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Wound Care

Instructor Information

Patient Name: Bronson, Norman

Simulation Developer(s): Donna Karr, Debra A. Mosley, and Bernadette Montano

Scenario Purpose:

- Assist staff with the assessment, detection, management, and prevention of wounds

Learner(s):

- **Registered Nurses (RN), Licensed Practical Nurses (LPN), Unlicensed Assistive Personnel (UAP)**
- **Others as desired, depending on facility protocols**
- **Recommend no more than 6 learners (3 of which can be observers)**

Time Requirements:

- **Setup:** 5 minutes
- **Scenario:** 25 minutes
- **Debrief:** 25 minutes
- **Reset/Breakdown:** 5 minutes

Confederate(s):

- **Dr. Maldonado (via telephone)**

Scenario Prologue:

- **Outpatient:** Fifty-six (56) year old male presents with a painful ulceration in the right ankle area which has progressively been getting worse. He has a history of methicillin resistant staphylococcus aureus (MRSA)
- **Inpatient:** Fifty-six (56) year old male inpatient admitted with a painful ulceration in the right ankle area.
- **The simulation begins when the learners are receiving report from the nurse**

Patient information:

- ***General:*** *Alert and oriented*
- ***Weight/Height:*** *111.4kg (245lbs) 175.3cm (69in)*
- ***Vital Signs:*** *BP 166/96, Temp 98.7, HR 81, RR 18, O2 Sat 96%*
- ***Pain:*** *8/10 right lower extremity*
- ***Neurological:*** *The patient is legally blind; able to see shadows; Bilateral plantar numbness*
- ***Respiratory:*** *Unremarkable*
- ***Cardiac:*** *Unremarkable*
- ***Gastrointestinal:*** *Unremarkable*
- ***Genitourinary:*** *Unremarkable*
- ***Musculoskeletal:*** *Gait unsteady due to right lower extremity pain and bilateral plantar numbness*
- ***Skin:*** *Right lower extremity is warm and edematous with 3 cm x 2 cm oval shaped ulcerated area in the outer aspect of the ankle surrounded by thick, brown, flaky skin, and whitish yellow drainage.*
- ***Past Medical History:*** *Legally blind. Hypertension and type 2 diabetes (has not taken his medication in more than 8 months). He smokes one pack per day and has a history of methicillin resistant staphylococcus aureus (MRSA).*
- ***Past Surgical History:*** *None*

Medications:

- Glyburide 5 mg daily
- Enalapril 2.5 mg daily
- Aspirin 81 mg daily

Allergies:

- No known Drug Allergies (NKDA)

Green Text Confederate

Red Text Physiology Change

Learning Objectives

Patient Name: Bronson, Norman

Simulation Developer(s): Donna Karr, Debra A. Mosley, and Bernadette Montano

Scenario Purpose:

- Assist staff with the detection, assessment, management, and prevention of wounds

Pre-Session Activities:

- Complete pertinent training on wound care
- Review policies and protocols on wound care

Potential Systems Explored:

- What facility specific policies or protocols exist for the management of wounds?
- How would the process differ for an outpatient versus an inpatient?
- How would the plan of care differ based on the type of wound (i.e. venous stasis, neurotrophic, arterial ischemic, etc.)?
- What facility specific tools are utilized for the assessment of wounds?
- What risk factors are important to consider when caring for the patient with a wound?
- What complications is the patient with a wound at risk for developing?
- What facility specific documentation is required for the patient with a wound?
- What interdisciplinary resources are available for the management of care of a patient with a wound?

Scenario Specific Learning Objectives (Knowledge, Skills, and Attitudes = K/S/A):

**The learner will apply ICARE principles throughout the scenario

Learning Objective 1: Perform a focused skin/wound assessment

a. ***S***- *Utilize facility specific skin/wound assessment tool(s)*

Learning Objective 2: Employ facility specific infection control measures

a. ***S***- *Perform hand hygiene*
b. ***S***- *Initiate contact precautions protocol*
c. ***S***- *Put on appropriate personal protective equipment (PPE)*

Learning Objective 3: Implement wound care orders

a. ***S***- *Verify orders*
b. ***S***- *Offer pain medication prior to performing wound care*
c. ***S***- *Perform a normal saline wet to dry dressing*
d. ***S-*** *Ensure wound care consult has been initiated*
e. ***S-*** *Implement measures to prevent future wounds/complications*

