the negative-pressure is functioning properly. Document procedure.

Activity #2
Tracheostomy Care and Suctioning

30 minutes
Your role as a student nurse:
Review Craven, Providing Tracheostomy Care, Procedure 25-6 p. 787-792 and also p 761
Review Craven, Suctioning Secretions from Airways, Procedure 25-7 p. 793-796 and also p 761

Critical Thinking Exercise:
- You are assigned to provide care for a patient with tracheostomy on your medical/surgical unit. Provide tracheostomy care and suctioning for the patient. Please provide an assessment of the tracheostomy stoma and document the assessment and the procedure interventions you completed.

Activity #3
Communication Tools

20 minutes
Your role as a student nurse:
Review Craven, Documentation and Communication in the Healthcare Team, p 252, 254-256
Scrubmag.com

Critical Thinking Exercise:
- You are assigned to provide care for Dorothy Dix on the observation unit. She has been admitted to the inpatient Pulmonary unit and you need to give the Pulmonary Unit RN a Transfer of Care Handoff report. Use the “how to give a good report” worksheet, patient orders, and the patient’s report from the ED to provide the Pulmonary RN a safe and efficient handoff nursing report.

Activity #4
Developing a Nursing Plan of Care

20 minutes
Your role as a student nurse:

Critical Thinking Exercise:
- Interactive discussion and review of Care Plan for Dorothy Dix.
Wound Vac

Indications for VAC use: acute wounds, traumatic wounds, subacute wounds, dehisced wounds, chronic wounds, diabetic ulcers, stage III & IV pressure ulcers, flaps, and grafts

VAC therapy precautions: active bleeding, anticoagulants, difficult wound hemostasis, enteric fistulas, and close proximity of blood vessels/ organs

Contraindications for VAC use: malignancy in the wound, untreated osteomyelitis, non-enteric fistulas, and eschar covered wound

Supplies needed for VAC application:
Dressing Assembly specific to wound type and size, includes tubing, foam and drape
- **V.A.C.® GranuFoam™ Dressing**
  - Helps promote healing by facilitating granulation tissue formation
  - Spiral-cut foam is simple to size
  - No scissors necessary
  - Design allows for easier bridging
- **T.R.A.C.™ Pad and Technology**
  - Helps assure prescribed therapy is delivered to the wound site
  - Low profile/more discreet
- **3M™ Tegaderm™ Dressing/Drape**
  - Designed exclusively for use with V.A.C.® Therapy
  - Provides a moist wound healing environment
  - Barrier to outside contaminants
  - Normal Saline for irrigation.
  - 30 cc syringe w/ 18 gauge angiocath for irrigation
  - Gloves.
  - Scissors.
  - Gauze (optional).
  - Skin barrier film wipes
  - Chux.

Dressing change process:
- Removes old dressing, measures wound size and documents assessment findings (size, appearance, odor, amount and color of exudate)
- Irrigates wound with Normal Saline; use a 30cc syringe to ensure irritation to hard to reach areas
- Cuts foam to fill the entire wound—See VAC clinical guidelines for specific application considerations
- **DO NOT PLACE FOAM ON INTACT SKIN**
- Gently applies drape over the wound, extend approximately 2 inches surrounding the wound
- **DO NOT PULL DRAPE TIGHTLY OVER THE FOAM**
- Cuts a quarter size hole through the top of the drape
- Connects dressing tube to canister tube
ATS Canister:
- Inserts ATS canister into the pump
- Connect the 2 halves of the T.R.A.C. connector. Push and twist until locks in place
- Verify that both clamps are open
- Turn Therapy ON

V.A.C. Therapy Canisters
- Charcoal filters help reduce odor
- Hydrophobic construction prevents leaks
- Available gel packs help solidify wound exudate
- 500 and 1,000 ml canisters
- Changes when full, removes canister from the ATS pump and dispose in biohazard container

ATS pump:
- Plug power source into the hospital outlet
- Turns ATS pump on
- Touches therapy pad.
- Ensures system is set at prescribed therapy setting
- Presses the target negative pressure arrows until prescribed pressure is selected
- Default settings- 125mmHg continuous
- Turns on therapy

Therapy Adjustment Options
- Negative Pressure: 50-200 mmHg
- Mode of Operation: Continuous and Intermittent
- Intensity: 10-50 mmHg/second
- Four-hour battery life for easier patient transport
- Accommodates small and large wounds
- Reviews other key features that are available on the ATS system (On screen user guide, intensity / intermittent therapy feature)

Wound Vac Assessment:
- Ensures that the dressing is compressed like a raisin once therapy is activated
- NO HISSING NOISES NOTED AROUND THE DRESSING.
- Ensures that all the clamps are open during the therapy and tubing is unobstructed
- Ensures that there is no exudates leaking onto the skin
- Identifies dressing change frequency (every 48hrs or as prescribed)
- Therapy must be ON a minimum of 22 hours a day

Troubleshoots alarms on the VAC pump:
- Air leak
- Intuitive touch screens with On-Screen User Guide

Most air leaks occur:
- Where the drape meets the skin
- Where the T.R.A.C."™ Pad is attached to the skin
- At tube connections

Discontinues therapy per physician order:
- Turns pump off
- Removes dressing and dispose in biohazard container
- Treats Wond Vac pump as contaminated
- Changing therapy from hospital ATS VAC machine to home FREEDOM VAC machine
- Changing home FREEDOM VAC machine to hospital ATS VAC machine.
### TRACHEOSTOMY CARE

