

WOUND MANAGEMENT

Estimated Time: 45 minutes • Debriefing Time: 45 minutes



Scan to Begin



Patient Name: Clint D. Fullerton

SCENARIO OVERVIEW

Clint D. Fullerton is a 67-year-old male who was admitted to the medical/surgical floor 2 days ago for treatment of a left ankle ulceration and is on contact precautions for CDiff. He has a past history of diabetes, venous insufficiency and self-care deficits. He has a PICC line in the left brachial for Vancomycin. This morning, labs showed an elevated peak Vancomycin level and the nurse found the patient short of breath with SpO₂ at 87% on RA. She increased his O₂ to 4 lpm nasal cannula and called the provider. New orders were received including an RT consult. After assessing the patient, the student(s) will receive new orders for a STAT ABG, portable chest x-ray and BiPAP per protocol.

LEARNING OBJECTIVES

1. Demonstrate proper infection control
2. Complete a respiratory assessment and evaluation
3. Recognize and respond to abnormal findings
4. Recommend appropriate treatment(s) to provider
5. Safely implement all respiratory therapy orders
6. Effectively communicate with the interprofessional team and patient
7. Document accurately

CURRICULUM MAPPING

WTCS RESPIRATORY THERAPY PROGRAM OUTCOMES

- Apply respiratory therapy concepts to patient care situations
- Demonstrate technical proficiency required to fulfill the role of a respiratory therapist
- Practice respiratory therapy according to established professional and ethical standards

RESPIRATORY AND CIRCULATORY PHYSIOLOGY

- Apply the principles of gas transport
- Interpret blood gas data
- Identify normal fluid and electrolyte balance values

RESPIRATORY DISEASE

- Evaluate radiologic images of the chest

RESPIRATORY LIFE SUPPORT

- Assess the need for mechanical ventilation
- Apply non-invasive mechanical ventilation

- Evaluate patient response to mechanical ventilation
- Correlate mechanical ventilation strategies to various disease states

RESPIRATORY CARDIO DIAGNOSTICS

- Interpret data from invasive and non-invasive procedures to assess oxygenation
- Interpret data from invasive and non-invasive procedures to assess ventilation

RESPIRATORY CLINICAL COMPETENCIES

- Apply standard precautions
- Assess vital signs
- Perform pulse oximetry
- Perform chart review
- Administer oxygen therapy
- Apply non-invasive positive pressure ventilation
- Perform arterial puncture

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT

Inside room: Patient lying in bed, IV pump

Inside or outside room: Modified Contact Precautions cart and sink

Outside room: Computer or form(s) for documentation

PATIENT PROFILE

Name: Clint D. Fullerton

Code Status: Unknown

DOB: 02/26/19XX

Primary Language spoken: English

Age: 67

Current Medications: None

MR#: 0508

Allergies: None

Gender: Male

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

Height: 173 cm (68 inches)

Weight: 65 kg (143 lbs)

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

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Hospital gown
- Pad, chux placed under patient or adult brief on
- No moulage
- ID band present with QR code
- IV in left hand
- PICC in left arm (set up medication administration)
- 4 lpm nasal cannula









Monitor Settings

- Vitals: BP 110/54, P 118, RR 32, O2 86% on 4lpm nasal cannula, T 38.2C (100.8)

Supplies

- General
 - Phone
 - Modified or CDiff precaution door sign
 - Contact precaution cart/supplies
 - Various O2 delivery devices and a BiPAP with assorted masks
- Medications
 - Vancomycin hanging on the PICC line, but not running
 - IV Pump
 - 0.9% NaCl running at TKO (1000ml bag)

QR CODES

<p>START</p> 	<p>PATIENT</p> 	<p>REPORT</p> 	<p>PATIENT ID</p> 
<p>CHEST 🗣️</p> 	<p>LEG</p> 	<p>IV</p> 	<p>PICC</p> 

