Skills Check-off Scenarios Scenario I

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

- 1. Assessment and recognition of the signs and symptoms of congestive heart failure
 - a. Assess for respiratory problems related to congestive heart failure
 - b. Assess vital signs related to congestive heart failure
 - c. Assess for dysrhythmias
 - d. Assess Intake and Output for other signs of fluid retention.
- 2. Initiate interdisciplinary collaboration in a hospital setting.
 - a. Report changes in the patient's condition to the physician
 - b. Implement new orders received from the physician
 - c. Chart findings on the appropriate charting sheets
- 3. Select appropriate interventions
 - a. Check vital signs.
 - b. Oxygen Apply 2-4 L/nasal cannula as ordered
 - c. Insert a Foley catheter
 - d. Complete an assessment specific to evaluate congestive heart failure.
 - e. Administer an IV medication
- 4. Monitor therapeutic response to interventions (Outcomes).
 - a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq 90\%$.
 - b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. John Sims, a seventy-five year old male was admitted to your unit with hypertension, peripheral edema and shortness of breath. He has a past history of congestive heart failure. He was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. His chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that John had taken his digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDER	ED	Name: John A. Sims DOB 5/11/32									
DATE	TIME										
	0730	ADMIT TO: Interesting Floor Interesting Floor									
		DIAGNOSIS: Diabetes, DR/O Myocardial Infarction, ICHF, DS/P CABG, DChest Pain, DHead Injury, DStroke, DGI Bleed, DS/P Lung surgery, DS/P abdominal surgery, DS/P ortho surgery, DMVC, DHTN, DCancerDOther ALLERGIES: ISNO DYes If yes, list:									
		ACTIVITY: Dedrest BRP D Activity as tolerated D Other:									
		□ I & O VITAL SIGNS: ⊠ Every 4 hours □ Every shift Other: ⊠O2 Sats. Q shift									
		DIET: DNPO Clear liquid IZ2gm Low Na, low fat, D1800kcal ADA, D2000kcal ADA									
		☑ IV: Saline Lock □ D51/2NS with 20mEq KCL TRA □ 0.9% Sodium Chloride IV TRA □ Lactated Ringers TRA □ Other:									
		O _{2:} □ None □ 2Liters/minute via Nasal Cannula □ Other:									
		 MEDICATIONS: ☑ Aspirin non enteric coated 325 mg po daily □ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☑ laxative of choice □ Zolpidem 5 mgs prn HS ☑ NS flush IV BID and prn for IV flush Others_<u>Nitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3</u> 									
		Digoxin 0.5 mg po q. AM									
		Repeat furosemide 40 mg IV x1 after admission to floor									
		(Treatments) ⊠ Place Foley to DD □Dressing Changes □ Place NG Tube □ Other									
		LAB TESTS: CBC Chem 7 Routine UA Others									
		X-Rays: ⊠ chest x-ray in AM □ Other □ ECG stat if chest pain occurs, notify MD									
		□ Additional orders									

Date_____ Time_1115____ Signature: Dr. Chester Hart

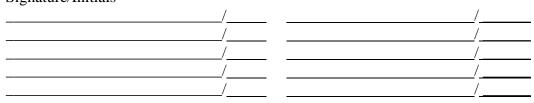
Patient ID

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

ROOM-	PATIENT	DOB	WT		AGE/SEX	ADM D		FTENDING
BED B5	John A Sims	5/11/32	81 kg		75/male	today		HYSICIAN :. Hart
DRUG ALI	LERGIES: No know	wn allergies						
MEDIC	ATION	ROUTE/SIG		ORDER	ING DOSE	0800-1559	1600-2359	0000-0759
Furosen	nide	IV on admiss to floor	sion	40 mg		1 1 1 1 1		
Digoxin		ро		0.5 mg		0900		
Aspirin		ро		325 mg		0900		
MOM		po prn		30 ml		 		<u> </u>
Nitroglycerin		SL prn chest q 5 min. x 3	t pain	0.4 mg		 		
Normal	Saline Flush	IV bid and p	rn			0900	2100	

Signature/Initials



Developed by faculty Butler Community College

LABORATORY REPORT

Date	Time	Exam	Result
	0845		
		CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		МСН	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		Magnesium	2.1 mg/dL
	0845	ABGs	
		pH	7.35
		PaCO2	35 mm Hg
		PaO2	77 mm Hg (L)
		SO2	88 % (L)

Developed by dms at Butler cc

l	Date	Date of Exam									
Note: This information	is for	[•] officia	al and n	nedically-confidential				I			
				MEDICAL R	ECO	RD					
se only and will not be	releas	sed to u	inautho								
1. Name of Patient (First, Mi				•		2. Ide	entificatio	n Number		3. Date of	of Birth
			John A	A Sims		004303336 5/11/					1/32
4a. Home street address						5. Exa	mining F	acility			
511 Eleventh St.					But	ler Coi	nmunity College				
4b. City			State		Sim	ulation	n Hospital				
Yourcity			KS	67042							
6. Patient's occupation						7a. H	leight	b. We	-		
Homemake	r						5'10		Kg		
8. Current Used Medications						9. All	ergies (in	clude medications, latex, b	ee sting	s and foc	od)
	Digo	xin 0.	125 m	g daily		D					
	Capo	ten 25	5 mg b	id		Pen	icillin				
				10. Past/Current M	edical	Histor	V				
Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone vith tuberculosis		х		Shortness of Breath	х			Bone or join deformity		х	
uberculosis or positive TB test		х		Pain or Pressure in chest	Х			Loss of finger or toe		х	
Blood in Sputum or when		Х		Chronic Cough	Х			Painful shoulder or elbow		х	
coughing Excessive bleeding after injury or		Х		Palpitation or pounding heart	х			Recurrent back pain or any	х		
dental work								back injury			
Suicide attempt or plans		X		Heart trouble	Х			Knee injury		Х	
Sleepwalking Near corrective lenses	х	Х		High blood pressure Low blood pressure	Х	х		Foot trouble Nerve injury		х	
Eye surgery to correct vision	^	x		Cramps in your legs		X		Paralysis		x	
Complete vision loss in either eye		x		Frequent Indigestion		x		Epilepsy or seizure		X	
Vears a hearing aid		х		Stomach, liver, or intestinal trouble		х		Car, train, or sea sickness		х	
Stutters or Stammers		х		Gall bladder trouble		х		Frequent trouble sleeping	Х		
Vears a brace or back support		х		Jaundice or Hepatitis		х		Depression or excessive worry		х	
Scarlet fever		х		Broken bones		х		Loss of memory		Х	
Rheumatic fever		Х		Skin diseases		Х		Nervous trouble of any sort		Х	
Swollen or painful joints		х		Tumor, growth, cyst, or Cancer		х		Periods of unconsciousness		Х	
requent or severe headache		Х		Hernia		Х		Parent/sibling with diabetes,		х	
Dizziness or fainting spells	х			Hemorrhoids or rectal Disease		х		cancer, stroke or <u>heart</u> disease.			
ye Trouble		х		Frequent or painful urination		х		X-Ray or other radiation		х	
Hearing Loss		х		Bed wetting since age 12		х		therapy Chemotherapy		х	
Recurrent ear infections		X		Kidney stones or blood in urine		X		Asbestos or toxic chemical		X	
Chronic or frequent colds	х		+	Sugar or Protein in urine		х		exposure Plate or pin in any bone		х	
Severe tooth or gum trouble	~	Х		Sexually transmitted disease(s)		X		Been told to cut down or		X	
Sinusitis		х		Recent gain or loss of weight	Х			criticized for alcohol use			
lay Fever or allergic rhinitis		Х		Eating Disorder		Х		Easily fatigued	х		
lead injury		X		Arthritis, Rheumatism, or Bursitis		X		Used illegal substances		х	
Asthma		х		Thyroid trouble		х	1	Used tobacco		х	1

