

# GERIATRIC SIMULATIONS TOOLKIT



The Center for Aging  
Research and Education

SCHOOL OF NURSING

UNIVERSITY OF WISCONSIN-MADISON

## **ACKNOWLEDGEMENTS**

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## WELCOME TO THE UW-MADISON GERIATRIC SIMULATIONS TOOLKIT

This toolkit is a resource for nurse educators wishing to advance the preparation of nurses to care for older adults across a variety of settings, including the hospital, the home, and skilled nursing facilities. The simulations are designed for students in a baccalaureate nursing program; however, we believe they are applicable to any student in a Registered Nursing program (e.g., ADN), or, with some adaptations, would be beneficial to practicing RNs.

The simulations were developed with the following goals:

- Increase nursing student competence and confidence in adapting care for older adults
- Increase nursing student appreciation for and confidence in collaborating with other disciplines
- Increase nursing student exposure to healthcare settings other than acute care
- Create a positive image of careers in aging, particularly in long term and community based care settings

In this toolkit you will find concrete guidance and materials to use in four simulations related to caring for older adults. The four simulations are:

1. Introduction to aging and home health nursing assessment
2. Hospital care of older adults with a fall and acute respiratory symptoms
3. Interprofessional home health assessments
4. Interprofessional skilled inpatient rehabilitation of older adults

Also included are reflections from students and instructors that have experienced the simulations, recommended resources, and tool recommendations for those wishing to evaluate implementation of the simulations and their impact on learners.

Thank you for your interest in advancing nurse preparation to care for older adults!

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## DOCUMENT CONTENTS KEY

|                                  |  |
|----------------------------------|--|
| <b>INSTRUCTOR</b>                | Instructor Preparation                 |
| <b>SCENE</b>                     | Scene Set Up                           |
| <b>LEARNER</b>                   | Learner Preparation                    |
| <b>SCRIPT</b>                    | Actor Scripts and Prep                 |
| <b>RESOURCES</b>                 | External Instructional Resources       |
| <b>HIGHLIGHTS<br/>&amp; TIPS</b> | Learner Highlights and Instructor Tips |

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## MEET MILLIE LARSEN



I'm Millie. I have lived in the same small house for the last 50 years. Harold and I raised our dear daughter Dina here and we had many good years together as a family. Harold passed last year – he was 91, you know – and I miss him terribly. I think about him every day. We were married for 68 years; most of them were happy. We did struggle with money at times, but who didn't? All of our family lived close by and I spent many a Sunday cooking for 15-20 after church. Our home was always full of people; many of them are gone now. Snuggles, my dog, keeps me company. Snuggles is about 10 years old; she is a stray who just showed up on my doorstep one day and she's been here ever since.

I've always kept myself busy, I used to sing when in the church choir and I volunteered in the church kitchen. I still love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I can't do as much as I used to, but that's ok. I am fortunate to have many close friends from church.

I also enjoy gardening and I am known for growing my prize roses. My rose garden is not quite as big as it used to be, but I still like to get outside and work with the soil and the flowers. Although, recently I haven't been out at much due to the cold. Did you know that my roses used to win blue ribbons at the county fair almost every year?

Since Harold is gone, I go over to my daughter Dina's house every week to visit and see my grandkids. Dina is a good cook, but her dumplings aren't quite as good as mine; I try to make a batch to take with me when I can. Dina works every day at the school so she is busy most of the time. She is a good daughter and helps me when I need to get to the doctor. She also picks up groceries for me once in awhile. I have three grandchildren. Jessica is 17 and graduates from high school this year. Daniel is 14 and is a handful! He can give his mother trouble about getting his homework done and I don't think his grades are very good. I know Dina worries about him. Megan is 12; she is such a sweet child. She likes to help me with my roses in the summer.

I am lucky that I can still get around pretty well and my house is not too big. Although recently some nurses came out and told me I wasn't moving enough and I had to clean more. I try to keep my house clean, thank you very much! Dina keeps checking my bottom for who knows what reason and keeps telling me to get out of my chair more. When Snuggles wants to cuddle, I have a hard time saying no! My knees are pretty bad; I think they are just worn out. They hurt a lot. My bladder isn't as good as it used to be. I really don't like a lot of people caring for me; I think I do pretty well for my age. Then the other night, I had to go to the bathroom and fell. Fortunately I could reach the phone and called Dina. Dina rushed over, called my doctor and now I hear I have to have more people visit me at home.

I hope all these hospital bills and home visits aren't too expensive, I already have to pay a lot for my medications and I don't get the pension anymore since Harold died. I don't know how Harold paid all the bills, it doesn't hardly seem like there's enough money for all that medicine.

Source: Adapted from ACES Cases: <http://www.nln.org/professional-development-programs/teaching-resources/aging/ace-s/unfolding-cases/millie-larsen>

# SCENARIO 1

## Millie is Independent at Home

**Summary:** Millie meets with a nurse in her home after a fall. The nurse is assessing her safety in the home and assistance she might need.

**Learner Level:** First year nursing students; suggested first semester

**Goal:** To improve nursing students' knowledge and skill to competently manage the needs of an aging clientele, with an emphasis on client communication and understanding physical assessment variations in the healthy older adult.

**Course suggestion:** Fundamentals of nursing practice

### Documents:

- Simulation Instructor Overview
- Materials and Scene Preparation
- Stations and Activities
- Photos of suggested set up
- Millie Larsen's Intro Monologue (adapted from ACES Cases)
- Learner Handout
- Millie's Actor/Voiceover: Background Information and Script
- Learner highlights
- Instructor tips

### Meets the AACN Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults:

#### (LIST)

- Assess barriers for older adults in receiving, understanding, and giving of information (correspond to Essentials IV & IX)
- Use valid and reliable assessment tools to guide nursing practice for older adults (correspond to Essentials IX)
- Assess the living environment as it relates to functional, physical, cognitive, psychological, and social needs of older adults (correspond to Essential IX)

## INSTRUCTOR OVERVIEW

|   |  |                    |                       |
|---|--|--------------------|-----------------------|
| <b>Case Name:</b> Millie Larsen Initial Home Assessment   | <b>"Patient" Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht.</b><br>5'3" | <b>Wt.</b><br>115 lbs |
| <b>Location:</b> Millie's Home  |  |                    |                       |
| <b>Goal of the Simulation</b><br>To improve nursing students' knowledge and skill to competently manage the needs of an aging clientele, with an emphasis on communication and understanding physical assessment variations in the healthy older adult.   |  |                    |                       |
| <b>Learner Objectives</b><br><ol style="list-style-type: none"> <li>1. Demonstrate understanding of variations in physical assessment findings in a healthy older adult</li> <li>2. Identify appropriate topics and information when communicating with clients</li> <li>3. Demonstrate a knowledge level that is adequate for safe practice in care of the healthy older adult</li> </ol>  |  |                    |                       |
| <b>Pre-simulation Requirements for the Learners</b> <ul style="list-style-type: none"> <li>• Review <i>Intro to Healthy Aging</i> PowerPoint</li> <li>• Read written Millie Larsen intro monologue</li> <li>• Review therapeutic communication techniques</li> <li>• Review age-related changes resource documents</li> </ul>   |  |                    |                       |
| <b>Pre-brief (Student-Instructor Discussion)</b><br>Discuss professional conversation with client in home, including therapeutic communication techniques.  |  |                    |                       |
| <b>Evaluation of Outcomes</b> <ol style="list-style-type: none"> <li>1. a) Students will perform focused health assessment interview.<br/>b) Students will wear vision simulators and arthritic gloves to complete assigned tasks.</li> <li>2. a) Students will use therapeutic communication.<br/>b) Students will maintain professionalism.</li> <li>3. a) Students will begin to identify safety considerations for older adults.</li> </ol>   |  |                    |                       |
| <b>History of Present Illness</b><br>Review Millie Larsen's intro monologue and script  |  |                    |                       |
| <b>Past Medical/Surgical History</b><br>Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, atrial fibrillation; cholecystectomy at age 30   |  |                    |                       |
| <b>Social History</b><br>Lives at home independently. Daughter, Dina, lives nearby and is her primary support system.   |  |                    |                       |
| <b>Current Medications</b><br>Hydrochlorothiazide 25mg daily; Carvedilol 3.125mg twice a day; Warfarin 5mg daily; Digoxin 0.125mg daily; Atorvastatin 40mg daily; Tylenol 325mg as needed for pain; Pilocarpine 1 drop 1% solution TID to R eye; Timolol maleate 1 drop 0.25% solution once daily to R eye  |  |                    |                       |
| <b>Allergies</b><br>No known allergies  |  |                    |                       |
| <b>Debrief Questions (entire simulation as group)</b> <ol style="list-style-type: none"> <li>1. What do you feel are Millie's strengths?</li> <li>2. What do you feel are Millie's challenges?</li> <li>3. What aspects of Millie's history (both medical and social) jump out as potential concerns?</li> <li>4. If you were to go back and talk to Millie again, would you ask or do anything different? Would you approach the situation in the same manner?</li> <li>5. Millie is 90 years old. How would your questions, concerns, interventions, or recommendations change if Millie was 60 years old?</li> <li>6. What will you take away from this simulation?</li> </ol> |  |                    |                       |

**Post-simulation Student Journal Questions**

1. If recorded: In watching your interaction with Millie in the video:
  - a. What is your body language like?
  - b. How is the tone of your voice?
  - c. Are you using open-ended questions or yes/no questions?
  - d. Are you talking fast, slow, repeating, using technical terms?
  - e. Who is doing most of the talking?
2. How did you feel during the simulation experience?
3. What part of the simulation was most helpful for you?
4. How did things go working with another student for this experience?
5. Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn't have?

**Submit within 48 hours following simulation.**

## MATERIALS AND SCENE PREPARATION

### Scene

A home-like setting with bedroom, kitchen, living room, bathroom. Two stations for student activities.

*Note: If you are able to record student activity in this simulation, it is a valuable tool for their learning. Students requested this during pilot testing of these simulations.*

### Station 1: Interview Millie in the bedroom

- Live actor or Geri-Manikin with instructor voice (e.g., using baby monitor or special room set up) in old nightgown in bedroom
- Millie's Script
- Glasses on nightstand
- Large print book in room
- Labeled pill bottles with matching client medications. Some pill bottles left open to simulate difficulty opening bottles

Students should have:

- CDC Fall Risk Checklist (see resources list)
- Millie's Medication list (see Learner Handout)

### Station 2: Home safety assessment (living room, kitchen, bathroom)

- Students role play Millie wearing vision simulators, arthritic gloves
- Simulated dog barking and walking around on floor as a distraction and safety consideration (e.g., <https://www.amazon.com/FurReal-Friends-Get-GoGo-Walkin/dp/B00ILDJXGK>)
- Rug turned up in living room
- Pot holders on stove
- Dishes in sink
- Medication bottles in disarray, pill bottles spilled
- Arthritic gloves (e.g., <http://hseb.gtri.gatech.edu/gloves.php>)
- Vision simulators (e.g., <http://www.lowvisionsimulators.com/product/full-set>)
- Food (e.g., highlight highly processed, prepacked frozen dinners, cake mix for grandkids)
- Labeled pill bottles with matching client medications. Some pill bottles left open to simulate difficulty opening bottles
- Clothing with buttons, zippers

Students should have:

- AARP Home Fit and Home Safety Checklist (see resources list)

## MATERIALS AND SCENE PREPARATION

### MILLIE INTERVIEW STATION 1: (10 mins)

Suggested learner configuration: Team of 2 students

Millie is an older adult sitting in her bedroom chair. She has difficulty getting around due to her knee pain, so she often rests for a period of time. Overall she would say she gets around pretty well and tries to be active.

During assessment with Millie, students will ask Millie questions in order to gather information about Millie's health status using the CDC Fall Risk Checklist and asking Millie about medications.

#### Expected Student Outcomes:

- Introduce self
- Utilize therapeutic communication with client
- Maintain professionalism in the home setting
- Obtain manual blood pressure (if desired)

### HOME SAFETY ASSESMENT STATION 2: (occurs concurrently- 10 mins)

Suggested learner configuration: Team of 2-4 students

Students to walk into home and assess living room, kitchen, bathroom for fall risk, safety.

One student per group will role play Millie. Student as Millie will put on arthritic gloves and goggles and perform activities in kitchen. Student as Millie will open pill bottles, practice with dressing, mobility (use of Millie's walker)

Other student as RN: Use AARP Fall Risk Checklist: focus on questions regarding:

- Steps/Stairways/Walkways
- Floor Surfaces
- Appliances/Kitchen/Bath
- Lighting/Ventilation

#### Expected Outcomes:

- Students will assess room safety and identify potential hazards (fall risk, fire).

## HOME SCENE PREPARATION WITH PHOTOS AND CUES



Entrance to Millie Larsen's home.

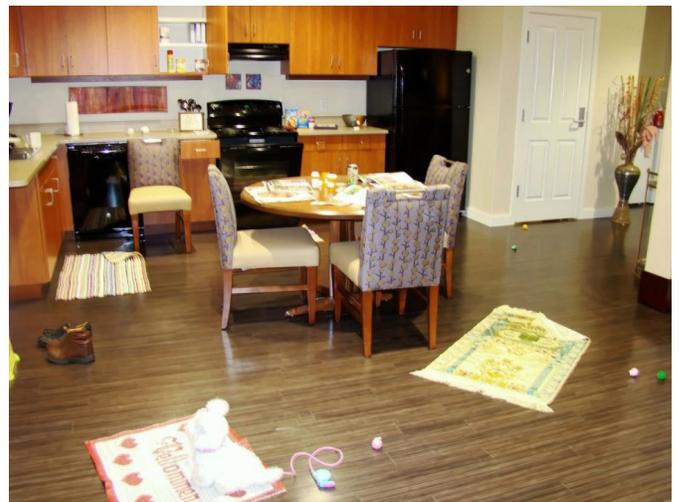
Key items:

- Barking dog & rugs as tripping hazards.
- The step poses tripping hazard as well.

### Kitchen/dining room.

Note:

- Overall unsafe situation with rugs
- Dog/cat toys
- Oven door open
- Chair next to counter with cupboard door open (depicting fall risk).





**Kitchen table.**

- Open sugary soda can
- Medication bottles throughout home and on table (some left open to indicate Millie has a hard time opening bottles)
- Coupon clippings (indicate fast food may be a significant source of her nutrition).

**Kitchen**

**Key features:**

- Chair in kitchen with drawer open next to it and lightbulbs on counter that Millie was trying to replace but couldn't do/finish.



**Kitchen**

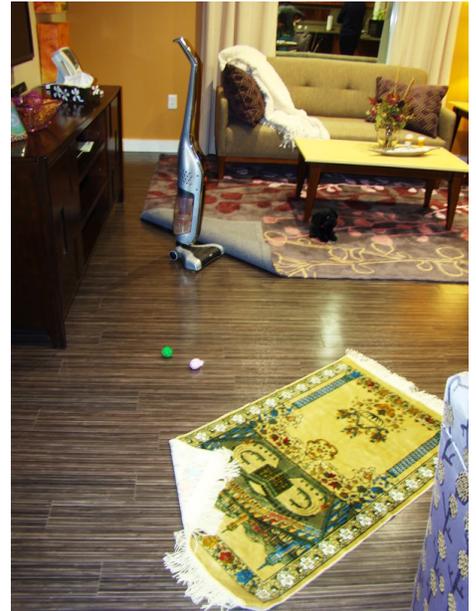
**Key features:**

- Fire hazard with oven mitt (burned).
- Convenience foods on counter to highlight highly processed, high sodium diet.
- No fresh fruits or vegetables in apartment.

## Living room

### Key features:

- Tripping hazards with rugs and vacuum left out (causes you to wonder if Millie was vacuuming or how long this has been there).



## Living room table

### Key features:

- Pill bottles in living room (indicates disorganization with taking meds).

### Hallway

Key features:

- Dog toys randomly throughout hallway walking area (fall risk/safety hazard)



### Bathroom

Key features:

- Towels strewn about
- Garbage full of used continence briefs that has not been taken out
- Incontinence concerns, fall risk, hygiene concerns

## Bedroom

### Key features:

- Millie in chair with heating pad behind her
- Note cord plugged in across doorway/ walkway
- Walker just barely out of reach and stuck on rug
- Slippers near door (slippers have smooth bottom, bulky and may be a fall risk).
- Heating pad highlights risk for impaired skin integrity.



## MEET MILLIE LARSEN



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I also enjoy gardening and I am known for growing my prize roses. My rose garden is not quite as big as it used to be, but I still like to get outside and work with the soil and the flowers. Although, recently I haven't been out at much due to the cold. Did you know that my roses used to win blue ribbons at the county fair almost every year?

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I hope all these hospital bills and home visits aren't too expensive, I already have to pay a lot for my medications and I don't get the pension anymore since Harold died. I don't know how Harold paid all the bills, it doesn't hardly seem like there's enough money for all that medicine.