Learning Objective 4: Communicate effectively when managing care for the patient with a wound

a. ***S***- *Provide ISBAR communication*
b. ***S***- *Explain procedure(s) to the patient/family at a level they can understand*
c. ***S-*** *Complete facility specific documentation*

Debriefing Overview:

- Ask the learner(s) how they feel after the scenario
- Have the learner(s) provide a summary of the scenario from a healthcare provider/clinical reasoning point of view
- Discuss the scenario and ask the learners what the main issues were from their perspective
- Ask what was managed well and why.
- Ask what they would want to change and why.
- For areas requiring direct feedback, provide relevant knowledge by stating "I noticed you *[behavior]…"* Suggest the behavior they might want to portray next time and provide a rationale. "Can you share with us?"

- Indicate closing of the debriefing but provide learners with an opportunity to voice one or two take-aways that will help them in future practice
- Lastly, ask for any outstanding issues before closing the debrief

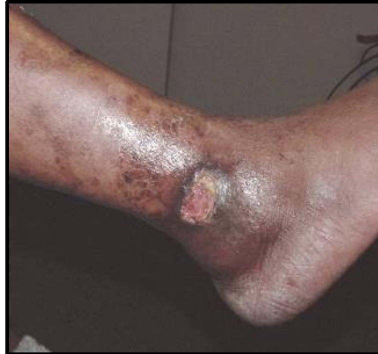
Critical Actions/Debriefing Points:

1. Perform hand hygiene
2. Follow facility specific infection control precautions
3. Perform focused assessment
4. Verify orders
5. Offer pain medication prior to application of dressing
6. Perform patient/family teaching
7. Perform ISBAR communication
8. Initiate wound care consult
9. Complete facility specific documentation

Simulation Set-Up

Patient Name: Norman Bronson (**Standardized patient or ALS Mannequin)**
Simulation Developer(s): Donna Karr, Debra A. Mosley, and Bernadette Montano
Room Set-up:
- Set up like an outpatient or inpatient room

Patient Preparation:
- The patient is wearing street clothes (outpatient) / hospital gown (inpatient)
- Ulcerated wound on his right ankle with serous drainage covered with a soiled piece of gauze
- Tape the isolation sign outside the door if the patient is an inpatient



Have the following equipment/Supplies available:
- Telephone
- Gloves (sterile and non-sterile)
- Isolation gown(s)
- Measuring tape
- Cotton applicators
- Chux
- Wet to dry dressing supplies:
  - Normal saline
  - Sterile 4" x 4" gauze pads
  - Stretch conforming gauze (1 roll)
  - Non-stick gauze pads
  - Stretch conforming gauze roll (Kling)
  - Paper tape
  - Biohazard bag for old dressing