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorde	r					
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

ITEM	Yes	No		0	•	•
12. Have you been refused employment or been unable						
to hold a job or stay in school because of:						
a. Sensitivity to chemicals?		x				
b. Inability to perform certain motions?		х				
c. Inability to assume certain positions?		х				
d. Other medical reasons? (If yes, give reasons.)		х				
13. Have you ever been treated for a mental condition?		x	Heart pr	oblems 2004		
(If yes, describe and give age at which occurred.)						
14. Have you had, or have you been advised to have, any	v	х				
operation? (If yes, describe and give age at which	, 					
occurred.)						
15. Have you ever been a patient in any type of hospital	? x					
(If yes, specify when, where, why, and name of doctor						
and complete address of hospital.)						
16. Have you consulted or been treated by clinics,		х				
physicians, healers, or other practitioners within the past	:					
5 years for other than minor illnesses? (If yes, give						
complete address of doctor, hospital, clinic, and details.)						
17. Have you ever been discharged from military service	e	х				
because of physical, mental, or other reasons? (If yes,						
specify.)						
18. Have you ever received, is there pending, or have		х				
you ever applied for pension or compensation for						
existing disability? (If yes, specify what kind, granted by	/					
whom, and reason.)						
19. Have you ever been diagnosed with a learning		х				
disability? (If yes, give type and what is needed to help						
overcome.)						
20. List all immunizations received						
Polio, Tetanus, Pneumonia						
I certify that I have reviewed the foregoing information	supplied by	me and that	t it is true a	nd complete	to the bes	st of my knowledge. I authorize any of the doctors,
hospitals, or clinics and their staff that are directly provi						
and federal laws.		-	-			
24a. Typed or Printed Name 24	4b. Signatu	re			2	24c. Date
John Sims	U	-	โท Sims			
John Shiis		Joh	որ Orms			
NO	FE: THIS I	DOCUMENT	Г WILL BI	E PLACED I	N THE M	IEDICAL RECORD
25. Physician's summary and elaboration of all pertinen	t data.					
Chronic Heart Failure						
Pleural effusion						
26a. Typed or Printed Name of Physician or Examiner	26b. Signa	ture		26c. Date		Patient Label Here
Dr. Simulation Getwell	n d.	7				
		nulațion				
	Getwel	7				
	<u>I</u> qqwqu	L				

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios Scenario II

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

1. Assessment and recognition of the signs and symptoms of pulmonary edema related to renal failure

- c. Assess for respiratory problems related to pulmonary edema
- d. Assess vital signs related to renal failure/pulmonary edema
- e. Assess for respiratory distress
- f. Assess Intake and Output for other signs of fluid retention.
- 2. Initiate interdisciplinary collaboration in a hospital setting.
 - g. Report changes in the patient's condition to the physician
 - h. Implement new orders received from the physician
 - i. Chart findings on the appropriate charting sheets
- 3. Select appropriate interventions
 - j. Check vital signs.
 - k. Oxygen Apply 2-4 L/nasal cannula as ordered
 - 1. Insert a Foley catheter
 - m. Complete an assessment specific to evaluate pulmonary edema.
 - n. Administer an IV medication
- 4. Monitor therapeutic response to interventions (Outcomes).
 - o. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq 90\%$.
 - p. Monitor urinary output

Case study: It is shift change and you were assigned Joel A Sims who was admitted to your unit yesterday with a new diagnosis of renal disease. The night nurse reports that about one hour ago Joel had difficulty breathing and crackles in both lungs. His blood pressure is steadily rising. At 0630 it was 172/114. She notified the physician. He ordered stat Bumetanide and Hydralazine along with some other new orders. She gave the Bumetanide and was waiting for the Hydralazine to arrive from the pharmacy. X-ray was just completing the portable chest x-ray. The unit secretary calls that the hydralazine has just arrived from pharmacy. Using the order sheet begin the care on your patient.

Butler Clinical Learning Center Simulation Orders

ORDERED		Name: Joel A. Sims DOB 12/23/32									
DATE	TIME										
	1500	ADMIT TO: Interesting Floor Interesting Floor									
		DIAGNOSIS: Diabetes, R/O Myocardial Infarction, CHF, S/P CABG, Chest Pain, Head Injury, Stroke, GI Bleed, S/P Lung surgery, , S/P abdominal surgery, S/P ortho surgery, , MVC, , HTN, Cancer, Other: renal disease ALLERGIES: NO Yes If yes, list:									
		ACTIVITY: □ Bedrest ⊠ BRP □ Activity as tolerated □ Other: □ I & O									
		VITAL SIGNS: I Every 4 hours □ Every shift Other: IO2 Sats. Q shift									
		DIET: DNPO Clear liquid 2gm Low Na, low fat, 1800kcal ADA, 2000kcal ADA Other <u>renal diet 800 ml per day fluid restriction</u>									
		☑ IV: Saline Lock □ D51/2NS with 20mEq KCL TRA □ 0.9% Sodium Chloride IV TRA □ Lactated Ringers TRA □ Other:									
		O _{2:} □ None □ 2Liters/minute via Nasal Cannula □ Other:									
		MEDICATIONS: Aspirin non enteric coated 325 mg po daily Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. I laxative of choice Zolpidem 5 mgs prn HS NS flush IV BID and prn for IV flush Others Bumetanide 1 mg IV now and repeat in four hours									
		hydralazine 40 mg IV now									
		(Treatments) ☑ Place Foley to DD now □Dressing Changes □ Place NG Tube □ Other LAB TESTS:									
		□ CBC I Chem 7 □ Routine UA ☑ Others:_renal profile, serum creatine X-Rays: I chest x-ray in AM □ Other □ ECG stat if chest pain occurs, notify MD									
		Additional orders									

Date_____ Time_1115____ Signature: Dr. Chester Hart

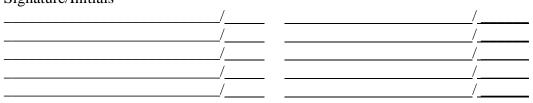
Patient ID

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

ROOM- BED B6	PATIENT Joel A Sims	DOB 12/23/32	WT 81 kg		AGE/SEX 75/male	ADM D today	P	TTENDING HYSICIAN
	LERGIES: No kno	wn allergies					D	r. Hart
MEDIC	ATION	ROUTE/SIG		ORDERI	NG DOSE	0800-1559	1600-2359	0000-0759
Hydrala	zine	IV now		40 mg		 		
Normal	Saline Flush	IV bid and prn				0900	2100	
Acetam	inophen	Po prn pain or temp > 101	.5	650 mg		1 1 1 1 1 1 1		
MOM		po prn		30 ml				
Bumeta	nide	IV now and repeat in 4 ho	urs	1 mg		1100		