<table>
<thead>
<tr>
<th>Cannula Care</th>
<th>Stoma Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency:</strong> BID and as needed</td>
<td><strong>Frequency:</strong> BID and as needed</td>
</tr>
<tr>
<td><strong>1.</strong> Gather equipment.</td>
<td>1. Visualize the trach stoma, noting the condition of the tissue and amount of bleeding or secretions.</td>
</tr>
<tr>
<td><strong>2.</strong> If indicated suction prior to procedure.</td>
<td>2. If minimal secretions are present:</td>
</tr>
<tr>
<td><strong>3.</strong> If on high flow O₂ keep in place as much as possible during procedure.</td>
<td>• Cleanse with cotton tip applicators and sterile saline</td>
</tr>
<tr>
<td><strong>4.</strong> Unless contraindicated, place patient in semi-Fowler’s.</td>
<td>3. If dry, tenacious secretions are present:</td>
</tr>
<tr>
<td><strong>5.</strong> Remove drain sponge if present.</td>
<td>• Cleanse with cotton tip applicators and ½ strength H₂O₂ solution.</td>
</tr>
<tr>
<td><strong>6.</strong> Perform hand hygiene and don clean gloves.</td>
<td>• Thoroughly rinse with NS &amp; dry with 4x4’s.</td>
</tr>
<tr>
<td><strong>7.</strong> Open tracheostomy care tray. If not available may substitute sterile specimen cups or other sterile containers.</td>
<td><strong>4. Insert sterile drain sponge around trach site under outer cannula flanges</strong></td>
</tr>
<tr>
<td>a. Fill one container w/NS</td>
<td>• Change drain sponges every shift (BID) and as needed if saturated</td>
</tr>
<tr>
<td>b. Fill the other container w/ ½ hydrogen peroxide &amp; ½ NS</td>
<td>• NEVER cut 4x4 gauze sponges to use as a trach dressing because aspiration of gauze threads can occur</td>
</tr>
<tr>
<td><strong>8.</strong> If patient does not have inner cannula skip to step <strong>10.</strong></td>
<td>• Indication for drain sponges includes excessive secretions, drainage, or skin irritation; if none of these are present the stoma should be left open to air for optimal healing</td>
</tr>
<tr>
<td><strong>9.</strong> Inner Cannula</td>
<td>**5. Granulomas (growth of inflammatory tissue), excoriations, erosion, or other wounds around the tracheostomy site should be reported to the medical and the wound care team promptly</td>
</tr>
<tr>
<td>a. <strong>Disposable</strong> – Remove old inner cannula from outer cannula by pressing inward on the snap lock connectors &amp; gently pulling the cannula outward. Discard old cannula and replace with new one.</td>
<td></td>
</tr>
<tr>
<td>b. <strong>Reusable</strong> - Remove inner cannula by twisting the cannula counter clockwise and then pulling gently outward.</td>
<td></td>
</tr>
<tr>
<td>• Cleanse inside of cannula with brush and ½ strength H₂O₂ solution.</td>
<td></td>
</tr>
<tr>
<td>• Rinse in NS, dry, &amp; replace cannula.</td>
<td></td>
</tr>
<tr>
<td><strong>10.</strong> Outer Cannula</td>
<td></td>
</tr>
<tr>
<td>a. Using sterile 4x4’s and cotton tip swaps, cleanse the exposed areas of the outer cannula &amp; area surrounding the stoma with ½ strength H₂O₂ solution, making sure to include the flanges of the outer cannula</td>
<td></td>
</tr>
<tr>
<td>b. Rinse with sterile saline, using 4x4’s and cotton tip swaps.</td>
<td></td>
</tr>
<tr>
<td>c. Wipe dry with 4x4’s.</td>
<td></td>
</tr>
<tr>
<td>d. Change trach ties if soiled or wet</td>
<td></td>
</tr>
<tr>
<td>• NOTE: this may take two people, one to hold the trach in place and one to change the ties.</td>
<td></td>
</tr>
<tr>
<td>• When changing the ties always cleanse the back of the neck and monitor for skin integrity.</td>
<td></td>
</tr>
<tr>
<td>• Apply and secure clean ties before removing old ones.</td>
<td></td>
</tr>
<tr>
<td>• Always ensure you can fit two fingers under trach tie otherwise excess pressure may be placed on stoma, causing skin break down.</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Care Considerations**

1. If accidental extubation occurs and patient develops respiratory distress and/or apnea cover stoma with 4x4’s and ventilate patient with resuscitation bag and mask.
2. Excoriation around trach can be prevented or decreased if peristomal skin is kept clean and dry. Do not allow secretions to remain around stoma for any length of time.
3. You must have a physicians order to cap or place a speaking valve on a trach.
4. In order to cap or place a speaking valve on a cuffed trach the cuff must be down/deflated and the patient must have a patent airway above the level of the trach.
BED SIDE SAFETY CHECKLIST

| Spare trach tube set of same size and manufacturer | Oxygen and oxygen delivery equipment |
| Replacement inner cannulas (if cannula is disposable) | Humidification system |
| Manual resuscitator bag | Trach care kit/supplies: |
| Bedside suction equipment | • Sterile 4x4 drain sponges |
| Portable suction equipment if patient is to be transported outside of room | • Sterile 4x4 gauze sponges |
| Sterile suction kits | • Sterile Normal Saline |
| Tonsil-Tip Suction catheter (Yankauer) | • Sterile cotton tip applicators |
| Trach ties | • Sterile hydrogen peroxide |

STERILE TRACHEOSTOMY SUCTIONING

1. Assess need for suctioning
2. Verify physicians order for suctioning
3. Inform patient of rationale and need for suctioning
4. Assess patient lung sounds, heart rate, and SpO2 prior to intervention
5. Set amount of suction between 100-120 mmHg
6. Place patient’s HOB between 30-50 degrees
7. Pre-oxygenate if patient’s oxygen saturation is <95%
8. Perform hand hygiene
9. Open and prepare sterile suction catheter kit
   a. Unfold sterile cup, touching only the bottom outside corners. Place on bedside Table. Pour sterile saline into cup.
10. Don Sterile Gloves.
11. Using your dominant hand pick up sterile suction catheter and “wrap” the catheter around your sterile gloved hand.
12. With the non-dominant hand, remove your oxygen source. This is now your “dirty” hand.
13. Place the end of catheter tubing into sterile saline to lubricate the catheter.
14. Insert catheter into trachea ~ 8 cm or 1 cm beyond the tip of the tracheostomy tube.
15. Begin retracting the catheter providing suction by placing thumb of non-dominant hand over open port of catheter intermittently. Suction no longer then 10 seconds.
16. Oxygenate the patient as needed to maintain oxygen saturation and assist patient with breathing.
17. Assess heart rate and SpO2 throughout the procedure.
18. Repeat 2-3 times to ensure secretions are cleared.

