

Scenario 1 (Sepsis)

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Med Rec Note

DOB: 03SEP1982

Gender: Male

HT: 71 in

WT: 81 kg

Pregnant: No

Lactating: No

Allergies: PCN

Onset Date: Unknown

Symptoms: UserSpecifiedSymptom

Other Symptom: Unknown

Severity: Unknown

Source: Other: Medical Records and Provider Handoffs from Afghanistan

Additional Medications:

Drug Name	Current Taking	Dosing Instructions	Inpatient Plan
ENOXAPARIN {30 mg/0.3mL SYRN} (Lovenox *Activa ...	YES	BID	Order Medication
PANTOPRAZOLE {40 mg } (Protonix)	YES	Daily	Order Medication
fentaNYL {50 mcg/mL INJ} (Sublimaze)	YES	Drip	Order Medication
KETAMINE {50 mg/mL INJ} (Ketalar)	YES	Drip	Order Medication
PROPOFOL {10 mg/mL INJ} (Diprivan)	YES	Drip	Order Medication
ALBUTEROL/IPRAtropium {2.5 mg/0.5mg/3mL SOLN} ...	YES	Q4 hours and PRN	Order Medication

Signature: Blank

Time/Date: Blank

H&P

NAME:	TBD	
Clinical Service:	Burn Service 4E	
Attending on Admit:	(NAME)	
Trauma:	Yes	
Trauma Number:	10987654321	
Date:	T-4	
Time:	Unknown	
EMS Arrived On Scene:	NA	
Time Arrived in Trauma Room:	NA	
Mechanism of Injury:	Thermal injury occurred in Afghanistan after his cloths caught on fire while he was checking the fuel level of his truck with a lighter.	
Vital Signs in Field:	NA for all	
Field GCS:	E4M6V5	
Procedures prior to arrival:	check all; Other: Burn Resuscitation	
Other Details of Injury:	See H&P	
Attending Staff Surgeon:	(NAME)	
Chief Resident:	NA	
Primary Care Manager:	NA	
Primary Care Clinic:	NA	
Attending on Admit:	(NAME)	
Admission Date:	Today	
Admission Time:	0330	
Discharge last 30 days:	No	
Acute Burn/Injury:	First Admission	
Time of Burn:	blank	
Date of Onset:	T-4	
Registry Items:	Deployment	
Information Sources:	Other	
Admission Diagnosis:	85% TBSA Burns	
Etiology of Burn:	Fire or Flame	
Chief Complaint:	Burns	

HPI:	34 yo AD E5 with no past medical history who was filling his vehicle with gasoline while on base in at Bagram in Afghanistan. He apparently checked the fuel tank with his lighter causing an immediate fireball and lighting his clothes on fire. Other soldiers on scene tackled him with blankets and put out the flames. He was taken to Joint Theater Hospital in Bagram where he was intubated prophylactically and underwent burn resuscitation that was complicated by hypotension, large fluid volumes (2L/hr x 3 hours, early albumin administration at 8 hours post burn), and vasopressor usage (vasopressin/levophed highest 30 mcg/min). 85% TBSA burns. Escharotomies were performed on all extremities, chest, and abdomen. 24 hour fluid resuscitation as 266mL/kg. Highest abdominal pressure was 24. He was transferred to LRMC by CCAT on post burn day 1 and was met at LRMC by the Burn Flight Team on Post Burn day 3. In LRMC, resuscitation was completed and started on the VDR for transport. The burn flight team performed wound care and then transferred the patient via CCAT to the ISR.
ROS:	Unable to Obtain
PMH:	None
Other Medical History:	None
Immunization History:	Checked
Last Tetanus Date:	Current
Last Influenza Date:	01Jan2016
All others:	Blank
Blood Transfusion History:	Checked; Hx Transfusion – no reaction
Past Surgical History:	Joint Arthroscopy: Right Knee; Date = Blank
Other Surgical History:	NA
Social History	
Special Duty Status:	Blank
Command Interest:	Combat;
Tobacco Use:	Active;
Type:	Cigarettes;
PPD/Years/Pack Years:	all blank
Alcohol Use:	Hx Unk;