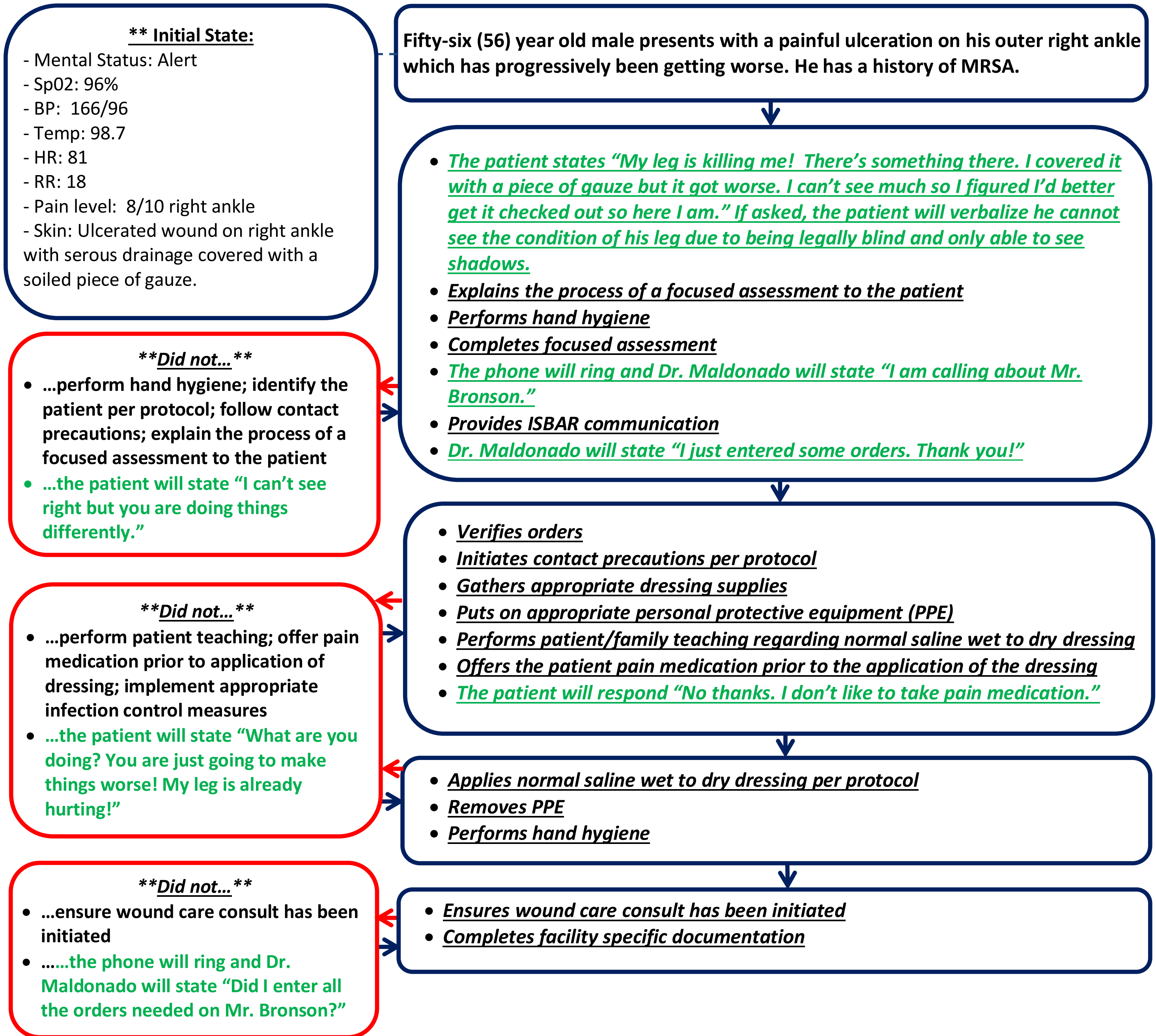
Medications-**Calibration will be required if using radiofrequency identification (RFID
- Acetaminophen/oxycodone tablet

Note: 5.8 Simpad software update is required to load scenarios. Below is the link to upgrade: http://cdn.laerdal.com/downloads/f4343/simpad-upgrade.vs2 Scenarios may be used with Laerdal or LLEAP software

Scenario Supplements:
- Confederate scripts
- Confederate name tags
- Patient identification band
- Orders Laminate
- Skin assessment tool (facility specific)
- Wound consult documentation (facility specific) Laminate
- Contact precautions door sign (facility specific) Laminate

- ZZ test patient/Demo patient in CPRS (if desired Laminate

Flowchart



Critical Actions/Debriefing Points:

- Perform hand hygiene
- Provide therapeutic communication and patient education
- Perform focused assessment and skin assessment per facility protocol
- Inquire about the patient's most recent blood sugar
- Correlate assessment findings with a venous ulcer
- Initiate call to Dr. Maldonado
- Perform ISBAR communication
- Verify orders
- Initiate wound care consultation
- Apply dressing utilizing aseptic technique and perform hand hygiene
- Complete facility specific documentation

Confederate

Change in physiology

Red border incorrect action

Supplements

Confederate Scripts

Confederate Name Tags

Patient Identification Band

Nurses Notes

Orders

Contact Precautions Door Sign

Risk Assessment Tool

Confederate Scripts

Norman Bronson (Patient)

Past Medical- Surgical History: Legally blind. Hypertension and type 2 diabetes (has not taken his medication in more than 8 months). He smokes one pack per day and has a history of methicillin resistant staphylococcus aureus (MRSA). No surgical history. He has an ulcerated area on the outer aspect of his right ankle.