DOCUMENTATION IN PATIENT RECORD

<table>
<thead>
<tr>
<th>Tracheostomy Care</th>
<th>Tracheostomy Suctioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoma Appearance:</td>
<td>Assessment (Lung sounds, HR, SpO2) Pre/Post Procedure:</td>
</tr>
<tr>
<td>Character of Secretions:</td>
<td>Number of Times Suctioned:</td>
</tr>
<tr>
<td>Character of Drainage:</td>
<td>Character &amp; Amount of Secretions:</td>
</tr>
<tr>
<td>Patient’s Tolerance of Procedure:</td>
<td>Patient’s Tolerance of Procedure:</td>
</tr>
<tr>
<td>Patient Education:</td>
<td>Patient Education:</td>
</tr>
<tr>
<td>Tracheostomy Tube Feature</td>
<td>Image</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------</td>
</tr>
</tbody>
</table>
| **Outer Cannula** (aka – the “trach”) | ![Image](image1.png) | **Hollow tube inserted into trachea between the cricoid cartilage & suprasternal notch.**  
- Generally reversible if the condition causing need for tracheostomy improves | Trachs can come out of the packaging with up to 3 separate parts:  
1) Outer cannula with flange  
2) Inner cannula  
3) Obturator – used only as a guide during insertion  
2 main types of procedures used to insert:  
1) Surgical – large incision, operating room  
2) Percutaneous – small incision, dilation procedure, bedside |
| **Cuff** | ![Image](image2.png) | Balloon at the distal portion of an outer cannula  
- Can be filled with sterile water or air depends on type of trach, usually air  
- Makes a closed circuit system for ventilation  
- Used to protect the lower airway & prevent aspiration of oral/stomach contents | **Cuff Up** = balloon inflated, prevents air flow into upper airway, prevents aspiration  
**Cuff Down** = balloon deflated, allows air flow into upper airway, does not prevent aspiration  
If pt is on a ventilator cuff should be inflated  
Cuff should be deflated for pt to use speaking valve  
Use lowest cuff pressure possible to prevent tissue damage and/or necrosis  
Cuff pressure should be checked BID by RT |
| **Inner Cannula** | ![Image](image3.png) | Plastic or metal tube that sits inside the outer cannula.  
- Usually twists or snaps into place.  
- Can be reusable or disposable.  
- Used in pt’s who have copious secretions & are prone to plugging off trach  
- Easier to remove and place new inner cannula or clean old inner cannula then it is to place a new outer cannula | **Inner cannula can be DISPOSABLE or REUSABLE**  
**Inner cannula must be inspected frequently for obstruction**  
If disposable must keep extra inner cannulas at bedside  
If reusable must keep cleaning kit or supplies at bedside |
| **Fenestration** | ![Image](image4.png) | Hole/Holes in the shaft of the outer & inner cannula of the tracheostomy tube  
- Allows airflow up and over the vocal cords, allowing for voice production.  
- Can be used in pt’s who can NOT tolerate a speaking valve | **If they have an inner cannula it must ALSO be fenestrated in order for pt to produce voice**  
Fenestration can come in contact with tracheal mucosa causing irritation that can lead to granuloma formation  
Higher aspiration risk  
UCH does not recommend these |
### Speaking Valves

**Many types:** Passy-Muir, Shikani Phonate, Shiley, Montgomery, SPIRO,
- Generally provide a one-way valve allowing air in during inhalation and but not out during exhalation
- Air is directed up over voice box to produce speaking

**Indications:**
- minimum 48 hours post trach placement
- Pt must be
  - alert & responsive
  - stable (HR, RR, BP, SaO2)
  - able to tolerate cuff deflations

**Contraindications:**
- foam-cuffed trach tube
- unable to tolerate cuff deflation
- upper airway obstruction
- Severe COPD
- Copious, thick, unmanageable secretions
- Increased Atelectasis
- unresponsive/comatose

- Requires MD order for use
- Some can be used while pt is on a ventilator some can NOT – *know your product!*
- Can only be used in patients who have a patent airway above the level of the trach tube
  - NEVER APPLY A SPEAKING VALVE TO A PATIENT WHO HAS THEIR CUFF UP
  - if the upper airway is removed or blocked they can NOT use a speaking valve
- On exhalation, air is directed upward toward vocal cords allowing voice production
- Helps restore positive airway pressure
- Should not be in place during nebulizer treatments
- Clean with warm soap and water daily, allow to dry completely
- Can use oxygen and humidifier delivery devices with speaking valves in place

### Caps

**A cap that completely plugs off the tracheostomy tube is placed allowing inhalation & exhalation only through the nose & mouth**

**Indications:**
- Pt’s who have a cuffless tube or can tolerate their cuff being down
- Pt’s who are being considered for decannulation

**Contraindications:**
- unable to tolerate cuff deflation
- upper airway obstruction
- Severe COPD
- Copious, thick, unmanageable secretions
- Increased Atelectasis
- unresponsive/comatose

- Requires MD order for use
- NEVER APPLY A CAP TO A PATIENT WHO HAS THEIR CUFF UP
- Usually a capping trial will need to be performed with continuous pulse ox monitoring to see if pt tolerated their trach being capped
**Handoff Communication**

**Quality Handoff Communication**

**Definition:**
- An organized, focused, and relevant verbal / written report about a patient that is given to another healthcare provider
  1. Nurse to Nurse
  2. Nurse to Physician
  3. Physician to Physician
  4. Nurse to other staff on patient’s healthcare team

**Primary Objectives of Handoff Report**

- Give accurate information about the patient’s ...
  1. Current condition
  2. Treatments
  3. Recent and/or anticipated needs or changes
- Facilitate continuity and improve quality of care and patient safety

**When Do Handoffs Occur?**

- As patient moves throughout the hospital from...
  - ED or nursing unit to testing/treatment departments or other nursing unit
  - Higher level of care (i.e. MICU, NICU, CICU, etc.) to lower level of care (i.e., Medical, Surgical, Ortho, PCU, etc.)
  - Lower level of care to higher level of care
  - OR to PACU
  - OR/PACU to any nursing unit
  - Hospital unit to Home Health Care, SNF, LTACH, etc.

**Importance / Relevance of Quality Reports**

- Approximately 4,000 patient handoffs occur every day in a typical hospital
- Even a great job of 95% translates into 200 communication failures per day

**Importance / Relevance (cont’d.)**

- Errors in communication can cause the following to occur:
  1. Inappropriate treatment(s)
  2. Lack or delay of appropriate treatment(s)
  3. Increase patient risk for complications
  4. Extend lengths of stay
  5. Increase healthcare costs

**Point to Ponder**

- The use of a standardized process, such as the SBAR communication tool
  1. Helps organize and guide the transfer of information from one person to another and
  2. Insures consistency of reported information.
Variations in Reports

• Not all reports are created equally ... some are brief, others are long and detailed.
• Content of a handoff report varies by the person receiving the report (RN, Physician, CNA, transport staff, etc.).
• Focus and content will vary by location of the person giving or receiving the report (ED, OR, PACU, ICU, Med-Surg unit, etc.)