all others:	blank	
Recreational Drug Use:	Hx Unknown;	
all others:	blank	
Employment History:	Active Duty	
Living Situation:	Unknown	
Other Social History:	Blank	
Family History:	Unknown	
Physical Exam		
Exam Time/Date:	Today at 0400	
Adt dosing wt:	104	
Temp (F):	101.4	
Temp (C):	Blank	
HR:	115	
RR:	15	
Pulse Ox:	99	
BP:	92/40	
MAP:	57	
Pain Score:	Blank or 4/10	
O2 Therapy:	Endotracheal tube	
Flow:	blank	
LPM/FiO2:	Vent	
Exam Date/Time:	Today, 0400	
Gen:	Sedated on ventilator.	
Head:	Burns as noted on L-B Chart, no trauma.	
Mouth:	Mucosa moist and teeth in good repair. ETT 24 cm at teeth. Lips, tongue (protruding) edematous	
ENT:	B/L r>l ear burns in SM cream. unable to evaluate with otoscope. Mild facial ulceration on right near ETT tie. Facial edema.	
Eyes:	Pupils react symmetrically to light (4mm), peri-orbital burn wounds involving b/l eye-lids; moisture chambers present and ophthalmic ointment present. Periorbital edema makes evaluating eyes difficult.	
Neck:	Supple neck, trachea midline, no apparent goiter, no jugular vein distention.	
Chest:	Burn as noted on L-B chart.	
Heart:	Tachy, regular rhythm, no murmurs.	
Lungs:	Coarse bilateral breath sounds without wheezes, as limited by VDR; escharotomy by report	
ABD:	Exam limited by dressings, but soft, no tender, non-distended, without peritoneal signs. No bowel sounds appreciated. Escharotomy by report.	
Back:	Burn wounds as noted on L-B chart. Pitting edema of b/l buttocks	

EXTREM:	In clean, moist dressings throughout, no bleeding; where palpable, edema of b/l LE symmetrically; escharotomies x 4 by report.
Skin:	Wounds per L-B. In dressings.
Neuro:	GCS E3M4V1T; sedated
Rectal:	Normal sphincter tone. No lesions, masses, or gross blood seen.
GU:	Edematous penis and scrotum, burns to glans only; Foley present.
VASC:	Symmetrical pulses throughout by Doppler only (b/l radial and palmer, b/l DP/PT)

	2 nd	3 rd	total
Head	33	2	5
Neck	.5	1	1.5
Ant Trunk	0	13	13
Post Trunk	0	13	13
R Buttock	1	.5	1.5
L Buttock	1	.5	1.5
Genitalia	.5	0	0.5
RU Arm	2	2	4
LU Arm	3	1	4
RL Arm	0	3	3
LL Arm	3	0	3
R Hand	0	2.5	2.5
L Hand	2	0	2
R Thigh	2.5	7	9.5
L Thigh	2.5	7	9.5
R Leg	4	1	5
L Leg	2	4	6
R Foot	0	0	0
L Foot	0	0	0
Total	27	57.5	84.5

24-hr fluid resuscitation requirements: 3 mL/kg/%TBSA = > 20 mL/24 Hours

Labs

CBC	12>7.3/23<110
Chemistry	130/3.4/110/24/45/0.7/175/ PO4 1.2 Ca 9.5
LFTs	6.8/3.3/4.0/101/160/134
ABG	7.38/35/110/23/98%

Multi-Drug Resistant Organism Status:

MDRO Screening Plan: Admitted with soft tissue infection, No history of MDRO. Will order MDRO Screening.

Radiology

CXR:	Bilateral infiltrates c/w history of inhalation injury, ETT 5 CM from carina, NGT in place past diaphragm.
-------------	--

CT:	No evidence of visceral or musculoskeletal injury from CT at Bagram.
MRI:	NA
Other:	NA
ECG:	The study demonstrated sinus tach, appropriate QT and QRS intervals, and no ST-T Wave changes.

No other studies

Assessment and Plan

NSI/SI/VIS: Very Seriously Ill (VSI)

CHECK Narrative

NARRATIVE:

85% TBSA burns in an active duty SM who underwent a difficult resuscitation in Afghanistan. Since that time, he has done reasonably well. Plan is:

- Prep for excision tomorrow morning
- Repeat BAL and wean off VDR if normal
- Wean sedation to get better neurologic exam
- Discuss starting enteral feeding
- DVT and GI Prophylaxis
- Change central line, arterial line

Tobacco Use:

Yes

Tobacco Cessation Counseling: Practical counseling was not offered to the patient at the time of admission, or unable to determine if tobacco use treatment was provided from medical documentation.

Tobacco Cessation Medication: The Patient was not offered a prescription for an FDA-approved tobacco cessation medication, or unable to determine if tobacco use treatment was provided from medical record documentation.

Prophylaxis

GI: Protonix

Other: Blank

VTE Risk: VTE High risk

Contraindications: None

VTE Prophylaxis Planned: Enoxaparin (Lovenox) 30 mg SQ BID (Creatinine clearance > 30 ml/min)

Active Code Status

Initial Resuscitation Status: Full

I have personally discussed... was part of this discussion: NOT CHECKED

Non-Behavioral Restraint Assessment: CHECKED

Indications for Restraints:	Confused;
Restrain Type(s):	2P

Specific Criteria for release from restraint:	Other: no longer intubated with facial edema
Patient informed:	No
Reason not informed:	Sedated/Intubated

Signatures:

CHECK **Resident**

SELECT: I have seen and discussed the patient with my supervising provider listed below and they agree with my assessment & plan.