TEACHING PLAN

PREBRIEF

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

- Scan the **QR Code: “Scan to Begin”** while students are in Prebrief.
- “Meet Your Patient” (on iPad) and explain how the iPad works in the simulated learning environment including:
 - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
 - For some scenarios, it may be helpful to tell students where the QR Code are located. For others, you may want students to “find” the QR Codes during their assessments. This is your choice.
 - Describe how a QR Code sound will work in the scenario. Show them how to use the ARISE “stethoscope” and the symbol on the QR Code that signifies when a QR Code is audio 🎧. Example: **QR Code: Chest 🎧**
 - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
 - Level Up tab – This tab “tells” the content in the iPad to change to what is needed for the next state of a simulation. It is used a few times in this scenario after the provider is notified to display new orders (those just given over the phone) and lab results, etc...
 - For this scenario, the only QR Code tied to iPad programming is **QR Code: Chest 🎧**. However, all other QR Codes listed below are active and can be used to augment realism in the simulated environment.
- Discuss the simulation “Learning Objective(s)” (on iPad) as well as any other Prebrief materials
- Get “Report” on iPad
 - Possible Facilitator Questions

- How will you prepare to consult on this patient given the nurses report?
 - What are your priorities for this patient?
- Play the “Patient” video (on iPad)
 - Possible Facilitator Questions
 - What communication strategies could you employ when you assess and evaluate Mr. Fullerton?
- 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.
 - You should give student some time (5 minutes) to review this content now, prior to entering the patient’s room.
- Now, students can enter the room and begin the next state of the simulation.

HISTORY & PHYSICAL

Name: Clint D. Fullerton

MR#: 0508

DOB: 02/26/19XX

DATE OF ADMISSION: two days ago

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

Orders														
Date	Time	Order												
Admit	1800	Admit to Med Surg												
		CBC with differential, Stool and Wound culture STAT												
		Diabetic Diet												
		Lisinopril 20mg PO daily												
		Ibuprofen 200mg PO 1-2 tablets Q 4-6 PRN for pain or fever												
		Saline lock flush 10mL IVP PRN												
		0.9% Normal Saline IV at 75mL/hr												
		Call if CDiff positive												
		Lantus insulin 0.2 units/kg/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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150-200	4													
201-250	8													
251-300	12													
301-350	16													
351-400	20													
		Dress L ankle wound with Tegaderm and compressive ACE wrap and consult wound care nurse												
		-----Dr. Robert Bennett												
Yesterday	0800	Chem 7 STAT												
		Vancomycin 25 mg/kg IVPB over 1 hour x 1 dose STAT then												
		Vancomycin 15 mg/kg IVPB over 1 hour every 12 hours												
		PICC line												
		Heparin 100IU/mL flush 10mL IVP PRN												
		Peak Vancomycin levels x 1, trough Vancomycin levels daily												
		Contact precautions -----Dr. Robert Bennett												
Today	Now	CBC, Chem 7 & eGFR STAT												
		Consult Nephrology												
		Hold Vancomycin. Call with trough result.												
		Consult Infectious Disease												
		Monitor I&O												
		Change NS IV to TKO												
		Lasix 40mg IVP STAT												
		O2 to keep Sat >90% & RT Consult --Dr. Robert Bennett												

Continue >

MAR

Facilitator Note: Students may click on each underlined medication for a hyperlink with medication information provided by National Library of Medicine.

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	Last given 0730	20mg
Lantus insulin 13 units daily subcutaneously	Last given 0730	13 units
0.9% Normal Saline IV at 75 mL/hour	Last bag 0330	
0.9% Normal Saline IV at 75 mL/hour		
Ibuprofen 200 mg PO 1-2 tablets Q 4-6 PRN for pain or fever	Last given 0730	400mg
Ibuprofen 200 mg PO 1-2 tablets Q 4-6 PRN for pain or fever		
Saline lock flush 10mL IVP PRN		

Novolin R insulin Sliding Scale subcutaneously with meals PRN:		Last given 0730	8 units
Fingerstick glucose level (mg/dL)	Novolin R (units)		
150-200	4		
201-250	8		
251-300	12		
301-350	16		
351-400	20		
Novolin R insulin Sliding Scale subcutaneously with meals PRN:			
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours	Given ystrdy 2030	975mg	
Vancomycin 15 mg/kg IVPB over 1 hour Q12 hours	HOLD		
Heparin 100 IU/mL flush, 10 mL IVP PRN	Given ystrdy 2140	10mL	
Heparin 100 IU/mL flush, 10 mL IVP PRN			
Lasix 40mg IV STAT			
Continue >			

VITALS

Today – 10 minutes ago

BP 128/68

P 118


RR 26

O2 87% on RA

T 38.2C (100.8)