Tips for Handoff Reports

1. Always be prepared: Get you “ducks in a row” by having gathered you information. Know what you want to say before you start saying it.
2. Anticipate: Questions will be asked. What might you want to know if you were receiving and not giving the report?

Tips for Handoff Reports (cont’d.)

3. Be organized in your thought process and in delivery of your report. Do not be scattered. That’s how things get missed and mistakes are made. It is common to give assessment findings in the same order as a head-to-toe assessment. There is no right or wrong order; just be organized!
4. Be a Team Player: Be sure to include the oncoming shift when making any change-of-shift decisions. Get their input. Patient care is much more effective and safe when it’s a collaborative, team effort.

Locations for Report

• Patient room, bedside
• Nursing unit report room
• Outside patient’s room
• Nurse’s station
• Via phone and Fax (RN contact info should be on Faxed report.)

Note: If location is public, keep voice low so other patients & family members cannot hear, thus maintaining patient privacy.

Something to Remember

• Although SBAR is a great tool to guide report, it does not contain all of a patient’s information.
• The oncoming or receiving nurse should still ask the reporting nurse questions that may not be included in the SBAR report but that s/he may consider important regarding the patient’s status.
Questions to Anticipate / Ask

- Does that patient have any family?
- Who is the patient’s primary contact if something was to happen?
- What is the patient’s Code Status?
- Are there any outstanding doctor orders that need to be completed?
- Does the patient have informed consent signed? (If patient is having surgery / invasive procedure)
- Does the patient have any type of testing that they must be NPO for?

Questions to Anticipate / Ask (cont’d.)

- Does the patient have pain? How are we controlling the pain? Medications, if so with what? When was patient last medicated?
- Is the patient a telemetry or non-monitored patient?
- Does the patient leave the room and go outside?
- How well does the patient walk on their own?
- When was the last time the patient was out of bed?
- Is the patient hard of hearing or have difficulty seeing?

Questions to Anticipate / Ask (cont’d.)

- Are the IV tubing dates still in date or do they need to be changed today?
- Wound Care - Next Dressing Change Due?
- Are there any upcoming or pending tests or procedures?
- Any concerns or requests you have about the patient?
- Does the patient need any consults (i.e., Case Manager, PT, OT, Dietitian, etc.)?

Questions to Anticipate / Ask (cont’d.)

- Is there any language barrier?
- Are there any cultural considerations?
- When was the patient’s last bowel movement?
- Are there any STAT orders that need to be done?
- Are there any abnormal lab results that need to be called at this time?
- Is there anything that needs to be done at this time?
- Have you signed off all your medications?

Conclusion

- Giving and getting a good nursing report during a patient handoff is very important for both the nurse and the patient.
- There is more than one way to effectively deliver or receive a good handoff report. A variety of “cheat sheets” and standard formats exists (e.g., SBAR) that you can use as is or adapt to your preferences.
- Remember to always ask questions when getting report. The more you know the better care you will be able to provide to your patient.
- Ultimately, it is your responsibility to be an effective and efficient communicator. Start working on it today!
Simulation

Your role as a student nurse:
Please review this workbook including each scenario, the patient's medical orders, MAR, and admission report

Review Administering Specialized Nutritional Support via Small-Bore Nasogastric, Gastrostomy, or Jejunostomy Tube, Craven Procedure 28-3 p. 921 and also p 904-911.


Critical Thinking Exercise:
- Be prepared to work for 15 minutes in groups of 3 to complete objectives for each scenario
- Three students will actively participate in simulation and 3 students will actively observe
- All 6 students will actively participate for 15 minutes with an instructor guided debrief

General Patient Medical Information for All Scenarios Today

**Primary Medical Diagnosis:** Pneumonia

**History of Present Illness:**
Ms. Dorothy Dix is a 66 year old female who you are receiving on your Observation Unit from the Emergency Department. Her diagnosis is Pneumonia and she is awaiting an inpatient bed on the pulmonary unit once a bed becomes available.

**Situation**
66 year old female admitted to Dr. Jeffrey Mann Pulmonary Service with Dx: Pneumonia

**Background**
Patient is 66 year old female who has had a recent history of cough, chills, fever, diaphoresis, pleuritic pain and dyspnea. She has complained of occasional shortness of breath with a productive cough with thick yellow-green sputum. She has a history of thyroid cancer which was treated 3 months ago with a total thyroidectomy and radiation therapy. The radiation therapy has made it difficult for her to swallow and clear secretions. She had a 7mm Portex tracheostomy placed 1 month after the thyroidectomy and a gastric tube placed 1 month ago to add in nutritional intake when a left hip stage 4 pressure ulcer was discovered. The left hip pressure ulcer was debrided and a wound vac placed at this time as well.

**PMH:** hypercholesterolemia, GERD, 20 year 1 pack a day smoker-quit 30 years ago, thyroidectomy with radiation therapy 3 months ago, tracheostomy placed 2 months ago, left hip pressure ulcer with wound vac 1 month ago, and a gastric tube with cyclic nightly feedings started 1 month ago.

She lives with her husband of 30 years and she is a retired elementary teacher. She goes to a speech therapist once a week to help her with swallowing therapy and exercises to improve pharyngeal mobility. She and her husband have been caring for her trach, GT, and wound vac at home with the oversight of home health care visits once a week. They go to a wound clinic bi-weekly for the pressure ulcer follow-up and management.

**Assessment:**
ED assessment: A & O x 4 with a headache and fatigue. S1 S2 no murmurs. Respiratory effort labored with crackles throughout on a 40% trach collar. Frequent trach suctioning for thick yellow-green sputum. BS active x 4 quads with some c/o nausea, GT in place with drain dressing. 4X4 dressing in place over Left hip PU while waiting for hospital wound vac to arrive to unit. MAE x 4. Right AC with 18 gauge PIV.

Please see each scenario for specific assessment changes

**Recommendations:**
Please see each scenario for specific objectives
Emergency Department Faxed Report Form CON Simulation

Date: Today  Time: 2300  Room # Sim  MD Mann

Diagnosis or Chief Complaint: Pneumonia

Patient is 66 year old female who has had a recent history of cough, chills, fever, diaphoresis, and dyspnea. PMH: GERD, hypercholesterolemia, GERD, total thyroidectomy 2/t Ca, trach, GT. Allergy: iodine, PCN.

Admission History: Yes  No  Isolation Required: Yes  No  Type:

Patient is 66 year old female who has had a recent history of cough, chills, fever, diaphoresis, and dyspnea.