Medications: Glyburide 5 mg daily, Enalapril 2.5 mg daily, Aspirin 81 mg daily

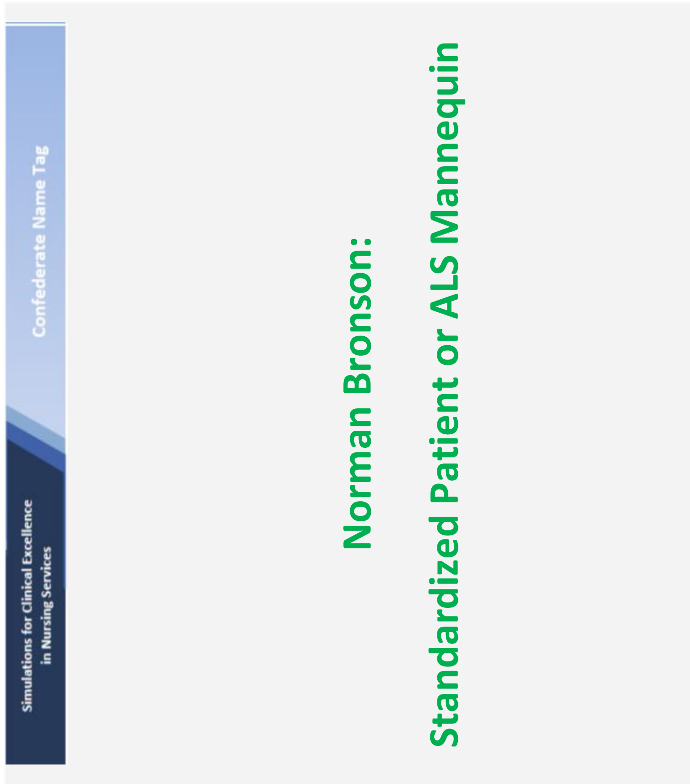
Allergies: NKDA

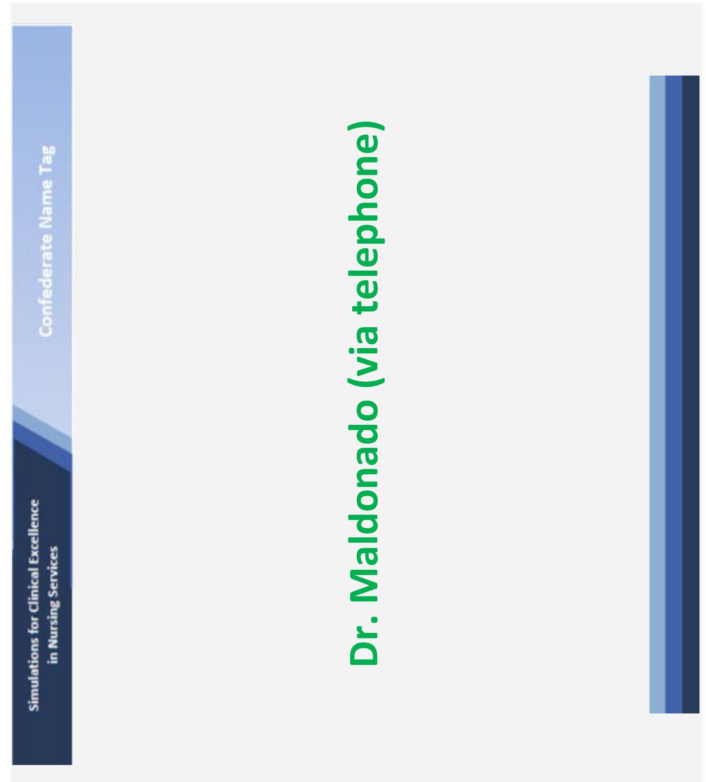
- **The patient will state "My leg is killing me! There's something there. I covered it with a piece of gauze but it got worse. I can't see much so I figured I'd better get it checked out so here I am."**
- **If asked, the patient will verbalize he cannot see the condition of his leg due to being legally blind and only able to see shadows."**
- **If offered pain medication prior to application of the dressing, the patient will state "No thanks. I don't like to take pain medication."**
- **If the learner(s) does not perform hand hygiene; identify the patient per protocol, follow contact precautions; explain the process of a focused assessment, the patient will state "I can't see much but you are doing things differently."**
- **If the learner(s) does not perform patient teaching; offer pain medication prior to applying the, the patient will state "What are you doing? You are just going to make things worse! My leg is already hurting!"**