Pain: 3/10

PROGRESS NOTES


Progress Notes

Patient Name: Clint D. Fullerton
DOB:02/26/19XX MR#: 0508

Progress Notes

Date & Time	Note
Yesterday 0945	Wound Care Nurse Initial Consult: Here to see Mr. Fullerton at the request of Dr. Bennett secondary to an ulceration of the left lower extremity. Patient agrees to let me assess the wound although he states, "It has been there for a while. I don't know what you think you're going to do about it." Assessment: This venous ulcer is located on the medial malleus of the left lower extremity with a dimension of approximately 8cm x 5cm x 1.5cm. A moderate amount of serous exudate without odor is noted on wound dressing. It is unstageable secondary to yellow slough and brown/tan eschar that covers most of the wound base. There is some granulation and epithelium around the wound edges from approximately 1300 to 1000. Wound edges are irregular with macerated periwound area and dry, flaky skin present. Patient states no pain during assessment. Culture already sent for analysis. Recommendation: I agree with MD ordered dressing choice and will await culture results. ----- ----- Maryann Klement, RN, WCC
Yesterday 1430	C.Diff positive. Vancomycin started. Full dictation to follow. -----Dr. Robert Bennett

[Continue >](#)

LAB-DIAGNOSTICS

Labs-Diagnostics						
Patient Name: Clint D. Fullerton DOB: 02/26/19XX MR#: 0508						
Blood Glucose						
Date	Yesterday	Today			Units	Reference Range
Time	AM	AM				
Glucose	210	208			mg/dL	Fasting 70 - 105
Chem 7						
Date	Yesterday				Units	Reference Range
Time	AM					
Glucose	210				mg/dL	Fasting 70 - 105
BUN	28				mg/dL	10-25
Creatinine	1.4				mg/dL	F: 0.4-1.4/M: 0.5-1.5
Sodium	156				mEq/L	135-145
Potassium	3.8				mEq/L	3.5-5.3
Chloride	98				mEq/L	98-108
Carbon Dioxide	26				mEq/L	23-27
CBC with Differential						
Date	Yesterday				Units	Reference Range
Time	AM					
WBC	13.2				x 10 ³ uL	4.5-11.0
RBC	3.9				x 10 ⁶ uL	F: 4.2-5.4/M: 4.6-6.2
HgB	12.1				g/dL	F: 13.0-15.0/M: 14.0-17.0
HCT	38.1				%	F: 38-47/M: 42-52
MCV	85.3				fL	80-90
MCH	27.8				pg	27-32
MCHC	33.6				g/dL	32-36
RDW	13.2				%	11.5-14.5
Platelet	204				x 10 ⁹ uL	150-450
MPV	7.8				fL	6.0-12.0
Neutro	74				%	40-70
Lymph	21.5				%	22-40
Mono	2.3				%	1-10
Eos	1.4				%	1-7
Baso	0.8				%	0-2
Wound Culture						
Date	Yesterday	Today			Units	Reference Range
Time	AM	AM				
Bacterial Growth	0	0				No growth

Stool Culture					
Date	Yesterday			Units	Reference Range
Time	AM				
Clostridium difficile	Positive				Negative

Vancomycin Peak Level					
Date	Yesterday			Units	Reference Range
Time	2315				
Vancomycin	76			Mcg/mL	15-20

Continue >

IMAGING

No reports available.

LEVEL UP


Option not available yet.

SCANNER


STATE 1

PATIENT ASSESSMENT

- Patient Overview
 - Patient is sarcastic and gruff. It is apparent that he does not care for medical personnel or medical facilities. He is very short of breath this morning and only speaking in one or two word sentences.
- Expected Student Behaviors
 - Perform appropriate hand hygiene and infection control
 - Introduce themselves and verify patient
 - Effectively communicate with the patient
 - Perform a respiratory assessment and evaluation: crackles (Scan the **QR Code: Chest** 📻)
 - Respond to abnormal findings and intervene appropriately: increase O2
 - Analyze laboratory and diagnostic test results
 - Communicate with the provider using SBAR format
- Technician Prompts
 - Patient is a quite short of breath. When he does speak, it is in short one to two word statements. He is gruff.
 - Patient responses can include:
 - “I can’t breathe.”
 - “Help me.”
 - “Am I dying?”
 - When the O2 is increased from 4 lpm to either 6 lpm or > than 50% (venti-mask or non-rebreather), change the monitor to reflect an increased SpO2, but do not go above 91%.
 - When the provider is called (technician or facilitator is playing this role):
 - Student(s) should communicate using SBAR format.
 - Ensure assessment findings and the vitals they provide are accurate.