Signature/Initials



Developed by second semester faculty Butler Community College

LABORATORY REPORT

Date	Time	Exam	Result
	0845		
		CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		МСН	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		CO2	20 mEq/L (L)
		Magnesium	1.9 mg/dL
	0845	BUN	22 mg/dL (H)
		Creatinine	1.7 mg/dL (H)
		Calcium	7.8 mg/dL (L)
		Phosphorus	4.9 mEq/dL (H)

MEDICAL REC	ORD			REPORT OF	MED	ICAL HISTORY				Date of I	Exam
Note: This information			al and n	nedically-confidential u	se onl	y and v	will not	be released to unau	thoriz		
1. Name of Patient (First, Mi	ddle, La	ıst)				2. Ide		n Number		3. Date o	of Birth
			Joel .	A Sims			(0023033375		12/2	3/32
4a. Home street address						5. Exa	mining F	acility			
1932 North First						Butler Community College					
4b. City			State	Zip Code				n Hospital			
Yourtown		KS	3	67042		Sim	ulatioi	i Hospitai			
6. Patient's occupation		11	,	07012		7a. H	eight	b. Wei	ight		
Retired	alactr		nginge	r		/ a. 11		11"	igin	81 K	a
8. Current Used Medications			inginee			0 411		clude medications, latex, b	aa atima		
8. Current Used Medications	at Hom	e				9. And	igies (in	ciude medications, ratex, o	ee sung	s and 100	u)
(Cresto	or 10	mg one	ce daily							
	ASA	81 m	ng once	e daily		NKA					
	/		-0	y							
				10. Past/Current M	edical	History	/				
Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone		х	IXIIO W	Shortness of Breath	х		ISHOW	Bone or join deformity		х	IXIIO W
with tuberculosis								, ,			
Tuberculosis or positive TB test		Х		Pain or Pressure in chest		Х		Loss of finger or toe		Х	
Blood in Sputum or when		х		Chronic Cough		х		Painful shoulder or elbow		х	
coughing											
Excessive bleeding after injury or dental work		Х		Palpitation or pounding heart	Х			Recurrent back pain or any back injury		х	
Suicide attempt or plans		Х		Heart trouble		х		Knee injury		x	
Sleepwalking		X		High blood pressure	Х	N.		Foot trouble		X	
Wear corrective lenses	х			Low blood pressure		х		Nerve injury		X	
Eye surgery to correct vision		х		Cramps in your legs	х			Paralysis		Х	
Complete vision loss in either eye		Х		Frequent Indigestion	Х			Epilepsy or seizure		Х	
Wears a hearing aid		Х		Stomach, liver, or intestinal		х		Car, train, or sea sickness		х	
Stutters or Stammers		х		trouble Gall bladder trouble		х		Frequent trouble sleeping	х		
Wears a brace or back support		X		Jaundice or Hepatitis		X		Depression or excessive	X		
		~				~		WOITY	~		
Scarlet fever		х		Broken bones		Х		Loss of memory		Х	
Rheumatic fever		Х		Skin diseases		Х		Nervous trouble of any sort		Х	
Swollen or painful joints		Х		Tumor, growth, cyst, or Cancer		Х		Periods of unconsciousness		Х	
Frequent or severe headache		Х		Hernia		Х		Parent/sibling with diabetes,	Х		
Dizziness or fainting spells		Х		Hemorrhoids or rectal Disease		Х		cancer, stroke or <u>heart</u> disease.			
Eye Trouble		х		Frequent or painful urination		х		X-Ray or other radiation		х	
,								therapy			
Hearing Loss	Х			Bed wetting since age 12		Х		Chemotherapy		Х	
Recurrent ear infections		Х		Kidney stones or blood in urine	Х			Asbestos or toxic chemical		х	
Chronic or frequent colds		х		Sugar or Protein in urine	х			exposure Plate or pin in any bone		х	
Severe tooth or gum trouble		X		Sexually transmitted disease(s)	~	х		Been told to cut down or		x	
Sinusitis		X	1	Recent gain or loss of weight	Х	^		criticized for alcohol use		^	
		``								1	
Hay Fever or allergic rhinitis		Х		Eating Disorder		х		Easily fatigued	Х		
Head injury		х		Arthritis, Rheumatism, or		х		Used illegal substances		Х	
Acthmo		V		Bursitis Thyroid trouble		V		Used tobacco		v	
Asthma		Х	1	Thyroid trouble		Х		OPER INDUCCO	L	Х	

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

		uni in olum	i opace to i	igna Else enplana	tion by them number.
ITEM	Yes	No			
12. Have you been refused employment or been unable					
to hold a job or stay in school because of:					
a. Sensitivity to chemicals?		х			
b. Inability to perform certain motions?		х			
c. Inability to assume certain positions?		Х			
d. Other medical reasons? (If yes, give reasons.)		Х	1933 rej	air of an inguinal	hernia
13. Have you ever been treated for a mental condition?		Х			
(If yes, describe and give age at which occurred.)					
14. Have you had, or have you been advised to have, any	v	Х			
operation? (If yes, describe and give age at which	,				
occurred.)					
15. Have you ever been a patient in any type of hospital	? x				
(If yes, specify when, where, why, and name of doctor					
and complete address of hospital.)					
16. Have you consulted or been treated by clinics,		Х			
physicians, healers, or other practitioners within the past					
5 years for other than minor illnesses? (If yes, give					
complete address of doctor, hospital, clinic, and details.)					
17. Have you ever been discharged from military service		Х			
because of physical, mental, or other reasons? (If yes,					
specify.)					
18. Have you ever received, is there pending, or have		х			
you ever applied for pension or compensation for					
existing disability? (If yes, specify what kind, granted by	7				
whom, and reason.)	, 				
19. Have you ever been diagnosed with a learning		х			
disability? (If yes, give type and what is needed to help					
overcome.)					
20. List all immunizations received					
Polio, Tetanus, Pneumonia					
I certify that I have reviewed the foregoing information	supplied by	me and that	tit is true	and complete to the	a best of my knowledge. I authorize any of the doctors
					ta into the Medical Record in accordance with local, state,
and federal laws.	ang manag	ement of m	y cure to h	oriew and input du	
	4b. Signatur	e			24c. Date
	ioi bigilatai		<u></u>	_	2101 2 40
Joel Sims		JOEL	Síms	>	
NO	FE: THIS D	OCUMENT	T WILL B	E PLACED IN TH	E MEDICAL RECORD
25. Physician's summary and elaboration of all pertinent					
History or hyperlipidemia					
Recent symptoms of dull pain in 1	ight fla	nk, 16 K	Ig weig	ght gain, sho	rtness of breath, blood in urine and
hypertension.	U	,	0 0		,
Diagnosis renal failure—unknow	n cause.				
C					
26a. Typed or Printed Name of Physician or Examiner	26b. Signat	140		26c. Date	Patient Label Here
26a. Typed of Printed Name of Physician of Examiner	200. Signat	ure		26c. Date	Patient Label Here
Dr. Chester Hart	Dr. Chi	oster Ha	irt		