PMH: GERD, hypercholesterolemia, GERD, total thyroidectomy 2/t Ca, trach, GT. Allergy: iodine, PCN.

Backgro: Patient is 66 year old female who has had a recent history of cough, chills, fever, diaphoresis, and dyspnea. PMH: GERD, hypercholesterolemia, GERD, total thyroidectomy 2/t Ca, trach, GT. Allergy: iodine, PCN.

Asessment: 1 hour ago @ 2200

Vital Signs

- Temp. 38.7
- Pulse Rate/Rhythm 102 / Reg
- Resp: 24
- O2 Sat.: 94%
- RA/24 OA/24 TC B/P 102/78
- BG N/A
- GCS: Yes Scale N/A  No Other

Physical Assessment

- Neuro: A/O x4 Alert Awake LOC Lethargic
- Comatose Fluctuating Agitated Confused Comatose
- Other:

Integumentary

- Skin W/D Color WNL Cap Refill < 3 sec
- Other:

Respiratory

- Unlabored Labored Tachypneic
- Clear Wheezes Rhonchi Diminished Crackles
- Other:

GI: BS Present Hypoactive Hyperactive Abd. Distended
- Other: GT with drain dressing Jevity 1.5 feedings @ 80 mL

MS: No deficits Contracted Cachetic Amputation
- Other:

Pain Management

- Pain level before meds: 3 /10
- Pain level now: 3 /10
- Location of Pain: chest, inc w/ cough
- Pain Medication: N/A
- Last Dose Given At: N/A  Pain Goal: less than 3/10

See triage note for list of home meds

Medications

- Albuterol 5mg Nebulized treatment given 1 hour ago, 500 mg of Tylenol given 1 hour ago, 40 mg Nexium given 1 hour ago, Zocor 40mg given 1 hour ago @ 2200
- Antibiotic Started: Yes  No  N/A Type Ceftriaxone 2 g IVPB & Zithromax 500 mg IVPB  Time 2 hrs & 1.5 hrs ago

ED Pathway Initiated: N/A

Precautions: Aspiration precautions

Care Issues: Lives with husband

HHC sees pt 1 x/wk, Seen in wound clinic 2x/month

Special Equipment Needed: wound vac-ordered in ED

Goals/ Things to watch out for:

- Watch for respiratory distress
- Wound/Ostomy nurse to place wound vac dressing when hospital wound vac pump arrives to unit-Ordered in ED

Labs or Medications to be done soon:

- Pending Lab Results

Signatures (PRINT)

ED RN Completing Report: Sue Sterwart RN NURS 3132
Pt. Transported By tech
Ext 1234

Pt. Transported By tech
Ext 1234
Dispensing by non-proprietary name under formulary system is permitted, unless checked here: □

DATE: Today  TIME: 2000

ATTENDING PHYSICIAN: Dr. Mann  UPI ID #1123

ORDERING HEALTHCARE PROVIDER: Kay Wortel NP  GME/UPI 1223

SERVICE: Pulmonary  CODE STATUS: Full

PAGER: 0812

ALLERGIES: Iodine, PCN

1. Admit to Observation unit awaiting Pulmonary unit bed availability
2. Admit height: 5’6”  Admit weight: 66.2 kg
3. Diagnosis: Pneumonia
4. PMH: GERD, hypercholesterolemia, total thyroidectomy 2/t Ca, trach, GIT
5. Vital Signs with pulse oximetry q 4 hours and pm
6. Call HO: for acute change in status, Temp ≥ 38.5 C or ≤ 35, SBP ≥ 160 or ≤ 90, DBP ≥ 100 or ≤ 40, HR ≥ 120 or ≤ 50, RR ≥ 24 or ≤ 8
7. Intake and Output q 8 hours
8. Oxygen continuous per trach collar as needed to keep SpO2 ≥ 92%
9. Trach care and suctioning as needed
10. Activity: Up ad lib, ambulate patient 3 times a day
    Change position every 2 hours while in bed
    Sitting no more than 1 hour times daily
11. Diet: Regular as tolerated
    Enteral Tube feeding-Cyclic (nocturnal feeding) Jevity 1.5 @ 60 mL/hour for 8 hours
    Water flushes 30ml every 4 hours via feeding tube, during feedings, at beginning and end of feedings, after aspiration for residuals, and before and after medication or protein modular administration. Use tap water.
    Tube feeding water bolus (for hydration) every 6 hours, administer 250 mL water
12. Aspiration precautions, raise head of bed 30-45 degrees unless otherwise contraindicated
13. Send Blood Cultures x 2, CBC, Prealbumin, BMP with phosphorus and Hepatic panel due is ED 1 hour ago
14. Send Sputum Culture, due is ED 1 hour ago
15. Send ABG, due is ED 1 hour ago
16. XR chest 2 view PA Lateral, due is ED 1 hour ago
17. Wound vac therapy: Apply wound vac to Sacral healing Stage 4 PU, change dressing every MWF, wound/ostomy RN to place initial dressing and unit RN to perform all other dressing changes
    On MWF irrigate wound with NS, place Med vac black foam to a Vac Cannister
    Pressure settings of: 125mmHg Continuous
18. Weigh patient every morning  (ORDERS CONT. on next page. Page 1 of 2)
19. Inpatient consult to Nutrition
20. Incentive spirometer, deep breathe and cough every hour while awake

SIGNATURE/TITLE
Kay Wortel NP

Orders transcribed by:  Title:  Date:  Time:

Verified by:  Title:  Date:  Time:
**DATE:** Today  
**TIME:** 2000

**ATTENDING PHYSICIAN:** Dr. Mann  
**UPI ID #** 1123

**ORDERING HEALTHCARE PROVIDER:** Kay Wortel NP  
**GME/UPI** 1223

**SERVICE:** Pulmonary  
**CODE STATUS:** Full

**PAGER:** 0812

**ALLERGIES:** Iodine, PCN

**DATE:** Today  
**TIME:** 2000

**DOB:** 8/12  
**MRN:** 77889978

**ORDERING HEALTHCARE PROVIDER:** GME/UPI  
**KAY WORTEL NP** 1223

**SERVICE:** Pulmonary  
**CODE STATUS:** Full

**PAGER:** 0812

**ALLERGIES:** Iodine, PCN

**DATE:** Today  
**TIME:** 2000

**DOB:** 8/12  
**MRN:** 77889978

**ORDERING HEALTHCARE PROVIDER:** GME/UPI  
**KAY WORTEL NP** 1223

**SERVICE:** Pulmonary  
**CODE STATUS:** Full

**PAGER:** 0812

**ALLERGIES:** Iodine, PCN

(ORDERS CONT. BELOW Page 2 of 2)

- IV Infusions: D5 ½ NS at 75 ml/hr started in ED 1 hour ago
- Synthroid 125 mcg orally/GT once daily
- Lipitor 10 mg orally/GT once at night, given in ED 1 hour ago
- Ceftriaxone IVPB 2 g every 24 hours, given in ED 2 hours ago
- Azithromycin (Zithromax) 500 mg IV every 24 hours, given in ED 1.5 hours ago
- Nexium 40 mg IVP every night
- Albuterol 5mg Nebulized treatment or Albuterol MDI Inhaler with spacer 2 puffs every 2 hours as needed for SOB, given in ED 1 hour ago
- Zofran 4 mg IV push every 6 hours as needed for nausea
- Tylenol 500mg orally every 4 hours as needed for mild pain 1-3, HA, or temp greater 38.5 C, given in ED 1 hour ago

**SIGNATURE/TITLE**

**Orders transcribed by:** Kay Wortel NP

**Title:**

**Date:**

**Time:**

**Verified by:** Kay Wortel NP

**Title:**

**Date:**

**Time:**
**Medication Administration Record (MAR)**

**Name:** Dorothy Dix  
**MRN:** 77889978  
**Date of Birth:** 8/12  
**Allergies:** Iodine, PCN  
**Admit height:** 5'6"  
**Admit weight:** 66.2 Kg

<table>
<thead>
<tr>
<th>Scheduled Medications</th>
<th>Time</th>
<th>Yesterday</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance IV fluid D5 ½ NS at 75ml/hr</td>
<td>Continuous</td>
<td>Started in ED 1 hour ago 2200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synthroid 125 mcg oral/GT once daily</td>
<td>0800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftriaxone 2 g IVPB every 24 hours</td>
<td>2000</td>
<td>Given in ED 2 hours ago 2100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azithromycin 500mg IVPB every 24 hours</td>
<td>2200</td>
<td>Given in ED 1.5 hours ago 2130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipitor 10 mg orally/GT once at night</td>
<td>2200</td>
<td>Given in ED 1 hour ago 2200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nexium 40 mg IVP every night</td>
<td>2000</td>
<td>Given in ED 1 hour ago 2200</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature** | **Initial**

Sue Stewart RN | SS

---

**NURS 3132: Integration II Day 1 CEC/Sim Workbook**

16
**Medication Administration Record (MAR)**

Name: Dorothy Dix  
MRN: 77889978  
Date of Birth: 8/12  
Allergies: Iodine, PCN  
Admit height: 5'6"  
Admit weight: 66.2 Kg

**PRN Medications**

<table>
<thead>
<tr>
<th>PRN Medications</th>
<th>Time 0700-0659</th>
<th>Yesterday</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol 5mg Nebulized Treatment every 2 hours as needed OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albuterol MDI Inhaler with spacer 2 puffs every 2 hours as needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tylenol 500 mg orally every 4 hours as needed for mild pain (1-3), HA or temp greater than 38.5 C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zofran 4 mg IV push every 6 hours as needed for nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Initial</th>
<th>Signature</th>
<th>Initial</th>
<th>Signature</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Stewart RN</td>
<td>SS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NURS 3132: Integration II Day 1 CEC/Sim Workbook  
17
Name: Dorothy Dix
MRN: 77889978
Date of Birth: 8/12
Allergies: Iodine, PCN
Admit height: 5'6"    Admit weight: 66.2 Kg

<table>
<thead>
<tr>
<th>TUBE FEEDING RECORD</th>
<th>Yesterday</th>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jevity 1.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enternal tube feeding per GT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cyclic nocturnal feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tube feeding water bolus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>250mL every 6 hours per GT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start 2200</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stop 0600</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0600</td>
<td>1200</td>
<td>1800</td>
</tr>
<tr>
<td></td>
<td>2400</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Started in ED 1 hour ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS @ 2200</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature

<table>
<thead>
<tr>
<th>Signature</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Stewart RN</td>
<td>SS</td>
</tr>
</tbody>
</table>

NURS 3132: Integration II Day 1 CEC/Sim Workbook
18
Simulation Scenarios

Your role as a student nurse:
- Be familiar with the patient’s medical orders, MAR, and ED faxed report
- The instructor will give you a minute to pre-brief and review the scenario’s objectives
- Be prepared to work for 15 minutes in groups of 3 to complete objectives for each scenario
- Three students will actively participate in simulation and 3 students will actively observe
- All 6 students will actively participate for 15 minutes with an instructor guided debrief

Critical Thinking Exercise:
- 3 active simulation participants should divide into nursing roles to meet the patient’s needs and scenario objectives
- You are working with an interdisciplinary team and may consult by phone a Physician, Provider, Charge Nurse, CNA, Pharmacist, Case Manager, Respiratory Therapist, Social Worker, Chaplin, Physical Therapist and others as available
- Role recommendations: 1 assessment/Vs nurse, 1 intervention/medication nurse, 1 leader/primary nurse
- The team will be randomly assigned to roles.
  - Student 1: Assessment/Vs nurse
  - Role to complete basic assessment, vital signs and communicate findings with team members
  - Student 2: Interventions/Medication administration nurse
  - Role to implement nursing interventions to include medication administration
  - Student 3: Intervention/Primary nurse
  - Role as leader, situational awareness, communication with provider and to implement nursing interventions
- 3 active observers should focus on observing simulation and be able to highlight successes and deficits in patient assessment, nursing interventions, and safety

Scenario #1-New Admission to Observation Unit @ 2330
Sim room 3

Recommendations: Admit Dorothy Dix to your unit by verifying orders, implementing orders, and educating the patient on the plan of care. As a team please admit this patient to your unit and provide any nursing care she may need.
At minimum please complete:
- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Admit patient to unit. Complete Patient Admission Assessment-Nursing. Provide patient education to hospital process and care, orders including aspiration precautions, and overall plan of care.
- Verify admission orders, verify MAR, and verify IVF and tube feeding along with review what medications the patient received in ED.
- Also provide any nursing care for patient and communication to provider as needed

Scenario #2 30 minutes after admission @ MN
Sim room 3

Recommendations: It is 30 minutes later and Dorothy Dix requires her tube feeding water bolus, oral care, a basic assessment, and as a team provide her with any nursing care he may need.
At minimum please complete:
- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Provide the tube feeding water bolus
- Provide oral care
- Also provide any nursing care for patient and communication to provider as needed