Sign with anyone's name 😊

USAISR Bronchoscopy Proc/Image

Date/Time:	today, 0500
Bronchoscopist:	whomever
Staff:	TBA
Assistant:	blank
ASA Classification:	Class IV
Indication:	Evaluation of inhalation injury.
Labs:	do not check
Informed Consent:	No
If not why?	New admission, no surrogates available

Premedications:

Medication	Route	Dose
Ketamine	IV	Drip
Fentanyl	IV	Drip
Propofol	IV	Drip

Findings/Images:

X Proximal	Normal
X Carina	Normal
X R Mainstem	Normal
X L Mainstem	Normal

Complications:	None
Comments:	No evidence of II at this time.
Summary:	Bronchoscopy performed without complication. Findings above.
Specimen:	None

Signatures:

CHECK **Resident**

I have seen and discussed the patient with my supervising provider listed below and they agree with my assessment & plan.

Name of Supervising Staff: TBA

Sign: anyone.

Nursing Admission History

Language spoken: English

Language Preferred: English

Race: White

Date of birth: 03Sep1982

Relationship: parent

Personal articles: None

Admission Ht: 71 in

Admission Weight: 81kg

BMI: 24.89

BSAm2: 2.010

Allergy Information: Name: Penicillins; no symptoms

Medications list: autopopulated from Med Rec note

Immunizations ADL, blank

Continuity of Care: anticipated d/c: home; ID d/c issues: DME; Assistance making transition, Medical supplies;

Case Manager: LT

My signature

Nursing Assessment (initial)

Service: critical care

Age: 33, M, White, stretcher; arrived from LRMC via Burn Flight Team air evacuation

Time/Date: t-4

Admission ht/wt: autopopulated

Full code

Standard Precautions

Behavioral Health Assessment: unable to assess

Pain Assessment: CPOT; facial expression 0; body movements 1; muscle tension 1 ventilator 0
vocalization 0: Total score 2

General appearance: burned approximately 85% of his body

Neuro: Patient is intubated and mildly sedated on Fentayl and Precedex drips

Orientation: when sedation is turned off, pt can follow simple commands

Motor: When not sedated, all extremities bilaterally strong and equal in movement, can move all extremities spontaneously

Pupils: Difficult to assess due to significant swelling and burns of eyelids. Pupils seemed equal round and reactive to light directly

Pupils: 2 mm, R B

HEENT: atraumatic, no drainage noted, swallows without difficulty

Head: normocephalic

Eyes: periorbital edema; scleral edema

Ears: burned nose/throat: nose symmetrical, no discharge

Oral cavity: oral mucosa is pink, moist and w/o lesions

Oral assessment tool: aspiration risk criteria: yes at risk intubated and sedated

CV: tele per protocol parameters: on Heart sounds: s1S2 EKG: ST PR: 0.16 sec

Ectopy: none

Pulses: cap refill <2 sec R&L all pulses doplerable ; color NFR, temp : cool , Edema: U

Pulm: regular unlabored : chest wall expansion: bilateral and equal BS diminished throughout;

secretions: small amount; Cont pulse ox; cont ETCO2 O2 therapy: vent; VDR

GI: Last bowel movement: Date: unknown; abdomen: soft non-tender; mildly distended BS: unable to auscultate; pt on VDR making

Gender: male; swollen genitalia voiding method: See inv devices flowsheet (indwelling catheter)

Braden Scale: Sensory 1; moisture 1; activity: 1 mobility: 1; nutrion1;friction and sheer1 totat 6:

Braden: severe

Skin: findings: burns over 85% of his body on his face, neck, circumferentially bilateral arms, anterior and posterior torso, small amount of genitalia; buttocks, anterior and posterior thighs; prior skin brkdown: No; PU: Yes Stage II; left cheek small exudate, open wound bed dsq: clean 5% SMS length 2 cm width 1cm; depth 0.5 cm

Burns: Deep partial and full thickness burns over body all areas but lower legs and feet odor: absent dsq:

5% SMS: optional comment: small ulceration noted on right side of faced secondary to umbilical tie

MS: muscles equally developed , no abnormal movements

Falls: Yes; No;No;No; Patient Risk Level: Low; Low fall risk:SRx3

I performed the above assessment

To Do:

Team Member 1: Orders (flowsheets); bronch procedure note, BAL,

Team member 2: -flowsheets; vitals, treatments, I&O, meds, invasive devices, neuro, ventilator, vascular

-find BFS, fill out w/ Team Member 1

-ask BFT what they use for documentation

-get blank SBAR form (nursing)

-ask where tetanus documented; flu shot current (correct in nurse hx);

-Lund Browder, red/blue pencil

-copy of an ABG strip; make ABG strip in Excel

-ask, "How often is the Nurse clinical shift note done."

