RIPE Simulation – Bill Marsden

RIPE Learning Objectives:

- Demonstrate a broader understanding of the roles of various health care professionals in delivering Interprofessional team based care
- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel: Patient, Bill & wife, Meredith.
Faculty in ward simulation: NUM, 2 observers/debriefers, other observers (if appropriate)
Faculty in Briefing Room: Facilitator for briefing

Participants: 10 students (2 from five of following disciplines – medicine, nursing, social work, physiotherapy, OT)

Props and Resources needed:
1. Bedside locker
2. Chair
3. MMP
4. Medication charts
5. Medical notes in folder (phase 1 & 2 separate)
6. Observation charts
7. Patient’s own medications
8. Makeup for blood – wound covering
9. Bandages for hip
10. Crutches
11. Newspapers for patient
Storyboard:

Bill is a 68 year old man who lives independently at home with his wife, Meredith. They have 2 sons who both live interstate with their families. Bill is fiercely independent and has been physically strong all his life. Before retiring nearly 10 years ago, Bill worked as a wharfie. These days he spends his time gardening, playing bowls and running the local surf club (he is vice president of Coogee Surf Club).

To date, Bill and Meredith have not required any services. Bill has a close relationship with his GP, Dr Harrison, who he has been seeing for nearly 30 years. He has a history of hypertension, high cholesterol and Atrial Fibrillation. He had a “mini-stroke” 10 years ago with no residual deficits.

Bill has a dominating personality and is very demanding of Meredith and believes she can nurse him at home while he recuperates. Meredith on the other hand is not overly keen on this idea, however; she finds it difficult to openly discuss this with Bill and instead speaks privately with health staff about alternative arrangements.

Background to hospital admission:
Yesterday Bill had slipped down his back steps, which were wet from him hosing the garden. He has broken his left hip and requires surgery. He is very unhappy about being in hospital and is already trying to convince staff to hurry up and send him home.

Information to be written in medical notes:

Day 1

PC:

68 year old male with # left NOF after a fall down steps of home
No LOC, Slipped on steps, mechanical fall
Immobile
Requiring surgery
In pain and requiring analgesia
**PMHx:**

Hypertension, mild CCF, high cholesterol, AF, previous TIA 10 years ago – No lasting problems  
Lives at home with wife Meredith (2 sons, live interstate with their families)  
NKA  
On Warfarin, Atorvastatin, Lasix, Slow k, Ramipril, Carvedilol, Amaryl?

**O/E:**  
Haemodynamically stable.  
shortened and rotated left leg, bruising around left hip  
Unable to move due to pain – pale  
Unable to weight bear  
Anxious – wants to leave ASAP

**Ix:**  
X-ray: Broken NOF (left)  
Bloods: Pending  
INR 2.1  
ECG

**Plan:**  
NBM from midnight  
Withold warfarin  
Start Clexane 40mg sc daily post op

**Nursing Notes:**  
Patient admitted with a broken left NOF  
Booked for surgery tomorrow morning – consent needed  
NBM from midnight  
Concerned about warfarin being withheld – previous TIA  
Patient wanting to go home ASAP – wife concerned may try and do too much too soon  
BSL’s 4.7  
BP 125/90  
Afebrile
SW Review:
Patient’s wife has requested to see social work regarding care for Bill when he is discharged, appears worried about how she will cope. Wife concerned about suitability of house (2 stories, small bathroom) while recuperating.

Physiotherapy Review:
Previously mobilised independently without aid. Limited at 3km by shortness of breath due to mild CCF. Independent with all ADLs – nil aids required. Nil previous falls. Regular physical activity including swimming, bowls and gardening. Wants to return to all pre-op activities as soon as possible.

Day 4 post admission:

RMO Round
3 days post op – seen by Dr Barrows - ? discharge tomorrow if all well
Bill is very keen to be discharged ASAP however his wife is very reluctant to care for him at home.
SW to r/v re: respite care?
Afebrile – still some pain
Now mobilising with assistance
? For Risedronate plus Ca and Vit D – needs counselling
Restart warfarin today??
Check INR

Nursing:
Patient requesting d/c ASAP – wife concerned, does not think can look after him at home without support – sw r/v
Refusing Amaryl? For RMO to r/v
Other meds as charted
**Equipment Required:**

<table>
<thead>
<tr>
<th>Drugs and Fluids</th>
<th>Medication chart</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No known allergies</strong></td>
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</tbody>
</table>

**Phase One:**
- Ramipril 5mg mane
- Warfarin 3mg daily – withheld
- Atorvastatin 40mg daily
- Frusemide 40mg mane
- Slow K 1 mane
- Amaryl 2mg mane - Refusing
- Carvedilol 25mg bd
- Oxycodone 5mg qid prn

**Phase Two:**
- Ramipril 5mg mane
- Clexane 40mg sc daily
- Atorvastatin 40mg daily
- Frusemide 40mg daily
- Slow K 1 mane
- Carvedilol 25mg bd
- Amaryl 2mg mane – refusing
- Oxycodone 5mg prn

**Patients Own Meds (In Bag):**
- Ramipril 5mg labelled Take one in the morning
- Warfarin 3mg daily (2mg and 1mg – labelled as directed
- Atorvastatin 40mg daily – labelled Take one daily
- Frusemide 40mg mane – labelled Take one in the morning
- Slow K 1 mane – labelled Take one in the morning
- Amaryl 2mg mane – labelled “Meredith Marsden” – Take one in the morning
- Carvedilol 25mg – labelled Take ONE twice a day
<table>
<thead>
<tr>
<th>Time</th>
<th>Phases</th>
<th>Expected Actions and outcomes for each discipline – To be included on handover sheet for each phase</th>
</tr>
</thead>
</table>
| 0 – 30 mins  | PHASE ONE – group A           | Medicine                                                                  
|              |                               | Explain the operation, consent                                                   |                                 |
|              |                               | Nursing                                                                    | Pre-op checklist, vitals, BSL’s, Obs |                                 |
|              | BACKGROUND                    | Physio                                                                     | Go through post-op treatment plan |                                 |
|              | Pt has been transferred from ED with a broken left NOF following a fall down front stairs of home | Social work                                                                 | Assess previous mobility         |                                 |
|              | Booked in for surgery for tomorrow |                                                                         |                                   |                                 |
| 30 – 60 mins | PHASE TWO – group B           | Medicine                                                                  | Wound ooze, pain in hip, anticoagulant dose?? |                                 |
|              |                               | Nursing                                                                    | Wound oozing blood                |                                 |
|              |                               | Physio                                                                     | Partial weight baring, crutches, stand with assist |                                 |
|              | Time Lapse – 4 days later      | Social work                                                                | Wife refusing to take patient home, feeling overwhelmed with the care needed though unable to speak with husband about this. Possible respite care required. |                                 |
|              | Consultant has agreed to Bill’s request to be discharged                  |                                                                          |                                   |                                 |
|              | NUM asks group to assess for discharge                                    |                                                                          |                                   |                                 |
|              | Blood on bandage and sheet as wound has broken down – redressed by wound CNC |                                                                          |                                   |                                 |
|              | Wife is reluctant to care for Bill at home                                |                                                                          |                                   |                                 |
Actors Briefs:

Patient – Bill Marsden
You are a 68 year old man called Bill Marsden. You have been married to Meredith for nearly 40 years (anniversary this September). You have 2 sons, John and Peter, who both live in Western Australia with their families. You see them once every few months when you go and visit. You have a very strong and demanding personality and feel angry about being in hospital. When asked about pain post op you minimise it and say “I feel fine and just want to go home as soon as possible.” You expect Meredith to care for you however; she is feeling quite the opposite and is very concerned about how she will cope (you are unaware of this as she has been unable to tell you). You believe you are pretty healthy except for your “heart problems” and are always active. You had a “mini stroke” ten years ago and the doctor put you on warfarin.

Carer (if needed)
You are a 62 year old woman called Meredith and your husband Bill has been admitted to hospital with a broken left hip. You tend to be quiet and nervous and very deferring to your husband. Your main concern is how you will be able to care for him as you are not very well yourself, only last year you had breast cancer and are still recovering from all the associated treatment. You also have also recently been diagnosed with diabetes and you are just coming to terms with that. You know Bill will be very demanding and also will ignore the doctor’s advice. You are also worried that your house will be unsuitable for Bill (lots of stairs, small and narrow bathroom). Although you are close to your sons, they are limited in the support they can offer you and Bill. You are considering moving to Western Australia to be closer to them but you know that Bill will be against the idea as he has a lot of ties to the local community. You miss your three grandchildren, Amy, Luke and Ben and really wish you could move over there.

Scenario Specific Questions:

If anyone asks about MEDICAL HISTORY:
Bill has a history of heart problems that were diagnosed a few years ago. He has mild heart failure and high blood pressure but these are usually well controlled with his medications. He had a minor stroke about 10 years ago but he made a full recovery. He considers himself to be pretty healthy for his age and is very active. He sometimes gets a bit breathless if he goes for a long walk but is generally OK going up and downstairs etc. He is in a quite a bit of pain with his broken hip but is a bit reluctant to let on how much.

If anyone asks about MEDICATIONS/DRUGS:
Bill is very conscientious with his medication and knows exactly what he takes and why! He is very concerned that they are going to stop his warfarin while he is having his operation as he doesn’t want to have another stroke! He refuses to take the Amaryl tablets as he doesn’t recognise them and doesn’t know what they are. (They are in fact mistakenly prescribed – his wife usually takes these and her box of tablets has been brought in by the paramedics. The ED RMO has prescribed them by mistake)
If anyone asks about DIET AND EXERCISE:
Bill has been fit all his life, worked on the wharfs for over 40 years and is still quite active, swims every morning at Coogee Beach, gardens every day, goes to bowls on Saturday and Wednesday and helps run Coogee Surf Club – he is a life member and still sometimes does a patrol in the summer. He thinks he has a very healthy diet – meat and two veg usually, none of the fancy stuff! He is aware about diet and warfarin. He doesn’t smoke any more – stopped 10 years ago after his stroke and only rarely has a beer on special occasions.

If anyone asks about his HOME OR FAMILY SITUATION:
Bill has lived in Coogee all his life. He loves the beach and doesn’t understand why his sons have gone to WA (they both have jobs in the mines and moved over there years ago). He knows his wife would like to go and live there but isn’t really willing to consider it at the moment – has too much involvement with the local community and would feel “lost and useless” over there! You live with your wife Meredith in a 2 storey 3 bed house. There are a lot of stairs – all the bedrooms are upstairs and the bathroom is quite old. The shower is over the bath. There are also stairs up to the front and back doors. You fell on the back steps when you were hosing the garden. You don’t think you will have a problem with anything going home and can’t wait to get back there. You think Meredith is being silly when you realise that she is concerned about looking after you there.

If anyone asks about your RELATIONSHIP WITH MEREDITH:
You think you are the one “in charge” in your relationship and do not usually take much notice of what Meredith’s needs are. You know she has been quite sick over the last few months but as far as you know she is OK now and it’s her turn to look after you! It won’t be for long anyway as you think you will be back to normal soon and be able to go about your normal activities in the next week or so. You are quite unrealistic in your expectations.

If anyone asks about RESPITE CARE:
You are quite opposed to going into any sort of care “like an old man!” You expect that Meredith will look after you at home and sort out anything you need. You are not as opposed to any in home services being organised “as long as its only while you are getting back to full strength!”
NUM Handover Sheet Guidelines

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Situation, Background, Admission, Diagnosis, History</th>
<th>Assessment</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase ONE</td>
<td>Bill Marsden</td>
<td>Wife on ward keen to talk with medical staff re: home care</td>
<td>Full nursing assessment Consent for OT Pre-op checklist Assess home situation Talk with wife about discharge plans Initial physio assess</td>
</tr>
<tr>
<td></td>
<td>Broken left NOF as a result of falling down front stairs of house 68 year old man Lives with wife Meredith 2 sons live in Western Australia p- no family support for wife</td>
<td>Tests required: CXR, ECG, FBC, EUC, INR, Group &amp; hold</td>
<td></td>
</tr>
<tr>
<td>Phase TWO</td>
<td>Bill Marsden</td>
<td>Operation successful however wound is now oozing blood needs to be looked at Wife very distressed about imminent discharge</td>
<td>Vitals ADLs Mobility OT Review - Assess home situation Talk with carer Wound ? Counselling on bisphosphonate Restart warfarin?</td>
</tr>
<tr>
<td></td>
<td>Broken left NOF as a result of falling Post – op 68 year man - demanding to be discharged Wife is very reluctant to care for him at home Dr Barrows - ? d/c tmoro following wound review</td>
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</tr>
</tbody>
</table>
RIPE Simulation - Elisa Little

RIPE Learning Objectives:

- Demonstrate a broader understanding of the roles of various health care professionals in delivering Interprofessional team based care
- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel:
Faculty in ward simulation: Eliza, James (Father), NUM
Faculty in Briefing Room: Briefer, debriefer x 2

Participants: 10 students (2 from five of following disciplines – Medicine, Nursing, Physio, Pharmacy, Social Work)

Props and Resources needed:
Oxygen and mask
Gastrostomy
Bag containing meds
IV fluids and line
Tracksuit pants
T-shirt - teenage
Bedside Locker with nebuliser and other inhaled meds by bed, plus ensure/sustagen
Chair for Carer
Medication Charts
Medical notes in folder (Phase 1 and Phase 2 separated)
Observation charts
Long Line
Storyboard:

History and Background:
Eliza Little is an 18 year old female unwell with an exacerbation of CF (chest infection). She presents with increased productive cough, wheeze and SOB, and has intermittent chest pain with coughing. She is lethargic and pale. She lives at home with her mum and dad, who are both supportive, but forgetful and get confused when it comes to her complex medication regimen. They try to give her as much independence as possible, but Eliza herself is unsure of her medications and often non compliant – constant parental supervision is required, plus regular routine. Eliza is emotional at every admission (3 times a year currently), when her weight goals are set and she is dreading transition to adult care. Eliza is to be admitted for IV antibiotics, and to re-establish home treatment and encourage her compliance with it.

Eliza normally has a good response to IV antibiotics (plus physio and dietetic input during admission).
Eliza needs encouragement to attend her monthly CF clinics – she will now be transferred to Dr Roberts at adult CF care at POW not SCH.

Information to be written in medical notes:

Day 1

PC:
18 yr old female with CF – Chest infection
Increased productive cough, wheeze, SOB
Intermittent chest pain with coughing

HPC:
Cystic Fibrosis – sees Prof Mellor in SCH – Now POW Dr Roberts Adult CF
Moderate lung disease
Pancreatic insufficiency
Pubertal and growth delay
CF related diabetes
Asthma
Gastrostomy
O/E:
Pale, lethargic
Clubbed
Mild work of breathing
Febrile – low grade 37.5
Bilat creps and wheeze
HS dual – no murmur
Abdo soft non-tender no organomegaly
Long line in situ
Gastrostomy – looks ? red

Ix:
EUC - Normal
FB
FEV – 60%
O2 sats – 93%
Sputum – mucoid and non mucoid pseudomonas
BSL’s – high - ? compliance
HbA1c 8.7%

Plan –
IV antibiotics, steroids,
Physio bd
Dietician r/v
Stoma nurse?
Endocrine r/v
Chest X - ray
Tobramycin levels
Dietician review
Losing weight – 4kg over last 2 months. High glycaemic index. Minimal protein sources in many meals/snacks.
Recommended regular meals and snacks, particularly high protein foods at breakfast and lunch. Discussed importance of creon, and having breakfast.
Increase feeds overnight as discussed.

Endocrine review
Poor management of BSLs and insulin – running high with BSLs >20. Levemir increased to 18 units BD and novorapid commenced pre meals.

Nursing Notes:
Young girl, anxious, low mood
Fearful of being on adult ward – requesting parents stay overnight
Gastrostomy site – red and sore – ? for review by stoma nurse/RMO
BP 120/90
Temp 37.5
IV fluids TKVO
Eating and drinking - Minimal ? dietician r/v
Cannula site – no redness or swelling

Day 4 post admission:

RMO round:
Physiotherapy – twice daily to good effect
Seen by endocrine – insulin doses adjusted further. Needs ongoing endocrine involvement
Dietician r/v and feeds increased
Stoma nurse r/v – site OK, stomatherapy paste given
Still SOB, wheeze slightly improved, but no change in FEV1 (now 58%) or sputum amount/appearance
Still on IV antibiotics – 10 more days – ? no improvement
Wanting to transfer back to SCH care??????
Low mood still evident – anxious about missing school and friends
Tobramycin level - WNL
### Equipment Required:

#### Drugs and Fluids

- **Medication chart**
- **Allergy – NKA**

#### Phase One:
- **Creon 10,000 capsules – with meals/snacks**
- **VitABDECK – 1 capsule daily**
- **Pulmozyme – 2.5mg nebulised daily**
- **Seretide 125/25 microgram – 2 puffs bd**
- **Sodium chloride 6% - 4ml nebulised bd (salbutamol beforehand)**
- **Azithromycin 250mg daily on Monday, Wednesday, Friday**
- **Prednisolone 25mg daily**
- **Levemir 14 units bd**
- **Tobramycin 320mg daily IV**
- **Timentin 3.1g tds IV**

#### Phase Two:
- **Creon 10,000 capsules – with meals/snacks**
- **VitABDECK – 1 capsule daily**
- **Pulmozyme – 2.5mg nebulised daily**
- **Seretide 125/25 microgram – 2 puffs bd**
- **Sodium chloride 6% - 4ml nebulised bd (salbutamol beforehand)**
- **Azithromycin 250mg daily on Monday, Wednesday, Friday**
- **Prednisolone 25mg bd**
- **Levemir 18 units bd**
- **Novorapid 5 units pre-breakfast, 10 units pre-lunch, 8 units pre-dinner**
- **Tobramycin 320mg daily IV**
- **Timentin 3.1g tds IV**
<table>
<thead>
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<th>Phases</th>
<th>Expected Actions and outcomes for each discipline – To be included on handover sheet for each phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0 – 30 mins</strong></td>
<td><strong>PHASE ONE – group A</strong></td>
<td></td>
</tr>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>Patient presented unwell with an exacerbation of CF – first admission post transfer from SCH</td>
<td>Medicine</td>
</tr>
<tr>
<td></td>
<td>Pancreatic insufficient, asthma, CFRelated Diabetes</td>
<td>Chest X-ray, dietetic and endocrine review, extremely anxious and emotional IV antibiotics and compliance</td>
</tr>
<tr>
<td></td>
<td>On average 3 admission per year</td>
<td><strong>Nursing</strong></td>
</tr>
<tr>
<td></td>
<td>Lethargic and pale, SOB and wheeze, FEV1 60%</td>
<td>Full nursing Assessment, falls risk assessment, ADRAT</td>
</tr>
<tr>
<td></td>
<td>Chest Xray, IV antibiotics, physio and steroids</td>
<td>Vitals, gastrostomy site – stoma nurse r/v</td>
</tr>
<tr>
<td><strong>30 – 60 mins</strong></td>
<td><strong>PHASE TWO – group B</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Time Lapse – x4 days later</strong></td>
<td>Physiotherapy – twice daily to good effect</td>
<td>Medicine</td>
</tr>
<tr>
<td></td>
<td>Seen by endocrine – insulin doses adjusted further. Poor oral intake</td>
<td>Chest X-ray - bronchiectasis, not much clinical improvement (change antibiotics), still highly anxious and emotional – Psych review?</td>
</tr>
<tr>
<td></td>
<td>Stoma nurse r/v – site OK, stomatherapy paste given Still SOB, wheeze slightly improved</td>
<td>Nursing – BSLs raised, poor oral intake (endocrine and dietician r/v and plans support</td>
</tr>
<tr>
<td></td>
<td>FEV1 (58%) sputum copious, greeny brown</td>
<td><strong>Social worker</strong></td>
</tr>
<tr>
<td></td>
<td>Still on IV antibiotics - 10 more days needed _ ? no improvement</td>
<td>Services for home _ ?physio, ongoing support for parents, support groups</td>
</tr>
<tr>
<td></td>
<td>Low mood- anxious about missing school and friends, weepy, uncommunicative</td>
<td><strong>Pharmacist</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compliance with medications, medication list and compliance aids</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Physiotherapist</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiotherapy support to continue at home</td>
</tr>
</tbody>
</table>
**Actors Briefs:**

**Eliza Little**

You are an 18 year old female. The last year has been challenging for Eliza with difficulties around adherence to a very complex treatment regime, frequent admissions, significant school loss and problems with anxiety and depression. Eliza feels she could do better at school but struggles to achieve this with the amount of time away from school. You are quite demanding with your parents and are very moody and manipulative, using emotional blackmail about your CF to get what you want.

You are slightly breathless, wheezy and teary. You get breathless with exercise, and have a moist cough most days. You usually skip breakfast which leads to low blood sugars at school, and by the evening your sugars are high. You basically don’t follow your prescribed diet too rigidly. When asked any questions you are defensive and uncommunicative, playing on your phone, not making eye contact. You live with your parents, James and Michelle you have no siblings, your circle of friends are very important to you. Your parents come to see you every other day and are very supportive, but struggle to manage your moods and are as confused as you about your treatment regime.

You do your physiotherapy, but your technique is poor and you often forget your salbutamol before your hypertonic saline nebulisers. You only use your nebulised antibiotics daily (not twice daily) and pulmozyme ‘most days’ when you remember.

**James Little – Dad**

You are a 45 year old male, Eliza’s father, a policeman. You find Eliza’s moods hard to deal with and are worried she is not taking her medication properly. You want her to be responsible for her treatment so allow her to manage them, but feel you need to supervise her more to get her into a routine. You are also concerned about her moods and think she may be depressed. It is often hard to get her to engage in any of her physiotherapy, and exercise activities recommended by the CF clinic, and although Eliza says she has taken all her medications you are unsure about that (she gets angry and defensive when asked). Eliza is frustrated, emotional and teary during this admission, a pattern similar to the last few admissions at the children’s hospital. The family has been offered consultations with psychologists in the past to help with these behaviours and concerns – The family have discharged Eliza against the CF teams’ recommendations on a number of occasions because that’s what Eliza wanted, and don’t seem to understand the Seriousness of her disease and the importance of the treatment regimen. James is at a loss for what to do, and at this point in time will consider all options offered. He realises that Eliza is quite manipulative but tends to give in to most of her demands. There is an element of guilt around her CF and the impact it has on her life. Her mother, Michelle, is working part time at the moment. She is doing the accounts at the office where she works and so is having to do extra hours. Eliza is a bit cranky that mum isn’t around more often at the hospital. You are a kind gentle man, who is a bit confused by the complex treatment regimen that Eliza has.
Scenario Specific Questions:

If anyone asks about MEDICAL HISTORY:
Eliza has been treated for her Cystic Fibrosis at the SCH by Professor Mellor since she was a baby. She is admitted to hospital about three times a year recently for her CF, usually because she has a chest infection or is not maintaining her weight. She is not very compliant with her treatment regimen and needs constant supervision. She is having a lot of issues adjusting to the fact that her care is being taken over by the adult respiratory doctors.

If anyone asks about MEDICATIONS/DRUGS:
Eliza is on a very complicated treatment regimen and takes a lot of medications. She gets very confused by what she is meant to be taking most of the time and has to be constantly reminded. She knows that her Creon needs to be taken with meals so that she can absorb food properly and maintain her weight but often doesn’t take them properly. She uses her inhalers but sometimes skips her nebuliser. She doesn’t really understand the importance of the Pulmozyme (Helps break down the mucus?) and having to take it every day so that it actually works. She knows she has to take her antibiotics to stop her getting a chest infection so tends to be more compliant with these. She finds her insulin a “pain in the neck” and thinks she can play around with her dose depending on what she eats.

If anyone asks about DIET AND EXERCISE
Eliza doesn’t do a great deal of exercise, she does go to gymnastics once a week and goes walking with her dog but probably not as often as she should. Her diet is erratic, often misses breakfast, eats a lot of carbs and fast food – (not enough protein for CF patient). She hates the Sustagen and Ensure so relies on her overnight feeds. She has been seen by a dietician many times – fed up of hearing it!

If anyone asks about FAMILY/LIVING SITUATION?
She lives at home with her parents in a 2 storey house. She has a dog, Max who she walks every day. She is an only child and her parents dote on her. Both parents work, Mum in an office three days a week, Dad is a police officer who works shift work. She is 18 and is due to finish her HSC this year and she is a bit worried about this as missed so much school this year. She wants to go to TAFE to do business studies.

If anyone asks about her TRANSITION TO ADULT CARE?
She is very apprehensive about transitioning to adult care and is now disgruntled that she here in the adult hospital. The staff at SCH were very accommodating and she is finding it difficult to be around strange staff who do not know her and aren’t as familiar with her condition.

If anyone asks about PLANS FOR DISCHARGE?
She wants to leave hospital ASAP, she doesn’t really have a plan, family happy for any services that can be offered.
### NUM Handover Sheet Guidelines

| Phase ONE | Eliza Little | 18 Year old girl with CF  
Patient presented unwell with an exacerbation of CF – first admission post transfer from SCH  
Pancreatic insufficient, asthma, CF Related Diabetes  
Low mood – father on ward, wanting him to stay, teary | Chest Xray,  
IV antibiotics, physio and steroids  
Lethargic and pale, SOB and wheeze, FEV1 60%  
Regular nebs and meds  
BSL’s raised  
Gastrostomy site red?  
Mobilising independantly | Compliance with treatment regimen an issue – Meds, diet and physio  
Physio for chest  
? dietician r/v – feeds and diet  
Gastrostomy site r/v  
Full nursing assessment  
SW – Transition to adult ward difficult |
| --- | --- | --- | --- |
| Phase TWO | Eliza Little | 18 Year old girl with CF  
Patient presented unwell with an exacerbation of CF – no real improvement with her IV antibiotics and steroids  
Still low mood – anxious  
Wants transfer back to SCH care  
Poor oral intake | R/v antibiotics? – needs 10 more days  
Still SOB, less wheeze  
BSL’s still unstable - ? ongoing endocrine r/v  
Seen by stoma nurse | ? R/V mood  
Continue physio - ? home physio  
SW r/v for ongoing support re: school  
Compliance aids for medications? |
RIPE Learning Objectives:

- Demonstrate a broader understanding of the roles of various health care professionals in delivering Interprofessional team based care
- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel:
Faculty in ward simulation:
Faculty in Briefing Room:

Participants: 10 students (2 from five of following disciplines – Medicine, Nursing, Physio, Pharmacy, Social Work)

Props and Resources needed:
Walking stick
Bruise Kit – has bruise on forehead and chin
Wig
Tracksuit pants
T-shirt – with stains
Bedside Locker
Chair for Carer
Medication Charts
Medical notes in folder (Phase 1 and Phase 2 separated)
Observation charts
Own medications and list
Storyboard:

History and Background:

Fran Collins is a 40 year old female presenting with recurrent falls, mainly due to being a little unsteady on her feet and sometimes forgetting to take her PD medications correctly.

She lives alone in a 1 bedroom unit, and accesses limited services mainly meals on wheels and community transport in the community.

Fran has supportive parents, Jean and Mike who live locally to her. Her parents are currently up the North Coast on holiday.

Sister, Maria, recently committed suicide. She is very distressed by this and often cries. She doesn’t understand why this happened. Maria took a drug overdose 6 months ago. She was younger than Fran – 36 when she died. Her GP has just assessed her for depression and has started her on Sertraline last week.

Patient has frequent presentations to ED often self discharges. This is the third presentation this year.

History of juvenile Parkinsons Disease and development delay
She attends a Day Care Program and has a close relationship with Maggie Barker, the Day Care Co-ordinator.

Information to be written in medical notes:

**Day 1**

*PC:
*Fall observed by bystander.

From paramedic: Had a fall at the supermarket. Hit head. No LOC
Bystander called ambulance.
No further history available.

*HPC:
Old notes not available.
Multiple falls
Familial onset PD
Developmental Disability
O/E:
Alert
Mumbling speech.
Following commands appropriately. Accurate Yes/No responses.
Bruising on Right Forehead.

Power:

RUL
Sab /5 Sad /5
Sfl /5 Sex /5
Elbow fl /5 elbow ex /5
Wrist fl /5 wrist ex /5
Finger ab
Finger ad
Thumb Fl
Thumb Ex
opposition

LUL
Sab /5 Sad /5
Sfl /5 Sex /5
Elbow fl /5 elbow ex /5
Wrist fl /5 wrist ex /5
Finger ab
Finger ad
Thumb Fl
Thumb Ex
Opposition

↑ tone, ↑ reflexes R>L
Afebrile
HS dual
Chest clear
Abdo soft non-tender no organomegaly

I:\x:
EUC
FB -
Plan: CT Head
BP 125/90

Nursing Notes:
Stable, afebrile. Alert and orientated. Requesting to see counsellor re: sisters recent suicide.
Impulsive at mealtimes, sometimes coughing with water

Day 4 post admission:
Pt represented with fall coming out of bathroom at Day Program. No LOC.
Recent self discharged from POWH yesterday following similar presentation 3 days ago
Pt’s day program coordinator present today - Maggie Barker
Reports patient has appeared a bit vague after hitting her head 3/7 ago.
Hadn’t eaten or taken PD meds this am.
Pt minimally verbal today
Equipment Required:

Drugs and Fluids
Medication chart
Allergy – NKA

Phase One:
Sinemet 125 1 tds
Sinemet CR 250 1 bd
Sertraline 50mg mane

Phase Two:
Sinemet 125 tds
Sinemet CR 250 1 bd
Sertraline 50mg mane
Temazepam 10mg nocte prn
Metoclopramide 10mg tds prn
<table>
<thead>
<tr>
<th>Time</th>
<th>Phases</th>
<th>Expected Actions and outcomes for each discipline – To be included on handover sheet for each phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0 – 30 mins</strong></td>
<td><strong>PHASE ONE – group A</strong></td>
<td>Medicine</td>
</tr>
<tr>
<td></td>
<td>BACKGROUN D</td>
<td>CT Head, Neuro exam done, Bruise on head, depressed</td>
</tr>
<tr>
<td></td>
<td>Patient presented following fall at supermarket – history of multiple falls</td>
<td>Seen by GP – sertraline initiated two days ago</td>
</tr>
<tr>
<td></td>
<td>Juvenile onset PD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bumped head, bruised – No LOC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CT Head</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PHASE TWO – group B</strong></td>
<td>Medicine</td>
</tr>
<tr>
<td></td>
<td><strong>Time Lapse – 4 days later</strong></td>
<td>CT Head – NAD, Complaining of nausea this morning, appears a bit vague</td>
</tr>
<tr>
<td></td>
<td>Patient self discharged yesterday</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Represented following fall at Day Care yesterday afternoon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CT – Head NAD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaining of nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimally interactive</td>
<td></td>
</tr>
</tbody>
</table>
**Actors Briefs:**

**Fran Collins**

You are a 40 year old female. Your right upper limb is quite constricted, but otherwise you are able to walk with a walking stick, with a shuffling gait. When asked any questions you **MAINLY** answer with gesture and facial expression. Your speech is quiet and difficult for people to understand. Unfamiliar people will have most success talking with your parents or staff at the day program.

You live alone in a housing commission flat on the first floor. There is a lift but it is often broken. Your parents, Jean and Mike live 2k away. They come to see you about three times a week and are very supportive. Your sister, Maria lived down the road with her partner and two children. You are devastated by her death and having great difficulty coming to terms with it. You have recently been started on some medicine for this but unsure of its name.

You do some cooking yourself but it is quite limited. Mum brings you some food when she visits that you heat up in the microwave. She also helps you with the cleaning. You do have some services in place e.g meals on wheels. You have had Parkinsons Disease since the age of 16 and have slowly been declining.

You attend the Rosebank Day Care Centre four days a week – there is a bus that comes and picks you up in the mornings and takes you home in the afternoon but sometimes you like to walk home if you are having a “good” day.

**Maggie Barker – Care Centre Co-ordinator**

You are a 35 year old female, who is the care coordinator at Fran’s Day Program. You have known Fran for many years, so are very good at understanding her speech and concerns. Fran is very comfortable with Maggie and loves going to the Day Program. They have a lot of activities for her to do.

You have noticed recently that Fran has been a bit “stiff” and are worried she is not taking her medication properly. You are also concerned about her depression following the death of her sister. It is often hard to get her to engage in any activities nowadays. You know she has been seen by her GP and he has prescribed her an anti-depressant the other day but you haven’t seen much improvement yet.

You are concerned about Fran’s ability to live at home anymore and think this should be discussed with her parents. They are currently up the Coast visiting their son George. They are back in two days.

You think that Fran has been a bit vague since her fall and are quite concerned about this.
Scenario Specific Questions:

If anyone asks about MEDICAL HISTORY:
Maggie - You are able to indicate Fran has a Developmental disability and Parkinson’s Disease – which is early onset familial. You think her her aunt also suffered from this. She died at the age of 48.

If anyone asks about MEDICATIONS/DRUGS:
Fran takes Sinemet for her Parkinson’s. She sometimes forgets to take these. Sometimes she won’t go the Day Program because of this. She probably forgets at least one or two mornings a week. Seems to be happening more regularly over the last few months.
She has no known allergies.
She has recently been started on Sertraline and ever since then has been feeling a bit nauseous after she takes it. She takes it as soon as she gets up with her other tablets, before she has breakfast. She does not have a webster pack. Mum usually puts her tablets out for her in a dosette box.

If anyone asks about DIET AND EXERCISE
Fran really enjoys being outside and going for walks. She regularly takes herself to the shops. She has been known to make impulsive and poor decisions, and is often discouraged from walking home from the Day Program if she is not having an ‘off’ day.
Mum often brings her meals which she heats up in the microwave and she gets meals on wheels the day she doesn’t go to the Day Program. She likes going to the café at the end of the street for a coffee.

If anyone asks about FAMILY/LIVING SITUATION?
She lives alone in a housing commission flat on the first floor. Mum comes and visits three or more times a week and most days she is at the Day Care Program. Fran has a great relationship with her parents but really misses her sister, Maria, who recently committed suicide. She doesn’t understand why this happened. She has another brother, George, who lives up the Coast in Coffs Harbour. She doesn’t get to see him very often.
When her parents are away (they are at the minute), her neighbour, Mrs Lever, checks in on her every night and morning.
She has a great relationship with Maggie, the Day Care Co-ordinator.

If anyone asks about her FALL?
Fran has had three falls over the last four months and had to come to hospital. She has always felt OK afterwards but this time she banged her head and has a nasty bruise.
She was out at the shops when she had the first fall as she had run out of milk and went to the supermarket. She is not really sure what happened. She banged her head and someone called an ambulance and brought her to hospital. She self discharged and went home and then to the Day Care
Centre where she fell again coming out of the bathroom. She thinks she slipped on the wet floor. She sometimes feels like she “stiffens up” and freezes however. She thinks she is fine and just wants to go home.

If anyone asks about RESPITE CARE?
Fran does not want to move into any sort of respite care and thinks she can still manage at home. She gets a bit upset if this is mentioned.

If anyone asks about plans for DISCHARGE?
Fran wants to go back to her flat as before. She is receptive to more services at home but does not want to consider respite care really. Maggie is concerned that Fran can no longer cope at home especially if her parents are away and would like her to consider respite for a few days.
<table>
<thead>
<tr>
<th>Introduction</th>
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<th>Assessment Monitoring, Vital Signs, PACE modes, Ambulation, ADL’s, Allied Health</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase ONE</td>
<td>Fran Collins</td>
<td>Patient presented following fall at supermarket – history of multiple falls Juvenile onset PD – uses walking stick Bumped head, bruised – No LOC CT Head Depressed following suicide of sister – on Sertraline (new)</td>
<td>For CT Head Neuro assessment done – NAD but? vague Unsteady on feet – shuffling gait – Falls risk ? Issues with compliance Parkinsons Disease meds Family away</td>
</tr>
<tr>
<td>Phase TWO</td>
<td>Fran Collins</td>
<td>Patient self discharged yesterday following fall four days ago Represented following fall at Day Care yesterday afternoon – No LOC, thinks she slipped on wet floor. CT – Head NAD Complaining of nausea – Vomited x 1 this morning Minimally interactive</td>
<td>Mobility assessment Not verbalising Day Care Co-ordinator on ward – Maggie Concerns re: discharge Nausea – charted for Maxolon by RMO this morning</td>
</tr>
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RIPE Learning Objectives:

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- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel: patient, wife
Faculty in ward simulation: NUM, observer (debrief) x 2
Faculty in Briefing Room: facilitator for briefing
Participants: 10 students (2 from five of following disciplines –) nursing, medical, OT, social work, pharmacy, physiotherapy

Props and Resources needed:
Phase ONE
Chair for wife
Bedside locker
MMP
Medication charts
Obs chart
Medical notes
Patient’s medications from home
Oxygen saturation machine
Gown for patient
Wig for wife
Wheelchair at end of bed
Phase TWO
Spacer and inhaler on locker
Nasal prongs
IV cannula for antibiotics

Storyboard:

History and Background:

Greg Wheeler is a 65 year old male admitted with shortness of breath secondary to severe pain. He has a long history of COPD and prostate cancer with spinal metastases which have caused paraplegia. He requires a wheelchair to move around. He had been managing in his hostel placement but increasing pain related to his cancer may mean he has to consider higher level care.
He is known to Dr Jessop, respiratory specialist, and Dr Raynor, palliative specialist and the community palliative team.
He has a partner, Sheila, who resides in their family home, and has 2 children from a previous relationship.

Information to be written in medical notes:

Day 1

PC:
65 year old male presenting with increasing SOB and worsening pain over the past 2 weeks.
Drowsy - ? analgesics
For admission under Dr Jessop for treatment of infective exacerbation of COPD, needs O2 at the moment
Meds:
On morphine liquid regularly plus 6x day extra doses recently
Regular paracetamol plus inhalers
Allergy – Penicillin - Rash

Hx:
COPD, still smokes
Ca prostate with spinal metastases – has had chemo and RTx – now palliative
Paraplegia secondary to metastases
Severe pain
Lives in a hostel.
**O/E:**
65 year old male sitting up in bed. 
Noted to have increased respiratory rate. 
Looks to be in pain. 
Remains drowsy. Not able to move lower limbs. 
Coughing up green sputum

**Ix:**
- Neuro obs
- Pain score
- CXR
- Arterial blood gas (ABG)
- Spirometry
- Palliative care referral
- R/v meds
- Social Work review
- OT review
- Chest physio

**Social work Entry:**
Referral from NUM - possible need for higher level care. Note patient currently resides in hostel. Wife Sheila lives in their jointly owned house. He has two grown children from a previous relationship. For review

**Nursing Notes:**
Admitted from ED
Admission and discharge risk assessment completed
Air mattress ordered as high risk of developing pressures sores
RR 28 breaths per minute
Oxygen saturations 92% on room air
Drowsy, possible related to analgesia but is telling staff he is in pain. Admitting team have been asked to review
**OT Review:**
Referred by NUM for assessment  
Patient currently drowsy, not able to be fully assessed.  
Wife Sheila is present. She informs me her husband had been functioning independently in the hostel until the last two weeks when his pain has been uncontrollable.  
For further review when more alert.

**Day 2 post admission**

**Ward Round RMO**  
CXR – Exacerbation of COPD – IV AB’s x 3 days  
Oral Prednisolone – reducing course  
Still drowsy and complaining of pain – rousable  
? Pall care review – analgesics changed  
? d/c in 2-3 days - ? where
### Drugs and Fluids

**Medication chart**

**Phase One:**
- Ventolin inhaler 2 puffs QID
- Spiriva handihaler 1 capsule daily
- Seretide inhaler 250/50 2 puffs BD
- Morphine liquid 5mg/0.5ml 4\textsuperscript{th} hourly regular
- Morphine liquid 5mg/0.5ml 4\textsuperscript{th} hourly prn
- Paracetamol 1 gram QID regularly

**Phase Two:**
- Ventolin inhaler 2 puffs 4\textsuperscript{th} hourly via spacer
- Spiriva handihaler 1 capsule daily
- Seretide inhaler 250/50 2 puffs BD via spacer
- Oxycontin SR 20mg BD
- Onynorm IR 5mg 4\textsuperscript{th} hourly prn
- IV Ceftriaxone 1g daily X 3 days
- Prednisolone 25mg daily tapering dose
  - 25mg x 2 days then
  - 10mg x 2 days
  - 5mg x 2 days then
  - 2.5mg x 2 days then stop
<table>
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</tr>
</thead>
</table>
| 0 – 30 mins | PHASE ONE – group A | Medicine  
Needs CXR, ABG & spirometry to investigate shortness of breath. Medication review  
Nursing  
Full nursing assessment including vitals, ADLs  
Social Work  
Current situation, possible need for higher level care, support for wife  
OT  
Concerns re declining functional ability  
Pharmacy  
MMP, medication history  
Physiotherapy (alternative)  
Initial assessment |
|            | BACKGROUND  
• 65 year old presenting with shortness of breath and increased pain over 2 weeks  
• Hx: COPD, Ca Prostate with spinal mets  
• Lives in a hostel, wheelchair independent  
• Dr Jessop |  |
| 30 – 60 mins | PHASE TWO – group B | Medicine  
Needs 3 days of IV antibiotics, tapering oral steroids  
Palliative care referral for analgesia review and symptom management  
Nursing  
Air mattress  
Pressure area care  
Application of nasal prongs for oxygen therapy  
Administration of IVAB  
Social Work  
Assess whether able to return to hostel or need to commence process for higher level care  
Ongoing emotional support for both patient and wife  
OT  
Contact hostel to confirm what equipment is in place, clarify if other equipment is required  
Assess whether pt can transfer safely to wheelchair  
Pharmacy  
Suggestions for improvement of pain control, clarification of inhaler prescriptions  
Physiotherapy (Alternative)  
Chest physio, upper body exercises |
**Actors Briefs:**

**Sheila does most of the talking but Greg can speak a few words.**

**Greg Wheeler**  
You are a 65 year old male. You cannot move below the waist. Your eyes are closed most of the time and can make groaning sounds to demonstrate the pain you are in. You are short of breath so only speak a few words at a time. Your wife is doing her best to reassure you that everything will be ok. You are co-operative for short periods but “nod off” mid conversation.  
You were diagnosed with Prostate cancer four years ago and have had long courses of chemotherapy and radiotherapy but have not had any active treatment for the last 6 months. All you want is to be pain free and don’t really care about much else at the moment.

**Sheila Wheeler, wife**  
You are a 55 year old female and have been married to Greg for the last 12 years. His first wife Annabel died about 18 years ago. You have been attending to your husband’s daily needs in the hostel for the last 2 years. He was able to transfer himself in and out of his wheelchair with minimal assistance from you until the last couple of weeks. Since then his pain and his breathing have become worse and he has been confined to bed.  
Greg has 2 grown up sons, Peter and James, from a previous marriage, but you do not see them often. They know their father is terminally ill. They both live in Melbourne.  
You are concerned that your husband may need to move to a nursing home if he does not improve. You know he will not really like this. You just want to see him pain free but you are concerned he is “overmedicating’ with his painkillers??

**Scenario Specific Questions:**

**If anyone asks about MEDICAL HISTORY:**  
You have had COPD for the last 8 years, for which you use puffers via a spacer. You were well until 4 years ago when you got prostate cancer. After it spread to the spine, you lost the use of your legs. You had long courses of chemotherapy and had some radiotherapy too but that has all stopped now.  
You are often in a great deal of pain and are quite reliant on your morphine mixture at the moment. You realise that you probably don’t have long to go and sometimes wish it was all over.  
After you started using the wheelchair you moved to a hostel as the house needed too many adaptations for the chair. You don’t really like living there but at least Sheila comes in to see you every day. You would like your sons to visit more often but they are busy with work so you understand.  
You have been short of breath for the last few days prior to coming into hospital and felt like you had to use your Ventolin much more often. You are coughing up green sputum.
If anyone asks about MEDICATIONS/DRUGS:
You use your puffers when you remember. Not sure if you really need the regular paracetamol but just keep taking it. The morphine used to work but now even the maximum dose doesn’t help enough. Haven’t spoken to GP as you didn’t think you would be allowed more morphine. You want something stronger for the pain and are asking every HCP if they can help you with this?
Sheila is concerned about the amount of morphine he has been using over the last few days and wants to change to something else too.

If anyone asks about DIET AND EXERCISE:
Greg can only manage soft, easy to eat foods because of the shortness of breath. Not much appetite over the last few months, may have lost some weight but has not been on scales since lost use of legs. Sheila brings over food which she knows he likes to try to tempt his appetite. Greg feels he gets enough exercise moving himself in and out of the wheelchair. They used to go out to the park when Sheila came over but he hasn’t felt like going for a while now.

If anyone asks about FINANCES:
Greg and Sheila own their own house and Sheila still works part time in the local bank. Greg used to work as an accountant so they are financially secure for their retirement however, Sheila is concerned about how they are going to pay for a nursing home??

If anyone asks about FAMILY:
Greg has two sons from his previous marriage. They both live in Melbourne and don’t come to visit often. Neither of them really get on well with Sheila. Greg would like them to visit more often and it makes him sad that they don’t. Greg has two grandchildren that he rarely sees. Sheila has looked after Greg since he got sick and remains devoted to his care. She doesn’t want him to go to a nursing home but is quite realistic that this will probably happen.
## NUM Handover Sheet Guidelines

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Situation, Background, Admission, Diagnosis, History</th>
<th>Assessment</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| **Phase ONE** | COPD, prostate cancer with spinal mets  
65 year old male with shortness of breath and uncontrollable pain over past 2 weeks. Drowsy  
Uses wheelchair, lives in hostel  
Wife Sheila lives in the family home. |  
CXR, bloods, spirometry  
Low blood oxygen  
Unable to move lower limbs  
Chest physio  
OT and social work to assess home situation  
Medication review  
Wife is present |  
Full nursing assessment  
Vitals  
ADLs  
CXR  
Neurological obs  
Pain assessment  
Assess home situation  
Palliative referral  
Air mattress |
| **Phase TWO** | Exac of COPD, prostate cancer with spinal mets.  
65 year old male now more awake following review of analgesia.  
Uses wheelchair, lives in hostel  
Wife Sheila lives in the family home.  
Discharge destination uncertain |  
CXR and spirometry done  
Unable to move lower limbs  
Palliative review complete  
OT & social work to reassess now patient more awake |  
Vitals  
ADLs  
CXR & spirometry show exacerbation of COPD; on 2l oxygen via nasal prongs  
IVC for IV antibiotics  
Different analgesic regime  
Home situation will depend on how patient progresses. |
RIPE Learning Objectives:

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Personnel: Patient
Faculty in ward simulation: NUM, facilitators for debrief
Faculty in Briefing Room: Facilitators for briefing

Participants: 10 students
(2 from five of following disciplines – medicine, nursing, social work, pharmacy and physiotherapy)

Props and Resources needed:
1. Bedside locker
2. Bedside chair
3. Medical notes (separate notes for phase 1 and phase 2)
4. Observation charts incl BSL’s
5. Medication charts incl insulin Chart
6. Medication management plan (MMP) blank
7. Bag of patient’s own medication (stored in bedside locker) insulin only
8. Dressing for head (spare one for re-dressing)
9. Black texter for drawing head wound and stitches. Shoulder wound
10. Hospital gown
Storyboard

**History and Background:**
James Hughes is a 25 year old male who was BIBA after an MVA. He sustained a head injury (GCS of 13) for which he was taken to the HDU. He remained in HDU for one day and was then transferred to the neurology ward for observation.
James sustained the head injury when driving home alone from the pub after watching the footy. He had a blood alcohol reading of 0.06 (low range drink driving). He was the only person in the car, lost control and drove into a telegraph pole. He thinks he may have “blacked out”.
James works full time in IT and has a large mortgage. He works for a big company and has to travel all over Sydney in his role. He is concerned that he may lose his license because of the drink driving charge. This is his second offence – has was picked up last year by an RBT with a blood alcohol level of 0.07. He was fined and banned from driving for three months.
James is married with no kids. He lives at home with his wife, who is a school teacher and is quite anxious about her husband. She is four months pregnant and very concerned about the mortgage repayments. James is also concerned about how his wife is coping with the stress of the current situation and the effect it may have on the baby.
James has type 1 diabetes mellitus, which he manages with insulin. He has been having a hard time managing his diabetes lately, experiencing hypos in the morning. His insulin was recently changed when attended the Diabetes Centre last week. He usually sees Dr Jarrow. Has been seeing him since he was 15 years old.
James is in hospital for observation following head injury.

**Information to be written in medical notes:**

James Hughes; MRN 1224578; DOB 21/08/1988

**Day 1**

**PC:**
James Hughes is a 25 year old male on the neurology ward after sustaining a head injury in a MVA. Transferred from HDU last night.
Has had an MRI and the results showed no acute changes. His neck was clear and is now allowed to mobilise, however he is still a little dizzy and complaining of slight headache
Has superficial wound to his head requiring stitches. Wound cleaned and stitched in HDU.
James has a penicillin allergy
Current medications are:
- Novorapid 6 units TDS with meals
- Lantus 16 units at bedtime
**Hx:**
Type 1 diabetes mellitus – has difficulty managing insulin  
Married with no kids, wife is 4 months pregnant

**O/E:** Co-operative, but wanting to go home and back to work (worried about mortgage) ASAP. Does not understand the impact of the MVA. Wound on forehead: superficial, 5 stitches in situ. Clean.

**Ix:**
MRI – brain and spine - No acute changes  
EUCs - Normal  
FBC  
Allied health review  
Diabetes management review

**Phase 1:**

**Nursing Notes:**
Pt admitted for MRI and observation following head injury from an MVA  
MRI revealed no brain injury  
Neuro obs every 2 hours  
Head wound dressing changed and healing well.  
BGLs pre and post prandial, pt has been experiencing hypos during the mornings – Need values on charts  
Vital signs stable  
Social work review. Financial/work situation? Wife very anxious – 4 months pregnant.

**Medical Notes:**
Requires two hourly neuro obs  
Physio review with view to mobilise  
Plan to review diabetes management and insulin therapy – endocrinology review
Phase 2 – 4 days later (pre-discharge)

Nursing Notes:
Pt mobilising without assistance
Neuro obs twice a day
Breakfast and lunch time insulin dose change, continue monitoring BGLs –
Wound on right shoulder showing some erythema and some pus – cephalixin initiated. Wound dressed and cleaned.

Endocrinology Review
James compliant with diabetic diet overall but sometimes skips meals – dietician review in community please
Morning and lunchtime Novorapid dose reduced
Lantus dose reduced
Have spoken with James re: change in insulin dose – may need further counselling
Follow up in OP in 2 weeks with Dr Jarrow

Social Work Notes:
Pt for discharge later today or early tomorrow?
Spoke with wife – very concerned about ongoing drinking and driving as is his second offence. Due to appear at Waverley Court in 2 weeks.
Wife wants to know about alcohol support groups??? Patient resistant to this but very concerned about impact on job if gets disqualified.
Equipment Required:

See ‘props and resources’ on page 1.

Drugs and Fluids
Medication chart
Allergies – Penicillin - Rash

Phase 1:
Novorapid 6 units TDS with meals
Lantus 16 units at 22:00
Panadeine Forte 2 QID

Phase 2:
Novorapid 4 units with breakfast, 4 units with lunch and 6 units with dinner
Lantus 14 units at 22:00
Panadeine Forte QID
Cephalexin 500mg QID

James brought his insulin in with him
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<td>0 – 30 mins</td>
<td><strong>PHASE ONE – group A</strong></td>
<td><strong>PHASE ONE – group A</strong>&lt;br&gt;<strong>BACKGROUND</strong>&lt;br&gt;- 25 year old male admitted on the neurology ward for observation following an MVA.&lt;br&gt;- MRI is clear&lt;br&gt;- Hx: type 1 diabetes, lives at home with wife, concerned about getting back to work&lt;br&gt;&lt;br&gt;<strong>Medicine</strong>&lt;br&gt;Review neurological obs, BGLs, review of insulin therapy and other medications&lt;br&gt;&lt;br&gt;<strong>Nursing</strong>&lt;br&gt;Neurological obs every two hours, BGL monitoring (before and after meals).&lt;br&gt;&lt;br&gt;<strong>Pharmacy</strong>&lt;br&gt;Obtain a medication history, investigate how he is using his insulin&lt;br&gt;&lt;br&gt;<strong>Social work</strong>&lt;br&gt;Anxious to go home and get back to work &amp; about licence. Wife is very anxious, but not currently at the hospital&lt;br&gt;&lt;br&gt;<strong>Physiotherapy</strong>&lt;br&gt;Mobility assessment, PTA</td>
</tr>
<tr>
<td>30 – 60 mins</td>
<td><strong>PHASE TWO – group B</strong></td>
<td><strong>PHASE TWO – group B</strong>&lt;br&gt;<strong>Time Lapse – 4 days later (pre-discharge)</strong>&lt;br&gt;- Appears Neurologically stable&lt;br&gt;- Mobilising independently – check safe for discharge&lt;br&gt;- Insulin dose change&lt;br&gt;- Review for discharge&lt;br&gt;&lt;br&gt;<strong>Medicine</strong>&lt;br&gt;Review neuro obs, review BGLs after insulin dose change&lt;br&gt;Arrange for discharge script and follow up appointments&lt;br&gt;Clear for discharge, pt requires medical certificate&lt;br&gt;&lt;br&gt;<strong>Nursing</strong>&lt;br&gt;Neuro obs twice a day, breakfast and lunch time insulin dose change, continue BGL monitoring before and after meals&lt;br&gt;&lt;br&gt;<strong>Pharmacy</strong>&lt;br&gt;Counsel patient on insulin dose change and diabetes management in general, discharge meds&lt;br&gt;&lt;br&gt;<strong>Social work</strong>&lt;br&gt;Spoken to wife – concerned - alcohol support groups, advice re: court and drink driving&lt;br&gt;&lt;br&gt;<strong>Physiotherapy</strong>&lt;br&gt;Ensure mobilising and safe for discharge</td>
</tr>
</tbody>
</table>
Actors Briefs:

**Patient: James Hughes**

You are a 25 year old male. You have just been in an MVA in which you were the sole driver. You were driving home from the pub after watching the footy with your friends. You were drinking driving (low range 0.06). You have a head wound which was been stitch ed up when you were in HDU. You work in I.T and are married with no children. Your wife’s name is Nina and she is a primary school teacher. You recently purchased your first home together and have just taken on a big mortgage. You are feeling a little sore and sorry for yourself but are anxious to get home and back to work as you are worried about finances in particular your mortgage repayments. You are still feeling a bit lightheaded and dizzy from the accident and your head is sore. You have type 1 diabetes since you were 15 years old and manage with insulin. You are currently on Lantus at bedtime and Novorapid with your three main meals. Nina brought your insulin shortly after you were admitted and it is kept in your bedside locker. You haven’t been managing that well lately and have been experiencing hypos in the morning (you don't eat much for breakfast or lunch). Your diabetes is getting in the way of having fun, you have to make sure you eat before you have any alcohol and you are just a little bit fed up with it really. You have been educated on diabetes management before and you know what you should and shouldn’t do but are just a bit frustrated.

*Scenario Specific Questions:*

**If anyone asks about MEDICAL HISTORY:**
You have type 1 diabetes (since you were 15 years old) which you manage with insulin (Lantus at bedtime and Novorapid with your three main meals). If asked you have your own insulin in the bedside locker. You manage your diabetes OK and have had all the education. You have experienced 2 or 3 hypos in the morning over the last month or so which you have put down to skipping breakfast when you were in a rush. You haven’t discussed this with your doctor yet. You don’t regularly do skin prick BSLs, but you’re pretty sure you can tell when your BSL is low. You feel lightheaded when a hypo is coming on, and you know to have some sugar or orange juice. You have never blacked out before. As a young person you are just a bit frustrated that you have this condition but you try to not make a bit deal of it, and aside from the inconvenience you don’t think you’ve had any diabetic complications.

**If anyone asks about MEDICATIONS/DRUGS:**
Insulin
Lantus: 16 units at bedtime
Novorapid: 5 units with breakfast, lunch and dinner
Recently your dose was changed by Dr Jarrow and you have been having a few hypos ever since.

**If anyone asks about DIET AND EXERCISE:**
You try to keep fit and go for a jog a couple of times a week.
You eat pretty healthily but sometimes skip breakfast if you are in a rush in the mornings. Sometimes miss lunch if out on a call. You have seen a dietician about your diabetes previously and she went through diabetic diet with you and you try to stick to it.

If anyone asks about ALCOHOL INTAKE?
You like to have a few beers with your mates, perhaps 4 - 6 schooners two or three times a week, but you don’t drink regularly and don’t feel you have an alcohol problem. You only had 3 schooners the night of the accident, so you remain surprised you were over the limit, but are relieved that no one else was injured. This is the second time you have been caught over the limit however.
You know your wife thinks that you drink too much and shouldn’t drive but think she is over-reacting. The only concern now is that you have to go to court in 2 weeks because of the drink driving charge and whether they will take away your license.

If anyone asks about FINANCES:
You have just taken on a big mortgage and are worried about getting back to work to make the repayments on time. You are also concerned about losing your license and this affecting your job. You have a court date in two weeks.
### NUM Handover Sheet Guidelines

<table>
<thead>
<tr>
<th><strong>Introduction</strong></th>
<th><strong>Situation, Background,</strong> Admission, Diagnosis, History</th>
<th><strong>Assessment</strong> Monitoring, Vital Signs, PACE modes, Ambulation, ADL’s, Allied Health</th>
<th><strong>Recommendation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase ONE</strong></td>
<td>James Hughes 25 year old male</td>
<td>Brain and spine MRI clear</td>
<td>Neuro obs</td>
</tr>
<tr>
<td></td>
<td>Head injury post MVA</td>
<td>EUC and FBC normal</td>
<td>Vitals</td>
</tr>
<tr>
<td></td>
<td>25 year old male. Transferred from HDU</td>
<td>BGL (before and after meals) – still having hypos in morning</td>
<td>BGLs</td>
</tr>
<tr>
<td></td>
<td>following GCS 13 on admission</td>
<td>Physio assessment</td>
<td>Physio assessment</td>
</tr>
<tr>
<td></td>
<td>For observation and mobilisation</td>
<td>Wife is anxious need some support – at work</td>
<td>Social work to speak to wife</td>
</tr>
<tr>
<td></td>
<td>Superficial head wound with stitches – dizzy</td>
<td></td>
<td>Review insulin dose and diabetes management</td>
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<tr>
<td></td>
<td>and slight headache</td>
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<td>Review for discharge</td>
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<td></td>
<td>GCS now 15</td>
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<td></td>
<td>Lives at home with wife (pregnant) – very anxious</td>
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<td></td>
<td>Hx – type 1 diabetes</td>
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<td>Not managing insulin well, having hypos during the</td>
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<td>morning – diet?</td>
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<td></td>
<td>Keen to go home</td>
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<tr>
<td><strong>Phase TWO</strong></td>
<td>James Hughes 25 year old male</td>
<td>Brain and spine MRI clear</td>
<td>Medical team to clear pt for discharge</td>
</tr>
<tr>
<td></td>
<td>Head injury after MVA</td>
<td>EUC and FBC normal</td>
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<td>For observation and mobilisation – mobilising well</td>
<td>BGL (before and after meals) – still having hypos in morning</td>
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<td></td>
<td>Superficial head wound with stitches – no longer has</td>
<td>Physio assessment</td>
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<td>headache</td>
<td>Wife is anxious need some support – at work</td>
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<td>Pt lives at home with wife. Wife is very anxious, is</td>
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<td>at work now but will be in later – advice re: court</td>
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<td>and alcohol support groups</td>
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<td>Hx – type 1 diabetes</td>
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<td>Frequent hypos, had endocrinology review and insulin</td>
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<td>dose adjusted</td>
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<td>Pt is very keen to go home and get back to work</td>
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<td></td>
<td>Neuro obs twice a day</td>
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<td></td>
<td>BGLs</td>
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<td></td>
<td>Head wound redressed</td>
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<td></td>
<td>Wound on shoulder red and inflamed – antibiotics</td>
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<td>initiated</td>
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<td>SW met with wife, addressed</td>
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<td>concerns and discussed sick leave options.</td>
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<td>Dietician referral in OP</td>
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<td></td>
<td>Social work</td>
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<td></td>
<td>Medical team to clear pt for discharge</td>
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<td></td>
<td>Medical certificate</td>
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RIPE Simulation – Sam Oates

RIPE Learning Objectives:

- Demonstrate a broader understanding of the roles of various health care professionals in delivering Interprofessional team based care
- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel:

Faculty in ward simulation: NUM; Observer x 2
Faculty in Briefing Room: Facilitator for briefing

Participants: 10 students (2 from five of following disciplines – Medicine, Nursing, Social Work, Podiatry and Physio)

Props and Resources needed:
- Bed
- Leg Bandage/ compression bandages?
- Med Chart
- Obs Chart
- Crutches (wrong height)
- ‘Black Toes’ makeup
- IV antibiotics – IV cannula
- Packet of Cigarettes – bedside table
- Chocolate wrappers
- Own medications – Ramipril, Endone, Insulin and Sertraline
Storyboard:

Sam is a 45 yr old male
Transferred from small town for management of necrotic foot due to diabetes. He has had Type 2 diabetes for 15 years and now uses insulin but has trouble controlling his BSL’s. He is not compliant with a diabetic diet and has smoked a packet of cigarettes every day since he was 17. Now needs amputation of his toes – Has had multiple courses of antibiotics. Has had ulcers previously on his toes – now healed but toes are necrotic – Vascular surgeons have reviewed him and decided on amputation.

Single parent, divorced from wife (Cathy) five years ago. Cathy has moved back to WA to be with her new partner. She has little contact with the son, Aiden. Sam has been unable to work for past 2/12 due to medical issues. He was working as a labourer for a local builder. He is currently receiving disability benefits???

15 yr old child, Aiden is at high school. Aiden is presently home alone but the grandparents are keeping an eye on him. They live in the next town 25k away and can only manage to go over every two or three days but they all think its OK as he is quite mature for his age.

Information to be written in medical notes:

Day 1

PC:

T/F from regional hospital with severe necrosis of toes with infection.
Awaiting fore-foot amputation and is on IV antibiotics
Several weeks of worsening foot pain and mobility with colour change to toes. Currently on regular Endone.
Atraumatic – Previous ulcers treated by GP.
Recently feeling feverish and noticed reddening of foot and pain in groin.
Seen in regional hospital by vascular VMO and told he has poor circulation and toes have died.
Mobile with crutches borrowed from neighbour but struggling.
Nil else chest, abdo
PMHx:
Diabetic (Type 2)
- Non compliant with insulin or diabetic diet
- Hypertensive - Ramipril
- Depressed – On sertraline
Smokes 20 cigarettes/day – reluctant to give up

O/E:
Temp 37.9, HR 85, BP 156/94, RR 12, BSL 13.2
Patient in bed. Flat affect.
Keen to go downstairs for smoke!

HS 1 + 2 + 0 other
Chest clear
Abdomen – soft, non-tender, no masses/organomegaly
Vascular system – No AAA
B/L peripheral pulses to popliteal.

Left foot – DP and PT present with CRT of 2 secs
Slight decreased sensation from forefoot distally

Right foot - Bandaged foot (compression bandage) with black toes.
Foot – cool with poor capillary refill. Dorsalis pedis not palpable and not easily heard with Doppler.
Posterior tibial audible with Doppler but not palpable
Tender area proximal to necrosis with erythema and slough.

Ix:
Swab culture, Blood culture
Xray on admission – ?osteomyelitis 2nd/3rd MTP joints
EUC
FBC
CRP
HBA1C
Bone Scan (awaits results)
CT angiogram leg – not ordered as yet

Nursing Notes:
Patient eating diabetic diet, q4hrly obs. Patient asleep ATOR. Booked for OT tomorrow - Pre-op fasting from midnight tonight.
BSLs raised – 14 – given 2u insulin as per sliding scale
Not very communicative – refusing to mobilise

Day 4 post admission – Phase TWO

Ward Round – RMO
Post op forefoot amputation 2/7 ago
May need revision to BKA as infection persists and possible wound breakdown
Remains in bed for past 2 days post op - refuses to participate with RN or Physio to get out of bed - for mobilisation by physio

Persistent low grade fever. Denies systemic symptoms.
BSL still persistently high – 12 to 15 - ? For endocrine r/v
CRP constant at 120
Wound R/V – area of dehiscence over medial wound. Slough and erythema with purulent discharge.
CRT 4 seconds in stump and decreased sensation
Wound swab sent - ? Start IV Tazocin 4.5g q6h
HbA1C 9%
EUC and FBC – Normal

CT Angiogram - normal flow seen throughout iliacs, profunda femoris and superficial femoral to level of popliteal. Multiple areas of partial occlusion and decreased flow distal to popliteal with absent flow in anterior tibial artery from the level of the talus'
Equipment Required:

**Drugs and Fluids**

Allergy: Codeine

**Phase One:**
- Lantus 12u nocte
- Novorapid 6u tds – has own pen
- Ramipril 5mg daily
- Cefazolin IV -2g TDS
- Gentamicin Variable dose 240mg day 1
- Endone 5mg qid regular
- Sliding scale insulin

**Phase Two:**
- Change antibiotic - Tazocin IV 4.5g q6h
- Ramipril withheld
- Post op pain relief – Oxycontin 10mg bd
- Oxycodone 5mg q6h prn – but using lots
  - Lantus 12u nocte
- Novorapid 8u tds – has own pen
- Heparin 5000u bd subcut
<table>
<thead>
<tr>
<th>Time</th>
<th>Phases</th>
<th>Expected Actions and outcomes for each discipline – To be included on handover sheet for each phase</th>
</tr>
</thead>
</table>
| 0 – 30 mins | PHASE ONE – group A            | **Medicine**  
Review of analgesia, Arrange CT, usual meds, Pre-op workup - Consent  
**Nursing**  
AD RAT, vitals, pre-op workup, Falls risk  
**Social work**  
Low socioeconomic background-labourer  
Bit worried about son (15yrs old living at home? alone at the moment)  
Patient reluctant to engage with clinicians and wants to go home  
**Podiatry**  
Neurovascular assessment  
Footwear assessment  
Assessment of skin integrity  
Checking opposite foot  
**Physio**  
Physio r/v for mobilisation |
| 30 – 60 mins | PHASE TWO – group B            | **Medicine**  
Chase 2nd microbiology and antibiotic RV, Surgical RV - reassess for stump revision/extension proximally, repeat bloods, Diabetic RV  
**Nursing**  
BSL’s, temp, wound care,  
**Social Work**  
Financial situation, ongoing issues with son, liaise with grandparents  
**Physio**  
R/v mobilisation for discharge,  
**Podiatry**  
Biomechanical assessment – determine functionality (with physiotherapist)  
Checking opposite foot  
Footwear assessment  
Consider offloading for amputation site. i.e. post-op shoe  
Wound management: i.e. dressing choices |

**BACKGROUND**  
45 year old male admitted for right forefoot amputation – necrotic toes  
PMH IDDM x 15 years not well controlled  
In pain, flat affect  
Toes – black, necrotic, ? infected – IV antibiotics  
CT Angiogram  

**PHASE ONE – group A**  
Time Lapse – 4 days later  
Two days post op – wound infected???  
IV antibiotics  
Endocrine review  
Pain team?  
For OT again?  
ID review?
Actors Briefs:

SAM OATES

You are a 45 yr old man. You have come from a small rural town (Wombat-3.5 hrs away). You moved there 10 years ago from WA and have lived in the same house ever since. You have a small mortgage left to pay off on the house. You are worried about this as you haven't been able to work much over the last couple of months as a labourer and after the amputation aren't sure how you are going to manage. Your parents have been supportive but you are afraid you will lose the house?
You are a single parent with a 15 yr old son, Aiden who is at home alone-your son attends the local high school and his grandparents (your parents) are in the next town and are going to drop in to make sure he is OK every two days. You are a bit concerned about him being alone but he's pretty mature for his age. Grandparents have their farm to run and you want him to stay at school.
You are divorced from your wife Cathy, who moved back to WA to be near her family. She doesn't really have much contact with you or Aiden – the divorce was quite nasty and she has a new partner and recently had a baby. Aiden doesn't get on with his mum and isn't really interested in keeping in touch with her.

You have insulin dependent diabetes (diagnosed 15 yrs ago) but are often non compliant with medications and diet. You smoke heavily – up to a pack a day. You have tried to give up many times but always fail! You like a few beers in the evening.

You were sent to hospital after being seen by the vascular doctor in the regional hospital. He has said you have necrotic toes which needs IV antibiotics and likely amputation. You are very depressed about this.

You are in denial, depressed and not really wanting to engage with the any of the staff.

Scenario Specific Questions:

If anyone asks about MEDICAL HISTORY:
You were diagnosed with diabetes at the age of 30, which came as a bit of a shock to you. No-one has ever had diabetes in your family and you really don’t understand how you got it? You also have a history of high blood pressure but this has been well controlled with the Ramipril tablets. You have recently been diagnosed with depression as your toes have got much worse, they are painful and you haven’t been able to work for the last few weeks.
The GP gave you a prescription for Endone and you take this regularly or else you can’t stand the pain. He has also started you on an antidepressant two weeks ago. You were admitted to Wombat Hospital last week for the issue with your toes and the doctor who was there has recommended IV antibiotics and the amputation as he feels there is little else he can do. You were transferred by air ambulance yesterday. You are very frightened by the thought of the amputation, particularly if as you fear, they may take the bottom half of your leg off!! After the operation, you just want to go home!!
If anyone asks about MEDICATIONS/DRUGS:
You take Ramipril 5mg each morning for your blood pressure and use your insulin – can’t remember the name of it but it’s in bag of meds you brought with you. You aren’t always very strict about using the insulin. You sometimes measure your blood sugar levels but probably only two or three times a week. Not too keen on needles. The doctor in Wombat recently started you on Zoloft – you take one in the morning. You don’t seem to think it’s working!

If anyone asks about DIET AND EXERCISE:
You have seen a dietician a few times and know you should stick to a diabetic diet but find it really difficult as you have a very sweet tooth and find it quite restricting. Normally you eat three meals a day (you and Aiden both do the cooking) but recently your appetite has been a bit low. You have still been cooking for Aiden though. You used to be quite active as you worked as a labourer and you and your son liked to go bike riding a lot but recently you haven’t been able to do much because of your toes. You like to have a few beers in the evening when you are watching TV.

If anyone asks about FINANCES or EMPLOYMENT:
You have been working as a labourer for Sapphire Building for the last 10 years since you moved to Wombat. You don’t really have a trade and left school without any real qualifications. You haven’t worked for the last two months and have been receiving disability support. You are a bit concerned about the mortgage as you haven’t been able to work and aren’t sure if you are going to be able to go back after the operation?

If anyone asks about your SON, AIDEN:
You are very proud of your son, who is 15 years old, as he is doing really well at school and wants to be an engineer. He has a good network of friends and doesn’t get into trouble. He is currently at home alone but your parents have said they will drop in on him every few days. It’s difficult as they have the farm to run. You don’t want to pull him out of school to go and live with them. You are a little bit concerned that he will be OK but he is quite mature for his age and you think he should be fine. You would like to get out of hospital ASAP though!! His best friend’s mum is also keeping an eye on him. Aiden’s mum, Cathy, is back living in WA with her new husband and small baby. You don’t really talk much and Aiden doesn’t really care about keeping in contact with her as he blames her for running off and breaking up the family.

If anyone asks about MOBILITY and HOME ENVIRONMENT:
You used to be quite fit and healthy but recently you haven’t been able to do anything much except sit around!!! You are reluctant to get up and move around due to the pain in your toes. You live in a single level house with a large yard. There are three steps going up to the front door but then it is all on one level. There is one bathroom with the shower over the bath. You and Aiden each have your own room. Aiden is very helpful around the house and you share the chores usually but you have been very reliant on him recently. You haven’t been able to drive, so your parents have dropped over the shopping and cooked some meals for you to heat up.
NUM Handover Sheet Guidelines

<table>
<thead>
<tr>
<th>Phase ONE</th>
<th>Phase TWO</th>
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</thead>
<tbody>
<tr>
<td><strong>Introduction</strong>&lt;br&gt;45 year old male</td>
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</tr>
<tr>
<td><strong>Situation, Background, Admission, Diagnosis, History</strong>&lt;br&gt;45 year old male admitted for right foot amputation – necrotic toes&lt;br&gt;PMH IDDM x 15 years not well controlled&lt;br&gt;In pain, flat affect&lt;br&gt;Toes – black, necrotic, ? infected – IV antibiotics</td>
<td><strong>Situation, Background, Admission, Diagnosis, History</strong>&lt;br&gt;Right foot amputation 2 days ago&lt;br&gt;Wound – pus and exudate – ? infected&lt;br&gt;Still on IV antibiotics&lt;br&gt;Not mobilising&lt;br&gt;HbAIC 9%&lt;br&gt;Still in lots of pain</td>
</tr>
<tr>
<td><strong>Assessment</strong>&lt;br&gt;CT Angiogram leg? – To be arranged&lt;br&gt;Pre-op workup – consent&lt;br&gt;BSL’s still high&lt;br&gt;Toes – infected – On IV antibiotics&lt;br&gt;Not mobilising&lt;br&gt;In pain&lt;br&gt;Sliding scale insulin</td>
<td><strong>Assessment</strong>&lt;br&gt;CT Angiogram – right leg&lt;br&gt;BSL’s still high – sliding scale insulin&lt;br&gt;PRN Endone??&lt;br&gt;? for BKA – patient aware and wants to go home&lt;br&gt;Still refusing to mobilise – encouragement +++</td>
</tr>
<tr>
<td><strong>Recommendation</strong>&lt;br&gt;Arrange CT angiogram right leg&lt;br&gt;ADRAT&lt;br&gt;Q4h BSL’s&lt;br&gt;Physio r/v for mobilisation&lt;br&gt;Consent for Theatre - Amputation&lt;br&gt;Social work r/v re: son and finances&lt;br&gt;Diabetes – compliance issues?</td>
<td><strong>Recommendation</strong>&lt;br&gt;Endocrine R/v needed&lt;br&gt;Ongoing social work support – Son&lt;br&gt;Physio re: mobilisation&lt;br&gt;Analgesic r/v&lt;br&gt;OT review</td>
</tr>
</tbody>
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RIPE Learning Objectives:

- Demonstrate a broader understanding of the roles of various health care professionals in delivering Interprofessional team based care
- Explore the features of Interprofessional teamwork including patient centred team care, effective communication between colleagues and expected benefits for patients from Interprofessional team care
- Identify potential barriers to effective interprofessional teamwork
- Consider how Interprofessional collaboration can be improved in the workplace

Personnel:
Faculty in ward simulation:
Faculty in Briefing Room:

Participants: 10 students (2 from five of following disciplines –)

Props and Resources needed:
Storyboard:

History and Background:

Information to be written in medical notes:

Day 1

PC:
Hx:

O/E:

Ix:

XXXXXX Entry:

Nursing Notes:

XXX Review:

Day X post admission
Equipment Required:

Drugs and Fluids
Medication chart

Phase One:

Phase Two:
<table>
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<td>Medicine</td>
</tr>
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<td>BACKGROUND</td>
<td>Nursing</td>
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<td>Allied Health 1</td>
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<td>Allied Health 2</td>
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<td>Allied Health 3</td>
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<td>Allied Health 4 (Alternative)</td>
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<td>30 – 60 mins</td>
<td>PHASE TWO – group B</td>
<td>Medicine</td>
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<td></td>
<td>Time Lapse – x days later</td>
<td>Nursing</td>
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<td>Allied Health 1</td>
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<td>Allied Health 2</td>
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<tr>
<td></td>
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<td>Allied Health 3</td>
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<td>Allied Health 4 (Alternative)</td>
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Patient

Carer (if needed)

Scenario Specific Questions:

If anyone asks about MEDICAL HISTORY:

If anyone asks about MEDICATIONS/DRUGS:

If anyone asks about DIET AND EXERCISE
<table>
<thead>
<tr>
<th>Introduction</th>
<th>Situation, Background, Admission, Diagnosis, History</th>
<th>Assessment Monitoring, Vital Signs, PACE modes, Ambulation, ADL’s, Allied Health</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Phase ONE</td>
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<tr>
<td>Phase TWO</td>
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