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios Scenario III

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

- 5. Assessment and recognition of the signs and symptoms of congestive heart failure
 - a. Assess for respiratory problems related to congestive heart failure
 - b. Assess vital signs related to congestive heart failure
 - c. Assess for dysrhythmias
 - d. Assess Intake and Output for other signs of fluid retention.
- 6. Initiate interdisciplinary collaboration in a hospital setting.
 - a. Report changes in the patient's condition to the physician
 - b. Implement new orders received from the physician
 - c. Chart findings on the appropriate charting sheets
- 7. Select appropriate interventions
 - a. Check vital signs.
 - b. Oxygen Apply 2-4 L/nasal cannula as ordered
 - c. Insert a Foley catheter
 - d. Complete an assessment specific to evaluate congestive heart failure.
 - e. Administer an IV medication
- 8. Monitor therapeutic response to interventions (Outcomes).
 - a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq 90\%$.
 - b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. Sally Sims, a seventy-two year old female was admitted to your unit with hypertension, peripheral edema and shortness of breath. She has a past history of congestive heart failure. She was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. Her chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that Sally had taken her digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDEF	RED	Name: Sally A. SimsDOB 4/30/36
DATE	TIME	
	0730	ADMIT TO: XTelemetry Floor INon-telemetry Floor
		DIAGNOSIS: □ Diabetes, □R/O Myocardial Infarction, ⊠CHF, □S/P CABG, □Chest Pain, □Head Injury, □Stroke, □GI Bleed, □S/P Lung surgery, □S/P abdominal surgery □S/P ortho surgery, □MVC, □HTN, □CancerOther ALLERGIES: ⊠No □Yes If yes, list:
		ACTIVITY: □ Bedrest ⊠ BRP □ Activity as tolerated □ Other: □ I & O
		VITAL SIGNS: ⊠ Every 4 hours □ Every shift Other: ⊠O2 Sats. Q shift
		DIET: □NPO □ Clear liquid ⊠2gm Low Na, low fat, □1800kcal ADA, □2000kcal ADA □ Other
		IV: Saline Lock □ D51/2NS with 20mEq KCL TRA 0.9% Sodium Chloride IV TRA □ Lactated Ringers TRA □ Other:
		O _{2:} □ None □ 2Liters/minute via Nasal Cannula □ Other: ⊠ titrate to keep sats > 90%
		 MEDICATIONS: ☑ Aspirin non enteric coated 325 mg po daily □ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☑ laxative of choice □ Zolpidem 5 mgs prn HS ☑ NS flush IV BID and prn for IV flush
		Others_ <u>Nitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3</u>
		Digoxin 0.5 mg po q. AM Repeat furosemide 40 mg IV x1 after admission to floor
		(Treatmente) 🖾 Diago Falou to DD
		(Treatments) ⊠ Place Foley to DD □Dressing Changes □ Place NG Tube □ Other
		LAB TESTS:
		X-Rays: ⊠ chest x-ray in AM □ Other □ ECG stat if chest pain occurs, notify MD
		□ Additional orders

Date_____ Time_1115____ Signature: Dr. Chester Hart

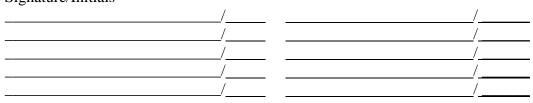
Patient ID

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

ROOM-	PATIENT	DOB	WT		AGE/SEX	ADM D	ATE A	ITENDING
BED B4	Sally A Sims	4/30/36	81 kg		72/female	today		HYSICIAN 7. Hart
DRUG ALI	LERGIES: No know	wn allergies						
MEDIC	ATION	ROUTE/SIG		ORDER	ING DOSE	0800-1559	1600-2359	0000-0759
Furosen	nide	IV on admiss to floor	sion	40 mg				
Digoxin		ро		0.5 mg		0900		
Aspirin		ро		325 mg		0900		
MOM		po prn		30 ml				<u> </u>
Nitrogly	cerin	SL prn chest pain q 5 min		0.4 mg		1 1 1 1 1 1		
Normal	Saline Flush	IV bid and p	'n			0900	2100	

Signature/Initials



Developed by faculty Butler Community College

LABORATORY REPORT

Date	Time	Exam	Result
	0845		
		CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		MCH	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		Magnesium	2.1 mg/dL
	0845	ABGs	
		pH	7.35
		PaCO2	35 mm Hg
		PaO2	77 mm Hg (L)
		SO2	88 % (L)

Developed by dms Butler cc

R	EPO	RT O	F ME	DICAL HISTORY						n	
Note: This information	is for	officia	al and r	nedically-confidential							
				MEDICAL R	ECO	RD					
l use only and will not	be rele	eased t	o unau								
1. Name of Patient (First, Mi						2. Ide	2. Identification Number				of Birth
· · ·			Sally	A Sims		004303336 4/30/3)/36
4a. Home street address			Sully			5. Exa	mining F			1723	0/00
430 Corona St.							-	mmunity College			
4b. City	State Zip Code							n Hospital			
Yourcity			KS	67042		SIIII	ulatio	i nospital			
6. Patient's occupation			Кb	070+2		7a. H	eight	b. We	ight		
Homemake	r					7 a. 11	5'5"		-		
8. Current Used Medications						0 411		clude medications, latex, b		rs and foo	d)
			125 m	a daily		9. And	ergies (ii	iciude medications, ratex, o	ee sung	gs and 100	u)
	-			g daily		NKA					
	-		5 mg b								
	Calci	um 50	00 mg	bid							
			Ũ								
				10 0 10	11 1						
	X 7	NT	D 1	10. Past/Current M Check Each Item					\$7	NL	D 14
Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone		х	KIIUW	Shortness of Breath	х		KIIUW	Bone or join deformity		x	KIIUW
with tuberculosis		~			~			Donio or join doronniky		~	
Tuberculosis or positive TB test		Х		Pain or Pressure in chest	Х			Loss of finger or toe		Х	
Blood in Sputum or when		х		Chronic Cough	х			Painful shoulder or elbow		х	
coughing				Delaitetian er neunding heert				Desument healt noin an anu			
Excessive bleeding after injury or dental work		х		Palpitation or pounding heart	х			Recurrent back pain or any back injury	х		
Suicide attempt or plans		Х		Heart trouble	х			Knee injury		х	
Sleepwalking		х		High blood pressure	х			Foot trouble			
Wear corrective lenses	Х			Low blood pressure		Х		Nerve injury		Х	
Eye surgery to correct vision		Х		Cramps in your legs		х		Paralysis		Х	
Complete vision loss in either eye		Х	-	Frequent Indigestion		Х		Epilepsy or seizure		Х	
Wears a hearing aid		х		Stomach, liver, or intestinal trouble		Х		Car, train, or sea sickness		х	
Stutters or Stammers		Х		Gall bladder trouble		х		Frequent trouble sleeping	х		
Wears a brace or back support		X		Jaundice or Hepatitis		X		Depression or excessive		х	
								worry			
Scarlet fever		х		Broken bones		Х		Loss of memory		Х	
Rheumatic fever Swollen or painful joints		X		Skin diseases Tumor, growth, cyst, or Cancer		X		Nervous trouble of any sort		X	
Frequent or severe headache		X X		Hernia		X X		Periods of unconsciousness Parent/sibling with diabetes		X	
Dizziness or fainting spells	х	^		Hemorrhoids or rectal Disease		X		cancer, stroke or heart		^	
								disease.			
Eye Trouble		х		Frequent or painful urination		х		X-Ray or other radiation		х	
				Ded watting since and 10				therapy			
Hearing Loss Recurrent ear infections		X X		Bed wetting since age 12 Kidney stones or blood in urine		X X		Chemotherapy Asbestos or toxic chemical		X	
		^		Numey stones of blood in diffe		^		exposure		^	
Chronic or frequent colds	Х		1	Sugar or Protein in urine		Х	1	Plate or pin in any bone		х	1
Severe tooth or gum trouble		Х		Sexually transmitted disease(s)		х		Been told to cut down or		Х	
Sinusitis		Х		Recent gain or loss of weight	Х			criticized for alcohol use			
Lay Foyor or alloraic rhipitic		v	+	Eating Disordor		v		Eacily fatigued	v		
Hay Fever or allergic rhinitis Head injury		X X	+	Eating Disorder Arthritis, Rheumatism, or		X X		Easily fatigued Used illegal substances	Х	Х	
nouu nijury		^		Bursitis		Â		อริธีน แต่งูน รับมริเมาตร		^	
Asthma		х	1	Thyroid trouble		х	1	Used tobacco		х	1