NURS 3132: Integration II Day 1 CEC/Sim Workbook
19
Patient Admission Assessment-NURSING

Medication Reconciliation Orders Completed  □ Yes □ No (on separate orders)
Admit Date: ___________  Unit: ___________  Service: ___________
Attending, Residents, and Providers: ________________________________________________
Diagnosis: ____________________________________________________________

Main reason for today’s visit: ______________________________________________________
Other concerns: _________________________________________________________________

Have you completed an Advance Directive for Health Care (ADHC) □ Yes □ No If yes, Type: □ Living Will □ CPR directive □
Medical power of attorney Name of MPOA __________________________________________ □ Copy made and entered into EMR

Do you have religious, cultural, or ethnic practices that we should consider while you are in the hospital? □ Yes □ No
Explain: _____________________________________________ Religious preference: _______________________

Allergies or intolerance to medications and food (include type of reaction): □ NONE □ Yes ________________________________

Surgical History. Include type of surgery and date □ NONE □ Yes ________________________________

Depression/Suicide Screening
Over the past 2 weeks, have you felt down, depressed, or hopeless? □ Yes □ No
If yes: Over the past 2 weeks, have you had thoughts of killing or hurting yourself? □ Yes □ No
If yes: Have you ever attempted to kill yourself? □ Yes □ No If yes to any screening question, call provider and consult social work immediately. Confirm patient is in safe current environment.

History of Falls
Have you fallen in the last month? □ Yes □ No If yes place patient on High Fall Risk

Tobacco Use
Do you currently smoke or use any form of tobacco? □ Yes □ No Tobacco History: □ Never □ Yes Quit date: ________ How many years did/do you smoke? ________ Approximately how many packs a day did/do you smoke? ________ Tobacco type: □ Cigarettes □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use
When was the last time you had more than 3 (for women/men >65yrs)/4 (for men) drinks in one day? ___________
Not within the past 3 months □ Yes □ No If yes: # of drinks/week: ___________ □ Beer □ Wine □ Liquor

Drug Use
In the past 12 months, have you used drugs other than those required for medical reasons? □ Yes □ No ___________
Do you use marijuana or recreational drugs? □ Yes □ No Have you ever used needles to inject drugs? □ Yes □ No

Abuse/Neglect
Have you been hit, slapped or kicked in the last month? □ Yes □ No Do you feel safe at home? □ Yes □ No
Do you feel safe in your relationship? □ Yes □ No Are you in immediate danger? □ Yes □ No If yes SW & provider notified
Denies physical abuse? □ Yes □ No Denies verbal abuse? □ Yes □ No Denies sexual abuse? □ Yes □ No

Immunizations (Influenza screen during Oct, March & flu season) NURS 3132 Integration II Day 1 CEC/Sim Workbook
□ Influenza □ Pneumovax (PNA) □ Zostavax □ Meningoitis □ Tdap OR □ Tetanus & □ Pertussis
If you qualify for vaccine, would you accept it? □ Yes □ No If yes: Pharmacy consulted for screening □ Yes □ No
### Patient Admission Assessment - NURSING

#### REVIEW OF SYMPTOMS

Please mark any diagnoses or persistent symptoms from the past few months. List other concerns above.

<table>
<thead>
<tr>
<th>General</th>
<th>Neurological</th>
<th>Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained weight loss / gain</td>
<td>Headache</td>
<td>Chest pain / discomfort</td>
</tr>
<tr>
<td>Unexplained fatigue / weakness</td>
<td>Hx of CVA</td>
<td>Palpitations (irr. heartbeat)</td>
</tr>
<tr>
<td>Fall asleep during day when sitting</td>
<td>Seizures</td>
<td>MI/Heart attack</td>
</tr>
<tr>
<td>Fever, chills</td>
<td>Memory loss</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>No problems</td>
<td>Fainting</td>
<td>No problems</td>
</tr>
<tr>
<td></td>
<td>Dizziness</td>
<td></td>
</tr>
</tbody>
</table>

| Allergic/Immune | | |
| Hay fever / allergies | Numbness / tingling | |
| Frequent infections | Unsteady gait | |
| No problems | Frequent falls | |
| No problems | No problems | |

| Skin | | |
| New or change in mole | Heartburn / reflux / indigestion | |
| Rash / itching | Blood or change in BM | |
| No problems | Liver disease/hepatitis | |

| Ears/Nose/Throat | | |
| Nosebleeds, trouble swallowing | Constipation | |
| Frequent sore throat, hoarseness | Trouble swallowing | |
| Hearing loss / ringing in ears | No problems | |

| Eyes | | |
| Change in vision / eye pain / redness | Kidney disease | |
| No problems | Leaking urine | |
| No problems | Blood in urine | |
| No problems | Nighttime urination or inc. freq. | |
| No problems | Discharge: penis or vagina | |
| No problems | Concern with sexual function | |

| Psychiatric | | |
| Anxiety / stress / irritability | Neck pain | |
| Sleep problem | Back pain | |
| Lack of concentration | Muscle / joint pain | |
| Depression | No problems | |
| Psychiatric conditions | No problems | |

### Functional Assessment

#### Nutrition Screen:

- > 10lb unintentional weight loss in the last 3 months □ Yes □ No
- Unable to tolerate oral intake or NPO >4 days □ Yes □ No
- Open non-healing wound □ Yes □ No
- Home Tube Feeding □ Yes □ No
- Home TPN □ Yes □ No

#### Functional:

- Vision adequate to safely complete daily activities □ Yes □ No □ Blind □ Glasses □ Contacts
- Hearing is functional - **Right** ear □ Yes □ No □ Left** ear □ Yes □ No □ Hearing aid □ 1 □ 2
- Patient’s judgment adequate to safely complete daily activities □ Yes □ No
- Patient’s memory adequate to safely complete daily activities □ Yes □ No
- Patient able to express needs/desires □ Yes □ No
- Patient functionally independent in: **Dressing** □ Yes □ No □ Grooming □ Yes □ No □ Feeding □ Yes □ No □ Bathing □ Yes □ No □ Toileting □ Yes □ No □ In/Out Bed □ Yes □ No □ Walking □ Yes □ No □ LE weakness □ Yes □ No □ UE weakness □ Yes □ No

#### Discharge Planning:

- Lives independent □ Yes □ No □ Lives with significant other □ Yes □ No with whom: ____________
- Current home care services □ Yes □ No Type: ____________
- Expected discharge location: ____________
- Consult made to: **Dietician** □ Yes □ No □ OT □ Yes □ No □ PT □ Yes □ No □ SW □ Yes □ No □ CM □ Yes □ No
**Scenario #3-Wound Vac in place @ 0630**

*Sim room 2*

**Recommendations:** The wound/ostomy nurse has placed a dressing and set-up the wound vac for Dorothy Dix. She is requesting to be trached suctioned and as a team provide her with any nursing care she may need.