## LEARNER HANDOUT

|  |                            |                |
|--|----------------------------|----------------|
| <b>Case Name:</b> Millie Larsen Initial Home Assessment  | <b>"Patient" Name/DOB:</b> | <b>Ht. Wt.</b> |
| <b>Location:</b> Millie's Home   | Millie Larsen 01/23/1927   | 5'3" 115 lbs   |
| <b>Pre-simulation Requirements for the Learners:</b>   |                            |                |
| <ul style="list-style-type: none"> <li>• Review <i>Intro to Healthy Aging</i> PowerPoint</li> <li>• Review age-related changes documents and article</li> <li>• Read Millie Larsen's introduction monologue</li> <li>• Review Therapeutic communication techniques</li> </ul>  |                            |                |
| <b>Goal of the Simulation:</b>   |                            |                |
| To improve nursing students' knowledge and skill to competently manage the needs of an aging clientele, with an emphasis on understanding physical assessment variations in the healthy older adult.   |                            |                |
| <b>Learner Outcomes:</b>   |                            |                |
| <ol style="list-style-type: none"> <li>1. Demonstrate understanding of variations in physical assessment findings in a healthy older adult</li> <li>2. Identify appropriate topics and information when communicating with clients</li> <li>3. Demonstrate a knowledge level that is adequate for safe practice in care of the healthy older adult</li> </ol>  |                            |                |
| <b>Evaluation of Outcomes:</b>   |                            |                |
| <ol style="list-style-type: none"> <li>1.             <ol style="list-style-type: none"> <li>a) Students will perform focused health assessment interview.</li> <li>b) Students will wear vision simulators and arthritic gloves to complete assigned tasks.</li> </ol> </li> <li>2.             <ol style="list-style-type: none"> <li>a) Students will use therapeutic communication.</li> <li>b) Students will maintain professionalism.</li> </ol> </li> <li>3.             <ol style="list-style-type: none"> <li>a) Students will begin to identify safety considerations for older adults.</li> </ol> </li> </ol> |                            |                |
| <b>History of Present Illness:</b>   |                            |                |
| See <i>Millie Intro monologue</i>  |                            |                |
| <b>Past Medical/Surgical History:</b>  |                            |                |
| Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, atrial fibrillation; cholecystectomy at age 30  |                            |                |
| <b>Social History:</b>   |                            |                |
| Lives at home independently. Daughter, Dina lives nearby and is her primary support system.  |                            |                |
| <b>Current Medications:</b> Hydrochlorothiazide 25mg daily; Carvedilol 3.125mg twice a day; Warfarin 5mg daily; Digoxin 0.125mg daily; Atorvastatin 40mg daily; Tylenol 325mg as needed for pain; Pilocarpine 1 drop 1% solution TID to R eye; Timolol maleate 1 drop 0.25% solution once daily to R eye   |                            |                |
| <b>Allergies:</b> No known allergies   |                            |                |
| <b>Video Self-reflection Journal:</b>  |                            |                |
| In watching your interaction with Millie in the video:   |                            |                |
| <ol style="list-style-type: none"> <li>a. What is your body language like?</li> <li>b. How is the tone of your voice?</li> <li>c. Are you using open-ended questions or yes/no questions?</li> <li>d. Are you talking fast, slow, repeating, using technical terms?</li> <li>e. Who is doing most of the talking?</li> </ol>   |                            |                |
| Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn't have?   |                            |                |
| How well did things go working with another student for this experience?   |                            |                |
| <b>Please submit 48 hours following your simulation.</b>   |                            |                |

## MILLIE'S MEDICATION LIST

| Medications                           | Frequency           | Indication | Side Effects |
|---------------------------------------|---------------------|------------|--------------|
| Hydrochlorothiazide 25mg              | daily               |            |              |
| Carvedilol 3.125mg                    | BID                 |            |              |
| Warfarin 5mg                          | daily               |            |              |
| Atorvastatin 40mg                     | daily               |            |              |
| Digoxin 0.125mg                       | daily               |            |              |
| Tylenol 325 mg                        | PRN                 |            |              |
| Pilocarpine 1 drop 1% solution        | TID to R eye        |            |              |
| Timolol maleate 1 drop 0.25% solution | once daily to R eye |            |              |

1. Look up medications currently prescribed and their side effects prior to coming to simulation to be able to assess Millie's understanding of her medications.
2. Examples of medication assessment questions: Which prescriptions do you take? When do you take them? How do you take them? Do you understand why you take them? What do you do to help you remember to take your medications?

### MILLIE INTERVIEW STATION 1: (10 mins)

During assessment with Millie, you will ask Millie questions in order to gather information about Millie's health status, focusing on safety and medication understanding. Please review the **CDC Fall Risk Checklist** as a guide for your interview: [https://www.cdc.gov/steady/pdf/fall\\_risk\\_checklist-a.pdf](https://www.cdc.gov/steady/pdf/fall_risk_checklist-a.pdf)

#### Expected Outcomes:

- Introduce yourself.
- Utilize therapeutic communication with client.
- Maintain professionalism in the home setting.

### HOME SAFETY ASSESMENT STATION 2: (occurs concurrently- 10 mins)

You will walk into home and assess living room, kitchen, bathroom for fall risk, safety.

One student per group will role play Millie: put on arthritic gloves and goggles and perform activities in kitchen. Student as Millie will open pill bottles, practice with dressing, mobility (use of Millie's walker).

Other student as RN: Use **Home Safety Checklist**

- AARP Home Safety Checklist  
[http://assets.aarp.org/external\\_sites/caregiving/checklists/checklist\\_homeSafety.html](http://assets.aarp.org/external_sites/caregiving/checklists/checklist_homeSafety.html)

#### Expected Outcomes:

- Students will assess room safety and identify potential hazards (fall risk, fire).

## TIPS FOR VERBAL COMMUNICATION WITH OLDER ADULTS

- Slow down your speech.
- Talk at a lower pitch, not at a louder volume.
- Maintain eye contact and face the person – this makes lip reading easier for the person.
- Present one piece of information or instruction at a time.
- Be careful with emotion-laden words (i.e. cancer).
  - Some older adults have selective hearing; they may hear “don’t have cancer” as “have cancer.”
- Be specific.
- Repeat.
- Use humor and laugh when appropriate.
- Use good listening skills.
  - Stop talking.
  - Be patient.
  - Do not interrupt.
  - Pay attention.
  - Double-check that you understand correctly what was said.
  - Try to verify that what was said was what was meant.



## GUIDELINES FOR INTERVIEWING

1. Greet the person by name – acknowledge their individuality. Introduce yourself and explain your purpose for being there (a handshake initiates physical contact).
2. Sit near the patient if possible where they can easily see and communicate with you. Face and look at them when speaking.
3. Begin with the topics which are easiest to discuss.
4. Limit questions to a single idea and ask only one question at a time.
5. Ask a short question rather than a long one.
6. Use language the patient can understand.
7. Allow sufficient time for the patient to answer.
8. Note the verbal and nonverbal signals from the person. Become aware of your own nonverbal communication (gestures, movement, body posture, etc.)
9. Maintain contact with the person during the interview as a means of encouraging communication verbally and nonverbal.



**Ex.:** nodding your head, altered posture, changing facial expressions, etc.; comments such as, “I understand,” etc.

10. Utilize physical contact to facilitate communication if necessary. It is useful in helping people express difficult material; a touch on the arm or hand may give them encouragement to continue. It is very useful when the person cries; silence at such moments may be appropriate as well.
11. Ask questions in such a manner they cannot be answered by “yes” and “no.” This strategy avoids needless repetition and keeps time and effort to a minimum.  
Ex. “Tell me what your pain feels like” rather than “Is the pain sharp?”

## MILLIE'S BACKGROUND DOCUMENT FOR STANDARDIZED PATIENT OR MANIKIN VOICE Older Adult Home Simulation Interview (Scenario 1)

Because this is a learning opportunity for students, feel free to communicate more than you might in other situations. Allow the students to guide the interview and respond to questions only when asked.

### **Background:**

You are Millie Larsen, a 90 year old recently widowed woman who has lived in the same small house for the last 50 years. Your primary care provider referred you to have home health follow up given a recent fall you had at home. The nurses are here to assess your home safety. They will ask you questions about your fall risk, activity level, and medications.

**Current Medications:** Hydrochlorothiazide 25mg daily, Carvedilol 3.125mg twice a day, Warfarin 5mg daily, Digoxin 0.125mg daily, Atorvastatin 40mg daily, Tylenol 325mg as needed for pain, Pilocarpine 1 drop 1% solution TID to R eye, Timolol maleate 1 drop 0.25% solution once daily to R eye

Your medications are scattered throughout your house. You have bottles placed in places you will remember to take them (bathroom, kitchen, bedroom nightstand). You understand why you take your medications and take them just fine one at a time with water. Your daughter, Dina, has tried to help you organize your pills in the past, but it doesn't always stick.

**Past Medical and Psychiatric History:** Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, atrial fibrillation; cholecystectomy at age 30.

You do not have any cognitive impairments or foot problems. You are mildly depressed. You have Afib, which is a problem with your heart rhythm. You are not taking any psychoactive medications or sedating medications. Your vision is acuity 20/60. You have some dizziness or lightheadedness when going from lying to standing but if you take your time getting up, you are fine.

**Family History:** Your parents both died in old age. After your mother died, your father eventually sold the farm and reluctantly moved into an assisted living apartment. That dairy farm was his life for so many years; it was hard to convince him it was time to let it go. He didn't complain of any health problems that you know of and lived off of beer and cookies - couldn't turn them down.

You had three siblings. One sister, Joan, died of cancer at the age of 70. Your sister Margaret died from the pneumonia she got after breaking her hip, and your brother, Joe, died in the service.

**Social History:** You love to sing; you used to sing when in the church choir and volunteered in the church kitchen. You also enjoy gardening and are known for growing prize roses. Your rose garden is not quite as big as it used to be, but you still like to get outside and work with the soil and the flowers. Recently, however, you haven't been out at much due to the cold. **"Did you know that my roses used to win blue ribbons at the county fair almost every year?"**



## SCRIPT

Since Harold is gone, you go over to your daughter Dina's house every week to visit and see your grandkids. All of your family lived close by and you spent many a Sunday cooking for 15 – 20 people after church. Your home was always full of people; many of them are gone now.

Snuggles, your dog, keeps you company. Snuggles is about 10 years old; she is a stray who just showed up on the doorstep one day and she's been here ever since. Harold passed last year; he was 91, and you miss him terribly. You think about him every day. You were married for 68 years, most of them were happy.

### **How to Present Yourself:**

- Alert, oriented
- Cooperative, friendly and at times overly talkative
- Sitting up in the chair

## MILLIE'S SCRIPT

### Older Adult Home Simulation Interview (Scenario 1)

When students knock on the door, answer it and mention you'd like to give them some more privacy so can lead them to bedroom to answer their questions, "**Because sometimes Snuggles can get in the way with new people.**"

"Student prompts" below are examples of how students might phrase questions. Actual wording may vary.

---

STUDENT PROMPT: "Can you tell me how are you doing?"

**MILLIE:** I'm doing pretty good, I can get around my house for the most part. Dina helps out with some housework and getting me groceries. I did have a little fall a few nights ago - but I didn't hurt myself. I can be so clumsy at times.

STUDENT PROMPT: "Can you tell me more about the fall?"

**MILLIE:** Well I was in a hurry to get to the bathroom, I couldn't find the light switch so I was shuffling along in the dark. I think I tripped on one of Snuggles' toys and down I went!

STUDENT PROMPT: Will question your energy/fatigue

**MILLIE:** I think I do pretty well for my age. I putt around my home - I love to look at my beautiful flowers growing out in my garden. But the other night, I had to go to the bathroom and fell in the hallway. Fortunately I could crawl back to my bedroom and could reach the phone on my bedside table to call Dina. She rushed over, called my doctor and now I hear I have to have more people visit me at home. I didn't hurt myself, such a fuss for just a little fall.

STUDENT PROMPT: Will question your sleep routine and adequacy

**MILLIE:** Well, I don't sleep like I used to that's for sure. Sometimes I doze off in my chair in the evening and then wake up and decide to go to bed. I go to bed around 9 pm and can fall asleep but then I have to get up 2 times at night to use the bathroom. If I don't hurry, I leak and that is so frustrating.

STUDENT PROMPT: Will question your exercise

**MILLIE:** I like gardening. You know, I have received first place at our local fair for my roses almost every year. My rose garden is not quite as big as it used to be, but I still like to get outside and work with the soil and the flowers. This recent cooler weather has prevented me from getting out there to trim my rose bushes.

**STUDENT PROMPT:** Other than the fall you had the other night at home, have you had any other recent falls. Are you worried about falling? Do you feel steady on your feet when walking and do you use your walker?

**MILLIE:** Well, I have had a few near misses if you know what I mean – I’ve been able to catch myself or fall into a chair, so that doesn’t count. I don’t worry about falling because I have lots of things to hang onto in my house when I’m walking. For the most part I feel steady – the only time I don’t feel steady is if I get up too fast from sitting or lying in bed. Or sometimes I feel a little tipsy in the morning. I use my walker when I go outside because the sidewalk is a bit uneven and if I go to the mall with Dina and I know I have to walk a far distance.

**STUDENT PROMPT:** Will ask questions about your diet and any weight change.

**MILLIE:** I love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I noticed I can’t do as much as I used to, but that’s ok; the young people can pick up the extra duties at church. When I’m by myself I don’t cook much. It’s not fun to cook just for yourself. So I go for the prepared meals - you know the frozen TV dinners; that is so much easier for me. Dina and the grandkids also bring over meals they have made and there are always brownies and cookies to snack on. I really don’t know if my weight has changed. I do notice that my clothes feel a little looser on me.

**STUDENT PROMPT:** Will ask questions about your family situation.

**MILLIE:** My dear husband Harold passed last year. He was 91, you know, and I miss him terribly. I think about him every day. We were married for 68 years; most of them were happy. Since Harold is gone, I go over to my daughter Dina’s house every week to visit and see my grandkids. Dina is a good cook, but her dumplings aren’t quite as good as mine and I try to make a batch to take with me when I can. Dina works every day at the school so she is busy most of the time. She is a good daughter and she helps me when I need to get to the doctor. She also picks up groceries for me once and awhile. I have three grandchildren. Jessica is 17 and she graduates from high school this year. Daniel is 14 and he is a handful! He can give his mother trouble about getting his homework done and I don’t think his grades are very good. I know Dina worries about him. Megan is 12 and she is such a sweet child. She likes to help me with my roses in the summer.

**STUDENT PROMPT:** Will ask questions about your substance use.

**MILLIE:** I haven’t had a sip of alcohol in I’m not sure how long, forever ago. It is not ladylike to smoke so I never did try that.

**STUDENT PROMPT:** Will question your mood/thoughts of suicide.

**MILLIE:** I guess I feel lonely often and I’ve had the blues since my Harold passed. But I would never consider hurting myself. But I would have to say there are times when I don’t want to get out of bed or clean my house. It’s just easier to sit in my favorite chair and watch my soaps on TV. Sometimes the

whole day passes without me going outside. I do love spending time with my grandkids. They bring such joy to my life. I really don't like living alone though. I don't know what I would do if I didn't have Snuggles; she is my buddy.

STUDENT PROMPT: Will ask questions about your worries or anxiety.

**MILLIE:** I worry about finances. After seeing my doctor after my fall he recommended that home health nurses should come out to my house to visit. I am concerned about how much this will cost and if my Medicare will pay for the bill. I already have to pay a lot for my medications and since Harold passed I don't get his pension so I just have my social security to live on. I just don't know how Harold paid all those bills. It doesn't hardly seem like there's enough money for all that medicine and my other bills.

## RESOURCES

### ACES Instructor Toolkit

[http://www.nln.org/docs/default-source/professional-development-programs/toolkit\\_monologue.pdf?sfvrsn=2](http://www.nln.org/docs/default-source/professional-development-programs/toolkit_monologue.pdf?sfvrsn=2)

### Therapeutic Communication

Students should be prepared with information on therapeutic communication. Have students review relevant material. You can use materials already in your curriculum, or use the suggested resource below:

- Potter and Perry 9th Edition Fundamentals of Nursing, pgs. 327-333 (therapeutic, non therapeutic examples).

Other resources (not specifically on therapeutic communication, but does set the stage for discussions about how to communicate and empathy. You could potentially use these as part of a pre-brief or have students view on their own.)

- Brene Brown on Empathy: <https://www.youtube.com/watch?t=17&v=1Evwgu369Jw>
- Cleveland Clinic Empathy: [https://www.youtube.com/watch?v=cDDWvj\\_q-o8](https://www.youtube.com/watch?v=cDDWvj_q-o8)
- Cleveland Clinic Vulnerability: <https://www.youtube.com/watch?v=1e1JxPCDme4>
- Student Tip Sheets: Communication and Interviewing (see following pages)

### Home Safety Assessment

- AARP Home Safety Checklist: [http://assets.aarp.org/external\\_sites/caregiving/checklists/checklist\\_homeSafety.html](http://assets.aarp.org/external_sites/caregiving/checklists/checklist_homeSafety.html)
- AARP Home Fit Guide: <http://www.aarp.org/livable-communities/info-2014/aarp-home-fit-guide-aging-in-place.html>
- CDC STEADI Fall Risk Checklist and Related Materials: <https://www.cdc.gov/steady/materials.html>

### Healthy Aging Powerpoint PDF

- <https://uwmadison.box.com/s/ej1sjqso9fb617pdbybnexk10saibr9>

### Age-Related Changes Documents and Article

- Age Related Changes Overview: <https://consultgeri.org/geriatric-topics/age-related-changes>
- Smith, C. M. & Cotter, V. T. (2016). Age Related changes in Health. In M. Boltz, E. Capezuti, T. Fulmer, & D. Zwicker (Eds.), Evidenced-Based Geriatric Nursing Protocols for Best Practice (5th ed.). New York: Springer.
- Delirium Decision Tree: <http://www.viha.ca/NR/rdonlyres/32A3D367-6868-4A91-9898-2B13FA32EB37/0/deliriumdecisiontree.pdf>

### Simulation Tools

- Arthritis Gloves: <http://hseb.gtri.gatech.edu/gloves.php>
- Vision Impairment Goggles: <https://www.lowvisionsimulators.com/product/full-set>
- Geri-Manikin: Several companies offer the Geri-Manikin for purchase. Be aware there are 4 versions of the Geri-Manikin (Basic, Complete, Advanced, and Complete plus heart and lung). Prices range from \$1,300-\$4,200.

## LEARNER HIGHLIGHTS

- “I feel like [this simulation] puts you more in an environment where a patient feels more comfortable. Usually a hospital setting, they’re in your environment, but in this situation where they’re in their environment, so it’s just kind of like a role reversal. [We have to] get more comfortable with them being in their personal space and vice versa.”
- “If we didn’t get [the preparatory materials] I think I would have went in with more misconceptions, and not been looking for signs of like, depression because they’re maybe isolated, or would have a wrong idea of what this person might be like, because they’re elderly.”
- “This apartment [was nice]...If this was real, the houses would not have that nice of furniture and normal smells, so maybe that would be something to incorporate to make people a little more uncomfortable?”
- “I thought the eyewear [simulation goggles] was really an eye opener, with the vision impairments. For the gloves I know it’s obviously hard but I know the one thing I noticed is that they’re really bulky, so I couldn’t tell if I was having a hard time opening things because of the thickness of the gloves or because of the arthritis effect.”
- “I was very focused on asking open ended questions. In the end, that is the part I really struggled with. I think Millie felt open to talking due to our sense of calmness, but I did not do well at asking open ended questions. This is something I still really need to work on.”
- “My biggest takeaway was seeing how complex the situation of home health truly is. Seeing a person’s desire for independence, fear of change, and emotional attachment to a home complicated the nursing assessment, which made it more realistic. When I will be working with real patients, their health needs will also be operating within various personal, emotional, and financial forces which must be taken into consideration. These forces must also be fully integrated into the nursing diagnosis and care plan, and this simulation helped us practice that art.”
- “I think that the therapeutic communication simulation we had in another class before was essential to this home health exercise. I might have ten ideas about how Millie could improve her home safety or quality of life, but her motivation for those changes has to come from within.”
- “I enjoyed working with another student for this experience. For a first time interviewing someone, it was nice to have a fellow classmate there. It not only gave support but also helped continue and direct conversation when necessary.”
- “I felt very nervous beforehand, but confident and prepared once the actual conversation began. I enjoyed practicing therapeutic communication with our assessment skills, and seeing how our knowledge from the reading or class applied in a more hands-on setting.”

## INSTRUCTOR TIPS

- We first piloted this using a geri-manikin and real person speaking into the room from an observation booth (we have an apartment built for simulation with wired sound throughout). The second time, we used standardized patients. Students were much more impacted by the standardized patients.
- Learners thought it would be helpful to have some information on arthritis prior to using the simulation gloves.
- Learners thought it was important to have practice with therapeutic communication prior to this simulation.
- Learners preferred to be able to perform home assessment prior to the interview as it often further focused their interview questions. If time allows, we would recommend student home assessment prior to interview.

## SCENARIO 2

### Millie is Hospitalized

**Summary:** Millie is experiencing dyspnea, cough, and fever. Her daughter, Dina, brought her to the emergency room.

**Learner Level:** First year nursing students, later in semester. Suggest second semester.

**Goal:** To improve nursing students' ability to identify changes in condition, communicate effectively and formulate a plan of care that promotes safety and person-centered care.

**Course suggestion:** Medical Surgical Nursing

#### Documents:

- Instructor Overview
- Materials and Scene Preparation
- Stations and Activities
- Photos
- Learner Handout
- Provider Orders
- Patient Labs
- Resources
- Learner Highlights and Feedback
- Instructor Tips

#### **Meets the AACN *Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults:***

- Recognize and respect the variations of care, the increased complexity, and the increased use of healthcare resources inherent in caring for older adults (corresponds to Essentials IV and IX).
- Implement and monitor strategies to prevent risk and promote quality and safety (e.g. falls, medication mismanagement, pressure ulcers) in the care of older adults with physical and cognitive needs (corresponds to Essentials II and IV).
- Recognize the complex interaction of acute and chronic co –morbid physical and mental conditions and associated treatments common to older adults (corresponds to Essential IX).

## INSTRUCTOR OVERVIEW

|  |                            |            |            |
|--|----------------------------|------------|------------|
| <b>Case Name:</b> Millie Larsen Acute care | <b>"Patient" Name/DOB:</b> | <b>Ht.</b> | <b>Wt.</b> |
| <b>Location:</b> Medical/Surgical Unit     | Millie Larsen 01/23/1927   | 5'3"       | 115 lbs    |

**Pre-simulation Requirements for the Learners:**

- Review respiratory and neurological content- specifically pneumonia and delirium
- Review Power Point: *Acute Care Management in the Older Adult*
- Review *Delirium Decision Tree* handout

**Goal of the Simulation:**

Familiarize students with the care of an acuity ill older adult with a respiratory and neurological changes.

**Learner Outcomes:**

1. Perform an assessment and be able to identify changes in patient condition.
2. Begin to identify age-specific nursing care related to the patient condition.
3. Identify nursing interventions for an acute care older adult patient and formulate a plan of care to promote safety.
4. Evaluate the patient response to nursing interventions and their effectiveness.
5. Communicate therapeutically with patient and 'visitor'.
6. Use the SBAR format to communicate with the provider.

**Pre-brief (Student-Instructor Discussion)**

Orientation to simulation lab.

**Evaluation of Outcomes:**

1. a) Students will perform a focused patient assessment.  
b) Students will identify a change in patient condition, specifically shortness of breath and altered mental status.
2. Students will discuss risk factors for delirium in the hospitalized older adult.
3. Students will identify safety considerations for the hospitalized older adult and utilize the CAM assessment tool to assess delirium.
4. Students will evaluate nursing interventions, specifically following administration of medications and after a change in patient condition.
5. Students will incorporate therapeutic communication and utilize SBAR format with the provider.

**History of Present Illness:**

Millie Larsen is a 90-year-old female with an 8-year history of osteoporosis and a 15-year history of hypertension. She is admitted through the Emergency Department with moderate respiratory distress, with a productive cough and a fever. Her chest x-ray is indicative of pneumonia. She has been admitted to your medical unit for IV antibiotic therapy and further testing.

*Vital signs in ED are: BP 148/82, P 106, RR 28, O2 Sat 90%, T 38.4 (101.2 °F).*

**Past Medical/Surgical History:**

Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, atrial fibrillation; cholecystectomy at age 30

**Social History:**

Lives at home alone and is independent. Daughter, Dina, involved.

**Current Medications**

Cefepime 1 g IV q 8 hours, Albuterol 180mcg (2 puffs) every 4-6hr PRN, Hydrochlorothiazide 25mg daily, Methylprednisolone 80mg IVP once, Carvedilol 3.125mg twice a day, Tylenol 650mg for mild pain or fever, Warfarin 5mg daily

**Allergies**

No known allergies

**Debrief Questions**

These questions are only a guide for debrief. Please feel free to individualize your debrief sessions based on the group and the events in the simulation.

**Debrief Questions for Scene 1**

- Thoughts about the scene?
- Observer comments?
- What are the main concerns for this patient?
- What are risk factors for older adult patients to develop pneumonia?
  - Elderly, history of recent hospitalizations, loss of appetite, emphysema, decreased activity, dehydration
- Discuss CAM Tool scoring. What did the observers score vs in room nurses? How did you perform scoring? Discuss clinical judgment in scoring tools- variance among practitioners?

**Debrief Questions for Scene 2**

- Thoughts about the scene?
- Observer comments?
- Discuss CAM Tool scoring. What did the observers score vs in room nurses?
  - What does the change in score mean? Improving?
- What are your priorities for her safety?
- Discuss what are her risk factors for developing delirium?
  - Fever in elderly, Medications- benzos, pneumonia infection, disrupt sleep/wake cycle, dehydration
- What are appropriate nursing interventions in delirium?
  - Use calm, consistent manner; assess unmet needs (pain, hunger, thirst, bowel/bladder); assess environment- noise, light, temperature

**Debrief Questions for Scene 3 + Overall Simulation**

- Thoughts about the scene?
- Observer comments?
- What was the main issue or concern for this scene?
- How would the plan of care change for an older adult, >65 than for an adult less than 65?
  - Functional assessment- mobility, transfers, balance, fall risk?
  - Impaired renal and hepatic function: pay close attention to drug dosages and drug interactions, fluid status.
  - Prevention of recurring Pneumonia: pneumococcal vaccinations, if a smoker = smoking cessation (tobacco smoking increases the risk of pneumonia), education.
  - Nutrition and Hydration needs: ability for patient to eat and drink adequate amounts.
  - Poly pharmacy.

## MATERIALS AND SCENE PREPARATION

### Scenes 1-3

Hospital room with hi-fidelity simulation Manikin moulded as older woman. Nurse's station with phone. Have a provider "on call."

#### Scene 1 Set Up:

- Head of bed flat
- Manikin settings:
  - Vocal setting; "Hard to breathe." Can you help me get out of this bed?"
  - Confused: location: hotel; states incorrect date and time, disorganized thoughts, rambling, unable to focus
  - Not hungry; just wants to take a nap and not be disturbed; denies pain
  - BP: 140/92
  - HR: 116
  - Rhythm: sinus
  - RR: 32
  - SpO2: 87% on 1LNC to 92% on 2L
  - Temp: 39.2C (101.2F)
  - Lungs Sounds: coarse bilaterally, cough
  - Heart Sounds: S1S2
  - Mental Status: A&O to self only

#### Scene 2 Set up:

- Mental Status: drowsy, oriented to person; disoriented to place, time. Thinks she is at Dina's house.
- Manikin settings
  - Vocal settings: Mildly confused, but improved. Easily distracted- "Who are you? What time is it?"  
Can do on repeat...
- BP: 142/88
- HR: 90s
- Rhythm: sinus tachycardia
- RR: 26
- SpO2: 93% on 2L
- Temp: 38.2 C (100.7F)
- Lungs Sounds: coarse crackles
- Heart Sounds: S1S2
- Mental status: confused- A&O x2 (unknown date/time)

**Scene 3 set up:**

- Mental Status: A&O x4
- Patient resting
- Manikin settings
  - Vocal Responses: occasional cough
  - BP: 142/88
  - HR: 74
  - Rhythm: sinus
  - RR: 22
  - SpO<sub>2</sub>: 91% on 2L
  - Temp: 37C
  - Lungs Sounds: diminished
  - Heart Sounds: S1S2

## STATIONS AND ACTIVITIES

### Scene 1: Today

Nurses will perform an assessment on Millie and communicate with visitor in room. The students should notice patient is confused, febrile, and has lower oxygen sats. Students should call the Provider and give Tylenol. Nurses will also perform CAM assessment and obtain score.

**Suggested learner configuration:** 2 nurses, 1 visitor, 1 observer

#### Expected Student Outcomes:

- Complete patient assessment.
- Identify cause of low spO<sub>2</sub>, adjust oxygen and raise head of bed.
- Use the SBAR format to communicate with the provider.
- Safely administer Tylenol.
- Perform CAM assessment and obtain score.

#### **Provider gives the following orders:**

(Ask for complete assessment data if not provided)

- Please give 650 mg Tylenol PO now and Q6 hrs PRN (already ordered)
- Let's start the CAM tool to assess her confusion. Monitor CAM score every 4 hours to rule out changes.

#### **Report (Instructor script):**

Millie Larsen is a 90-year-old female with an 8-year history of osteoporosis and a 15-year history of hypertension.

She is admitted through the Emergency Department with moderate respiratory distress, with a productive cough and a fever. Her chest x-ray is indicative of pneumonia. She has been admitted to the medical unit for IV antibiotic therapy and some further testing.

*Vital signs are:* BP 148/82, P 106, RR 28, O<sub>2</sub> Sat 90% on 2L, T 38.4 (101.2°F).

Her daughter shared she is normally alert and oriented at home, but now she is confused. She is alert only to herself. Lungs are coarse crackles bilaterally; abdomen is soft with bowel sounds present. Voids clear, amber urine. Voided 200mLs over the last 8 hours. She is on oxygen 1L per nasal cannula with goal of saturations to be 90 or greater. She has an IV of D5/0.45% NS at 75 ml/hr. She recently received her Albuterol inhaler. Millie's friend comes to visit while you are in the room.

#### CAM Tool Answers

1. Acute Onset: Yes (change MS from baseline) = 1
2. Inattention:
  - a) Did pt have difficulty focusing attention? Yes, mild form = 1
  - b) Did behavior fluctuate during assessment? No
3. Disorganized thinking: Yes, unpredictable/rambling thoughts = 1
4. Altered LOC: No, she is alert = 0

**CAM score 3 = Delirium suggested**

**Visitor Script (friend of patient):**

“Is Millie Ok?”

“She seems a little confused to me. Why is she being like that?”

**As nurses complete CAM tool, ask:**

“What are you scoring?”

“What does her score mean?”

\*\*You will ask 2 additional questions of your choosing:

If this was your friend, what questions would you ask? What concerns do you have? What would you want to know?

Debrief 10 minutes.

**Scene 2: 4 hours later.**

Mental status slightly improved. Millie mildly confused. Administration of Methylprednisolone 80mg IV. Nurses will reassess CAM score and give scheduled methylprednisone. Evaluate O2.

**Suggested learner configuration:** 2 nurses, 1 visitor, 1 observer

Expected Student Outcomes:

- Focused patient assessment
- Reassess CAM score
- Evaluates effectiveness of intervention – (recheck O2 level and neuro status)
- Safely administer methylprednisone IVP

**Report (Instructor Script):**

It's 4 hrs later. Millie continues to be intermittently confused, (A &O x2) couldn't say date and time. Her temp was 39.2 and the MD was notified. She was given 650 mg of Tylenol. She has had a poor appetite and only ate 50% of her meal this morning, and hasn't been drinking at all. Her last vitals were: BP 168/92, HR 116, ST, RR 32, pulse ox 91% on 2L oxygen. Respiratory just gave her a nebulizer treatment. There is a visitor in the room. She needs another CAM score and is due for methylprednisone 80 mg IVP now. Her friend comes to visit while you are in the room.

\*If students call Provider with improved CAM score: “Ok, let's continue to check the CAM every 4 hours until tomorrow. I'm glad to hear she is less confused.”

CAM Tool:

1. Acute Onset: Yes (change MS from baseline) = 1
2. Inattention:
  - a) Did pt have difficulty focusing attention? Yes, mild form = 1
  - b) Did behavior fluctuate during assessment? No
3. Disorganized thinking: No = 0
4. Altered LOC: No, she is alert = 0

**CAM score 2= Negative for delirium**

**\*(Need 1+2+3 or 4 for delirium)**

**Visitor Script (friend of patient):**

“I am worried that Millie is not making sense.”  
 “Is her pneumonia getting better?”

**While nurses give methylprednisone:**

“Is that medicine going to help with her confusion?”

\*\*You will ask 2 additional questions of your choosing:

If this was your friend, what questions would you ask? What concerns do you have? What would you want to know?

Debrief 10 minutes

**Scene 3: Two days later**

**Suggested learner configuration:** 2 nurses, 1 visitor, 1 observer

Provider puts in discharge home with home oxygen orders for today.

Expected Student Outcomes:

- Focused patient assessment, safety assessment of home
- Assess support system- grand-daughter/son visiting
- Begin to provide patient education- home oxygen

**Report (Instructor Script):**

2 days later, her mental status has improved. Millie is eager to talk about her flower gardens. Nursing and RT have been trying to wean Millie off her oxygen. She denies SOB at rest, however when ambulating in halls on RA SpO2 desats to 86%. She remains on 2LNC continuously with O2 sats 91-92%. Millie is ready to be discharged home with home oxygen. She requires teaching about safety concerns and assessment of her support system at home. The Case Manager has been working closely with Millie and daughter Dina to set up home oxygen through a home health agency. Dina, Millie’s daughter, could not get away from work today; her granddaughter is visiting.

**Visitor Script (grandchild of patient):**

You like to help out your Grandmother when you can, but you have a busy schedule, being in college and working at a local restaurant. You live nearby but can only check on Millie once every couple weeks. Your Mom, Dina is a bit better...she lives close and is Millie’s main support.

“My mom asked me to be here today to take Grandma home...I heard she has to go home with a tank. What’s that for?”

After nurses explain oxygen tank needs, ask questions:

- “Grandma has some steps up to her house, how is she going to manage with that thing and keep her balance?”
- “You mean she has to use that all the time? “
- “What if she runs out of air?”

\*\*Ask 2 additional questions of your choosing: If this was your grandmother, what questions would you ask? What concerns do you have? What would you want to know?

**Debrief:** 30 minutes for scene 3 and overall simulation

## LEARNER HANDOUT

|   |                            |                |
|---|----------------------------|----------------|
| <b>Case Name:</b> Millie Larsen Acute care  | <b>"Patient" Name/DOB:</b> | <b>Ht. Wt.</b> |
| <b>Location:</b> Medical/Surgical Unit  | Millie Larsen 01/23/1927   | 5'3" 115 lbs   |
| <b>Pre-simulation Requirements for the Learners:</b> <ul style="list-style-type: none"> <li>• Review respiratory and neurological content- specifically pneumonia and delirium</li> <li>• Review Power Point: <i>Acute Care Management in the Older Adult</i></li> <li>• Review <i>Delirium Decision Tree</i> handout</li> </ul>  |                            |                |
| <b>Goal of the Simulation:</b><br>Familiarize students with the care of an acutely ill older adult with a respiratory and neurological changes.   |                            |                |
| <b>Learner Outcomes:</b> <ol style="list-style-type: none"> <li>1. Perform an assessment and be able to identify changes in patient condition.</li> <li>2. Begin to identify age specific nursing care related to the patient condition.</li> <li>3. Identify nursing interventions for an acute care older adult patient and formulate a plan of care to promote safety.</li> <li>4. Evaluate the patient response to nursing interventions and their effectiveness.</li> <li>5. Communicate therapeutically with patient and 'visitor'.</li> <li>6. Use the SBAR format to communicate with the provider.</li> </ol>  |                            |                |
| <b>Pre-brief (Student-Instructor Discussion)</b><br>Orientation to simulation lab.  |                            |                |
| <b>Evaluation of Outcomes:</b> <ol style="list-style-type: none"> <li>1. a) Students will perform a focused patient assessment.<br/>b) Students will identify a change in patient condition, specifically shortness of breath and altered mental status.</li> <li>2. Students will discuss risk factors for delirium in the hospitalized older adult.</li> <li>3. Students will identify safety considerations for the hospitalized older adult and utilize the CAM assessment tool to assess delirium.</li> <li>4. Students will evaluate nursing interventions, specifically following administration of medications and after a change in patient condition.</li> <li>5. Students will incorporate therapeutic communication and utilize SBAR format with the provider.</li> </ol> |                            |                |
| <b>History of Present Illness:</b><br>Millie Larsen is a 90-year-old female with an 8-year history of osteoporosis and a 15-year history of hypertension. She is admitted through the Emergency Department with moderate respiratory distress, with a productive cough and a fever. Her chest x-ray is indicative of pneumonia. She has been admitted to your medical unit for IV antibiotic therapy and further testing.<br><i>Vital signs in ED are: BP 148/82, P 106, RR 28, O2 Sat 90%, T 38.4 (101.2 °F).</i>  |                            |                |
| <b>Past Medical/Surgical History:</b><br>Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, atrial fibrillation; cholecystectomy at age 30  |                            |                |
| <b>Social History:</b><br>Lives at home alone and is independent. Daughter, Dina, involved.   |                            |                |
| <b>Current Medications</b><br>Cefepime 1 g IV q 8 hours, Albuterol 180mcg (2 puffs) every 4-6hr PRN, Hydrochlorothiazide 25mg daily, Methylprednisolone 80mg IVP once, Carvedilol 3.125mg twice a day, Tylenol 650mg for mild pain or fever, Warfarin 5mg daily   |                            |                |
| <b>Allergies</b><br>No known allergies  |                            |                |

## PROVIDER ORDERS

| Provider Orders   | Frequency     | Indication                 | Status   |
|---|---------------|----------------------------|----------|
| Vital Signs   | Every 4 hours | Monitoring                 | Active   |
| Diet: Regular diet with no added salt   | Each meal     | Nutrition                  | Active   |
| Activity: ambulate with assist  | 4X day        | DVT prevention             | Active   |
| Intake and Output   | Every 8 hours | Monitoring                 |          |
| Peak flow measurements  | Daily         | Monitoring                 | Active   |
| Consults: Diet, PT, OT, SW, Pulmonary   | Once          | Plan of Care               | Active   |
| Perform CAM tool scoring every 4 hours. Notify Provider if presence of delirium=feature 1: acute onset and fluctuating course +2: inattention+either 3: disorganized thinking or 4: altered level of consciousness. Notify Provider with changes. | Ongoing       | Monitoring                 | Active   |
| Labs: CBC, Chem Panel   | Daily         | Monitoring                 | Active   |
| PFTs  | Once          | Monitoring                 | Complete |
| Oxyben 1-2L per nasal cannula to keep sats > 90%  | Ongoing       | Oxygenation                | Active   |
| Call Provider: SBP<90 or >180; HR<60 >100; RR<10 >20; P.O. <88% Temp >38.4; Urine output <30mLs per hour  | Ongoing       | Monitoring                 | Active   |
| Medications   | Frequency     | Indication                 | Status   |
| Hydrochlorothiazide 25mg orally   | Daily         | Hypertension               | Active   |
| Methylprednisolone 80mg IVP   | Daily         | Pneumonia                  | Active   |
| Carvedilol 3.125mg orally   | Twice daily   | Hypertension               | Active   |
| Acetaminophen 650mg orally  | 4-6 hours PRN | Fever                      | Active   |
| Albuterol 180mcg (2 puffs)  | 4-6 hours PRN | Wheezing                   | Active   |
| Cefepime 1g IV antibiotic   | Every 8 hours | Pneumonia                  | Active   |
| Warfarin 5mg orally   | Daily         | Atrial fibrillation        | Active   |
| D5 .45NS IV at 75mLs/hr   | Ongoing       | Hydration and electrolytes | Active   |