- If lab results are not provided, ask for them.
 - Give student(s) the following orders:
 - STAT ABG & portable chest x-ray – call with results
 - BiPAP per protocol
 - Student(s) should repeat orders back using closed-loop communication.
- Possible Facilitator Questions
 - What infection control concerns do you have?
 - Analyze the vital signs: do you have any concerns?
 - Analyze your physical assessment findings: do you have any concerns?
 - What do you think is the underlying pathophysiology causing Mr. Fullerton's current state?
 - How do you plan on prioritizing your findings? What is most important to do first and why?
 - Why was the Vancomycin held? (What types of infection was it supposed to treat)?
 - Why is an elevated peak Vancomycin level concerning and how does it affect the management of this patient?
 - How does the SBAR format facilitate interprofessional communication?
- Tabbed iPad Prompts & Content
 - Leveling Up to State 2: After the **QR Code: Chest**  is scanned, the tabbed Level Up option will become available (students are not prompted about this).
 - When the Level Up tab is tapped (students are not prompted to this), the tabbed content will read, "Have you called the provider?"
 - If "No" is selected, the iPad will read, "You need to call the provider to advance to Level 2."
 - If "Yes" is selected, the iPad will read, "The iPad is now set to Level 2. You have new orders to review."

LEVEL UP

- The **QR Code: Chest**  must be scanned for the Level up option to appear.
- When the Level Up tab is tapped (students are not prompted to this), the tabbed content will read, “Have you called the provider?”
 - If “No” is selected, the iPad will read, “You need to call the provider to advance to Level 2.”
 - If “Yes” is selected, the iPad will read, “The iPad is now set to Level 2. You have new orders to review.”

STATE 2

INTERVENTIONS & REASSESSMENT

- Patient Overview
 - The patient continues to be short of breath. He is anxious and scared about his current condition while remaining gruff and sarcastic.
- Expected Student Behaviors
 - Perform appropriate infection control
 - Effectively communicate with the patient
 - Draw Arterial Blood Gas prior to BiPAP initiation
 - Initiate BiPAP
 - Reassess the patient
 - Interpret ABG and chest x-ray results
 - Communicate with the provider using SBAR format
 - Update the patients' nurse on the procedures performed and the patients current state
 - Document appropriately
- Technician Prompts
 - The patient is still short of breath. He doesn't like the idea of either the ABG or the BiPAP. Student(s) will need to convince him to do both.
 - Patient responses can include:
 - "I can't breathe." "I'm scared."
 - "What do I need that for?"
 - "I'm not sure about that."
 - When updating the provider (technician or facilitator is playing this role):
 - Student(s) should communicate using SBAR format.
 - Ensure current vitals, ABG's and x-ray results are accurate.
 - When updating the patient's nurse (technician or facilitator is playing this role):

- Student(s) should communicate using SBAR format.
 - Ensure current vitals, ABG's and x-ray results are accurate.
 - Ensure current settings and the plan for the BiPAP are communicated.
- Possible Facilitator Questions
 - How will you prioritize the new orders you've received?
 - After reassessing the patient, do you have any concerns? If so, how will you address them?
 - How often should the patient be reassessed/monitored? Why?
 - How will you address Mr. Fullerton's concerns?
 - Describe how you will maintain proper infection control during the ABG draw and BiPAP implementation?
 - Interpret the ABG results: how will the results affect the management of this patient?
 - Review the chest x-ray: does the image correspond to Mr. Fullerton's physical signs and symptoms? Why or why not?
 - How does the SBAR format facilitate interprofessional communication?
- Tabbed iPad Prompts & Content
 - Lab/Diagnostics
 - When the Lab/Diagnostics tab is tapped, the iPad will read, "Has the ABG been drawn?"
 - If "No" is selected, the iPad will read, "An ABG needs to be drawn per the new provider orders."
 - If "Yes" is selected, the iPad will read, "ABG results will be available soon." When tapped after this, the Lab/Diagnostics tabbed content will change to the content below.
 - Imaging
 - When the Imaging tab is tapped, the iPad will read, "Has an x-ray been taken?"

- If “No” is selected, the iPad will read, “An x-ray needs to be taken per the new provider orders.”
 - If “Yes” is selected, the iPad will read, “X-ray results will be available soon.” When tapped after this, the Imaging tabbed content will change to the content below.
- Level Up/Exit
 - The Level Up tab changes to an Exit tab after both the Lab/Diagnostics and Imaging results have been reviewed by the student(s).
 - When the Exit tab is tapped (students are not prompted to this), the iPad will read, “Have you updated the provider?”
 - If “No” is selected, the iPad will read, “You must update the provider before exiting.”
 - If “Yes” is selected, the iPad will read, “Are you sure you have completed the simulation? When you exit, all iPad progress will be lost.”
 - If “No” is selected, the iPad will return to the tabbed content.
 - If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

LAB-DIAGNOSTICS



Labs-Diagnostics with ABG

Patient Name: Clint D. Fullerton DOB: 02/26/19XX MR#: 0508

Blood Glucose

Date Time	Y-day AM	Today AM		Units	Reference Range
Glucose	210	208		mg/dL	Fasting 70-105

Chem 7

Date Time	Y-day AM	Today 15 min. ago		Units	Reference Range
Glucose	210	115		mg/dL	Fasting 70-105
BUN	28	31		mg/dL	10-25
Creatinine	1.4	1.7		mg/dL	F: 0.4-1.4/M: 0.5-1.5
Sodium	156	146		mEq/L	135-145
Potassium	3.8	3.9		mEq/L	3.5-5.3
Chloride	98	101		mEq/L	98-108
Carbon Dioxide	26	27		mEq/L	23-27

CBC with Differential

Date Time	Y-day AM	Today 15 min. ago		Units	Reference Range
WBC	13.2	11.4		x10 ³ /uL	4.5-11
RBC	3.9	4.2		x10 ⁶ /uL	F: 4.2-5.4/M: 4.6-6.2
HgB	12.1	12.6		g/dL	F:13.0-15.0/M:14.0-17.0
HCT	38.1	38.7		%	F: 38-47/M: 42-52
MCV	85.3	84.6		fL	80-90
MCH	27.8	28.2		pg	27-32
MCHC	33.6	33.9		g/dL	32-36
RDW	13.2	13.0		%	11.5-14.5
Platelet	204	196		x10 ⁹ /uL	150-450
MPV	7.8	7.2		fL	6.0-12.0
Neutro	74			%	40-70
Lymph	21.5			%	22-40
Mono	2.3			%	1-10
Eos	1.4			%	1-7
Baso	0.8			%	0-2

Wound Culture

Date Time	Y-day AM	Today AM		Units	Reference Range
Bacterial Growth	0	0			No growth

Stool Culture

Date Time	Y-day AM			Units	Reference Range
Clostridium difficile	Positive				Negative

Vancomycin Peak Level

Date Time	Y-day 2315			Units	Reference Range
Vancomycin	76			mcg/mL	15-20

eGFR					
Date	Today			Units	Reference Range
Time	15 min. ago				
eGFR	31			mL/min	90-120

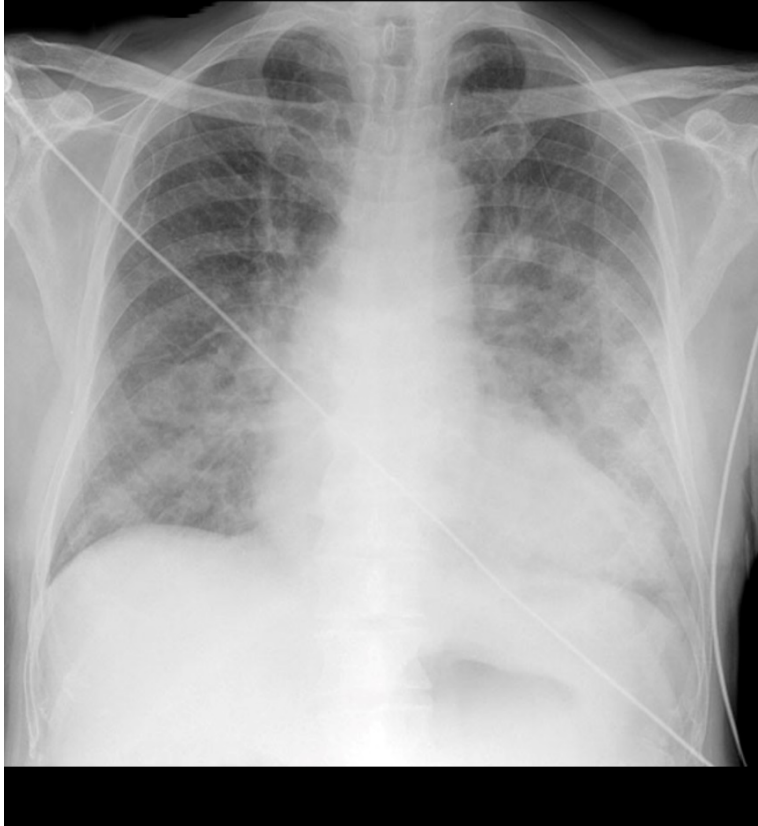
Arterial Blood Gas (ABG)					
Date	Today			Units	Reference Range
Time	Now				
pH	7.37			units	7.35-7.45
PaCO ₂	43			mmHg	35-45
PaO ₂	61			mmHg	80-100
HCO ₃	24			mmol/L	22-26
Base Excess (BE)	1			mmol/L	0+/-3
SaO ₂	91			%	

Continue >

IMAGING



XRAY Result



Patient: Clint D. Fullerton
MR#: 0508
Date: Today

Continue >

LEVEL UP/EXIT

- The Level Up tab changes to an Exit tab after both the Lab/Diagnostics and Imaging results have been reviewed by the student(s).
 - When the Exit tab is tapped (students are not prompted to this), the iPad will read, “Have you updated the provider?”
 - If “No” is selected, the iPad will read, “You must update the provider before exiting.”
 - If “Yes” is selected, the iPad will read, “Are you sure you have completed the simulation? When you exit, all iPad progress will be lost.”
 - If “No” is selected, the iPad will return to the tabbed content.
 - If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

DEBRIEF

Nothing needed from the iPad.

QUESTIONS

1. How did you feel this scenario went?
2. What were the main issues you had to deal with Mr. Fullerton?
3. Review understanding of learning objective: demonstrate proper infection control.
 - a. What infection control measures did you institute for Mr. Fullerton and why?
4. Review understanding of learning objective: complete a respiratory assessment and evaluation.
 - a. What did concerns did you find during your initial assessment and evaluation?
 - b. How did those concerns relate to the patient's overall state at the time?
5. Review understanding of learning objective: recognize and respond to abnormal findings.
 - a. What abnormal findings did you find in the vital signs, physical assessment or labs? How did you respond to these findings?
6. Review understanding of learning objective: recommend appropriate treatment(s) to provider.
 - a. Based on your assessment and evaluation, what recommendations did you make to the provider and why?
 - b. Would you change what you recommended and why?
7. Review understanding of learning objective: safely implement all respiratory therapy orders.
 - a. Describe the orders implemented and procedures performed on Mr. Fullerton.
 - b. If you could change how you performed the ABG or BiPAP initiation, what would it be and why?
 - c. Did you agree with the orders you received? Why or why not?
 - d. How did you prioritize the orders you received?
8. Review understanding of learning objective: effectively communicate with the interprofessional team and patient.

- a. Describe the information you used for SBAR communication with the provider.
 - b. Was this communication effective? Why or Why not?
 - c. If you could change anything about your SBAR communications, what would it be and why?
 - d. Describe the communication techniques you used with Mr. Fullerton.
 - e. Were your techniques effective?
 - f. Did any barriers occur?
 - g. If you could “do over,” how would you change your communication with Mr. Fullerton?
9. Review understanding of learning objective: document accurately.
- a. Describe the documentation you performed after assessing, evaluating and implementing the provider orders for Mr. Fullerton.
 - b. If you could change anything about your documentation, what would it be and why?
10. Summary/Take away Points
- a. “Today you cared for a patient with Cdiff and increasing respiratory distress requiring BiPAP as a result of renal failure and fluid overload. What is one thing you learned from participating in this scenario that you will take with you into your respiratory therapy 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. Questions

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

CREDITS

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