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder	х					
Change in menstrual pattern			Х	1988	2/07	2/07

Check each item. If "yes," explain in blank space to right. List explanation by item number.

			space to right. List explanat	uon by nem number.				
ITEM	Yes	No						
12. Have you been refused employment or been unable	e							
to hold a job or stay in school because of:								
a. Sensitivity to chemicals?		Х						
b. Inability to perform certain motions?		Х						
c. Inability to assume certain positions?		х						
d. Other medical reasons? (If yes, give reasons.)		Х	Hysterectomy 1998 at Butler Simulation Hospital					
13. Have you ever been treated for a mental condition	?	х						
(If yes, describe and give age at which occurred.)			Heart problems 2004					
14. Have you had, or have you been advised to have, a	iny	х						
operation? (If yes, describe and give age at which	-							
occurred.)								
15. Have you ever been a patient in any type of hospit	al? x							
(If yes, specify when, where, why, and name of doctor								
and complete address of hospital.)								
16. Have you consulted or been treated by clinics,		х						
physicians, healers, or other practitioners within the pa	ast							
5 years for other than minor illnesses? (If yes, give								
complete address of doctor, hospital, clinic, and details	s.)							
17. Have you ever been discharged from military service		х						
because of physical, mental, or other reasons? (If yes,								
specify.)								
18. Have you ever received, is there pending, or have		х						
you ever applied for pension or compensation for								
existing disability? (If yes, specify what kind, granted	by							
whom, and reason.)	0,9							
19. Have you ever been diagnosed with a learning		х						
disability? (If yes, give type and what is needed to help	n	~						
overcome.)	P							
20. List all immunizations received								
20. Elst an minimunizations received								
Dolio Totomuo Duoumonio								
Polio, Tetanus, Pneumonia								
				e best of my knowledge. I authorize any of the doctors,				
	viding manage	ement of my	v care to review and input da	ta into the Medical Record in accordance with local, state,				
and federal laws.								
24a. Typed or Printed Name	24b. Signature			24c. Date				
Sally Sims		ลิสโ	y Sims					
•								
		OCUMENT	WILL BE PLACED IN TH	E MEDICAL RECORD				
25. Physician's summary and elaboration of all pertine	ent data.							
Chronic Heart Failure								
Pleural effusion								
Osteophorosis								
r								
F								
26a. Typed or Printed Name of Physician or Examiner	26b. Signatu	ire	26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				
			26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner	26b. Signatu Dr. Sinc Getwell		26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				
26a. Typed or Printed Name of Physician or Examiner			26c. Date	Patient Label Here				

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios Scenario IV

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

1. Assessment and recognition of the signs and symptoms of pulmonary edema related to renal failure

- c. Assess for respiratory problems related to pulmonary edema
- d. Assess vital signs related to renal failure/pulmonary edema
- e. Assess for respiratory distress
- f. Assess Intake and Output for other signs of fluid retention.
- 2. Initiate interdisciplinary collaboration in a hospital setting.
 - g. Report changes in the patient's condition to the physician
 - h. Implement new orders received from the physician
 - i. Chart findings on the appropriate charting sheets
- 3. Select appropriate interventions
 - j. Check vital signs.
 - k. Oxygen Apply 2-4 L/nasal cannula as ordered
 - 1. Insert a Foley catheter
 - m. Complete an assessment specific to evaluate pulmonary edema.
 - n. Administer an IV medication
- 4. Monitor therapeutic response to interventions (Outcomes).
 - o. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq 90\%$.
 - p. Monitor urinary output

Case study: It is shift change and you were assigned Sarah A Sims, a 78 year old female, who was admitted to your unit yesterday with a new diagnosis of renal disease. The night nurse reports that about one hour ago Sarah had difficulty breathing and crackles in both lungs. Her blood pressure is steadily rising. At 0630 it was 172/114. The nurse notified the physician. He ordered stat Bumetanide and Hydralazine along with some other new orders. She gave the Bumetanide and was waiting for the Hydralazine to arrive from the pharmacy. X-ray was just completing the portable chest x-ray. The unit secretary calls that the hydralazine has just arrived from pharmacy. Using the order sheet begin the care on your patient.

Butler Clinical Learning Center Simulation Orders

ORDER	ED	Name: Sarah A. Sims DOB 9/1732
DATE	TIME	
	1500	ADMIT TO: XITelemetry Floor INon-telemetry Floor
		DIAGNOSIS: Diabetes, R/O Myocardial Infarction, CHF, S/P CABG, Chest Pain, Head Injury, Stroke, GI Bleed, S/P Lung surgery, S/P abdominal surgery, S/P ortho surgery, MVC, HTN, CancerOther: renal disease ALLERGIES: NO Yes If yes, list:
		ACTIVITY: □ Bedrest ⊠ BRP □ Activity as tolerated □ Other: □ I & O
		VITAL SIGNS: ⊠ Every 4 hours □ Every shift Other: ⊠O2 Sats. Q shift
		DIET: DNPO Clear liquid 2gm Low Na, low fat, 1800kcal ADA, 2000kcal ADA
		 ☑ IV: Saline Lock □ D51/2NS with 20mEq KCL TRA □ 0.9% Sodium Chloride IV TRA □ Lactated Ringers TRA □ Other:
		O _{2:} □ None □ 2Liters/minute via Nasal Cannula □ Other:
		MEDICATIONS: ☐ Aspirin non enteric coated 325 mg po daily ⊠ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ⊠ laxative of choice ☐ Zolpidem 5 mgs prn HS ⊠ NS flush IV BID and prn for IV flush Others Bumetanide 1 mg IV now and repeat in four hours
		hydralazine 40 mg IV now
		(Treatments) ⊠ Place Foley to DD now □Dressing Changes □ Place NG Tube □ Other
		LAB TESTS: □ CBC I Chem 7 □Routine UA I Others:_renal profile, serum creatine
		X-Rays: ⊠ chest x-ray in AM □ Other □ ECG stat if chest pain occurs, notify MD
		□ Additional orders