-Name of AD case manager

-BAL note-say it looks good;

-CXR images (normal);

-KUB images

-How do you get PMH on SM? From the record? How much of "record" comes

-How do you document pre-ICU admission fluids?

-Remember trauma # is 10987654321

-Do you know the parents name before admission

Pressure Ulcer Note:

No pressure ulcers on admission.

Yes military patient

Valuable Note:

Treasury yes: ID card and ID tags.

Sent pt property w/ family: Family not present at this time.

Non valuables retained by pt: NO

Health aids: check NO on all

Allergy Note: wait for H&P to be written and that info will autofill into this note.

Allergic to PCN

Admit note: wait for H&P to be written and ht and wt will auto-populate to this note. **THIS NOTE MUST BE WRITTEN IN ORDER TO DOCUMENT DRIP DOSAGES IN VS FLOWSHEET**

ADVANCED MEDICAL DIRECTIVES NOTE:

AMD STATUS: Complete (the patient is incompetent or unable to communicate)

DOES THE PATIENT HAVE A DIRECTIVE TO PHYSIANS, A LIVING WILL ETC: Patient intubated and sedated. Unable to get info from pt at this time. Family not available.

WOUND CARE PROCEDURE NOTE:

%TBSA: 84.7

TIME STARTED: 0430

TIME ENDED: 0600

STAFF INVOLVED: 2 NURSES, RT, TOTAL #3

TYPE OF WOUND CARE HYGIENE: Shower

WOUND CARE LOCATION#1:

FACE

Red, beefy, dry, insensate; without infection, cleansed and debrided, 5% dressings, 5% solution

LOCATION #2: CHEST AND BACK

thick, yellow-brown, leathery eschar on entire chest and back. Escharotomies to chest and bilateral flanks. without infection, cleansed and debrided, 5% dressings, 5% solution

LOCATION #3:

R & L ARMS: thick, yellow-brown, leathery eschar, circumferential on entire both arms, w bilateral medial and lateral escharotomies; without infection, cleansed and debrided, 5% dressings, 5% solution

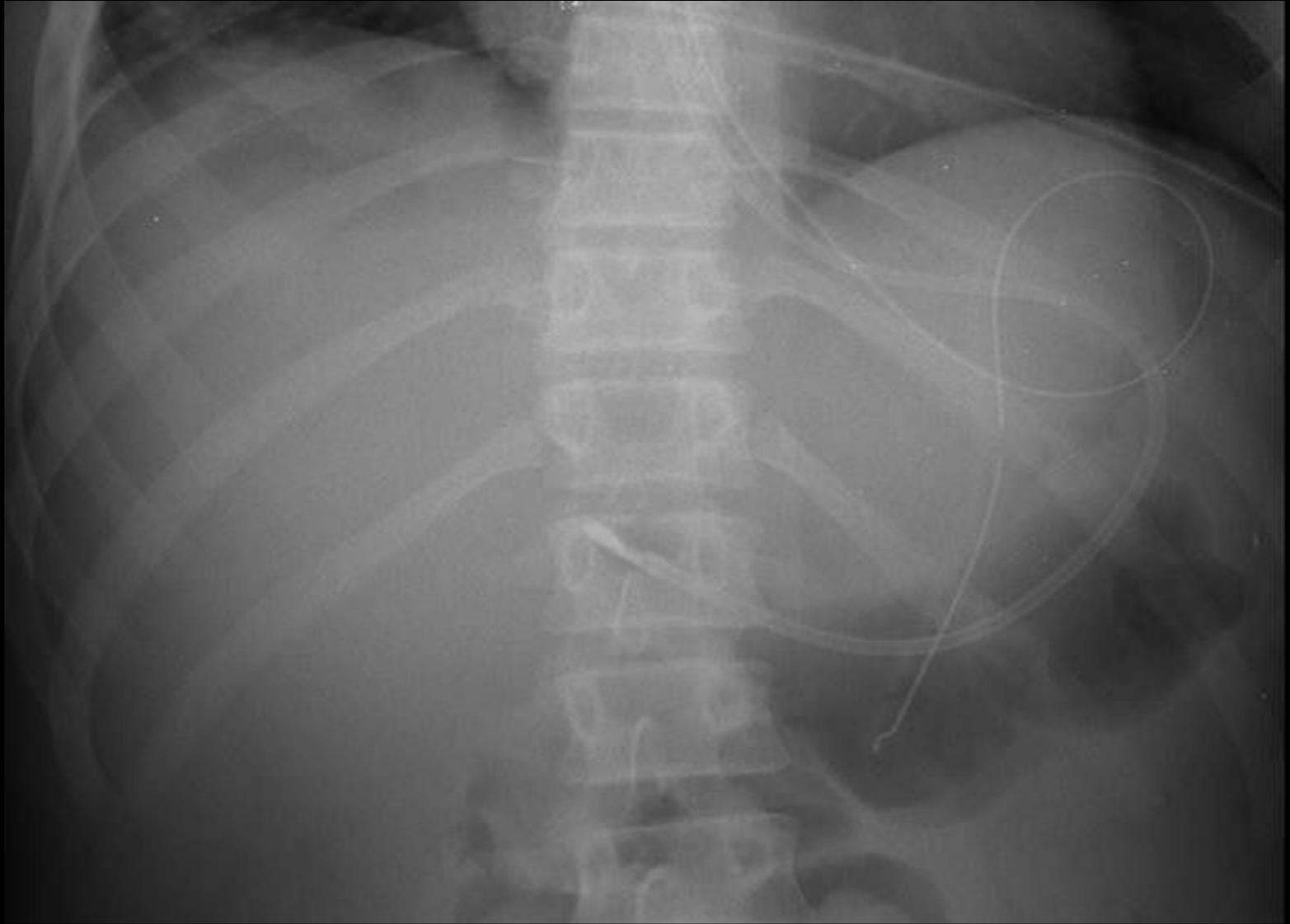
LOCATION#4:

BUTTOCKS and PENIS: Buttocks: thick, yellow-brown, leathery eschar, burn on glans, scrotum edematous, about size of a softball; without infection, cleansed and debrided, 5% dressings, 5% solution

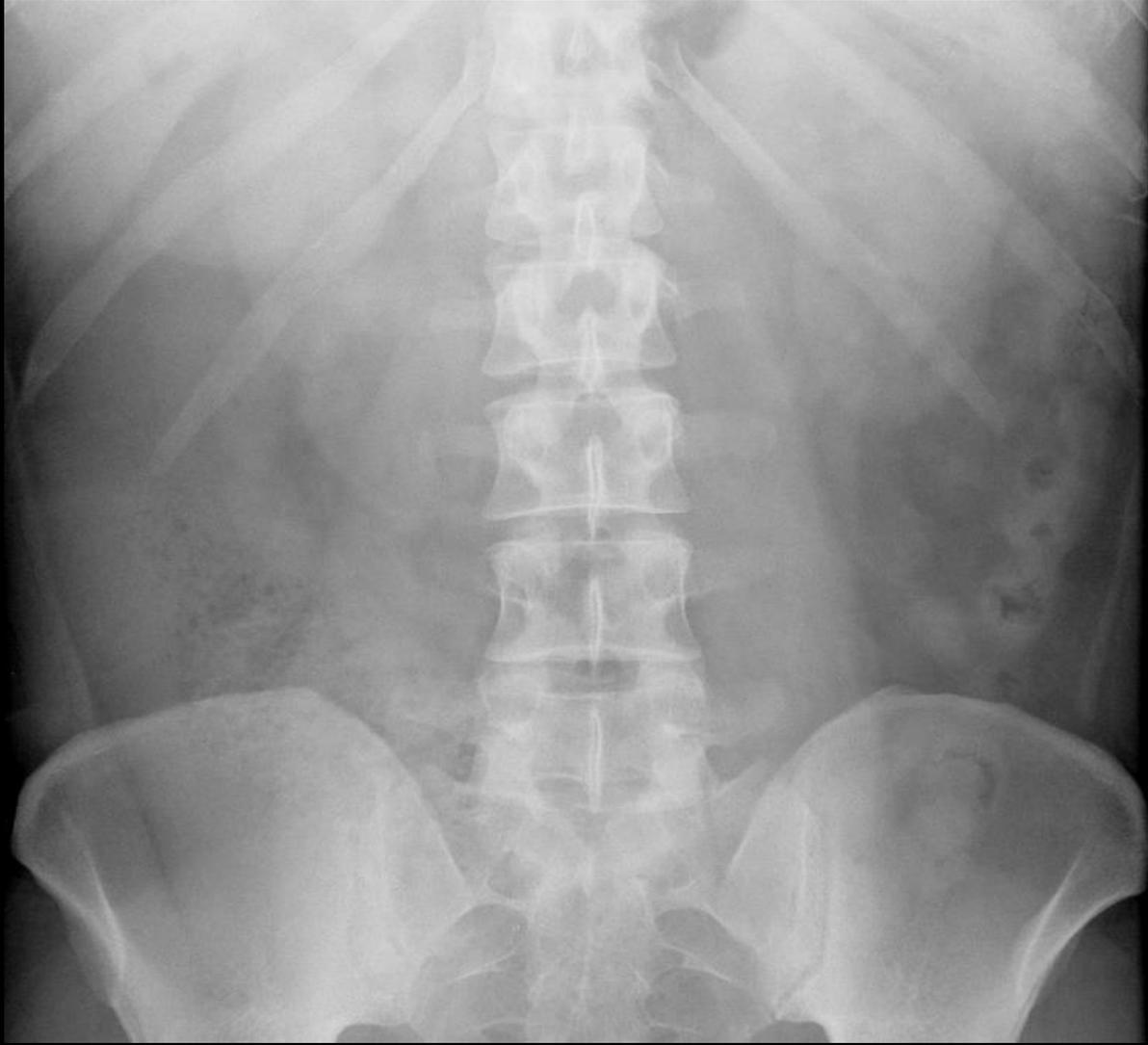
LOCATION#5:

R & L LEGS: burns circumferential w/ thick, yellow leathery eschar, bilateral escharotomies intact; without infection, cleansed and debrided, 5% dressings, 5% solution









Gen THI
S MB



Abd
P21
MI
1.1
TIS
0.8
A
B

16

THI
MB

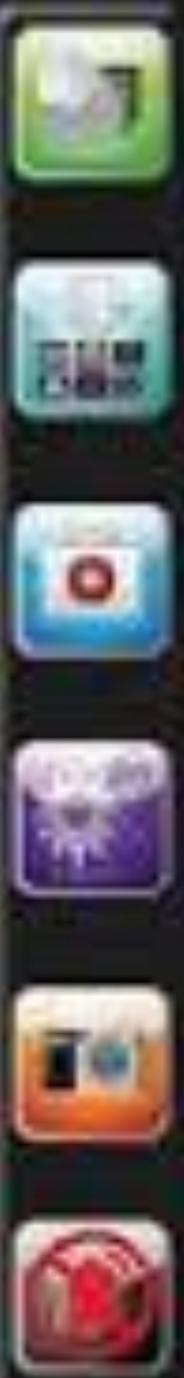
Abd
P21



MI
1.1

A

B



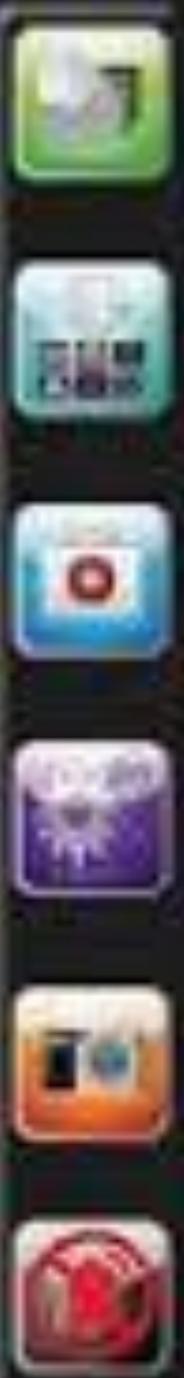
7



11.1
CO

300
SVR

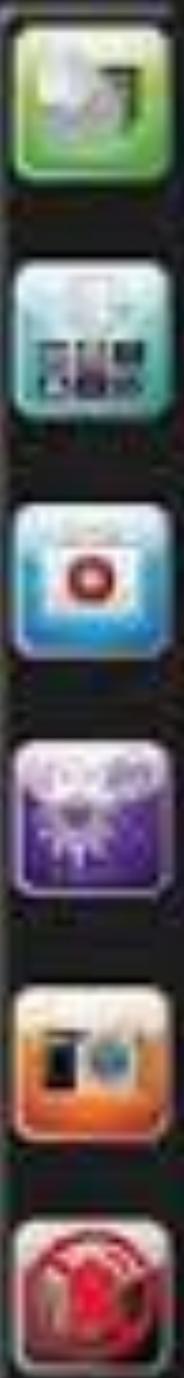
84
SV



14.1
CO

364
SVR

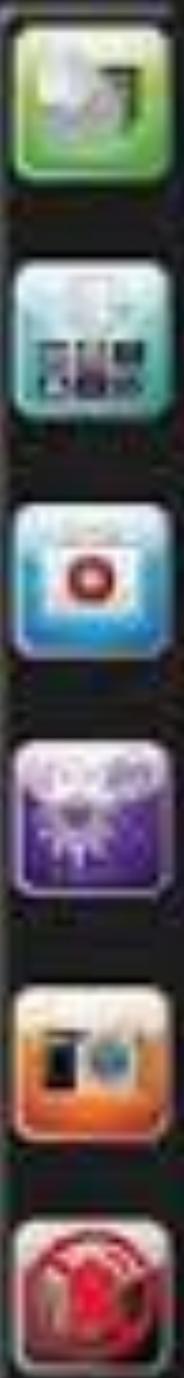
90
SV



12.2
CO

340
SVR

79
SV

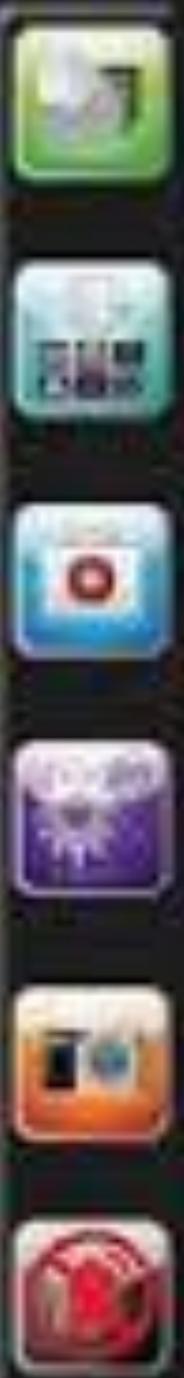


CO

SVR

SV

A vertical column of three large white circles, each with a yellow light indicator above it. The circles are labeled CO, SVR, and SV from top to bottom.

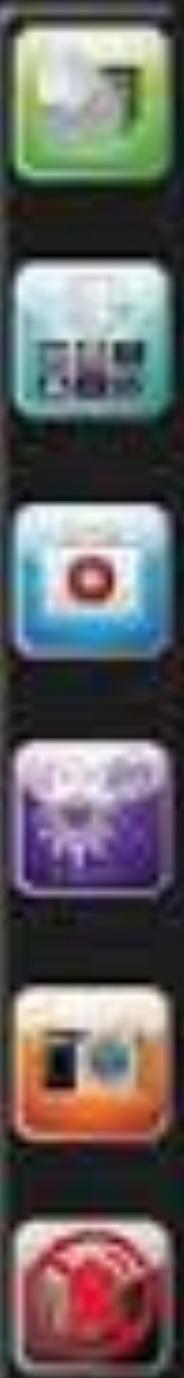


CO

SVR

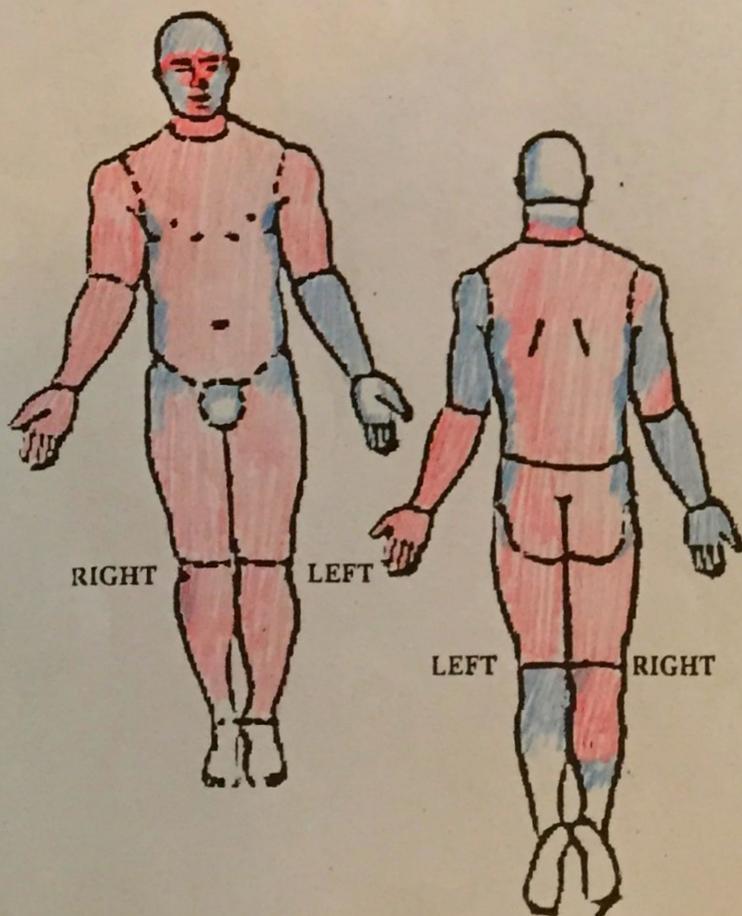
SV

A vertical column of three large white circles, each with a yellow light indicator above it. The circles are labeled CO (Cardiac Output), SVR (Systemic Vascular Resistance), and SV (Stroke Volume) from top to bottom.