## LAB RESULTS

| Chemistry Panel | Result | Normal Range   |
|-----------------|--------|----------------|
| Sodium          | 146    | 135-145 meq/L  |
| Potassium       | 3.6    | 3.5-4.5 meq/L  |
| Calcium         | 9.4    | 8.5-10.5 meq/L |
| Magnesium       | 2.0    | 1.5-2.0 mg/dL  |
| Phosphorus      | 2.6    | 2.4-2.7 mg/dL  |
| Chloride        | 100    | 95-105 meq/L   |
| BUN             | 20     | 6-20 mg/dL     |
| Creatinine      | 1.0    | 0.5-1.0 mg/dL  |
| GFR             | 102    | >100 mL/min    |

| Medication Orders: Meds that will be given during the simulation |                        |           |         |
|--|------------------------|-----------|---------|
| Medication Name  | Form (pill, vial, ...) | Frequency | Scene   |
| Acetaminophen 650 mg   | PO                     | once      | Scene 1 |
| Methylprednisolone 80mg/4mLs                                     | IVP syringe            | once      | Scene 2 |

| Diagnostic Tests: Labs, radiology, ...)          | Results                                 | Indication             |
|--|---|------------------------|
| Chest xray in ED                                 | Right middle and lower lobe infiltrates | Pneumonia              |
| Sputum gram stain, culture and sensitivity, sent | pending                                 | Identify microorganism |

## RESOURCES

### Handouts/References

- Delirium Decision Tree  
<http://www.viha.ca/NR/rdonlyres/32A3D367-6868-4A91-9898-2B13FA32EB37/0/deliriumdecisiontree.pdf>
- Yoshikawa, T. T. & Marrie, T. (May 2000). Community-Acquired Pneumonia in the Elderly. Special Section: Aging and Infectious Diseases, Clinical Infectious Diseases. Vol. 31, pp. 1066-78.  
<http://cid.oxfordjournals.org/content/31/4/1066.short>

### Acute Care of the Older Adult Narrated Powerpoint

- <https://vimeo.com/179907494>

## LEARNER HIGHLIGHTS

“...Glad we did this because I don’t want to say it’s overlooked per say, but I think it’s one of those things that’s a lot more prevalent as you know, dealing with the more behavioral aspect and psychological aspect of patient care.”

“It was good to address [what we learned in the classroom] here, like self-efficacy and the willingness to do and follow up with the patient education that we give them. So if we’re not assessing their behavioral status, their mental status, we’re not going to know if they’ll be back in a week or if it’s something that’s going to be taken care of.”

“If I [hadn’t used the Powerpoint and article] then I would have seen the patient like, start getting confused and like, kinda started to freak out...I don’t think I would have been very prepared, to be like proactive.”

“I was an underlying thing where, you see the delirium and you go, okay, now what could be causing it, and that is tied into the respiratory distress. If we wouldn’t have been prepared with the materials, we wouldn’t have made that connection very quickly.”

“The Powerpoint and article were good, but rather than just like stating facts you could like give like case studies or something, and that would have helped. Something more circumstantial... it just makes it much easier for me to tie them together with context.”

“I felt like there could have been more in the EMR. There wasn’t a lot of information. In order to like, cough and deep breathe, like the standard is every two hours but like nowhere in the EMR did it say that it should be two hours, so I just kinda guessed two hours.”

## INSTRUCTOR TIPS

If using two groups (e.g., scene 1 group then observes scene 2 group), student observers from group 1 can also complete CAM tool during scene 2.

## SCENARIO 3

### Millie needs Home Health Assistance

**Summary:** Millie meets with a nurse and occupational therapist in her home after a fall. Nursing follows up on safety, nutrition and stage 1 pressure ulcer. Occupational Therapy follows up on safety.

**Learner Level:** Second year nursing students and second year occupational therapy students

**Goals:** To improve occupational therapy and nursing students' competence in management of the needs of an aging clientele, specifically focusing on the transition of care and client safety at home. To improve knowledge of professional and interprofessional roles in a community health setting.

**Course suggestions:** Community health course

#### Documents:

- Instructor Overview
- Materials and Scene Preparation
- Stations and Activities
- Millie's Introductory Monologue
- Learner Overview
- Millie and Dina Scripts
- STOPP/START medication review answers
- Resources
- Learner Highlights
- Instructor Tips

#### ***Meets the AACN Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults:***

- Assess barriers for older adults in receiving, understanding, and giving of information (corresponding to Essentials IV & IX).
- Assess the living environment as it relates to functional, cognitive, psychological, and social needs of older adults (corresponding to Essential IX).
- Integrate leadership and communication techniques that foster discussion and reflection on the extent to which diversity (among nurses, nurse assistive personnel, therapists, physicians, and patients) has the potential to impact care of older adults (corresponding to Essential VI).
- Use valid and reliable assessment tools to guide nursing practice for older adults (corresponding to Essentials IX).

## INSTRUCTOR OVERVIEW

|  |  |                                 |
|--|--|---------------------------------|
| <b>Case Name:</b><br>Millie Larsen Interdisciplinary Home Visit  | <b>“Patient” Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>5’3” 115 lbs. |
| <b>Location:</b> Millie’s home   |  |                                 |
| <b>Goals of the Simulation</b>   |  |                                 |
| <ul style="list-style-type: none"> <li>• To improve occupational therapy and nursing students’ competence in management of the needs of an aging clientele, specifically focusing on the transition of care and client safety at home.</li> <li>• To improve knowledge of professional and interprofessional roles in a community health setting.</li> </ul>   |  |                                 |
| <b>Learner Objectives:</b>   |  |                                 |
| <ol style="list-style-type: none"> <li>1. Demonstrate the ability to develop, implement, and evaluate a plan for addressing identified needs of an older adult at home.</li> <li>2. Demonstrate socialization into the role of becoming an entry-level professional occupational therapist or nurse, respectively, in a community health setting and as a member of the community health team.</li> <li>3. Demonstrate written and verbal communication skills with individuals and groups appropriate to the role of becoming a professional occupational therapist or nurse, respectively.</li> <li>4. Develop confidence while working collaboratively in an interprofessional setting.</li> <li>5. Identify safety considerations in the care of older adults aging in place.</li> </ol>   |  |                                 |
| <b>Pre-simulation Requirements for the Learners</b>  |  |                                 |
| <ul style="list-style-type: none"> <li>• Read <i>Millie Intro Monologue, Learner Overview</i> and any other instructor provided handouts</li> <li>• Review assessments prior to simulation with group members</li> </ul>   |  |                                 |
| <b>Pre-brief (Student-Instructor Discussion)</b>   |  |                                 |
| <ul style="list-style-type: none"> <li>• 5 mins: Introduce student interdisciplinary groups (RN/OT). Allow student time to organize plan for simulation.</li> <li>• 5 mins: Orient students to home environment, manikin capabilities (if applicable, able to assess skin, turn).</li> </ul>   |  |                                 |
| <b>Evaluation of Outcomes</b>  |  |                                 |
| <p><b>History of Present Illness</b></p> <p>Millie Larsen is an 89 yr old female previously seen by home health nursing staff 1 month ago. Nursing concerns include safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Provider notified of concerns. Millie and daughter, Dina, educated about ways to promote home safety: decrease clutter, use non-skid rugs, improve lighting, organize medications pills in pill box, and address fire hazards- remove miscellaneous cords under rugs. Millie was encouraged to reposition frequently and Dina educated about pressure ulcer and ways to manage at home. She has had a couple falls at home recently.</p> <p>Home health RN to follow-up, OT consult made for initial home assessment. Visit being made to Millie’s home to interview Millie and assess her home addressing safety, specifically her medications and fall risk assessment. Students will also assess her nutrition and skin integrity.</p> |  |                                 |

**Past Medical/Surgical History**

Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib, UTI, stage I pressure ulcer, CHF  
Cholecystectomy at age 30

**Social History**

Lives at home independently. Daughter, Dina lives nearby and is her primary support system. Millie insists on not needing help at home - "I've got Snuggles and that's all I need". Daughter Dina is concerned about the safety of Millie's home environment and her recent fall.

**Current Medications**

Metoprolol 100mg every day, Warfarin 5mg daily, Furosemide 40mg twice a day- Tylenol 325mg as needed for pain, Captopril 25 mg po three times a day, Lipitor 50 mg once daily, Pilocarpine eye drops two drops each eye four times a day, Tramadol 50 mg. po every 4-6 hours for arthritis pain prn

**Allergies**

No known allergies

**Provider Orders**

Home health to follow

Occupational Therapy referral: recent fall, home safety eval

Low sodium diet

captopril 25 mg po three times a day

metoprolol 100 mg every day

furosemide 40 mg po twice per day

Lipitor 50 mg once daily for coronary artery disease

pilocarpine eye drops two drops each eye four times a day

For mild pain: Tylenol 325mg po PRN

Warfarin 5mg po daily for chronic A.Fib

For moderate- severe pain: Tramadol 50 mg. po every 4-6 hours PRN for arthritis pain

Dr. Eric Lund

**Debrief Questions (20 min)**

1. Now that you have seen Millie and assessed her environment, take 1-2 minutes to write down your top priorities, from the RN or OT perspective.
  - Ask for students to share their priorities
2. How might the care for Millie as an older adult be different than a younger client? What specific concerns do have related to her aging? Are there similarities for older and younger clients? Differences?
3. Do you think it's important to be paired (OT and RN) for your assessment? Or do you think you could have gathered the same information independently?
4. How can we encourage collaboration between these disciplines?
5. Say you were working with another profession and there was a conflict in opinions. How would you maintain professionalism regardless of differing opinions?
6. What will you take away from this experience?

Following the simulation, students to submit a reflection journal within 24 hours.

## MATERIALS AND SCENE PREPARATION

### Station 1: nutrition and medication assessment interviews

Millie's bedroom at home with Millie present.

- Millie: GeriManikin or actor in apartment bedroom
  - Wearing nightgown
  - Wearing incontinence briefs
- Millie's script
- Dina: Facilitator (e.g., instructor) to play "Dina," Millie's daughter.
- Dina's script

#### Students should have:

- STEADI Tool (see resources page)
- STOPP/START Tool (see resources page)

### Station 2: home safety assessment

Millie's living room, bathroom and entryway at home (no manikin/actor present)

- Simulated dog barking and walking around on floor as a distraction and safety consideration (e.g., <https://www.amazon.com/FurReal-Friends-Get-GoGo-Walkin/dp/B00ILDJXGK>)
- Rug with corner turned up in living room
- Pot holders on stove with burn mark
- Dirty dishes in sink
- Medication bottles throughout house in disarray/spilled
- Dim lighting

#### Students should have:

- "Occupational Therapy Home Evaluation" form (see Learner Handout)
- Home Fall Prevention checklist (e.g., Minnesota Safety Council )
- STEADI Fall Risk Assessment (see resources page)

### Station 3: fall risk assessment

Millie's living room

- GeriManikin or actor in nightgown in apartment bedroom (student can play the part of Millie)
- Millie Station 3 Interview Script

#### Students should have:

- Timed Get up and Go Test Instructions (see resources page)
- Home fall prevention checklist (e.g., Minnesota Safety Council )
- STEADI Fall Risk Assessment (see resources page)

**Station 4: nutrition assessment**

**Millie's kitchen**

- Highly processed food on counters/in cabinets/in fridge (no fresh fruits/vegetables)
- Expired food
- Moldy food
- Burnt oven mitt
- Oven left on unattended
- Chair leans against counter simulates client's use of chair as step stool

Students should have:

- Home fall prevention checklist (e.g., Minnesota Safety Council )

## STATIONS AND ACTIVITIES

### Station 1: Bedroom

Nursing and OT collaborate on interview. Nursing leads med reconciliation and nutrition assessment with Millie (Standardized patient or Geri-manikin who will be lying in bed). OT leads COPM (Canadian Occupational Performance Measure) interview.

Duration: 15 minutes

Suggested learner configuration: 2 Nursing, 2 OT

Activities: Learners start by knocking on door. Dina answers and tells them Millie is in the bedroom. Learners will communicate with Millie – asking questions about her medications, nutrition, and skin integrity. Learners will use the following during interview:

- Nutrition assessment: **DETERMINE Tool** (see resources page)
- Medication assessment: **STOPP/START Criteria**
- Client self-perception of occupational performance: **Canadian Occupational Performance Measure**

\*See Dina Station 1 Script

\*See Millie Station 1 Interview Script

Expected Student Outcomes:

1. Utilize therapeutic communication and COPM interview style with client.
2. Maintain professionalism in the home setting.
3. Perform focused assessment – notice older adult changes in skin, musculature.
4. Identify pressure ulcer on sacrum, redness under breast.
5. Complete nutrition, medication assessment.
6. Identify safety concerns.

### Station 2: Entire apartment

Occupational therapy leads home safety assessment

Duration: 15 minutes

Suggested learner configuration: 2 OT, 2 Nursing

Activities: OT leads home safety assessment using “**Occupational Therapy Home Evaluation**” form

Fill out the following:

Comments/ Problems – In this area please list any safety or accessibility concerns. It is often helpful to provide drawings/ diagrams of problem areas.

1. Recommendations – In this area please list recommendations to remedy the safety or accessibility problems. If you need more space than is provided please attached a typed, double-spaced report. It is often helpful to provide drawings/ diagrams of proposed changes.
2. Equipment Needs – Please list any equipment needs for patient safety, independence, or ease of ADL performance. (This is often helpful in justification of equipment for third party payers.) Write a letter of medical necessity (LMN) for all equipment for third party payer.

Expected Student Outcomes:

1. Students will assess room safety and identify potential hazards (fall risk, fire).
2. Complete “Home Evaluation” form which provides a comprehensive assessment of the environment.

**Station 3: Living room**

Learners complete fall risk assessment

Duration: 15 minutes

Suggested learner configuration: 2 OT, 2 Nursing

Activities: Select one group member to role-play “Millie”, the client. Have the client complete the “Get-up and Go” test (nursing takes the lead). Practice functional transfers and mobility (OT takes the lead). Complete fall risk assessments: **STEADI** “Stay Independent” fall risk assessment and **another fall risk tool of choice, for example the Minnesota Safety Council checklist** in “resources” section (OT takes the lead). Do not complete the “kitchen” section until station 4.

\*See Millie Station 3 Interview Script

Expected Student Outcomes:

1. Students will assess fall risk and safety considerations
2. Score Millie’s fall risk and compare findings using different assessment tool

**Station 4: Kitchen**

Students complete visual assessment of Millie’s nutrition sources

Duration: 15 minutes

Suggested learner configuration: 2 Nursing, 2 OT

Activities: Select one group member to role-play “Millie”, the client. Have the client address questions in a fall risk assessment (e.g., **Minnesota Safety Council checklist**) related to the kitchen. Students will look into refrigerator/cabinets- see highly processed food, expired, moldy. Consider community resources, dietary consult.

\*See Millie Station 4 Interview Script

Expected Student Outcomes:

1. Students will assess and evaluate nutrition status.
2. Students will assess safety considerations.
3. Students will prepare dialogue with a provider or dietary consult using SBAR.
4. Students will begin to identify community resources to promote adequate nutrition.

## ROTATION SUGGESTION

|               | <b>Station 1:<br/>Interview Millie</b> | <b>Station 2: Home<br/>Evaluation -<br/>entrance, bathrm,<br/>bedrm, living room</b> | <b>Station 3: Client<br/>Assessment and<br/>Falls/STEADI<br/>Assessment</b> | <b>Station 4: Home<br/>Evaluation -<br/>Kitchen</b> |
|---------------|--|--|---|---|
| 11:40 - 11:55 | Group 1                                | Group 2  | Group 3   | Group 4   |
| 11:55 -12:10  | Group 2                                | Group 3  | Group 4   | Group 1   |
| 12:10 - 12:25 | Group 3                                | Group 4  | Group 1   | Group 2   |
| 12:25 - 12:40 | Group 4                                | Group 1  | Group 2   | Group 3   |

## MEET MILLIE LARSEN



I'm Millie. I have lived in the same small house for the last 50 years. Harold and I raised our dear daughter Dina here and we had many good years together as a family. Harold passed last year – he was 91, you know – and I miss him terribly. I think about him every day. We were married for 68 years; most of them were happy. We did struggle with money at times, but who didn't? All of our family lived close by and I spent many a Sunday cooking for 15-20 after church. Our home was always full of people; many of them are gone now. Snuggles, my dog, keeps me company. Snuggles is about 10 years old; she is a stray who just showed up on my doorstep one day and she's been here ever since.

I've always kept myself busy, I used to sing when in the church choir and I volunteered in the church kitchen. I still love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I can't do as much as I used to, but that's ok. I am fortunate to have many close friends from church.

I also enjoy gardening and I am known for growing my prize roses. My rose garden is not quite as big as it used to be, but I still like to get outside and work with the soil and the flowers. Although, recently I haven't been out at much due to the cold. Did you know that my roses used to win blue ribbons at the county fair almost every year?

Since Harold is gone, I go over to my daughter Dina's house every week to visit and see my grandkids. Dina is a good cook, but her dumplings aren't quite as good as mine; I try to make a batch to take with me when I can. Dina works every day at the school so she is busy most of the time. She is a good daughter and helps me when I need to get to the doctor. She also picks up groceries for me once in awhile. I have three grandchildren. Jessica is 17 and graduates from high school this year. Daniel is 14 and is a handful! He can give his mother trouble about getting his homework done and I don't think his grades are very good. I know Dina worries about him. Megan is 12; she is such a sweet child. She likes to help me with my roses in the summer.

I am lucky that I can still get around pretty well and my house is not too big. Although recently some nurses came out and told me I wasn't moving enough and I had to clean more. I try to keep my house clean, thank you very much! Dina keeps checking my bottom for who knows what reason and keeps telling me to get out of my chair more. When Snuggles wants to cuddle, I have a hard time saying no! My knees are pretty bad; I think they are just worn out. They hurt a lot. My bladder isn't as good as it used to be. I really don't like a lot of people caring for me; I think I do pretty well for my age. Then the other night, I had to go to the bathroom and fell. Fortunately I could reach the phone and called Dina. Dina rushed over, called my doctor and now I hear I have to have more people visit me at home.

I hope all these hospital bills and home visits aren't too expensive, I already have to pay a lot for my medications and I don't get the pension anymore since Harold died. I don't know how Harold paid all the bills, it doesn't hardly seem like there's enough money for all that medicine.

Source: Adapted from ACES Cases: <http://www.nln.org/professional-development-programs/teaching-resources/aging/ace-s/unfolding-cases/millie-larsen>

## LEARNER OVERVIEW

|   |  |                                 |
|---|--|---------------------------------|
| <b>Case Name:</b> Millie Larsen Interdisciplinary Home Visit  | <b>“Patient” Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>5’3” 115 lbs. |
| <b>Location:</b> Millie’s home  |  |                                 |
| <b>Goals of the Simulation</b>  |  |                                 |
| <ul style="list-style-type: none"> <li>To improve occupational therapy and nursing students’ competence in management of the needs of an aging clientele, specifically focusing on the transition of care and client safety at home.</li> <li>To improve knowledge of professional and interprofessional roles in a community health setting.</li> </ul>  |  |                                 |
| <b>Learner Objectives:</b>  |  |                                 |
| <ol style="list-style-type: none"> <li>Demonstrate the ability to develop, implement, and evaluate a plan for addressing identified needs of an older adult at home.</li> <li>Demonstrate socialization into the role of becoming an entry-level professional occupational therapist or nurse, respectively in a community health setting and as a member of the community health team.</li> <li>Demonstrate written and verbal communication skills with individuals and groups appropriate to the role of becoming a professional occupational therapist or nurse, respectively.</li> <li>Develop confidence while working collaboratively in an interprofessional setting.</li> <li>Identify safety considerations in the care of older adults aging in place.</li> </ol>  |  |                                 |
| <b>Pre-simulation Requirements for the Learners</b>   |  |                                 |
| <ul style="list-style-type: none"> <li>Read Millie Intro Monologue, Learner Overview and any other instructor provided handouts</li> <li>Review assessments prior to simulation with group members</li> </ul>   |  |                                 |
| <b>History of Present Illness</b>   |  |                                 |
| <p>Millie Larsen is a 90 yr old female previously seen by home health nursing staff 1 month ago. Nursing concerns include safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Provider notified of concerns. Millie and daughter, Dina, educated about ways to promote home safety: decrease clutter, use non-skid rugs, improve lighting, organize medications pills in pill box, and address fire hazards – remove miscellaneous cords under rugs. Millie was encouraged to reposition frequently and Dina educated about pressure ulcer and ways to manage at home. She has had a couple falls at home recently.</p> <p>Home health RN to follow-up, OT consult made for initial home assessment. Visit being made to Millie’s home to interview Millie and assess her home addressing safety, specifically her medications and fall risk assessment. Students will also assess her nutrition and skin integrity.</p> |  |                                 |
| <b>Past Medical/Surgical History</b>  |  |                                 |
| <p>Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib, UTI, stage I pressure ulcer, CHF</p> <p>Cholecystectomy at age 30</p>  |  |                                 |
| <b>Social History</b>   |  |                                 |
| <p>Lives at home independently. Daughter, Dina, lives nearby and is her primary support system. Millie insists on not needing help at home – “I’ve got Snuggles and that’s all I need”. Dina is concerned about the safety of Millie’s home environment and her recent fall.</p>  |  |                                 |
| <b>Current Medications</b>  |  |                                 |
| <p>Metoprolol 100mg every day, Warfarin 5mg daily, Furosemide 40mg twice a day – Tylenol 325mg as needed for pain, Captopril 25 mg po three times a day, Lipitor 50 mg once daily, Pilocarpine eye drops two drops each eye four times a day, Tramadol 50 mg. po every 4-6 hours for arthritis pain prn</p>   |  |                                 |
| <b>Allergies</b>  |  |                                 |
| No known allergies  |  |                                 |

**PROVIDER ORDERS**

Home health to follow

Occupational Therapy referral: recent fall, home safety eval

Low sodium diet

captopril 25 mg three times a day

metoprolol 100 mg every day

furosemide 40 mg po twice per day

Lipitor 50 mg once daily for coronary artery disease

pilocarpine eye drops two drops each eye four times a day

For mild pain: Tylenol 325 mg po PRN

Warfarin 5 mg po daily for chronic Afib

For moderate-severe pain: Tramadol 50 mg po every 4-6 hours PRN for arthritis pain

Dr. Eric Lund

## OCCUPATIONAL THERAPY HOME EVALUATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Address: \_\_\_\_\_

Style of Home: \_\_\_\_\_

Details Provided by: \_\_\_\_\_

### ENTRANCES TO BUILDING OR HOME/PARKING

1. Location of Most Accessible Entrance (check one): \_\_\_ Front \_\_\_ Back \_\_\_ Side  
Comments:

2. Stairs:

a. Width of Stairway \_\_\_\_\_

b. Number of Steps \_\_\_\_\_ Height of Steps \_\_\_\_\_

c. Railing present as you go up: (R) \_\_\_\_\_ (L) \_\_\_\_\_ Both \_\_\_\_\_

d. Dimensions of Landing: Width \_\_\_\_\_ Length \_\_\_\_\_

3. Door:

a. Is a threshold present? \_\_\_\_\_ Height \_\_\_\_\_

b. Width of doorway \_\_\_\_\_

c. Direction of swing (in/out) \_\_\_\_\_ Springloaded? \_\_\_\_\_

d. Type of door handle \_\_\_\_\_

Comments/Problems:

Recommendations:

APPROACH TO APARTMENT OR LIVING AREA

1. Hallway

- a. Width \_\_\_\_\_ Length \_\_\_\_\_
- b. Obstructions \_\_\_\_\_
- c. Flooring \_\_\_\_\_

2. Steps

- a. Width of stairway \_\_\_\_\_
- b. Number of steps \_\_\_\_\_ Height of steps \_\_\_\_\_
- c. Railing present as you go up: (R) \_\_\_\_\_ (L) \_\_\_\_\_ Both \_\_\_\_\_

3. Door(s)

- a. Width of doorway \_\_\_\_\_
- b. Threshold height \_\_\_\_\_

4. Elevator present \_\_\_\_\_

Comments/Problems:

Recommendations:

BEDROOM:

- 1. Room dimensions: \_\_\_\_\_
- 2. Door width: \_\_\_\_\_ Obstructions: \_\_\_\_\_
- 3. Light switch height: \_\_\_\_\_
- 4. Bed height: \_\_\_\_\_ Size/type: \_\_\_\_\_
- 5. Flooring: \_\_\_\_\_

Comments/Problems:

Recommendations:

BATHROOM1. Dimensions:

2. Door width: \_\_\_\_\_ Obstructions: \_\_\_\_\_

3. Light switch height: \_\_\_\_\_

4. Toilet

a. Toilet dimensions &amp; style: \_\_\_\_\_

b. Tank dimensions: \_\_\_\_\_

c. Grab bars: \_\_\_\_\_

5. Bathtub:

a. Height of tub from floor to rim: \_\_\_\_\_

b. Width/length of inside of tub: \_\_\_\_\_

c. Is tub: \_\_\_\_\_ Built-in \_\_\_\_\_ On legs

d. Grab bars: \_\_\_\_\_

6. Flooring: \_\_\_\_\_

7. Vanity:Comments/Problems:Recommendations:

LIVING AREA

1. Hallway width: \_\_\_\_\_
2. Width of entrance: \_\_\_\_\_
3. Height of light switch: \_\_\_\_\_
4. Height of sofa: \_\_\_\_\_
5. Can furniture be arranged to allow maneuvering of w/c? \_\_\_\_\_
6. Flooring: \_\_\_\_\_

Comments/Problems:

Recommendations:

KITCHEN

1. Door width: \_\_\_\_\_
  2. Table height: \_\_\_\_\_
  3. Sink height: \_\_\_\_\_
  4. Stove/microwave access: \_\_\_\_\_
- Controls: \_\_\_\_\_ Front \_\_\_\_\_ Rear

Comments:

Recommendations:

Therapist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**HOME EVALUATION**

Appointment date? \_\_\_\_\_ Appointment time? \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Age of Homeowner(s) \_\_\_\_\_

Number in household \_\_\_\_\_

Will homeowner have family present during evaluation? \_\_\_\_\_

## Description of home:

Approximate year home built \_\_\_\_\_ How many levels? \_\_\_\_\_

Color \_\_\_\_\_

Address easily seen from road  Yes  NoDoes owner have a dog?  Yes  No

Name of volunteer(s) conducting evaluation? \_\_\_\_\_

## Pertinent physical or medical conditions:

Does anyone in your household have trouble walking?  Yes  NoDoes anyone in your household have visual problems?  Yes  NoDoes anyone in your household having hearing loss?  Yes  NoDoes anyone in your household have memory loss?  Yes  NoHas anyone in your household fallen in the past?  Yes  No

Special Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

| GENERAL  | OKAY | NEEDS WORK | PRIORITY RANKING | RECOMMENDATIONS<br>Note OT/PT Teams: Please provide a clearly written recommendation for each area needing work. Please write legibly. |
|--|------|------------|------------------|--|
| 1. Smoke detectors (working) on each level of the home?  |      |            |                  |  |
| 2. Are batteries changed twice a year?   |      |            |                  |  |
| 3. Working light within easy reach when entering each room?  |      |            |                  |  |
| 4. Stairs – free from clutter, adequate lighting, having two sturdy, easy-to-grip handrails fastened securely and running continuously from the top to the bottom of stairs? |      |            |                  |  |
| 5. Throw rugs away from landings?  |      |            |                  |  |
| 6. Outline of each step easy to see?   |      |            |                  |  |
| 7. Runners in good condition?  |      |            |                  |  |
| 8. Floors – carpets in good condition without ridges or tears?   |      |            |                  |  |
| 9. Tile floors free from broken or loose tiles?  |      |            |                  |  |
| 10. Has a qualified technician checked the furnace within the last 12 months? YES/NO   |      |            |                  |  |
| 11. Is furnace filter changed monthly? YES/NO  |      |            |                  |  |
| 12. Walkways free of clutter/tripping hazards?   |      |            |                  |  |
| 13. Furniture arrangement?   |      |            |                  |  |
| 14. Chairs in good repair & have armrests?   |      |            |                  |  |
| 15. Other: Emergency Exit Plan?  |      |            |                  |  |
| 16. Step stool?  |      |            |                  |  |
| 17. Door knobs?  |      |            |                  |  |
| 18. Outlets?   |      |            |                  |  |

| BEDROOM  | OKAY | NEEDS WORK | PRIORITY RANKING | RECOMMENDATIONS<br>Note OT/PT Teams: Please provide a clearly written recommendation for each area needing work. Please write legibly. |
|--|------|------------|------------------|--|
| 1. Clear, well-lighted pathway from bedroom to bathroom? |      |            |                  |  |
| 2. Flashlight within easy reach of bed?                  |      |            |                  |  |
| 3. Telephone within easy reach of bed?                   |      |            |                  |  |
| 4. Personal items within easy reach of bed?              |      |            |                  |  |
| 5. Bed easy to get in and out of?                        |      |            |                  |  |
| 6. Night light?  |      |            |                  |  |
| 7. Other?  |      |            |                  |  |

| KITCHEN  | OKAY | NEEDS WORK | PRIORITY RANKING | <b>RECOMMENDATIONS</b><br>Note OT/PT Teams: Please provide a clearly written recommendation for each area needing work. Please write legibly. |
|--|------|------------|------------------|---|
| 1. Oven/range - door opens easily and safely?  |      |            |                  |   |
| 2. Controls easy/safe to reach, easy to grasp/turn, clearly marked?                  |      |            |                  |   |
| 3. Free of items stored above?   |      |            |                  |   |
| 4. Balance while using oven?   |      |            |                  |   |
| 5. Refrigerator - is most space accessible?  |      |            |                  |   |
| 6. Temperature no higher than 40 degrees?  |      |            |                  |   |
| 7. Sink – Appropriate height?  |      |            |                  |   |
| 8. Appropriate depth?  |      |            |                  |   |
| 9. Hardware easy to use?   |      |            |                  |   |
| 10. Appliances near sink?  |      |            |                  |   |
| 11. Counters - Appropriate height?   |      |            |                  |   |
| 12. Adequate work surface?   |      |            |                  |   |
| 13. Within reach of stove, sink and refrigerator?                                    |      |            |                  |   |
| 14. Need for open space below so that person can sit while working?                  |      |            |                  |   |
| 15. Need for stool?  |      |            |                  |   |
| 16. Has a qualified technician checked the furnace within the last 12 months? Yes/No |      |            |                  |   |
| 17. Is furnace filter changed monthly? YES/NO  |      |            |                  |   |
| 18. Walkways free of clutter/tripping hazards?                                       |      |            |                  |   |
| 19. Furniture arrangement?   |      |            |                  |   |
| 20. Chairs in good repair & have armrests?   |      |            |                  |   |
| 21. Other: Emergency Exit Plan?  |      |            |                  |   |
| 22. Step stool?  |      |            |                  |   |
| 23. Door knobs?  |      |            |                  |   |
| 24. Outlets?   |      |            |                  |   |

| BATHROOM   | OKAY | NEEDS WORK | PRIORITY RANKING | RECOMMENDATIONS<br>Note OT/PT Teams: Please provide a clearly written recommendation for each area needing work. Please write legibly. |
|--|------|------------|------------------|--|
| 1. Sink -- Appropriate height?                                     |      |            |                  |  |
| 2. Need for open space below?                                      |      |            |                  |  |
| 3. Faucet controls easy to use?                                    |      |            |                  |  |
| 4. Insulated pipes?  |      |            |                  |  |
| 5. Mirror at good height?  |      |            |                  |  |
| 6. Toilet - Appropriate height?                                    |      |            |                  |  |
| 7. Grab bar present/needed?  |      |            |                  |  |
| 8. Grab bar appear secure?   |      |            |                  |  |
| 9. Toilet paper dispenser in easy reach?                           |      |            |                  |  |
| 10. Shower/Bathtub -- Easy to get into?                            |      |            |                  |  |
| 11. Tub/shower seat needed/available?                              |      |            |                  |  |
| 12. Grab bar present/needed?                                       |      |            |                  |  |
| 13. Grab bar appear secure?  |      |            |                  |  |
| 14. Faucet controls easily reached from sitting/standing position? |      |            |                  |  |
| 15. Shower has hand-held unit?                                     |      |            |                  |  |
| 16. Floor has non-slip surface?                                    |      |            |                  |  |
| 17. Towel racks -- Appropriate height, easy to reach?              |      |            |                  |  |
| 18. Are towel racks used as grab bars?                             |      |            |                  |  |
| 19. Adequate lighting-light switches easy to turn on/off?          |      |            |                  |  |
| 20. Electrical outlets within reach?                               |      |            |                  |  |
| 21. Nightlight present?  |      |            |                  |  |
| 22. Adequate storage within easy reach?                            |      |            |                  |  |
| 23. Medicine cabinet in reach & easy to open?                      |      |            |                  |  |
| 24. Adequate space to get around?                                  |      |            |                  |  |
| 25. Throw rugs present -- rubber-backed?                           |      |            |                  |  |
| 26. Ventilated?  |      |            |                  |  |
| 27. Other: Appliances?   |      |            |                  |  |

| APPROACH TO HOUSE   | OKAY | NEEDS WORK | PRIORITY RANKING | RECOMMENDATIONS<br>Note OT/PT Teams: Please provide a clearly written recommendation for each area needing work. Please write legibly. |
|---|------|------------|------------------|--|
| 1. Home address easily seen from roadway?   |      |            |                  |  |
| 2. Parking space close to door?   |      |            |                  |  |
| 3. Adequate space to get in/out of car?   |      |            |                  |  |
| 4. Continuous smooth, level pathway, free of cracks/holes from driveway to house? |      |            |                  |  |
| 5. Level changes at front/rear door manageable?                                   |      |            |                  |  |
| 6. Steps/railings in good condition?  |      |            |                  |  |
| 7. Able to get groceries from car to house?                                       |      |            |                  |  |
| 8. Curbs manageable?  |      |            |                  |  |
| 9. Is there a ramp? YES/NO<br>If yes, does it have appropriate slope?             |      |            |                  |  |
| 10. Provide stable, non-slip surface?   |      |            |                  |  |
| 11. Have handrails/wheel rails on both sides?                                     |      |            |                  |  |
| 12. Front/rear doorways wide enough?  |      |            |                  |  |
| 13. Negotiable beveled threshold?   |      |            |                  |  |
| 14. Adequate lighting (automatic)?  |      |            |                  |  |
| 15. Doors -- easy to open/close?  |      |            |                  |  |
| 16. Have easy-to-use locks?   |      |            |                  |  |
| 17. Accessible door peephole/viewpanel?   |      |            |                  |  |
| 18. Front/rear landings adequate for opening and moving into house?               |      |            |                  |  |
| 19. Landings free from ice potential (gutters)?                                   |      |            |                  |  |
| 20. Adequate space inside front/rear door to maneuver while closing door?         |      |            |                  |  |
| 21. Other: Emergency Exit Plan?   |      |            |                  |  |

## STATION 1: DINA SCRIPT

Daughter Dina (played by facilitator) answers the door to let care workers in.

**Dina:** (to care workers) I came by to feed Snuggles, but I'm on my way out to work.

**Dina:** (to Millie) Bye mom!

## STATION 1: MILLIE LARSEN INTERVIEW SCRIPT

- Focus: Older adult not taking meds consistently (disorganized), unable to clean apt (doesn't like help), poor intake -- processed diet (supposed to be on low fat diet: difficulty cooking d/t vision and low apt lights; doesn't see point of diet change at her age; eats what grandkids bring over).
- Recently fell trying to get up at night to go to bathroom
- Tries to keep track of pills, but it's hard
- Has a pressure ulcer she never pays attention to, Dina keeps checking but Millie doesn't realize why big fuss

### Millie's DETERMINE Tool answers:

You will be asked the following 10 questions. Your responses are in bold.

|  |   |
|--|---|
| 1. I have an illness or condition that made me change the kind and/or amount of food I eat.<br><b>NO</b> | 2 |
| 2. I eat fewer than two meals a day.<br><b>Sometimes I forget, generally eat 2 meals so NO</b>           | 3 |
| 3. I eat few fruits or vegetables, or milk products.<br><b>Not sure what I have, YES</b>                 | 2 |
| 4. I have three or more drinks of beer, liquor, or wine almost every day.<br><b>NO</b>                   | 2 |
| 5. I have tooth or mouth problems that make it hard for me to eat.<br><b>NO</b>                          | 2 |
| 6. I don't always have enough money to buy the food I need.<br><b>YES, Harold always paid the bills.</b> | 4 |
| 7. I eat alone most of the time.<br><b>YES</b>   | 1 |
| 8. I take three or more different prescribed or over-the-counter drugs a day.<br><b>YES</b>              | 1 |
| 9. Without wanting to, I have lost or gained ten pounds in the last six months.<br><b>NO</b>             | 2 |
| 10. I am not always physically able to shop, cook, and/or feed myself.<br><b>YES</b>                     | 2 |
| Total Score: 10 (high nutritional risk)  |   |

## STATION 3: MILLIE LARSEN SCRIPT

### Get Up and Go Test Millie Script

You will be asked to do the following eight tasks. Your responses are in bold.

1. Sit comfortably in straight-backed chair – **very slightly abnormal with a hunch or lean (Millie can say, “difficult to do with the pressure ulcer on my bottom, it’s a bit sore”)**
2. Rise from the chair – **Press off from the arms and stand up slowly.**
3. Stand still momentarily – **Stand still momentarily. Normal, deny dizziness.**
4. Walk a short distance – **Able to walk slowly. Grab on to chairs/walls if learner does not offer you a walker.**
5. Turn around – **slowly turn around. Grab walls/surfaces if learner does not offer you walker.**
6. Walk back to chair – **walk back to chair slow, hesitant**
7. Turn around – **turn around slowly**
8. Sit down in chair – **slow, hesitant, grip arms of chair while sitting down (Millie can say “my knees hurt going up and down too quickly”)**

### STEADI Millie Script:

You will be asked the following 12 questions. Your responses are in bold.

1. I have fallen in the past year. **YES**
2. I use or have been advised to use a cane or walker to get around safely. **YES**
3. Sometimes I feel unsteady when I am walking. **YES**
4. I steady myself by holding onto furniture when walking at home. **YES**
5. I am worried about falling. **YES**
6. I need to push with my hands to stand up from a chair. **YES**
7. I have some trouble stepping up onto a curb. **NO**
8. I often have to rush to the toilet. **YES**
9. I have lost some feeling in my feet. **NO**
10. I take medicine that sometimes makes me feel light-headed or more tired than usual. **NO**
11. I take medicine to help me sleep or improve my mood. **NO**
12. I often feel sad or depressed. **YES**

## STATION 4: MILLIE LARSEN NUTRITION/KITCHEN SAFETY SCRIPT

### Home Fall Prevention

You are not taking meds consistently (disorganized), unable to clean apt (don't like to bother people), poor intake – processed diet (supposed to be on low fat diet: difficulty cooking d/t vision and low apt lights; eats what grandkids and daughter bring over).

You recently fell trying to get up at night to go to bathroom. You get up once or twice a night usually. You don't shower that often because it gets slippery and don't have anything to hold on to. It's hard to step into shower, so you wait for Dina to come over to help you get cleaned up.

Pathways are dark in house, typically you hold onto furniture to navigate around home, often reaching for items (ie. Kitchen cabinets, use of chair as step stool).

## STOPP/START REVIEW ANSWER KEY

\*\*\*\*\*Answers in Bold\*\*\*\*\*

| Provider Orders   |
|---|
| Home health to follow   |
| Occupational Therapy referral: recent fall, home safety eval  |
| Regular, low-fat diet   |
| captopril 25 mg po three times a day <b>START, ok</b>   |
| metoprolol 100 mg every day <b>START, ok</b>  |
| furosemide 40 mg po twice per day <b>not recommended, STOP</b>  |
| Lipitor 50 mg once daily for coronary artery disease <b>START, ok</b>   |
| pilocarpine eye drops two drops each day four times a day   |
| Fosamax 10 mg every day <b>START, ok</b>  |
| Celebrex 200 mg po once a day <b>not recommended, STOP</b>  |
| For mild pain: Tylenol 325 mg po PRN <b>START, ok</b> (but students may question why multiple pain meds)                |
| Warfarin 5 mg po daily <b>START, ok due to afib</b>   |
| For moderate-severe pain: Tramadol 50 mg po every 4-6 hours PRN for arthritis pain <b>opioids not recommended, STOP</b> |
| Dr. Eric Lund   |

## RESOURCES

### Occupational Therapy Interview Tool

- The Canadian Occupational Performance Measure (COPM): <http://www.thecopm.ca/learn/>

### Nutritional Health Screening Tools

- DETERMINE Checklist from the National Nutritional Screening Initiative: <https://www.healthcare.uiowa.edu/igec/tools/nutrition/determineNutrition.pdf>

### Fall Risk and Mobility Screening Tools

- Timed Get up and Go Test: [https://www.cdc.gov/steady/pdf/tug\\_test-a.pdf](https://www.cdc.gov/steady/pdf/tug_test-a.pdf)
- STEADI Fall Risk Checklist: <https://www.cdc.gov/steady/materials.html>
- ConsultGeri.org: <https://consultgeri.org/geriatric-topics/falls>
- Minnesota Safety Council: Fall Prevention Home Safety Checklist <http://www.minnesotasafetycouncil.org/SeniorSafe/fallcheck.pdf>

### Home Safety Solutions

- University of Buffalo Aging and Technology Research Center. Home Safety Self Assessment Checklist with recommended solutions. <http://agingresearch.buffalo.edu/hssat/>

### Medication Review Tools

- STOPP START Toolkit: <http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/StopstartToolkit2011.pdf>

## LEARNER HIGHLIGHTS

“Working with the OT students was a truly valuable experience. It was helpful to have multiple eyes on the house, hear different insights, and discuss recommendations from both nursing and OT perspectives. This allowed up to come up with a more comprehensive, detailed, unique plan for Millie, and improved the quality of her care overall.”

“Going through each station together allowed for a continuous dialogue so we were able to come up with a plan for Millie as we went along. While we didn’t have different opinions necessarily, we sometimes had different views of what the main priorities for her care and home safety improvements should be. When these differing ideas arose, we discussed where we were coming from, and most often could come to an agreement after that.”

“One thing that we decided was important is education, not only for Millie, but for her daughter. Her daughter seems to be extremely involved in her care so educating her on the things that could be changed to benefit Millie’s safety and health.”

“Home health nurses sometimes carry much more responsibility and autonomy than other nursing specialty areas. Although healthcare professionals can recommend a million things to a patient, we have to always consider how doable those changes would be. Home health nurses have to considerer financial reimbursements, social support of patients, how to prioritize the most important aspects of a patient’s life (even if we see more room for improvement), and if the patient will follow through with the recommendations much more than in acute care settings.”

“I learned when acting as a home health nurse you assume a completely different role. The nurse is no longer just evaluating the patient, but they are also evaluating the environment surrounding the patient.”

“Oftentimes, in the hospital or acute care settings, our nursing focus is on the patient’s present condition, and the disease process that brought them to our setting. However, the home health nurse makes observations about every aspect of the patient’s lifestyle, including their nutrition, medications, home environment, family relationships, etc.”

“The home health nurse is a guest that the person has welcomed into their life, rather than a worker that is there to take care of them and do a job. When a nurse works in a hospital unit, it really is their environment, where they have more control. However, the home is a much more intimate setting, and it is a place where your client has more control. Therefore, the home health nurse has to be very considerate of the environment they’re in, and has to learn what the client feels comfortable having them do in their house.”

## INSTRUCTOR TIPS

We found it helpful for students to be aware of the stations and rotations prior to the simulation. Send out the station schedule and IPE groups of students in advance.

We created a shared course website for students to view all assessment tools. Many students wanted to learn more about the tool the other discipline was utilizing, so the shared course site was a way to address this question.

During the simulation, we encouraged students to be respectful of the other participants in the space and told them to remain in their assigned groups throughout the simulation. It helped keep the simulation organized. We also found it helpful to use a standardized chime to indicate time to rotate to the next station.

Some students felt it was helpful to assess the environment first before interviewing the client, however due to time restrictions we were unable to accommodate this need into our pilot.

## **SCENARIO 4**

### **Care Conference at Skilled Nursing Facility**

**Summary:** Millie meets with members of her care team in a care conference to plan her care during her short stay at a Skilled Nursing Facility (SNF). She was transferred to the SNF after a hospitalization due to a fall at home resulting in a hip fracture. Members include students from Nursing, Occupational Therapy and Social Work. The team is assessing her safety in the home and assistance she might need.

**Learner Level:** Second year nursing students, SOCIAL WORK??, and second year graduate occupational therapy students

**Goals:**

*Nursing:* To improve nursing students' knowledge and skill to competently manage the needs of an aging clientele, specifically focusing on the transition of care and client safety at home.

*Occupational Therapy:* To improve occupational therapy students' ability to identify and convey the focus and needs of a client upon admission to a skilled nursing facility (SNF) from an OT perspective at an initial interprofessional case conference; To improve occupational therapy students' ability to create an appropriate and effective client-centered treatment plan for safe transition from SNF to home.

*Social Work:* To assess the support system for older adults returning home after a long term care placements and recommend resources to improve support; to identify ways social work supports can help obtain therapy and assistive devices per therapy recommendations; to assess financial implications of care options (transfer to home, assisted living, or continuation in skilled nursing).

**Course suggestions:** Nursing Care of Persons and Families with Complex Health Care Needs; Middle and Late Adulthood Occupations and Therapeutic Intervention; Human Behavior and the Environment

**Documents:**

- Simulation Instructor Overview-one for nursing and one for occupational therapy
- Materials and Scene Preparation
- Stations and Activities
- Photos of suggested set up
- Millie Larsen's Intro Monologue (adapted from ACES Cases)
- Learner Handout-one for nursing and one for occupational therapy
- Millie's Actor/Voiceover: Background Information and Script
- Instructor tips

**Meets the AACN Recommended Baccalaureate Competencies and Curricular Guidelines for the Nursing Care of Older Adults:**

- Assess barriers for older adults in receiving, understanding, and giving of information (corresponding to Essentials IV & IX).
- Gain understanding about how to: facilitate safe and effective transitions across levels of care, including acute, community-based, and long-term care (e.g. home, assisted living, hospice, nursing homes) for older adults and their families (corresponding to Essentials IV & IX).

## NURSING: INSTRUCTOR OVERVIEW

|   |  |                                 |
|---|--|---------------------------------|
| <b>Case Name:</b> Millie Larsen<br>Skilled Nursing Facility Care Conference | <b>"Patient" Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>5'3" 110 lbs. |
|---|--|---------------------------------|

### Goal of the Simulation

To improve nursing students' knowledge and skill to competently manage the needs of an aging clientele, specifically focusing on the transition of care and client safety at home.

### Learner Objectives:

1. Recognize pertinent information exchanged in care conference.
2. Recognize Minimum Data Set (MDS) Nursing Home Comprehensive Item Set as essential tool for creating client's care plan.
3. Create patient plan of care with goals, progress, and discharge plans/goals/recommendations that is client centered.
4. Begin to understand the roles and responsibilities of each discipline.
5. Begin to understand the role of collaborating with other disciplines to create optimal client outcomes.
6. Identify the purpose of using a SNF for rehabilitation and purpose of care coordination meeting.
7. Communicate effectively with team members and client and family in a professional manner.

### Pre-simulation Requirements for the Learners

- Read *Nurses Roles in Healthcare and Long Term Care*.
- Review *Skilled Nursing Facility Structure and Background presentation*.
- Read *Discharge Summary*.
- Use *Millie Monologue, Discharge Summary, and Client interview for Nursing Home Admission* video to create Millie's plan of care. Draft plan of care should include short term goals, identification of progress, and discharge plans/goals/recommendations to discuss in care conference with OT, SW and Nursing. Anticipate any barriers to Millie's discharge to home.

### Pre-brief (Student-Instructor Discussion)

Discuss object of care conference, including roles of each discipline, role of Millie and Dina, professional communication, patient centered care, and outcome of care plan for Millie's stay at SNF.

### Evaluation of Outcomes

1. Students will communicate effectively with team members, client and family in a professional manner.
2. Students will identify similarities and differences in their role and the role of other SW, OT and Nursing.
3. Students will be able to verbalize basic understanding of care conference in creating plan of care for Millie.

### History of Present Illness

Millie Larson is a 90 yr old female previously seen by home health monthly for nursing concerns including safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Most recently she was discharged from the hospital s/p hip fracture and transferred to a Skilled Nursing Facility (SNF) for a short stay. Millie has high hopes to be discharged to home ASAP. However, there were safety issues in her home previous to her hospitalization.

Home health RN has been involved with her care as well as OT for an initial home evaluation. This scenario is a care conference with Occupational Therapy, Social Work, and Nursing to discuss Millie's plan of care at the SNF, with a specific focus on goals, progress, and discharge plans/goals/recommendations for Millie. Two students of SW, OT and Nursing are present along with Millie and Dina.

**Past Medical/Surgical History**

Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib  
Cholecystectomy at age 30, UTI, stage I pressure ulcer

**Social History**

Lived at home independently prior to hospitalization. Daughter, Dina, lives nearby and is her primary support system. Millie insists on not needing help at home – “I’ve got Snuggles and that’s all I need.” Dina is concerned about the safety of her home environment and recent fall.

**Current Medications**

Metoprolol 100mg every day, Warfarin 5mg daily, Furosemide 40mg twice a day, Fosamax 10mg every day, Mild pain: Tylenol 325mg po as needed, Captopril 25 mg po three times a day, Lipitor 50 mg once daily, Pilocarpine eye drops two drops each eye four times a day, for mod-severe pain: Tramadol 50 mg. po every 4-6 hours PRN for arthritis pain

**Allergies: NKDA****De-brief Questions: (entire simulation as a group without Millie and Dina)**

1. What are Millie’s top concerns/priorities (2-3) for treatment during her stay at the SNF?
2. What aspects of Millie’s history (both medical and social) jump out as potential concerns or barriers?
3. What services do you think Millie will need to return home?
4. How can you continue to help Millie and Dina reach discharge goals?
5. What will you need from the interprofessional team over the next two weeks to complete Millie’s discharge plan?
6. What did you learn about your own role from this simulation?
7. What did you learn about another disciplines role from this simulation?
8. Were there any disagreements regarding goals for Millie? If so, how did you solve them?
9. What will you take away from this simulation?

**Post-simulation Student Journal Questions**

1. How did you feel during the simulation experience?
2. What part of the simulation was most helpful for you?
3. How did things go working with another student and/or other disciplines for this experience?
4. Did you feel you had enough of a voice to advocate for Millie during the care conference amongst the other students?
5. Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn’t have?

**Submit within 48 hours following simulation.**

## OCCUPATIONAL THERAPY: INSTRUCTOR OVERVIEW

|   |  |                               |
|---|--|-------------------------------|
| <b>Case Name:</b> Millie Larsen<br>Skilled Nursing Facility Care Conference   | <b>“Patient” Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>61in. 48 kg |
| <b>Goals of the Simulation</b> <ol style="list-style-type: none"> <li>To improve occupational therapy students’ ability to identify and convey the focus and needs of a client upon admission to a skilled nursing facility (SNF) from an OT perspective at an initial interprofessional case conference.</li> <li>To improve occupational therapy students’ ability to create an appropriate and effective client-centered treatment plan for safe transition from SNF to home.</li> </ol>   |  |                               |
| <b>Learner Objectives:</b> <ol style="list-style-type: none"> <li>Recognize useful/non-useful information exchanged in care conference.</li> <li>Recognize Minimum Data Set (MDS) Nursing Home Comprehensive Item Set as essential tool for creating client’s care plan.</li> <li>Create patient plan of care with goals, progress, and discharge plans/goals/recommendations that is client centered to discuss in care conference with OT, SW and Nursing.</li> <li>Begin to identify resources that are useful in care coordination.</li> <li>Begin to understand the roles and responsibilities of each discipline.</li> <li>Begin to understand the role of collaborating with other disciplines to create optimal client outcomes.</li> <li>Identify the purpose of using a SNF for rehabilitation and purpose of care coordination meeting.</li> <li>Begin to understand how to communicate effectively with team members and client and family in a professional manner.</li> </ol> |  |                               |
| <b>Pre-simulation Requirements for the Learners</b> <ul style="list-style-type: none"> <li>Read <i>Millie Intro Monologue</i></li> <li>Read <i>Discharge Summary</i></li> <li>Watch <i>Client interview for Nursing Home Admission</i> video</li> <li>Use <i>Millie Monologue</i>, <i>Discharge Summary</i>, and <i>Client interview for Nursing Home Admission</i> video to create Millie’s plan of care. Draft plan of care should include short term goals, identification of progress, and discharge plans/goals/recommendations to discuss in care conference with OT, SW and Nursing. .</li> </ul>  |  |                               |
| <b>Pre-brief (Student-Instructor Discussion)</b><br>Discuss objective of care conference, including roles of each discipline, role of Millie and Dina, professional communication, patient centered care, and outcome of care plan for Millie’s stay at SNF.  |  |                               |
| <b>Evaluation of Outcomes</b> <ol style="list-style-type: none"> <li>Students will communicate in a professional manner within own and other disciplines.</li> <li>Students will actively listen to Millie and Dina when appropriate.</li> <li>Students will identify similarities and differences in their role and the role of other SW, OT and Nursing.</li> <li>Students will be able to verbalize basic understanding of care conference in creating plan of care for Millie.</li> </ol>   |  |                               |

**History of Present Illness:**

Millie Larson is a 90 yr old female previously seen by home health monthly for nursing concerns including safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Most recently she was discharged from the hospital s/p hip fracture and transferred to a Skilled Nursing Facility (SNF) for a short stay. Millie has high hopes to be discharged to home ASAP. However, there were safety issues in her home previous to her hospitalization. Home health RN has been involved with her care as well as OT for an initial home evaluation and periodic follow-up care in the home. This scenario is a care conference with OT, SW, and Nursing to discuss Millie's plan of care at the SNF, with a specific focus on goals, progress, and discharge plans/goals/recommendations for Millie. Two students of SW, OT and Nursing are present along with Millie and Dina.

**Past Medical/Surgical History**

Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib Cholecystectomy at age 30, UTI, stage I pressure ulcer

**Social History**

Lived at home independently prior to hospitalization. Daughter, Dina, lives nearby and is her primary support system. Millie insists on not needing help at home – "I've got Snuggles and that's all I need." Dina is concerned about the safety of her home environment and recent fall.

**Current Medications**

Metoprolol 100mg every day, Warfarin 5mg daily, Furosemide 40mg twice a day, Fosamax 10mg every day, Mild pain: Tylenol 325mg po as needed, Captopril 25 mg po three times a day, Lipitor 50 mg once daily, Pilocarpine eye drops two drops each eye four times a day, for mod-severe pain: Tramadol 50 mg. po every 4-6 hours PRN for arthritis pain

**Allergies: NKDA****De-brief Questions: (entire simulation as a group without Millie and Dina)**

1. What are Millie's top concerns/priorities (2-3) for treatment during her stay at the SNF?
2. What aspects of Millie's history (both medical and social) jump out as potential concerns or barriers?
3. What services do you think Millie will need to return home?
4. How can you continue to help Millie and Dina reach discharge goals?
5. What will you need from the interprofessional team over the next two weeks to complete Millie's discharge plan?
6. What did you learn about your own role from this simulation?
7. What did you learn about another disciplines role from this simulation?
8. Were there any disagreements regarding goals for Millie? If so, how did you solve them?
9. What will you take away from this simulation?

**Post-simulation Student Journal Questions**

1. How did you feel during the simulation experience?
2. What part of the simulation was most helpful for you?
3. How did things go working with another student and/or other disciplines for this experience?
4. Did you feel you had enough of a voice to advocate for Millie during the care conference amongst the other students?
5. Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn't have?

**Submit within 48 hours following simulation.**

## MATERIALS AND SCENE PREPARATION

### Scene

A care conference room for each group, with video recording live viewing is possible. Seating for students plus Millie and Dina.

### Orientation for Standardized Patients (SP)

*Recommended the week of the simulation and reconvene prior to simulation starting to answer any questions.*

Standardized patients (Millie and Dina) were given scripts that summarized the character's stories and situation for the care conference. Included were answers to questions the healthcare students might ask during the simulation. Standardized Patients (Millie and Dina) also watched the assessment video that given to students in order to gather information on Millie and Dina's mannerisms, attitudes regarding discharge, and current state. Additionally, any remaining questions were answered prior to care conference. See *Scripts*

### Video

#### Prior to the day of the simulation

#### Station 1: Pre-Brief (5-10 minutes)

2 Nursing students, 2 OT students, 2 Social Work students, 1-2 instructors in a room discussing care conference objectives and answering any brief questions.

#### Station 2: Communication Huddle (5 min)

Students of own discipline talk briefly about goals prior to care conference. See *Communication Huddle Script*.

#### Station 3: Care Conference (20 minutes)

2 Nursing Students, 2 OT students, 2 Social Work students, Millie and Dina are in care conference discussing goals and concerns to create interdisciplinary care plan for Millie's short stay and future discharge.

Instructors will live view conversation from outside the conference room on laptop in order to give feedback during de-brief.

Provide a walker for Millie if using standardized patients for care conference, as she uses a walker to ambulate.

#### Station 4: De-brief

2 Nursing Students, 2 OT students, 2 Social Work students, 2 instructors in a room discussing de-brief questions. See *De-brief questions*.

## NURSING: LEARNER HANDOUT

|  |  |                                 |
|--|--|---------------------------------|
| <b>Case Name:</b> Millie Larsen<br>Skilled Nursing Facility Care Conference  | <b>“Patient” Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>5’3” 110 lbs. |
| <b>Goal of the Simulation</b><br>To improve nursing students’ knowledge and skill to competently manage the needs of an aging clientele, specifically focusing on the transition of care and client safety at home.  |  |                                 |
| <b>Learner Objectives:</b> <ol style="list-style-type: none"> <li>1. Recognize pertinent information exchanged in care conference.</li> <li>2. Recognize Minimum Data Set (MDS) Nursing Home Comprehensive Item Set as essential tool for creating client’s care plan.</li> <li>3. Create patient plan of care with goals, progress, and discharge plans/goals/recommendations that is client centered.</li> <li>4. Begin to understand the roles and responsibilities of each discipline.</li> <li>5. Begin to understand the role of collaborating with other disciplines to create optimal client outcomes.</li> <li>6. Identify the purpose of using a SNF for rehabilitation and purpose of care coordination meeting.</li> <li>7. Communicate effectively with team members and client and family in a professional manner.</li> </ol>   |  |                                 |
| <b>Pre-simulation Requirements for the Learners</b> <ul style="list-style-type: none"> <li>• Read <i>Nurses Roles in Healthcare and Long Term Care</i>.</li> <li>• Review <i>Skilled Nursing Facility Structure and Background presentation</i>.</li> <li>• Read <i>Discharge Summary</i>.</li> <li>• Use <i>Millie Monologue</i>, <i>Discharge Summary</i>, and <i>Client interview for Nursing Home Admission</i> video to create Millie’s plan of care. Draft plan of care should include short term goals, identification of progress, and discharge plans/goals/recommendations to discuss in care conference with OT, SW and Nursing. Anticipate any barriers to Millie’s discharge to home.</li> </ul>  |  |                                 |
| <b>Pre-brief (Student-Instructor Discussion)</b><br>Discuss objective of care conference, including roles of each discipline, role of Millie and Dina, professional communication, patient centered care, and outcome of care plan for Millie’s stay at SNF.   |  |                                 |
| <b>Evaluation of Outcomes</b> <ol style="list-style-type: none"> <li>1. Students will communicate effectively with team members, client and family in a professional manner.</li> <li>2. Students will identify similarities and differences in their role and the role of other SW, OT and Nursing.</li> <li>3. Students will be able to verbalize basic understanding of care conference in creating plan of care for Millie.</li> </ol>   |  |                                 |
| <b>History of Present Illness:</b><br>Millie Larson is a 90 yr old female previously seen by home health monthly for nursing concerns including safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Most recently she was discharged from the hospital s/p hip fracture and transferred to a Skilled Nursing Facility (SNF) for a short stay. Millie has high hopes to be discharged to home ASAP. However, there were safety issues in her home previous to her hospitalization. Home health RN has been involved with her care as well as OT for an initial home evaluation. This scenario is a care conference with Occupational Therapy, Social Work, and Nursing to discuss Millie’s plan of care at the SNF, with a specific focus on goals, progress, and discharge plans/goals/recommendations for Millie. Two students of SW, OT and Nursing are present along with Millie and Dina. |  |                                 |

**Past Medical/Surgical History**

Right hip fracture and rod repair s/p fall at home, Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib

Cholecystectomy at age 30, UTI, stage I pressure ulcer

**Social History**

Lived at home independently prior to hospitalization. Daughter, Dina, lives nearby and is her primary support system. Millie insists on not needing help at home – “I’ve got Snuggles and that’s all I need.” Dina is concerned about the safety of her home environment and recent fall.

## Inpatient Discharge Summary

## IP Orthopedics

Dear Dr. Eric Lund,

Thank you for the opportunity to care for your patient, Millie Larsen, at the University of Wisconsin Hospital and Clinics who was recently admitted for a right total hip arthroplasty following a fall sustained at home.

## Brief Overview

Admitting Provider: Ashkin Sadar, MD

Discharge Provider: Joshua Smith, MD

Primary Care Physician at Discharge: Gordon Williams, MD

Admission Date: 2/26/2017 Discharge Date: 3/1/2017

Primary Discharge Diagnosis: Hip Fracture

Secondary Discharge Diagnoses:

Osteoarthritis

Glaucoma

Hypertension

Stress incontinence

Stage I Pressure Ulcer

Atrial Fibrillation

Discharge Disposition:

Skilled Nursing Facility for short stay rehab with physical and occupational therapy

Code status at Discharge: Full

Active Issues Requiring Follow-Up:

Issue: Anticoagulation

Responsible Individual: PCP

What is Needed: INR twice weekly

Follow-up Appointments ?

Labs that are Recommended to be drawn after discharge:

INR twice weekly starting 3/3/2017

## Details of Hospital Stay

### Presenting Problem/History of Present Illness

Patient Millie Larsen is a 89 year old female with right hip pain and dysfunction secondary to a femur fracture sustained from a fall in her home.

### Hospital Course

Millie Larsen was admitted on the day of surgery, taken to the OR and underwent the above procedure. She tolerated the procedure well and was taken to the PACU in stable condition with A. Fib being monitored. Subsequently she was transferred to the floor in stable condition. Her postoperative course was unremarkable short of closely monitoring her chronic A. Fibrillation. Her pain was moderately controlled and her diet was advanced without incident. Physical Therapy was started on POD #1 which she tolerated for short periods of time due to her pain. Millie has struggled throughout to be mobile independently, in addition to having a history of stress incontinence, and a pressure ulcer on her sacrum. On 2/28/2017 it was deemed appropriate for Millie to be placed in a Skilled Nursing Facility to continue her rehab until she is able to be discharged home to live independently once again. Her pain has been moderately under control, though occasionally she refuses to take her pain medications as she is worried they might make her tired. She has been completing inpatient PT successfully and working with OT, but still has further to go until she can return to home independently. Her wound on her sacrum continues to be monitored, and her surgical wound on her right hip continues to heal without evidence of infection. Millie was tolerating a general diet. At this time, it is appropriate for Millie to be discharged and transferred to a SNF as she no longer requires inpatient hospitalization.

### Infectious Disease

Mrs. Larsen received cefuroxime via I.V. All doses were given within 24 hours of surgery.

### Pain

Millie's pain as been controlled as well as possible with her occasionally refusing pain medications. Her pain was controlled on oral analgesics at time of discharge to SNF.

- DVT Prophylaxis
- Warfarin
- Osteoporosis Screening
- The patient should be screened by the patient's primary physician.

**Operative Procedures Performed**

- Right Total Hip Arthroplasty

**Medications**

- Captopril 25 mg po three times a day
- Metoprolol 100 mg every day
- Furosemide 40 mg po twice per day
- Lipitor 50 mg once daily for coronary artery disease
- For mild pain: Tylenol 325mg po PRN
- Celebrex 200 mg po once a day
- Warfarin 5mg po daily for chronic A.Fib

**Current Medications**

Hydrochlorothiazide 25mg daily, Carvedilol 3.125mg twice a day, Warfarin 5mg daily, Digoxin 0.125mg daily, Atorvastatin 40mg daily, Tylenol 325mg as needed for pain, Pilocarpine 1 drop 1% solution TID to R eye, Timolol maleate 1 drop 0.25% solution once daily to R eye

**Allergies**

No known allergies

**Provider Orders**

Home health to follow

Occupational Therapy referral: recent fall, home safety eval

Regular, low-fat diet

captopril 25 mg po three times a day

metoprolol 100 mg every day

furosemide 40 mg po twice per day

Lipitor 50 mg once daily for coronary artery disease

pilocarpine eye drops two drops each eye four times a day

Fosamax 10 mg every day

For mild pain: Tylenol 325mg po PRN

Celebrex 200 mg po once a day

Warfarin 5mg po daily for chronic A.Fib

For moderate- severe pain: Tramadol 50 mg. po every 4-6 hours PRN for arthritis pain

**Dr. Eric Lund**

**Post-simulation Student Journal Questions**

1. How did you feel during the simulation experience?
2. What part of the simulation was most helpful for you?
3. How did things go working with another student and/or other disciplines for this experience?
4. Did you feel you had enough of a voice to advocate for Millie during the care conference amongst the other students?
5. Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn't have?

**Submit within 48 hours following simulation.**

## OCCUPATIONAL THERAPY: LEARNER HANDOUT

|  |  |                                 |
|--|--|---------------------------------|
| <b>Case Name:</b> Millie Larsen<br>Skilled Nursing Facility Care Conference  | <b>"Patient" Name/DOB:</b><br>Millie Larsen 01/23/1927 | <b>Ht. Wt.</b><br>5'3" 110 lbs. |
| <b>Pre-simulation Requirements for the Learners:</b> <ul style="list-style-type: none"> <li>• <i>Millie Intro Monologue</i></li> <li>• Review <i>Skilled Nursing Facility Structure and Background PPT</i></li> <li>• Read <i>Discharge Summary</i></li> <li>• Watch <i>Client interview for Nursing Home Admission</i> video</li> <li>• Use <i>Millie Monologue, Discharge Summary, and Client interview for Nursing Home Admission</i> to create Millie's plan of care</li> <li>• Patient plan of care should include short term goals, identification of progress, and discharge plans/goals/recommendations to discuss in care conference with OT, SW and Nursing.</li> </ul>  |  |                                 |
| <b>Goal of the Simulation</b> <ol style="list-style-type: none"> <li>1. To improve occupational therapy students' ability to identify and convey the focus and needs of a client upon admission to a skilled nursing facility (SNF) from an OT perspective at an initial interprofessional case conference.</li> <li>2. To improve occupational therapy students' ability to create an appropriate and effective client-centered treatment plan for safe transition from SNF to home.</li> </ol>   |  |                                 |
| <b>Learner Objectives:</b> <ol style="list-style-type: none"> <li>1. Recognize useful/non-useful information exchanged in care conference.</li> <li>2. Create patient plan of care with goals, progress, and discharge plans/goals/recommendations that is client centered to discuss in care conference with OT, SW and Nursing.</li> <li>3. Begin to identify resources that are useful in care coordination.</li> <li>4. Begin to understand the roles and responsibilities of each discipline.</li> <li>5. Begin to understand the role of collaborating with other disciplines to create optimal client outcomes.</li> <li>6. Identify the purpose of using a SNF for rehabilitation and purpose of care coordination meeting.</li> <li>7. Begin to understand how to communicate effectively with team members and client and family in a professional manner.</li> </ol>  |  |                                 |
| <b>Evaluation of Outcomes</b> <ol style="list-style-type: none"> <li>1. Students will communicate in a professional manner within own and other disciplines.</li> <li>2. Students will actively listen to Millie and Dina when appropriate.</li> <li>3. Students will identify similarities and differences in their role and the role of other SW, OT and Nursing.</li> <li>4. Students will be able to verbalize basic understanding of care conference in creating plan of care for Millie.</li> </ol>  |  |                                 |
| <b>History of Present Illness:</b> <p>Millie Larson is a 90 yr old female previously seen by home health monthly for nursing concerns including safety of home environment, high fall risk, skin integrity for stage I pressure ulcer on coccyx. Most recently she was discharged from the hospital s/p hip fracture and transferred to a Skilled Nursing Facility (SNF) for a short stay. Millie has high hopes to be discharged to home ASAP. However, there were safety issues in her home previous to her hospitalization.</p> <p>Home health RN has been involved with her care as well as OT for an initial home evaluation. This scenario is a care conference with OT, SW, and Nursing to discuss Millie's plan of care at the SNF, with a specific focus on goals, progress, and discharge plans/goals/recommendations for Millie. Two students of SW, OT and Nursing are present along with Millie and Dina.</p> |  |                                 |

**Past Medical/Surgical History**

Right hip fracture and rod repair s/p fall at home, Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia, A.Fib  
Cholecystectomy at age 30, UTI, stage I pressure ulcer

**Social History**

Lived at home independently prior to hospitalization. Daughter, Dina, lives nearby and is her primary support system. Millie insists on not needing help at home – “I’ve got Snuggles and that’s all I need.” Dina is concerned about the safety of her home environment and recent fall.

**Current Medications**

Hydrochlorothiazide 25mg daily, Carvedilol 3.125mg twice a day, Warfarin 5mg daily, Digoxin 0.125mg daily, Atorvastatin 40mg daily, Tylenol 325mg as needed for pain, Pilocarpine 1 drop 1% solution TID to R eye, Timolol maleate 1 drop 0.25% solution once daily to R eye

**Allergies:** No known allergies

**Provider Orders**

Home health to follow  
Occupational Therapy referral: recent fall, home safety eval  
Regular, low-fat diet  
captopril 25 mg po three times a day  
metoprolol 100 mg every day  
furosemide 40 mg po twice per day  
Lipitor 50 mg once daily for coronary artery disease  
pilocarpine eye drops two drops each eye four times a day  
Fosamax 10 mg every day  
For mild pain: Tylenol 325mg po PRN  
Celebrex 200 mg po once a day  
Warfarin 5mg po daily for chronic A.Fib  
For moderate- severe pain: Tramadol 50 mg. po every 4-6 hours PRN for arthritis pain

**Dr. Eric Lund**

**OT Assignment to be Completed Prior to Case Conference Simulation:**

**I. Provide current FIM scores or assist level for the following based on OT initial evaluation video:**

1. Feeding
2. Grooming
3. UE Dressing
4. LE Dressing
5. Toileting
6. Bathing
7. Tub transfers
8. Toilet transfers
9. Overall cognition (social interaction, expression, comprehension, etc.)

**II. List OT long-term goal ( and projected LOS) and initial short-term goals given the information provided in the OT initial evaluation video:**

(For example: LTG: Pt. will return to prior living situation independent and safe with BADL with AE within 3 weeks. STG 1. Pt. will safely dress LE independently with AE within hip precautions.)

**Post-simulation Student Journal Questions**

- How did you feel during the simulation experience?
- What part of the simulation was most helpful for you?
- How did things go working with another student and/or other disciplines for this experience?
- Did you feel you had enough of a voice to advocate for Millie during the care conference amongst the other students?
- Did you feel you had enough information about Millie for this exercise? If not, what did you feel you needed that you didn't have?

**Submit within 48 hours following simulation.**

## MEET MILLIE LARSEN



I'm Millie. I have lived in the same small house for the last 50 years. Harold and I raised our dear daughter Dina here and we had many good years together as a family. Harold passed last year -- he was 91, you know -- and I miss him terribly. I think about him every day. We were married for 68 years; most of them were happy. We did struggle with money at times, but who didn't? All of our family lived close by and I spent many a Sunday cooking for 15-20 after church. Our home was always full of people; many of them are gone now. Snuggles, my dog, keeps me company. Snuggles is about 10 years old; she is a stray who just showed up on my doorstep one day and she's been here ever since.

I've always kept myself busy, I used to sing when in the church choir and I volunteered in the church kitchen. I still love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I can't do as much as I used to, but that's ok. I am fortunate to have many close friends from church.

I also enjoy gardening and I am known for growing my prize roses. My rose garden is not quite as big as it used to be, but I still like to get outside and work with the soil and the flowers. Although, recently I haven't been out at much due to the cold. Did you know that my roses used to win blue ribbons at the county fair almost every year?

Since Harold is gone, I go over to my daughter Dina's house every week to visit and see my grandkids. Dina is a good cook, but her dumplings aren't quite as good as mine; I try to make a batch to take with me when I can. Dina works every day at the school so she is busy most of the time. She is a good daughter and helps me when I need to get to the doctor. She also picks up groceries for me once in awhile. I have three grandchildren. Jessica is 17 and graduates from high school this year. Daniel is 14 and is a handful! He can give his mother trouble about getting his homework done and I don't think his grades are very good. I know Dina worries about him. Megan is 12; she is such a sweet child. She likes to help me with my roses in the summer.

I am lucky that I can still get around pretty well and my house is not too big. Although recently some nurses came out and told me I wasn't moving enough and I had to clean more. I try to keep my house clean, thank you very much! Dina keeps checking my bottom for who knows what reason and keeps telling me to get out of my chair more. When Snuggles wants to cuddle, I have a hard time saying no! My knees are pretty bad; I think they are just worn out. They hurt a lot. My bladder isn't as good as it used to be. I really don't like a lot of people caring for me; I think I do pretty well for my age. Then the other night, I had to go to the bathroom and fell. Fortunately I could reach the phone and called Dina. Dina rushed over, called my doctor and now I hear I have to have more people visit me at home.

I hope all these hospital bills and home visits aren't too expensive, I already have to pay a lot for my medications and I don't get the pension anymore since Harold died. I don't know how Harold paid all the bills, it doesn't hardly seem like there's enough money for all that medicine.

Source: Adapted from ACES Cases: <http://www.nln.org/professional-development-programs/teaching-resources/aging/ace-s/unfolding-cases/millie-larsen>

## COMMUNICATION HUDDLE SCRIPT

### Nursing Student Lead

First we are going to introduce ourselves. You will do this by stating your name and position title (OT, Nurse), i.e. “My name is \_\_\_\_, I am a Nursing Student working with Ms. Larsen.”

Second, I will provide a brief background on Ms. Larsen, i.e. “Ms. Larsen sustained a femoral fx on\_\_\_\_ and underwent subsequent ORIF THA, surgery was tolerated well. She received OT/ PT services while in inpatient acute hospital for 3 days. The hospital acute care team subsequently recommended Ms. Larsen for subacute rehab.”

Third, we will provide a predicted outcome of the meeting, i.e. “We are meeting today to discuss discharge plan and goals; we will hear from all of the team members (and Ms. Larsen as well) and by the end of the meeting we will project LOS (length of stay). So now, let’s go around the room and have everyone introduce themselves and state your area of practice.”

“Each discipline should take a turn to state their thoughts about Millie’s condition and their priorities/ goals for her. We will also give Millie and/or Dina a chance to respond.”

“Finally using the priorities we have heard, we as a group should create 2-3 reachable goals for Millie, keeping her safety and her priorities in mind.”

# OLDER ADULT CARE CONFERENCE SIMULATION

## Standardized Patient Script- Millie

**Background:** You are Millie Larsen, a 90 year old recently widowed woman who has lived in the same small house for the last 50 years. You recently had a hip surgery after having fallen and broken your hip at home. You were discharged from the hospital to the skilled nursing facility for a short stay for rehab and pain management. The healthcare team, consisting of nurses, occupational therapists and social workers, will work together with you to create the best plan of care for you to reach your goals to get back home living independently. They may ask you questions about your pain management, fall risk, activity level, and medications.

*The bottom line is that you just want to get back home to be with your dog Snuggles and get back to gardening!*

First the students will introduce themselves and you will introduce yourself.

Note: As this is a learning opportunity for students, feel free to communicate more than you might if it were an exam. Please allow the students to guide the care conference and respond to questions only when asked.

**Introduce yourself: “I’m Millie and this is my daughter, Dina.”**

Second, the Nursing student running the conference will provide a brief background on your situation.

Third, the Nursing student will provide direction for the meeting. “We are meeting today to discuss discharge plan and goals; we will hear from all of the team members (and Ms. Larsen as well) and by the end of the meeting we will project LOS (length of stay). So now, let’s go around the room and have everyone introduce themselves and state your area of practice.”

*Below are answers to questions you might be asked:*

### **PAIN**

Nursing: “How has your pain been?” OR “Can you rate your pain on a scale of 1-10?”

**Millie:** My pain has been OK, about a 2, a dull ache in my hip. I have been using ice packs and the nurses have been giving me Tylenol a couple times a day, which helps as the pain never gets too bad. It hurts most after therapy and when I move so I try not to move so much and then it is ok. I keep forgetting to ask for something for pain as I don’t want to bug anyone.

### **SLEEP**

Students may or may not ask about sleep.

**Millie:** It is been a little more difficult to sleep on the hard bed here. I go to bed around 9 pm and can fall asleep but then I have to get up 2 times at night to use the bathroom and now that I need help from someone and a walker, it takes me even longer to get anywhere.

## ACTIVITY/ EXERCISE

Nursing: With regard to Millie's activity level, she does walk with one assist and a walker and tolerates activity well. How do you think you are doing Millie?

**Millie:** Well, I have had a few near misses if you know what I mean -- I've been able to catch myself or fall into a chair so that doesn't count. But, this time I wasn't able to catch myself as there was no chair around and I didn't have my walker. I'm not sure what I will do now to catch myself as I don't want to hurt myself again. I used to get outside and do gardening for my exercise. Since I fell and broke my hip, I have to have one person walk with me and use my walker, which can be cumbersome. It does hurt when I walk but I know it is important to move around.

Nurse: Other than the fall you had the other night at home, have you had any other recent falls. Are you worried about falling? Do you feel steady on your feet when walking and do you use your walker?

OT/Nurse: Do you know about your hip precautions?

**Millie:** I do know I can't bend too far over, but sometimes if I am doing something quick like grabbing for my slippers to go to the bathroom, I forget.

## NUTRITION/APPETITE

Nursing: "How has your appetite been?"

**Millie:** The food here is not very good. I can't wait to get home because I love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I try the best I can to eat the food here because I know it is important for my energy to be able to go back home.

## FAMILY

Students may ask about family available to help provide care and support.

**Millie:** My family is very helpful. Now that my dear husband Harold is gone, I have to rely more on Dina and her kids to help me out. Dina does work everyday at the school so she is busy most of the time. She is a good daughter and she helps me when I need to get to the doctor. She also picks up groceries for me once and awhile. I have three grandchildren. Jessica who is 17, Daniel is 14 I think, and Megan is... 12. She likes to help me with my roses in the summer.

## ANXIETY

Students may ask about any worries or concerns.

**Millie:** I worry about finances. Now that I have to pay for the hospital bill and being in this place, it makes me worry even more. I am concerned about how much this will cost and if my Medicare will pay for the bill. I already have to pay a lot for my medications and since Harold passed I don't get his pension so I just have my social security to live on. I just don't know how Harold paid all those bills. It doesn't hardly seem like there's enough money for all that medicine and my other bills and then these medical expenses.

Dina: Finances are difficult as I am doing them all for my Mom now.

## SAFETY

Social Work: Do you feel that you are safe in your home living alone? Do you think you are able to go back there?

Millie: I understand that things are different now, but really want to live there as that is where I have always lived and it is safe there. It would be hard to imagine living anywhere else.

## OTHER

**Current Medications:** Tylenol 650 mg for pain Q 6 hours, Captopril 25 mg three times a day, Metoprolol 100 mg every day, Furosemide 40 mg twice per day, Lipitor 50 mg once daily, Fosamax 10 mg daily, Celebrex 200 mg daily, Warfarin 5mg daily, Tylenol 325mg as needed for pain, Pilocarpine 1 drop 1% solution TID to R eye, Timolol maleate 1 drop 0.25% solution once daily to R eye

Note: SPs do not need to memorize medications listed above. The list is more for your reference, since students may ask about them. An appropriate response would be, "I know I take something for that."

You are not very good at taking your medications but you try your best to remember them.

### Past Medical and Psychiatric History:

- glaucoma (vision problems that can lead to vision loss, but treatable),
- hypertension (high blood pressure),
- osteoarthritis (joint pain and stiffness),
- stress incontinence (urine loss when pressure exerted on abdomen),
- hypercholesterolemia (high cholesterol),
- atrial fibrillation (irregular heartbeat)
- Cholecystectomy (gallbladder removal) at age 30

You do not have any major cognitive impairments, but can be forgetful at times, especially since being in the hospital. You are mildly depressed. You are not taking any psychoactive medications or sedating medications.

### You are:

- Alert, oriented, somewhat fatigued and occasionally forgetful
- Cooperative, friendly and at times overly talkative
- Sitting up in a chair

## OLDER ADULT CARE CONFERENCE SIMULATION

### Standardized Patient Script- Dina

**Background:** You are Dina Jones, the mother of Millie Larsen, a 90 year old recently widowed woman who has lived in the same small house for the last 50 years. Your mother recently had a hip surgery after having fallen and broken her hip at home. She was then discharged from the hospital to the skilled nursing facility for a short stay for rehab and pain management. You have trying to balance your busy life with supporting hers and come and see her every day at the Skilled Nursing Facility. The healthcare team, consisting of nurses, occupational therapists, and social workers, will work together with your Mom and you to create the best plan of care for your Mom to reach her goals to get back home living independently. They will ask your mother questions about her pain management, fall risk, activity level, and medications. Feel free to speak up as needed to feel comfortable with the plan of care.

Students (who are representing as healthcare team members, 2 nursing students, 2 Social work students, 2 occupational therapy students) will enter the care conference room and introduce themselves to you and Dina.

Note: As this is a learning opportunity for students, feel free to communicate a lot of information. However, please allow the students to guide the care conference and respond to questions only when asked.

**Introduce yourself: "I'm Millie's daughter, Dina."**

One of the nursing students will then lead the meeting in presenting your Mom's case to the members in the room and then each pair of students will talk about her plan of care and goals to meet to get her discharged back home. The students may ask you questions regarding the below topics at some point, but most likely not in any given order. Bottom line is you want what is best for your Mom and are concerned about financial costs, but also how you will safely take care of your Mom at home since you have a full time job and have three kids and are your Mom's primary support system. You are a little overwhelmed.

The Nursing student or one of the students will be asking questions about the following topics to Millie.

#### **PAIN**

Nursing: "How has your pain been?" OR "Can you rate your pain on a scale of 1-10?"

Millie: My pain has been OK, about a 2, a dull ache in my hip. I have been using ice packs and the nurses have been giving me Tylenol a couple times a day, which helps as the pain never gets too bad. It hurts most after therapy and when I move so I try not to move so much and then it is ok. I keep forgetting to ask for something for pain as I don't want to bug anyone.

**Dina:** Mom, I think you might have a little more pain than a 2/10. You seem to rub your hip quite a bit. I just want you to be comfortable and be able to do the things you used to do. Ever since they scheduled

her Tylenol to twice a day instead of being “as needed” I think mom’s been doing better.

## **SLEEP**

Students may or may not ask about sleep.

**Millie:** It is been a little more difficult to sleep on the hard bed here. I go to bed around 9 pm and can fall asleep but then I have to get up 2 times at night to use the bathroom and now that I need help from someone and a walker, it takes me even longer to get anywhere.

**Dina:** Mom slept well when dad was still around. I think this last year has been hard for her to adjust. She always has her dog nearby . . . she’s a great cuddler.

## **ACTIVITY/ EXERCISE**

**Nursing:** With regard to Millie’s activity level, she does walk with one assist and a walker and tolerates activity well. How do you think you are doing Millie?

**Millie:** Well, I have had a few near misses if you know what I mean – I’ve been able to catch myself or fall into a chair so that doesn’t count. But, this time I wasn’t able to catch myself as there was no chair around and I didn’t have my walker. I’m not sure what I will do now to catch myself as I don’t want to hurt myself again. I used to get outside and do gardening for my exercise. Since I fell and broke my hip, I have to have one person walk with me and use my walker, which can be cumbersome. It does hurt when I walk but I know it is important to move around.

**Dina:** Mom, you are much more steady when you use your walker. You have to be patient and wait for someone to help; we don’t want you to fall again. The staff here try their best.

**Nurse:** Other than the fall you had the other night at home, have you had any other recent falls. Are you worried about falling? Do you feel steady on your feet when walking and do you use your walker?

**OT/Nurse:** Do you know about your hip precautions?

**Millie:** (OT fill in info please) I do know I can’t bend too far over, but sometimes if I am doing something quick like grabbing for my slippers to go to the bathroom, I forget.

**Dina:** Mom does seem to forget her hip precautions a lot but I try to remind her that she doesn’t want to re-injure it. This is lot of new information for her!

## **NUTRITION/APPETITE**

**Student:** “How has your appetite been?”

**Millie:** The food here is not very good. I can’t wait to get home because I love to cook; the church is always asking me to make my famous chicken and dumplings when we have special dinners. I try the best I can to eat the food here because I know it is important for my energy to be able to go back home.

**Dina:** Mom's appetite isn't what it was before dad passed. She was always cooking and baking something. Now it's just too much for her. My kids and I go over to her house as often as we can to bring food and make sure she has groceries 2-3 times a week at least.

## **FAMILY**

Students may ask about family available to help provide care and support.

**Millie:** My family is very helpful. Now that my dear husband Harold is gone, I have to rely more on Dina and her kids to help me out. Dina does work every day at the school so she is busy most of the time. She is a good daughter and she helps me when I need to get to the doctor. She also picks up groceries for me once and awhile. I have three grandchildren. Jessica who is 17, Daniel is 14, I think, and Megan is . . . 12. She likes to help me with my roses in the summer.

## **ANXIETY**

Students may ask about any worries or concerns.

**Millie:** I worry about finances. Now that I have to pay for the hospital bill and being in this place, it makes me worry even more. I am concerned about how much this will cost and if my Medicare will pay for the bill. I already have to pay a lot for my medications and since Harold passed I don't get his pension so I just have my social security to live on. I just don't know how Harold paid all those bills. It doesn't hardly seem like there's enough money for all that medicine and my other bills and then these medical expenses.

**Dina:** Finances are difficult as I am doing them all for my Mom now. Do you think there are special supplies she will need when she goes back home? She has a 4 wheeled walker at home. Do you think we can use that?

## **SAFETY**

**Social Work:** Do you feel that you are safe in your home living alone and able to go back there?

**Millie:** I understand that things are different now, but really want to live there as that is where I have always lived and it is safe there. It would be hard to imagine living anywhere else.

**Dina:** I want my mom to be safe and happy, if both of those things are possible. Financially, it would be hard to have her live in an assisted living place, but I am not sure how safe she is at home on her own now that she has hurt herself.

## **OTHER**

### **Your Mom's Current Medications:**

Tylenol 650 mg for pain Q 6 hours, Captopril 25 mg three times a day, Metoprolol 100 mg every day, Furosemide 40 mg twice per day, Lipitor 50 mg once daily, Fosamax 10 mg daily, Celebrex 200 mg daily, Warfarin 5mg daily, Tylenol 325mg as needed for pain, Pilocarpine 1 drop 1% solution TID to R

eye, Timolol maleate 1 drop 0.25% solution once daily to R eye

Note: You do not need to memorize medications listed above. The list is for your reference, since students may ask about them. An appropriate response would be, "I know she takes something for that."

\*Millie's pills are disorganized at home. She takes her pills just fine here. If asked, you have tried to organize her pills for her at home in pill boxes but it doesn't always stick. You check with your mom a lot to make sure she is taking her medications.

**Your Mom's Past Medical and Psychiatric History:**

- Glaucoma (vision problems that can lead to vision loss, but treatable), hypertension (high blood pressure), osteoarthritis (joint pain and stiffness), stress incontinence (urine loss when pressure exerted on abdomen), hypercholesterolemia (high cholesterol), Atrial fibrillation (irregular heartbeat)
- Cholecystectomy (gallbladder removal) at age 30
- Millie does not have any major cognitive impairments, but can be forgetful at times, especially since being in the hospital. She is mildly depressed.

**You are:**

- Concerned about the plan for your Mom and where she will end up.
- Overall, you are a very caring person and want your mom to be happy but are realistic about her limitations.

## RESOURCES

Nurses Roles in Healthcare and Long Term Care Article:

Brandburg, G. (2007). Nursing roles in health care and long-term care. Encyclopedia of Health & Aging (K.S. Markides, Ed.). Thousand Oaks, CA: SAGE. doi: <http://dx.doi.org/10.4135/9781412956208.n165>

Millie Larson's Interprofessional Assessment Pre-Simulation Video: <https://vimeo.com/189829143>

Skilled Nursing Facility Structure and Background presentation PDF: <https://uwmadison.box.com/v/uwmadisonnursingsim4snf>

## LEARNER HIGHLIGHTS

“It was nice to get a sense of some of the [interprofessional] overlap, but also what we’re specialized in.”

“I don’t think I would have wanted to do it nearly as much if it wasn’t an actual simulated care conference. Because we’re not gonna be able to get the full picture if we’re not working with other disciplines . . . with all the other disciplines it’s more realistic. Seeing how much our goals were related to each other was really valuable. Seeing there’s a lot of crossover and a lot of communication that needs to happen.”

“It definitely helps to see that in action and see how overarching someone’s plan of care looks and how we can work together to, in some cases, achieve the same goals, in some cases have slightly different goals that kind of bring the patient in the same direction.”

“I liked having actors and actresses because it gave us a different perspective than if we had a professor come in and do it. Like we might not take it as realistic or as seriously, probably.”

“I think that it gives us a good atmosphere to kind of just really see, to really see how we would respond maybe in a situation without actually getting in trouble. So, then I realize that interdisciplinary is really great because then we can kind of see and not be shocked when we go out into the real world what’s actually going on and kind of have a glimpse of like, what these other practices look like.”

“I think including the patient is something we talk a lot about in our program. [In the preconference], we talked about just really making sure that we were just including Millie and the daughter with the goals that we were making so that, you know, they felt included. Really making her feel a part of this and not just us talking and kind of just like telling her what we’re gonna do, which I think was very important.”

“Because Millie and her daughter are together quite often, I think it was good to have the daughter there so that not only Millie could hear what we were saying, but also the daughter. So that she kinda knew where each one of us stood, and our goals for Millie, and where she needed to go just in case, let’s say, Millie would forget, she had another ear, to give her a reminder.”

“Having the mother-daughter relation, it was enlightening. We’re talking to Millie and she’s nodding her head and she’s agreeing but sometimes the client might not totally be following, or she’s just focused on getting out, and then watching the caregiver’s expressions or concerns, and, you know, addressing both of those, because both people are crucial to improving the situation.”

“It was interesting seeing how our goals we have made might not address their [patient] concerns. Like when Millie says she wants to garden, but we didn’t make a goal about gardening.”

“In our debrief, [the simulation instructor] was explaining about how we use specific jargon in our everyday, professional lives, but when we talk to patients we have to tone it down a bit and kind of unlearn fancy words.”

“You’ve got to communicate what you do plan to do, in a way that other people understand like the client and the other professions. Um, and I think one of the things that the OT professor or one of them said, just like telling the patient that ‘this is what you have to do before we send you home,’ can be so helpful.”

“In our program we have like a series of professionalism and professional development courses, and I think there’s a lot of crossover in terms of interprofessional communication, how you present yourself in meetings, and certain terminology in client-centered care. I kind of thought that was pretty relevant in today’s activity . . . I was talking about how it’s important to like actively listen in those meetings, and not just plan what you’re gonna say next but also like really take in what the other disciplines are saying and how that affects the client, and you interact with them.”

“In a couple of the experiences I’ve had out in certain hospitals, sometimes there’s a defensive relationship between all the professions, because every profession has their own jargon and everyone wants to make sure that they’re seen as important, and obviously that’s not in the best interest of the client. So having this experience as new professionals, understanding each profession, and being comfortable right off the get-go to communicate together and know that we’re all really important.”

## INSTRUCTOR TIPS

- The primary objective was that care conference was student led. Therefore, the care conference was live viewed by faculty from another conference room. The care conference was also recorded for students to view their own simulation if they wished. OT faculty required this for all their students in order to have learning from care conference include whole OT class (those unable to participate in simulation). Nursing and Social work did not require this. Recording and live view are options if available to expand students and faculty members learning.
- OT, Nursing and SW faculty live viewed from another room and were able to reflect on the students current knowledge base. This aided in a gap analysis for the faculty to improve their teaching. In this way, live view aided in student and faculty learning.