Date_____ Time_1115____ Signature: Dr. Chester Hart

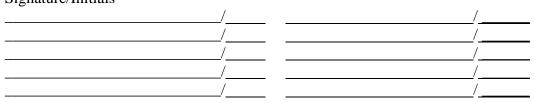
Satient ID

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

ROOM- BED B2	PATIENT Sarah A Sims	DOB 9/17/32	WT 69 kg	-	AGE/SEX 78/female	ADM D. today	PH	TTENDING HYSICIAN :. Hart
DRUG ALI	LERGIES: No know	wn allergies						
MEDIC	ATION	ROUTE/SIG		ORDERIN	IG DOSE	0800-1559	1600-2359	0000-0759
Hydrala	zine	IV now		40 mg		 		
Normal	Saline Flush	IV bid and prn				0900	2100	
Acetam	inophen	Po prn pain or temp > 101	.5	650 mg		1 1 1 1 1 1 1		
MOM		po prn		30 ml				
Bumeta	nide	IV now and repeat in 4 hor	urs	1 mg		1100		
								<u>.</u>

Signature/Initials



Developed by faculty Butler Community College

LABORATORY REPORT

Date	Time	Exam	Result
	0845		
		CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		MCV	84 f
		MCH	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	135 mEq/L
		Sodium	2.9 mEq/L (L)
		Potassium	96 mEq/l
		Chloride	20 mEq/L (L)
		CO2	1.9 mg/dL
		Magnesium	
	0845	BUN	22 mg/dL (H)
		Creatinine	1.7 mg/dL (H)
		Calcium	7.8 mg/dL (L)
		Phosphorus	4.9 mEq/dL (H)

Developed by dms at Butler cc

MEDICAL RECORD REPORT OF MEDICAL HISTORY									Date of I	Exam	
Note: This information	is for	· officia	al and n	nedically-confidential u	se onl	y and	will not	t be released to unau	thoriz	ed pers	sons.
1. Name of Patient (First, Mi				•				n Number		3. Date o	
			Sarah	A Sims			(0023033378		9/17	7/32
4a. Home street address						5. Examining Facility					
1932 North First						Butler Community College					
4b. City			State	Zip Code							
Yourtown		K		67042		SIIII	ulation	n Hospital			
6. Patient's occupation		L'	3	07042		7. 11	1- 4	b. Wei	-1-4		
-	1	1 4	.1			7a. H	-		0		
Retired			cher				4"		9 Kg		
8. Current Used Medications	at Hom	ie				9. Alle	ergies (in	clude medications, latex, b	ee sting	s and foo	od)
(mg one	ce daily e daily		NKA					
~				10. Past/Current M			-	~			
Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know	Check Each Item	Yes	No	Don't Know
Household Contact with anyone		х		Shortness of Breath	Х			Bone or join deformity		х	
with tuberculosis				Dein er Dressurs in shest				Loop of finance on too			
Tuberculosis or positive TB test		Х		Pain or Pressure in chest		X		Loss of finger or toe		X	
Blood in Sputum or when coughing		х		Chronic Cough		х		Painful shoulder or elbow		х	
Excessive bleeding after injury or dental work		х		Palpitation or pounding heart	х			Recurrent back pain or any back injury		х	
Suicide attempt or plans		Х		Heart trouble		Х		Knee injury		х	
Sleepwalking		X		High blood pressure	х	~		Foot trouble		X	
Wear corrective lenses	х			Low blood pressure		х		Nerve injury		х	
Eye surgery to correct vision		Х		Cramps in your legs	Х			Paralysis		Х	
Complete vision loss in either eye		Х		Frequent Indigestion	Х			Epilepsy or seizure		Х	
Wears a hearing aid		х		Stomach, liver, or intestinal trouble		х		Car, train, or sea sickness		х	
Stutters or Stammers		Х		Gall bladder trouble		Х		Frequent trouble sleeping	х		
Wears a brace or back support		х		Jaundice or Hepatitis		х		Depression or excessive worry	Х		
Scarlet fever		Х		Broken bones		Х		Loss of memory		Х	
Rheumatic fever		Х		Skin diseases		Х		Nervous trouble of any sort		Х	
Swollen or painful joints		Х		Tumor, growth, cyst, or Cancer		х		Periods of unconsciousness		Х	
Frequent or severe headache		Х		Hernia		Х		Parent/sibling with diabetes,	х		
Dizziness or fainting spells		х		Hemorrhoids or rectal Disease		х		cancer, stroke or <u>heart</u> <u>disease</u> .			
Eye Trouble		х		Frequent or painful urination		х		X-Ray or other radiation therapy		х	
Hearing Loss	Х			Bed wetting since age 12		Х		Chemotherapy		Х	
Recurrent ear infections		х		Kidney stones or blood in urine	Х			Asbestos or toxic chemical exposure		х	
Chronic or frequent colds		Х		Sugar or Protein in urine	Х			Plate or pin in any bone		Х	
Severe tooth or gum trouble		Х		Sexually transmitted disease(s)		Х		Been told to cut down or		х	
Sinusitis		х		Recent gain or loss of weight	х			criticized for alcohol use			
Hay Fever or allergic rhinitis		х		Eating Disorder		х		Easily fatigued	Х	1	
Head injury		х		Arthritis, Rheumatism, or Bursitis		Х		Used illegal substances		х	
1				Thyroid trouble							

11. Females only answer section 11

Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder	х			1979		2007
Change in menstrual pattern						

		lain in blank s	space to ri	ght. List explanat	ion by item number.
ITEM	Yes	No			
12. Have you been refused employment or been unable					
to hold a job or stay in school because of:					
a. Sensitivity to chemicals?		х			
b. Inability to perform certain motions?		х	1984 Hys	sterectomy, cystoc	ele repair
c. Inability to assume certain positions?		х			
d. Other medical reasons? (If yes, give reasons.)		х			
13. Have you ever been treated for a mental condition		x			
(If yes, describe and give age at which occurred.)		A			
14. Have you had, or have you been advised to have, a	237	х			
operation? (If yes, describe and give age at which	iy	Λ			
occurred.)					
,	10				
15. Have you ever been a patient in any type of hospita	1? X				
(If yes, specify when, where, why, and name of doctor					
and complete address of hospital.)					
16. Have you consulted or been treated by clinics,		х			
physicians, healers, or other practitioners within the pa	st				
5 years for other than minor illnesses? (If yes, give					
complete address of doctor, hospital, clinic, and details	.)				
17. Have you ever been discharged from military servi	ce	х			
because of physical, mental, or other reasons? (If yes,					
specify.)					
18. Have you ever received, is there pending, or have		x			
you ever applied for pension or compensation for		A			
existing disability? (If yes, specify what kind, granted					
whom, and reason.)	,y				
19. Have you ever been diagnosed with a learning		х			
disability? (If yes, give type and what is needed to help					
overcome.)					
20. List all immunizations received					
Polio, Tetanus, Pneumonia					
I certify that I have reviewed the foregoing information	supplied by	me and that	it is true a	nd complete to the	best of my knowledge. I authorize any of the doctors,
					a into the Medical Record in accordance with local, state,
and federal laws.	0 0	, ,		1	, ,
	24b. Signatur	e			24c. Date
Sarah Sims		Saral	n Sim	lS	
N	TE: THIS I	OCUMENT	WILL BE	E PLACED IN TH	E MEDICAL RECORD
25. Physician's summary and elaboration of all pertine		JOCCULLUI	THE DE		
	in uata.				
History or hyperlipidemia					
Recent symptoms of dull pain in	right fla	nk 16 K	a weia	ht gain shor	tness of breath, blood in urine and
• • •	iigin iia	IIK, 10 IX	g weig	in gain, shoi	thess of breath, blood in drifte and
hypertension.					
Diagnosis renal failure—unknov					
Diagnosis tenai tanute—unknov	in cause.				
26a Typed or Printed Name of Physician or Evaminer	26h Signat	ure		26c Date	Patient I abel Here
26a. Typed or Printed Name of Physician or Examiner	26b. Signat	ure		26c. Date	Patient Label Here
	-			26c. Date	Patient Label Here
26a. Typed or Printed Name of Physician or Examiner Dr. Chester Hart	-	ure ester Ha		26c. Date	Patient Label Here
	-			26c. Date	Patient Label Here
	-			26c. Date	Patient Label Here
	-			26c. Date	Patient Label Here
	-			26c. Date	Patient Label Here

