SCE Title: Discharge Planning & Teaching

Patient Name: *Richard Price*

Patient Age: *70*

DOB: *11/12/52*

Patient Gender: *Male*

Patient Weight: *191 lbs/ 86.8 kgs*

Base Patient:
70-year-old Caucasian male present in a Medical/Surgical room. Patient has oxygen 4L via NC, foley catheter, SCDs and IV line in place. Incentive spirometer at bedside. Patient is going to be discharged with home oxygen and a new antibiotic, after a three-day stay for COPD exacerbation and a CAUTI.

Overview/Synopsis:
70-year old Caucasian male who was seen in the emergency department three days ago for shortness of breath. Patient has a history of COPD but was not requiring oxygen at home. Admitted to the medical/surgical unit after CXR showed a COPD exacerbation. Sputum cultures negative. Patient c/o urinary retention and a catheter was placed on the Med/Surg unit on date of admission. After placement day 2, patient started having UTI symptoms. Urine analysis and culture was sent down. Patient requiring 4L O2 and unable to titrate. Urine analysis showed positive with nitrates. Provider awaiting urine culture results from admission sample, along with rest and exercise evaluation for home oxygen use, then will place discharge orders.

Phase 1:

Students will enter Richard's room and he will state that respiratory therapy was just in and completed his 'Rest and Exercise'. O2 determination results will be left on the counter that state that patient will need 4L O2 via NC continually while at rest, 6L O2 via NC upon exertion. Students will be expected to notify the provider of the results.

Provider will then give the following orders:

1. *Repeat UA from catheter prior to DC to evaluate nitrate levels.*
2. *Order PTT, CMP & CBC prior to DC.*

Students will find need to call laboratory to ask them to draw PTT, CMP & CBC. Students will then send urine sample to the lab for analysis.

Students will complete a head-to-toe assessment. Students will note bilateral lower lobe crackles and catheter in place with cloudy urine. All other system findings will be normal. Patient will consistently ask when he can be discharged. Students will have to explain that they are awaiting laboratory results and then will notify the provider for discharge instructions.

Students should note abnormal vital signs: elevated blood pressure and temperature. Students should administer morning medications that include blood pressure medication and Tylenol for antipyretic effects. MAR will note that provider needs to be contacted for temperature greater than 38 degrees C.

Laboratory will call students and give results of testing. UC is positive for Escherichia coli. Students will be expected to call the provider. The provider will give them verbal orders to remove the foley catheter and provider will place Azithromycin on his discharge medication list for his UTI. Provider will also state to remove IV catheter and provider will be bringing down discharge paperwork. Students will discontinue foley catheter and IV, educate the patient on a CAUTI and patient treatment.

First phase of simulation will end. Students will be pulled and debriefed.

Phase 2:

Students will receive a copy of the discharge instructions prior to entering the room, after phase 1 debrief. Students will complete a discharge assessment and document appropriate findings.

Actors will be in the room, will complete discharge assessment with students and will receive discharge instructions. Actors can bring up additional questions/topics of conversation such as:
I really need to get out of here and have a smoke. (Students should provide smoking cessation and oxygen use counseling)
Do I have to remove it to take a shower?
Those oxygen concentrators are so big, I will just keep in in the closet with the furnace. (Should not be exposed to extreme heat or open flames within 6 feet)

I have some azithromycin at home. I didn't need to finish the whole bottle last time because I started to feel better. (Ensure education to complete entire course of antibiotics)

Once students have completed the discharge checklist, all the discharge instructions, made follow-up appointments and questions have been answered, simulation will end.

Patient History:
Past Medical History: *Hypertension, COPD, Hyperlipidemia, Smoker*
Allergies: *NKDA*
Medications: *Albuterol- PRN for COPD, Lisinopril 10 mg BID, Simvastatin 40 mg daily in evening*
Code Status: *Full Code*

Social/Family History:
The patient lives at home with his wife, Sheryl. Him and his wife never had children. He retired 4 years ago as a diesel mechanic at a local machine shop. He has a smoking history of 1 PPD for 50 years. He has no history of smokeless tobacco. ETOH use history is 1 drink per day. No other illicit drug use noted. Patient is functionally independent with no assistive devices at home.