Dr. Maldonado (Healthcare provider)

- **The phone will ring and Dr. Maldonado will state "I am calling about Mr. Bronson."**
- **The learner will provide ISBAR communication**
- **Dr. Maldonado will state "I just entered some orders. Thank you!"**
- **If the learner(s) does not ensure wound consult has been ordered, Dr. Maldonado will state "Did I enter all the orders needed on Mr. Bronson?"**

Confederate Name Tags





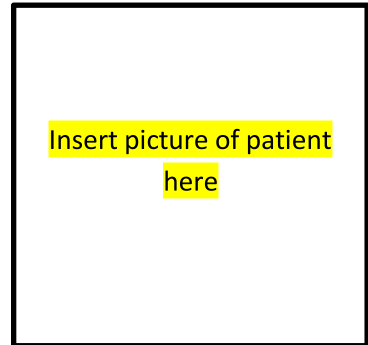
Patient Identification Band

Bronson, Norman Dr. F. Maldonado

Age: 56

000-00-0000 Allergic: **NKDA**

Nurses Notes



Date: Today
Patient Name: Norman Bronson
Mode of Arrival: Public bus
Accompanied by: Self

Chief Complaint: Presents to outpatient clinic with a wound with an ulceration on the outer aspect of his right ankle, hyperpigmentation, and edema which has been progressively getting worse.
Active Problems: Hypertension, type 2 diabetes, coronary artery disease (CAD), obesity, and non-compliance. He also smokes one pack of cigarettes per day for forty (40) years. Patient is legally blind.
Patient information:

- ***General:*** *Alert and oriented*
- ***Weight/Height:*** *111.4kg (245lbs) 175.3cm (69in)*
- ***Vital Signs:*** *BP 166/96, Temp 98.7, HR 81, RR 18, O2 Sat 96%*
- ***Pain:*** *8/10 left lower extremity*
- ***Neurological:*** *The patient is legally blind; able to see shadows; Bilateral plantar numbness*
- ***Respiratory:*** *Unremarkable*
- ***Cardiac:*** *Unremarkable*
- ***Gastrointestinal:*** *Unremarkable*
- ***Genitourinary:*** *Unremarkable*
- ***Musculoskeletal:*** *Gait unsteady due to right lower extremity pain and bilateral plantar numbness*
- ***Skin:*** *Right lower extremity is warm and edematous with 3 cm x 2 cm oval shaped ulcerated area surrounded by thick, brown, flaky skin whitish with yellow drainage in the outer ankle.*
- ***Past Medical History:*** *Legally blind.* Hypertension and type 2 diabetes *(has not taken his medication in more than 8 months). He smokes one pack per day and has a history of methicillin resistant staphylococcus aureus (MRSA).*
- ***Past Surgical History:*** *None*

Medications:
- Glyburide 5 mg daily
- Enalapril 2.5 mg daily
- Aspirin 81 mg daily

Allergies:
- No known Drug Allergies (NKDA)

SCREEN FOR ABUSE/NEGLECT: N/A
Does the patient show any evidence of abuse? No
Does the patient feel safe in his/her current living arrangements? Yes
Suicidal or Homicidal Ideation in the past two weeks? No
Is the patient currently enrolled in primary care? Yes
Diagnostic Procedures Ordered:
( ) X-Ray
( ) Labs
( ) None
( ) EKG
( ) Head CT without contrast
( ) Other
Triage Classification: Emergency Severity Index
Patient Disposition: Medical-Surgical Unit
Signed by: /DM/

Orders

Patient Information

Bronson, Norman
Dr. F. Maldonado
Age: 56
Social Security #: 000-00-0000
Allergies: NKDA
Weight: 111.4kg (245lbs)
Height: 175.3cm (69in); BMI 36.3

Medications	Acetaminophen/oxycodone 1 tablet by mouth every four hours for pain
Miscellaneous	Normal saline wet to dry dressing to right lower extremity wound
Isolation	Contact Precautions

DO NOT WRITE IN THIS SPACE

Contact Precautions

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

Patient's Name ______________________ Evaluator's Name ______________________ Date of Assessment

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours.				
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.				
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
				Total Score				

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