Designed by mt revised by dms Butler Community College

Skills Check-off Scenarios ScenarioV

The following scenarios were designed for the beginning of the semester skills check-offs for the fourth semester students. The skills including vital signs, IV medications, abbreviated physical assessments and catheterizations.

Objectives:

- 9. Assessment and recognition of the signs and symptoms of congestive heart failure
 - a. Assess for respiratory problems related to congestive heart failure
 - b. Assess vital signs related to congestive heart failure
 - c. Assess for dysrhythmias
 - d. Assess Intake and Output for other signs of fluid retention.
- 10. Initiate interdisciplinary collaboration in a hospital setting.
 - a. Report changes in the patient's condition to the physician
 - b. Implement new orders received from the physician
 - c. Chart findings on the appropriate charting sheets
- 11. Select appropriate interventions
 - a. Check vital signs.
 - b. Oxygen Apply 2-4 L/nasal cannula as ordered
 - c. Insert a Foley catheter
 - d. Complete an assessment specific to evaluate congestive heart failure.
 - e. Administer an IV medication
- 12. Monitor therapeutic response to interventions (Outcomes).
 - a. Monitor that patient will not have difficulty breathing and will maintain oxygen saturations at $\geq 90\%$.
 - b. Monitor urinary output

Case study: You are working the day shift at Butler Simulation Hospital. Chad Sims, a seventy-seven year old male was admitted to your unit with hypertension, peripheral edema and shortness of breath. He has a past history of congestive heart failure. He was started on oxygen at 4 L via nasal canula and given 40 mg furosemide IV in the ER. His chest x-ray showed bilateral effusions in both lower lobes of his lungs. The ER doctor sent preliminary orders and said his primary care doctor would be in to write further medication orders. In report the ER nurse told you that Chad had taken his digoxin and aspirin this AM. It is now 1300. Begin initiating the orders from the order sheet.

Butler Clinical Learning Center Simulation Orders

ORDER	RED	Name: Chad A. Sims DOB 8/27/31
DATE	TIME	
	0730	ADMIT TO: I Telemetry Floor INon-telemetry Floor
		DIAGNOSIS: □ Diabetes, □R/O Myocardial Infarction, ⊠CHF, □S/P CABG, □Chest Pain, □Head Injury, □Stroke, □GI Bleed, □S/P Lung surgery, □S/P abdominal surgery, □S/P ortho surgery, □MVC, □HTN, □Cancer□Other □ALLERGIES: ⊠No □Yes If yes, list:
		ACTIVITY: □ Bedrest ⊠ BRP □ Activity as tolerated □ Other: □ I & O
		VITAL SIGNS: ⊠ Every 4 hours □ Every shift Other: ⊠O2 Sats. Q shift
		DIET: □NPO □ Clear liquid ⊠2gm Low Na, low fat, □1800kcal ADA, □2000kcal ADA □ Other
		IV: Saline Lock D51/2NS with 20mEq KCL TRA 0.9% Sodium Chloride IV TRA Lactated Ringers TRA Other:
		O _{2:} □ None □ 2Liters/minute via Nasal Cannula □ Other:
		 MEDICATIONS: ☑ Aspirin non enteric coated 325 mg po daily □ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F. ☑ Iaxative of choice □ Zolpidem 5 mgs prn HS ☑ NS flush IV BID and prn for IV flush OthersNitroglycerin 0.4 mg SL prn chest pain q 5 minutes x 3
		Digoxin 0.5 mg po q. AM Repeat furosemide 40 mg IV x1 after admission to floor
		(Treatments) 🖾 Place Foley to DD DDressing Changes Place NG Tube
		□ Other LAB TESTS: □ CBC □ Chem 7 □Routine UA □ Others
		X-Rays: ⊠ chest x-ray in AM □ Other □ ECG stat if chest pain occurs, notify MD □ Additional orders

Date_____ Time_1115____ Signature: Dr. Chester Hart

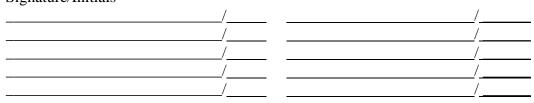
Patient ID

Developed by dms Butler Community College

Butler Clinical Learning Center Medication Sheet

ROOM- BED B3	PATIENT Chad A Sims	^{DOB} 8/27/31	WT 81 kg		AGE/SEX 77/male	ADM D today	PI	ITENDING HYSICIAN :. Hart
DRUG ALI	LERGIES: No know	wn allergies						
MEDIC	ATION	ROUTE/SIG		ORDER	ING DOSE	0800-1559	1600-2359	0000-0759
Furosen	nide	IV on admiss to floor	on	40 mg				
Digoxin		ро		0.5 mg		0900		
Aspirin		ро		325 mg		0900		
MOM		po prn		30 ml				
Nitrogly	cerin	SL prn chestr q 5 min. x 3	bain	0.4 mg				
Normal	Saline Flush	IV bid and pri	۱			0900	2100	

Signature/Initials



Developed by faculty Butler Community College

LABORATORY REPORT

Date	Time	Exam	Result
	0845		
		CBC	
		RBC	5.2 mc/L
		WBC	6400 mc/L
		Hct.	42%
		Hgb	13 gm/dL
		Platelet	160,000 ul
		MCV	84 f
		MCH	28 pg/cell
		MCHC	33 gm/dL
	0845	BMP	
		Sodium	135 mEq/L
		Potassium	2.9 mEq/L (L)
		Chloride	96 mEq/l
		Magnesium	2.1 mg/dL
	0845	ABGs	
		рН	7.35
		PaCO2	35 mm Hg
		PaO2	77 mm Hg (L)
		SO2	88 % (L)