Pt's mother is still living. She lives in a LTC facility and was diagnosed with Alzheimer's Dementia at the age of 80. Pt's mother also has a history of HTN and breast cancer diagnosed 1 year ago. Pt's father was killed in a mining accident when the patient was 7 years old. Unable to recall any significant medical history for his father. Pt has one sibling, a brother, who is in good health with no significant medical history.

Handoff Report:
Richard arrived at the emergency department via ambulance, three days ago. Richard had reportedly eaten a small amount of breakfast and told his wife Sheryl, "It is too hard to eat because I can't breathe". Richard did take two doses of his albuterol rescue inhaler but was unable to recover. Sheryl called EMS and when paramedics arrived, they found his oxygen saturation at 78% on room air. Oxygen applied and the ambulance transported him to the ER at 0923.

In the ER, Richard's oxygen saturation was 91% on 6L via simple mask. Respiratory therapy was paged and administered a duo-neb. Dr. Reynolds ordered a STAT CXR and sputum cultures. CXR showed consolidations consistent with a COPD exacerbation. Sputum cultures were negative.

Upon transfer from the ER to his Medical/Surgical Admission room, Richard complained of "having to pee but can't". He had a bladder scan and it showed he was retaining 800 ml. The primary nurse received an order for a foley catheter and it has been in place since admission. It was draining copious amounts of clear, yellow urine until 1900 yesterday. Urine output at 1900 yesterday was cloudy, with an unpleasant odor. The attending was paged, and a urine analysis (UA) and urine culture (UC) was sent to lab. Foley catheter is still in place and urine culture still pending. UA was positive for nitrates, but the provider wanted to wait to remove catheter until cultures came back.

SCE Development

Attending provider anticipating discharge today. Awaiting culture and Respiratory Therapy to complete 'Rest & Exercise' to determine home O2 use.

Patient has been on a regular diet with good intake. Patient ambulates with stand by assistance with no assistive devices.
His last set of vitals are as follows:
Vital signs: HR 67, BP 159/91, RR 18, SpO2 94% on 4L NC and temperature 37.9 C
General Appearance: sunken appearance, appears older than stated age
Cardiovascular: Sinus rhythm, no murmurs noted
Respiratory: Breath sounds diminished; fine crackles noted to bilateral lower lobes. Labored breathing on exertion.
GI: Normoactive bowel sounds. Last bowel movement noted yesterday.
GU: Foley catheter in place. 500 ml of cloudy, odorous urine at 0600
Extremities: Moves upper extremities and right lower extremity in full range of motion. SCDs in place
Skin: Pink, cool and dry. Skin turgor good.
Neurological: Alert and oriented to person, place, time, situation (x 4). Pupils equal and reactive to light and accommodation. No neurological deficits noted.

Orders:

Admission Order Set

Admit to Medical/Surgical Inpatient Room (Date)
Saline Lock
Lisinopril 10 mg PO BID
Simvastatin 40 mg daily in evening
Albuterol Inhaler PRN for SOB
Acetaminophen 325 mg 2 tabs PO every six hours prn pain or fever. Notify provider if fever greater than 38 F
Regular Diet
Up with assist of one staff
Ambulate QID
Vital signs Q8 hours
Oxygen Therapy as needed
Consult to Respiratory Therapy
Bilateral SCDs
Notify healthcare provider of any acute changes
Strict I & O every shift

Discharge Order Set

Discharge to home (Date)
Discontinue saline Lock
Discontinue foley catheter
Resume home medication regimen

Regular Diet
Encourage ambulation at home
DME: Home oxygen use per RT evaluation
Encourage Incentive Spirometer use, every hour while awake
Azithromycin 500 mg po QD X7 days for UTI
Additional discharge education: Smoking Cessation
Call PCP and schedule discharge follow-up visit in 1 week

Learning Objectives:

- *LPN Students will perform a basic physical assessment, vital signs, patient care.*
- *LPN Students will identify and document normal and abnormal assessment findings.*
- *LPN Students will conduct a discharge needs assessment of the patient and document these findings accurately.*
- *LPN Students will recognize the need to inform the provider of critical lab values and provide SBAR report to them.*
- *LPN Students will identify appropriate nursing care of patient with a COPD exacerbation.*
- *LPN Students will use therapeutic communication in interactions with patient and family.*
- *LPN Students will identify and assess potential safety concerns and provide detailed discharge education to patient and family.*
- *LPN Students will work collaboratively with MLT students to provide safe and quality, patient centered care.*

Learning Performance Measures:

- *Reviews patient's medical record and plans priorities for patient care interventions.*
- *Performs hand hygiene before and after patient contact*
- *Demonstrates appropriate use of personal protective equipment*
- *Introduces self to patient*
- *Verifies patient identity with two identifiers*
- *Conducts basic environmental safety assessment and maintains safety measures*
- *Identify physical assessment findings within normal parameters VS abnormal parameters.*
- *Uses therapeutic communication to establish rapport and reduce patient anxiety*
- *Primary nurse performs head-to-toe assessment, and delegates other tasks to co-workers, triaging appropriately (vital signs, foley discontinuation, morning medications, IV discontinuation). Multi-task as a nursing team as much as possible to promote efficiency.*
- *Calculates and administers medications safely according to the Six Rights*
- *Ascertain AM lab findings and report to provider as requested, prior to discharge, via telephone using SBAR communication format.*
- *Transcribe and perform any verbal orders to the patient's record. Document care/findings in the record.*
- *Complete a discharge checklist of patient needs.*
- *Educate patient AND family member regarding home discharge oxygen use and practices,*

medications, concerns.
- *Documents all findings, interventions, and patient responses*

Preparation Questions:

1) *When do we start a patient's discharge planning? Why?*

2) *Who are the members of a patients care team, that assist with discharge planning, and what are their roles?*

3) *What is the purpose of an at home oxygen determination test? How do clinicians perform these tests?*

4) *What is a CAUTI? Why is a CAUTI of concern in the hospital setting?*

5) *What are the signs and symptoms of a CAUTI?*

6) *What is the purpose of a discharge assessment?*

7) *Identify and prioritize three discharge teaching topics that would be relevant to a patient being discharged on home oxygen.*

Equipment & Supplies:

IV Supplies:
Saline Lock
Transparent Dressing
20-gauge IV catheter

Medication Supplies:
Simulated oral medications labeled:
Lisinopril 10 mg BID
Simvastatin 40 mg daily in evening
Acetaminophen 650 mg po PRN

Oxygen, Airway and Ventilation Supplies
Incentive Spirometer
Nasal Cannula

Monitors:

NIBP
SPO2

Miscellaneous
Patient chart with appropriate forms/order
Patient identification band
Stethoscope
BP cuff adapted for use with simulator
Non-sterile gloves
Sharps Container
Audio and video recording devices
Sequential compression device with sleeves
Foley catheter with urine

Facilitator Notes:
Phase 1:

- *Vital Signs on initial assessment will be: HR 74, BP 163/91, RR 18, SpO2 93% on 4L NC and temperature 38.4 C*
- *Once students enter the room, patient will state that Respiratory Therapy was just in and left his results of his 'Rest and Exercise' on the counter.*
- *Patient will repeatedly ask when he can go home.*
- *Patient will ask how long he has to have his catheter and IV in place.*
- *Phase 1 will complete once medications are given, IV and foley catheter removed (once provider has given orders) and morning medications are given.*

Phase 2:

- *Actors will be in the room, will complete discharge assessment with students and will receive discharge instructions. Actors can bring up additional questions/topics of conversation such as:*
    - *I really need to get out of here and have a smoke. (Students should provide smoking cessation and oxygen use counseling)*
    - *Do I have to remove it to take a shower?*
    - *Those oxygen concentrators are so big, I will just keep in in the closet with the furnace. (Should not be exposed to extreme heat or open flames within 6 feet)*
    - *I have some azithromycin at home. I didn't need to finish the whole bottle last time because I started to feel better. (Ensure education to complete entire course of antibiotics)*
- *Phase 2 will be complete when discharge instructions have been covered in entirety, questions by patient/family have been answered and discharge checklist completed.*

First 20 minutes of debriefing, will be spend with Laboratory students, being educated on their process and roles.

Debriefing Points:

1) *Were you satisfied with your ability to care for the patient?*

2) *What was done well and what could have been handled differently?*

3) *What did you learn?*

4) *In what ways did you personalize your care for this patient and family members (recognition of culture, concerns, anxiety, etc.)?*

5) *What does a "safe discharge plan" mean? How does nursing impact this?*

6) *What are different resources you can use, if you are having barriers to discharge?*

   Examples: Patient needs to use a walker, but it his personal one is broken.
   His regular pharmacy does not have his new medication in stock.

Teaching Q&A:

References:

Preloaded Scenarios: