

WOUND MANAGEMENT

Estimated Time: 30 minutes • Debriefing Time: 30 minutes



Patient Name: Clint D. Fullerton

SCENARIO OVERVIEW

Clint D. Fullerton is a 67 year old male who was admitted to the medical/surgical floor for treatment of a non-healing left ankle wound. Mr. Fullerton resides at a local skilled nursing facility secondary to self-care deficits and being a brittle diabetic. He had multiple rounds of antibiotic treatment with no successful results.

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness

BASIC SKILLS

- Provide wound care
- Administer medications via the enteral and parenteral routes
- Perform a basic physical assessment

NURSING FUNDAMENTALS

- Use appropriate communication techniques
- Use the nursing process
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings
- Provide nursing care for patients with integumentary disorders
- Provide nursing care for patients with infection

LEARNING OBJECTIVES

1. Perform a head to toe assessment
2. Perform a focused wound assessment
3. Recognize abnormal findings
4. Safely administer medications: PO, insulin
5. Document accurately
6. Demonstrate appropriate therapeutic communication

QR CODE



Scan to begin

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT

Inside room: Patient on bed

Inside or outside room: Hand sanitizer or sink

Outside room: Computer or form(s) for documentation

PATIENT PROFILE

Name: Clint D. Fullerton

DOB: 02/26/19XX

Age: 67

MR#: 0508

Gender: Male

Ht: 68 inches

Wt: 143 lbs (65 kg)

Admitting Diagnosis: wound, open, ankle (S91.00)

Medical History: Diabetes Mellitus (E11.9), HTN (I87.33), Venous Insufficiency (I87.2)

Code Status: Unknown

Ethnicity: Caucasian

Allergies: None

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Hospital gown
- No moulage
- ID band with QR code
- IV in left hand

Monitor Settings

- Vitals: BP 188/98, P 108, RR 12, O2 99%, T 38.2C (100.8)

Supplies

- Medications
 - Novolin R insulin vial
 - Lantus insulin vial
 - Insulin syringes
 - Alcohol
 - Lisinopril 20 mg PO
- IV Pump
 - 0.9% NaCl running at 75ml/hr

QR CODES

START



REPORT



PATIENT



PATIENT ID



LEG



IV SITE



STATE 1—PREBRIEF, REPORT & PATIENT INTRODUCTION

The facilitator should lead this portion of the simulation. The following steps will guide you through State 1.

- “Scan to Begin” using scenario start QR Code while students are in Prebrief.
- “Meet Your Patient” (on iPad) and explain how the iPad works in the simulated learning environment including the scanner/QR codes.
- Discuss the simulation “Learning Objective(s)” (on iPad) as well as any other Prebrief materials
- Get “Report” (on iPad)
 - Possible facilitator discussion questions
 - What is clinically significant in the shift-to-shift report?
- Play the “Patient” video (on iPad)
 - Possible facilitator discussion questions
 - What nursing problems do you anticipate based on the information you heard in report and from the patient?
 - How will you respond therapeutically to the patient’s concerns?
- Advance to the “Patient Profile” screen (on iPad). This will act as a simulated patient chart.
- Students can view the tabbed content on the iPad (see below) prior to entering the patient’s room and throughout the simulation as needed.
- Now, students can enter the room and begin the next state of the simulation.

HISTORY AND PHYSICAL

Name: Clint D. Fullerton

MR#: 0508

DOB: 02/26/19XX

DATE OF ADMISSION: 09/18/XX

CHIEF COMPLAINT: Ulceration Left Lower leg

HISTORY OF PRESENT ILLNESS: This is a 67-year-old male who resides at a local skilled nursing facility due to self-care deficits. He has a stage 2 ulceration on his left medial lower leg superior to ankle. He has been previously treated by Dr. Paulson who ordered multiple rounds of antibiotic treatment with no successful results. He is a brittle diabetic with his last HgbA1c being 9.2%.

PAST MEDICAL HISTORY: History of diabetes, HTN, venous insufficiency.

MEDICATIONS:

- Lisinopril 20mg PO daily
- Lantus insulin 0.2 units/kg/daily subcutaneously
- Novolin R insulin sliding scale subcutaneously with meals

ALLERGIES: None

SOCIAL HISTORY: Divorced; No children; Lived in LTC for 5 years. History of extensive alcohol use prior to LTC admission. Refuses to quantify current use but states LTC staff will take it away if they find it.

FAMILY HISTORY: Father - died in MVA at age 59. Mother – living, diabetic, age 91. Brothers – 2, status unknown.

REVIEW OF SYSTEMS:

Obtained From patient General: Current state of health described as fine.

Integument: Denies itching, dryness, rashes, pigmentation changes. Denies recent changes in birthmarks, moles, nails, or hair. Describes a sore above left ankle that has been present for several months. He has taken several antibiotics but it won't heal.

Lymph Nodes: Denies enlargement or tenderness

Head: Denies injury, change in level of consciousness, or headaches.

Eyes: Denies change in vision. Denies diplopia, eye pain, eye redness/inflammation. Denies glaucoma or cataracts. Wears glasses.

Ears: Denies hearing loss, change in acuity, tinnitus, vertigo, infection, or ear pain.

Nose: Denies sinusitis, nasal discharge or obstruction, post nasal drip, or epistaxis.

Mouth: Denies bleeding gums, mouth pain, oral cavity sores or growths, difficulty swallowing, sore throat, or hoarseness.

Respiratory: Denies excessive snoring, orthopnea, hemoptysis, productive cough, shortness of breath or wheezing. Denies history of pulmonary embolism, sleep apnea, bronchitis, pneumonia, recurrent infections or TB exposure. Denies occupational exposure to asbestosis or pneumoconiosis.

Cardiovascular: Denies chest pain or pressure. Denies palpitations or orthopnea. No history of murmur or valve disorder. History of hypertension for which he takes lisinopril.

Peripheral Vascular: Denies claudication, leg cramps, varicose veins, phlebitis, cramping. History of venous insufficiency and paresthesias in lower legs. States my legs get swollen every now and then, but it gets better when I sit in my recliner and put them up, and it used to feel like pins and needles in my feet but now I can't really feel my toes anymore.

Gastrointestinal: Denies change in appetite, weight gain/loss, abdominal pain, constipation, diarrhea, nausea or vomiting. Denies bloody or tarry stools. Denies change in bowel habits. Bowel movements occurring every 1-2 days. Denies history of colon polyps, hemorrhoids, liver problems, jaundice, or hepatitis. Denies symptoms of GERD.

Genitourinary: Denies dysuria, hematuria, hesitancy or change in stream. Denies history of infections or stone. Denies incontinence or nocturia.

Males: Denies history of hernias, testicular masses, prostatitis, STDs, or BPH. Denies current testicular pain, penile discharge/lesions or sexual dysfunction.

Musculoskeletal: Denies joint pain or stiffness. Normal ROM. Denies myalgias. No history of gout, osteopenia/ osteoporosis or osteoarthritis. Denies back pain. Denies history of compression fractures, broken bones, falls or amputations.

Hematopoietic: Denies easy bruising or bleeding. Denies anemia or prolonged bleeding. Denies history of previous transfusions or blood dyscrasias.

Endocrine: Denies polydipsia or polyuria. Denies heat or cold intolerance. Denies tremors. Denies history of thyroid disorder. History of diabetes for which he is taking Lantus and sliding scale regular insulin. Last HgbA1c was 9.2%.

Nervous System: Denies dizziness, syncope, vertigo, sensory or motor disturbances, tremor or weakness.

Psychiatric: Denies depression, anxiety, or panic attacks. Denies memory concerns. Denies history of mania. No recent personality changes. No history of previous psychiatric care.

LABORATORY AND DIAGNOSTIC STUDIES: Pending

ASSESSMENT: Ulceration, left lower leg.

RECOMMENDATIONS/PLAN: Admit to med/surg floor. Orders will include wound culture, wound nurse consult, and dietitian consult. I discussed with him the exact nature of the wound and his risk factors including diabetes management and personal hygiene. Patient will be continued on his medication regimen from long term care until his diabetic status can be reviewed. Wound treatment regimen will be determined once culture results are back. All questions were answered and he agreed with treatment plan.

Electronically Signed – Dr. Robert Bennett

ORDERS

Date	Time	Order												
Yesterday	1800	Admit to Med Surg												
		Stool and Wound culture STAT												
		Diabetic Diet												
		Lisinopril 20mg PO daily												
		Saline lock flush 10mL IVP PRN												
		0.9% Normal Saline IV at 75mL/hr												
		Call if CDiff positive												
		Lantus insulin 13 units daily subcutaneously												
		Novolin R insulin Sliding Scale subcutaneously with meals:												
		<table border="1"> <thead> <tr> <th>Fingerstick glucose level (mg/dL)</th> <th>Novolin R (units)</th> </tr> </thead> <tbody> <tr> <td>150-200</td> <td>4</td> </tr> <tr> <td>201-250</td> <td>8</td> </tr> <tr> <td>251-300</td> <td>12</td> </tr> <tr> <td>301-350</td> <td>16</td> </tr> <tr> <td>351-400</td> <td>20</td> </tr> </tbody> </table>	Fingerstick glucose level (mg/dL)	Novolin R (units)	150-200	4	201-250	8	251-300	12	301-350	16	351-400	20
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		Wound care nurse consult												
		-----Dr. Robert Bennett												

MAR

Patient Name: Clint Fullerton
DOB:02/26/19XX Weight(kg):65
MR#: 0508
Provider: Dr. Robert Bennett
Allergies: None

Order	Sch. Time	Dose												
Lisinopril 20mg PO daily														
Lantus insulin 13 units daily subcutaneously														
0.9% Normal Saline IV at 75 mL/hour														
Saline lock flush 10mL IVP PRN														
Novolin R insulin Sliding Scale subcutaneously with meals:														
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VITALS

P 108
 RR 12
 BP 188/98
 T 38.2C (100.8)
 O2 99%
 Pain: 3/10

PROGRESS NOTES

No reports available.

LAB/DIAGNOSTICS

Patient Name: Clint D. Fullerton

DOB: 02/26/19XX

MR#: 0508

Blood Glucose				
Date	Today		Units	Reference Range
Time	AM			
Glucose	210		mg/dL	Fasting 70 - 105

IMAGING

No reports available.

LEVEL UP

Option not available yet.

SCANNER

Used for students to scan QR codes during simulation.

STATE 2 –PATIENT ASSESSMENT

- Patient Overview
 - Patient is sarcastic, angry and gruff. It is apparent that he is not fond of medical personnel or medical facilities, including the skilled nursing care facility where he currently resides.
- Learner Expected Behaviors
 - Perform appropriate infection control
 - Introduce themselves and verify patient
 - Communicate therapeutically
 - Perform general assessment
 - Perform focused assessment: leg wound (Scan Leg QR code)
 - Analyze the lab/diagnostic results
 - Give required meds: see MAR
- Technician Prompts
 - Patient is sarcastic, angry and gruff.
 - Patient responses can include:
 - “I hate hospitals. I came in here with a little scratch and now I’m sick.”
 - “I’m tired of answering questions. Just do what you have to do and get out.”
- Facilitator Questions
 - What factors are important to include in a wound assessment?
 - What other factors place Mr. Fullerton at risk for poor wound healing?
 - Analyze the lab results: are there any abnormal findings? What do you believe are the cause(s) of these findings for Mr. Fullerton?
- Tabbed iPad content
 - Changed tabbed content includes:

LEVEL UP

There is an “end the scenario” option available now. At the end of the simulation, direct students here to end the iPad application.

STATE 3 – DEBRIEF

Nothing needed from the iPad.

DEBRIEFING QUESTIONS

1. How did you feel this scenario went?
2. What were the main issues you had to deal with Mr. Fullerton?
3. What did you do for Mr. Fullerton?
4. Review understanding of learning objectives: perform a head to toe assessment and recognize abnormal findings.
 - a. During your head to toe assessment, were there any particular areas you focused on that could be associated with his poorly healing wound?
 - b. Did you discover any abnormal findings in his physical assessment or lab work? How do they relate to Mr. Fullerton's health status?
 - c. Mr. Fullerton is receiving 0.9% NS at 75 ml/hr. What will you assess when a patient is receiving IV fluids?
5. Review understanding of learning objective: safely administer medications PO, insulin
 - a. Compare/contrast regular insulin and Lantus insulin in terms of peak, onset and duration.
 - b. Can you mix regular insulin and Lantus? Why or why not?
 - c. What are your pre-assessments before administering regular insulin?
 - d. What are your pre-assessments before administering Lisinopril?
6. Review understanding of learning objective: perform a focused wound assessment
 - a. What did characteristics did you assess while assessing the wound? Are there any others that should be included?
7. Review understanding of learning objective: accurately document a wound assessment in narrative format
 - a. How did you choose to document the wound?
 - b. Compare documentation samples across students; create a "best response" narrative note

8. Review understanding of learning objective: demonstrate appropriate therapeutic communication
 - a. What “cues” did you notice that indicated therapeutic communication was needed with Mr. Fullerton?
 - b. Describe communication techniques you used with Mr. Fullerton.
 - i. Were your techniques effective?
 - ii. Did any barriers occur?
 - iii. If you could “do over,” how would you change your therapeutic communication with Mr. Fullerton?

9. Tie the scenario back to the nursing process in a large group discussion. Concept mapping can be used to facilitate discussion.
 - a. List 3 priority nursing problems you identified for Mr. Fullerton.
 - b. Create a patient centered goal for each nursing problem you identified.
 - c. Discuss focused assessments for each nursing problem.
 - d. Discuss nursing interventions for each nursing diagnosis.
 - e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?

10. Take away points
 - a. Ask each student to share one thing they learned from participating in this scenario that they will take with them into their nursing practice. (Each student must share something different from what the others’ share.)

Note: Debriefing technique is based on INASCL Standard for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
 - a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
 - b. This QR Code will not work in the ARIS app.



2. Copy and paste the following survey link into your browser.
 - a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

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