Developed by dms at Butler cc

REPORT OF MEDICAL HISTORY Note: This information is for official and medically-confidential									Date of Exam		
Note: This information	is for	officia	al and n	nedically-confidential							
				MEDICAL R	ECO	RD					
se only and will not be	releas	ed to u	inautho								
1. Name of Patient (First, Mi						2. Ide	ntificatio	n Number		3. Date of	of Birth
			Chad		004303336				7/31		
4a. Home street address			enna			5. Exa	mining F			0, 2	
430 Corona St.								nmunity College			
4b. City			State	Zip Code				• •			
4b. City State Zip Code Yourcity KS 67042						SIIII	ulation	n Hospital			
6. Patient's occupation			КS	07042		7a. H	aight	b. We	ight		
1	~						-		•		
Retired Bak							10"	81 Kg			
8. Current Used Medications			105	1 '1		9. Alle	ergies (in	clude medications, latex, b	ee sting	gs and foo	d)
	-			g daily		NKA					
	Capo	ten 25	5 mg b	id							
	-		-								
				10. Past/Current M	adiaal	Listom	-				
Check Each Item	Yes	No	Don't	Check Each Item	Yes	No	Don't	Check Each Item	Yes	No	Don't
Check Each Item	res	INU	Know	Check Each Rein	res	NO	Know	Check Each Hem	res	INO	Know
lousehold Contact with anyone		х	ISHOW	Shortness of Breath	х		IXHOW	Bone or join deformity		х	IXIIO W
with tuberculosis								, ,			
uberculosis or positive TB test		Х		Pain or Pressure in chest	Х			Loss of finger or toe		Х	
Blood in Sputum or when		х		Chronic Cough	х			Painful shoulder or elbow		х	
coughing											
Excessive bleeding after injury or dental work		х		Palpitation or pounding heart	Х			Recurrent back pain or any back injury		х	
Suicide attempt or plans		х		Heart trouble	х			Knee injury		х	
Sleepwalking		X	-	High blood pressure	X			Foot trouble			
Wear corrective lenses	Х	~		Low blood pressure	X	х		Nerve injury		Х	
ye surgery to correct vision		х		Cramps in your legs		X		Paralysis		X	
Complete vision loss in either eye		Х		Frequent Indigestion		х		Epilepsy or seizure		Х	
Nears a hearing aid		Х		Stomach, liver, or intestinal		Х		Car, train, or sea sickness		Х	
				trouble							
Stutters or Stammers		Х		Gall bladder trouble		Х		Frequent trouble sleeping	Х		
Nears a brace or back support		х		Jaundice or Hepatitis		х		Depression or excessive		х	
Scarlet fever		v		Broken bones		v		WOITY		V	
Rheumatic fever		X		Skin diseases		X		Loss of memory Nervous trouble of any sort		X	
Swollen or painful joints		X	-	Tumor, growth, cyst, or Cancer		X		Periods of unconsciousness		X	
requent or severe headache		X		Hernia		X		Parent/sibling with diabetes		X	
Dizziness or fainting spells	х			Hemorrhoids or rectal Disease		X		cancer, stroke or heart			
0.1								disease.			
Eye Trouble		х		Frequent or painful urination		х		X-Ray or other radiation		Х	
le este este este		-		Deducetting da 40				therapy	──	+	
Hearing Loss		X		Bed wetting since age 12		X		Chemotherapy	┣───	X	<u> </u>
Recurrent ear infections		х		Kidney stones or blood in urine		Х		Asbestos or toxic chemical exposure		х	
Chronic or frequent colds	х			Sugar or Protein in urine		х		Plate or pin in any bone	├──	x	
Severe tooth or gum trouble	~	Х		Sexually transmitted disease(s)		X		Been told to cut down or		X	
Sinusitis		X		Recent gain or loss of weight	Х			criticized for alcohol use		1	
Hay Fever or allergic rhinitis		Х		Eating Disorder		Х		Easily fatigued	Х		
Head injury		х		Arthritis, Rheumatism, or		х		Used illegal substances		х	
A				Bursitis		-			┝──	<u> </u>	<u> </u>
Asthma	1	х	1	Thyroid trouble	l I	х	1	Used tobacco	1	Х	1

11. Females only answer section 11

· · · · · · · · · · · · · · · · · · ·						
Check each item	Yes	No	Don't Know	Date of last menstrual period	Date of last pap smear	Date of last mammogram
Treated for a female disorder						
Change in menstrual pattern						

Check each item. If "yes," explain in blank space to right. List explanation by item number.

		T T	right. List explana	tion by item number.			
ITEM	Yes	No					
12. Have you been refused employment or been unable							
to hold a job or stay in school because of:							
a. Sensitivity to chemicals?		х					
b. Inability to perform certain motions?		Х					
c. Inability to assume certain positions?		x Repair	Repair of inguinal hernia 1987				
d. Other medical reasons? (If yes, give reasons.)		Х					
13. Have you ever been treated for a mental condition?		x Heart p	roblems 2004				
(If yes, describe and give age at which occurred.)							
14. Have you had, or have you been advised to have, an	v	X					
operation? (If yes, describe and give age at which	5						
occurred.)							
15. Have you ever been a patient in any type of hospital	? x						
(If yes, specify when, where, why, and name of doctor							
and complete address of hospital.)							
16. Have you consulted or been treated by clinics,	+	X					
		х					
physicians, healers, or other practitioners within the pas	L						
5 years for other than minor illnesses? (If yes, give							
complete address of doctor, hospital, clinic, and details.		├ ───┤					
17. Have you ever been discharged from military servic	e	х					
because of physical, mental, or other reasons? (If yes,							
specify.)							
18. Have you ever received, is there pending, or have		х					
you ever applied for pension or compensation for							
existing disability? (If yes, specify what kind, granted by	у						
whom, and reason.)							
19. Have you ever been diagnosed with a learning		х					
disability? (If yes, give type and what is needed to help							
overcome.)							
20. List all immunizations received		-					
Polio, Tetanus, Pneumonia							
	1. 1.1	1.1.1.1.1.1.1	1 1 1				
I certify that I have reviewed the foregoing information							
1	ding manage	ement of my care to i	review and input da	ata into the Medical Record in accordance with local, state,			
and federal laws.							
24a. Typed or Printed Name 24	4b. Signatur			24c. Date			
Chad Sims		Chad Sims					
			-				
		OCUMENT WILL F	BE PLACED IN TH	IE MEDICAL RECORD			
25. Physician's summary and elaboration of all pertinen	t data.						
Chronic Heart Failure							
Pleural effusion							
	0.4 6		26 D				
26a. Typed or Printed Name of Physician or Examiner	26b. Signati	ure	26c. Date	Patient Label Here			
Dr. Simulation Getwell	Dr. Sin Getwell	nulation					
	1 , 11	•					
	GALMAN						
	GALMALL						
	GALWALI						
	Getwell						

Designed by mt revised by dms Butler Community College

Scenario References

Black, J. & Hawks, J (2005) <u>Medical Surgical Nursing Clinical Management for Positive</u> *Outcomes* 7th ed. Elsevier Saunders, St Louis

Hopper, J. & Vallerand, A (2005) <u>Davis's Drug Guide for Nurses</u> 10th ed. F.A. Davis, Philadelphia

Palm Skyscape (2006) Drug Guide Skyscape, Inc.

Potter, P. & Perry, A. (2007) <u>Basic Nursing Essential for Practice</u> 6th ed. Mosby Elsevier, St. Louis

Reviewed and edited by Faculty at Butler community College