At minimum please complete:

- A focused assessment and vital signs as needed.
- Assess and verify the wound vac and the dressing
- Suction patient as needed
- Total I & Os for last 8 hours
- Also provide any nursing care for patient and communication to provider as needed

**Scenario #4-Transferring to Pulmonary Unit @ 0700**

*Sim room 2*

**Recommendations:** A bed is available and the Pulmonary Unit is ready for Dorothy Dix. Please provide trach care, prepare the patient for transfer to the Pulmonary unit, call the Pulmonary RN Patty with a handoff SBAR report before transfer, and as a team provide him with any nursing care he may need.

At minimum please complete:

- A basic assessment including any needed focused assessments. Please include a set of vital signs.
- Prepare the patient for transfer to Pulmonary unit
- Provide trach care
- Call the Pulmonary RN Patty with a handoff SBAR report before transfer (*use the SBAR Shift/Transfer Report Form as a guide*)

**ADDITIONAL NOTES**
**SBAR Shift/Transfer Report Form CON Simulation**

*Report should take 5 minutes or so and the nurse should report and review only RELEVANT and PERTINENT information patient

* Utilizing SBAR communication with your peers will help you better your technique when working with other multidisciplinary team members

<table>
<thead>
<tr>
<th>Pt. Name/room number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>MD/service</td>
<td></td>
</tr>
<tr>
<td>Who’s on call?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis/Hospital Course</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of admission/ Reason for admit (history of presenting illness/course of hospitalization, surgeries/medical procedures, surgery date, secondary to/transferred from (i.e. PACU, discuss relevant treatments or procedures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pt. History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief and Relevant Past Medical History (Prior illnesses, surgeries, chronic illnesses)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social History/Cultural/Religious</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(highlight clinically relevant data)</td>
<td></td>
</tr>
<tr>
<td>Smoke/ETOH/Drug Use/Occupation/Family Situation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Status</td>
<td>Advance Directive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan of Care Update</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened during shift (i.e. HCT low, went to test, gave blood, changed med)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last set/Trends/ BP/MAP/HR/rhythm/Resp/Temp/Pulse ox/CVP/ABP/Goals?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PABS, WILDA or Pain Score/ Meds Given and time/PCA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC/A&amp;Ox4/ Voice/PERRLA/Neuro checks/Extremity strength &amp; symmetry spontaneous, to command or to pain</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiac/Rhythm</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate/Rhythm/Heart sounds/Pulses-UE and LE/cap refill/Edema/Pacer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lungs sounds/Resp. rate &amp; effort/O2/pulse ox/Cough/IS/Trach/BiPap/Vent/Suctioning—type and frequency</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GI/GU</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>U.O.-characteristics/incontinent?: Foley/LBM/Gas/Bowel Sounds/tenderness/N/V</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I &amp; O’s/Weight</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I &amp; O w/ goal-last 8hr &amp; 24 hr/Urine Output/ Drains output/Wt-today &amp; yesterday</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin/Incision/Drains/Wounds</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucous membranes/turgor/moisture/temp/color/skin breakdown or issues/ Incisions, Drains, Wounds-locations/Drainage/Ecchymosis/Staples/Sutures/JP’s/Drains/wound care/dressings-how, when, where, &amp; how often</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vascular Access/IVF/Drips</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location &amp; assessment of Central Line/PICC/PIV-when was it placed/IV Fluid &amp; rate/IV drips-titration goals</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertinent lab values and related interventions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accu checks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency/ Insulin Regimen</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical mobility/functional ability/gait/up to chair/turn schedule or activity schedule/Fall risk/Full care/assist device/precautions/orthopedic braces (cervical collar, jewett, CTLSO, TLSO)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diet</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Type/Fluid restriction/NPO/swallow concerns/Feeding tube-NG, G, J, PEG/Type of tube feed-rate &amp; flush amount</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications (if applicable)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss any medication concerns/unalusual medications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tests/ Procedures Ordered or Pending</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan of Care Needs or Routines (Not already discussed or VERY important you want to reiterate)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge planning/Teaching needs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Interdisciplinary consults/needs</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Review chart/MAR/New MD Orders (assure all orders have been implemented or noted)</th>
<th></th>
</tr>
</thead>
</table>

**Room Rounds!!!** Include introductions and farewells/Review the patient’s plan of care with patient/Complete an assessment at the bedside to include high alert assessments and interventions (may be population, unit or hospital specific). Most would include:

- Double check of all IV medications, rate, dose, connections, IV sites, central access. **Check IV lines from bag to patient.**

  **NURS 3132: Integration II Day 1 CEC/Sim Workbook**

- Verify major monitoring equipment programming/monitoring parameters/settings/alarms.

- Assess drains, CT, incisions and review wound care orders.

- Visualize the appropriate arm band.
<table>
<thead>
<tr>
<th>Site</th>
<th>Parenteral Intake</th>
<th>Enteral Intake</th>
<th>Other Intake</th>
<th>Total Hourly Intake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tube Checked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hgb Elevated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GT Flush</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jejuni 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Urine</th>
<th>Gastric</th>
<th>Enteric</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parenteral Intake**
- Infusate A
- Rate 80
- Amount 80
- Site 80
- Total

**Enteral Intake**
- Infusate B
- Rate 80
- Amount 80
- Site 80
- Total

**Other Intake**
- Infusate C
- Rate 80
- Amount 80
- Site 80
- Total

**Total Hourly Intake**
- Infusate D
- Rate 80
- Amount 80
- Site 80
- Total

**Notes**
- Tube checked
- Hgb elevated
- Residual
- Oral
- GT flush
- Jejuni 15

**Additional Information**
- **MRN:** 77689078
- **DOB:** 4/12
- **Gestational Age:** 36 weeks 6 days
- **Weight:** 2600 g
- **Height:** 48 cm
- **Temperature:** 36.5°C
- **Blood Pressure:** 90/60 mm Hg
- **Respiratory Rate:** 30
- **SpO2:** 98%
- **O2 Concentration:** 29%