Body Estimate and Diagram
Age vs. Area

AREA	Birth-1 year	1-4 years	5-9 years	10-14 years	15 years	ADULT	2nd Degree	3rd Degree	TOTAL
Head	19	17	13	11	9	7	3	2	5
Neck	2	2	2	2	2	2	0.5	1	1.5
Ant. Trunk	13	13	13	13	13	13	0	13	13
Post. Trunk	13	13	13	13	13	13	0	13	13
R. Buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	1	0.5	1.5
L. Buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	1	0.5	1.5
Genitalia	1	1	1	1	1	1	0.5	0	0.5
R. U. Arm	4	4	4	4	4	4	2	2	4
L. U. Arm	4	4	4	4	4	4	3	1	4
R. L. Arm	3	3	3	3	3	3	0	3	3
L. L. Arm	3	3	3	3	3	3	3	0	3
R. Hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	0	2.5	2.5
L. Hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2	2	0	2
R. Thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2	2.5	7	9.5
L. Thigh	5 1/2	6 1/2	8	8 1/2	9	9 1/2	2.5	7	9.5
R. Leg	5	5	5 1/2	6	6 1/2	7	4	1	5
L. Leg	5	5	5 1/2	6	6 1/2	7	2	4	6
R. Foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	0	0	0
L. Foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2	0	0	0
TOTAL							27	57.5	84.5



BURN DIAGRAM

Age 34

Sex M

Date of Burn _____

ISR Staff MD _____

COLOR CODE

Blue = 2nd Degree

Red = 3rd Degree

Cooperative Communication System Scenario 1 (Sepsis)
Master Packing List (Updated 10Jun2016)

To do:

Checklist items:

- Updated Calling cards (Attending, Resident, Bedside Nurse, Pharmacy, Radiology, Consultants)
- Blank Lab Sheets (printed)
- CXR Images
- KUB Images
- US Images
- Vent settings flow sheet (printed)
- EV1000 Prints
- UOP Cards
- Subject badges
- Blank SBAR Sheet
- Blank POIP Sheet
- Charge nurse checklist
- Hard Chart, Blank Consents, labels (i.e. For labs)
- Artificial Scrotum
- Extra IV Bag and Medication stickers
- Laptop with Essentris at Simulation Table outside room

Day before	
0800-1200 or after Sim	- Sim team members set up room
NLT 1200	- Team members 1, 2: Enter New patient
NLT 1600	- Enter Notes & Orders
	<ul style="list-style-type: none"> • Team member 1: <ul style="list-style-type: none"> <input type="checkbox"/> Med Rec <input type="checkbox"/> H&P <input type="checkbox"/> Bronchoscopy Note <input type="checkbox"/> Enter Orders <ul style="list-style-type: none"> ○ BICU ISR Admission excluding DVT & GI Prophylaxis ○ Foley to gravity ○ Propofol, fentanyl, ketamine, vasopressin ○ Electrolyte protocol ○ Wound care Orders
	<ul style="list-style-type: none"> - Team members 2, 3: <ul style="list-style-type: none"> <input type="checkbox"/> Nurse Admission History <input type="checkbox"/> Admit Data <input type="checkbox"/> Nurse Assessment Initial <input type="checkbox"/> Wound Care Procedure Note <input type="checkbox"/> Enter NIOs
1300-1500	- Orientation (All Team Members)
	<ul style="list-style-type: none"> ○ Test DVE with subject (at appropriate terminals – constitutes terminal checks) ○ Test CCS in DVE with subject ○ Ensure subject consented
1600	- Review Checklist/Huddle and Review Scenario (walk through)
Morning Sequence:	
0600	

<ul style="list-style-type: none"> ○ Team Member 1: <ul style="list-style-type: none"> □ Turn on vent; □ Write vent settings on white board and record on vent flow sheet (vent check note?) □ Ensure Vent Flow Sheet on Ventilator. □ Update POIP Board
<ul style="list-style-type: none"> ○ Team Member 3: <ul style="list-style-type: none"> □ Enter Flow Sheets □ Turn on/set IV Pumps □ Make room hot □ Open Blood bag and NGT bag. □ BP Cuff with 10 Pumps (Team Member 3 Only)
<ul style="list-style-type: none"> ○ Team members 2, 4: Log into mobile DVE computers as back-ups
<ul style="list-style-type: none"> ○ Engineer: Enters morning labs into CCS if running.
0630 – Huddle:
<ul style="list-style-type: none"> ○ review pre-flight Checklist ○ Turn on pumps/equipment in room
0645 – Start Handoffs, give badges, and log into DVE computers with their users (Team members 2, 4)
<ul style="list-style-type: none"> ○ Resident –Team member 2 does CAC login & DVE set Up whilst Team member 1 does Handoff ○ Bedside Nurse <ul style="list-style-type: none"> ▪ Team member 4 does CAC login & DVE set Up whilst Team member 3 does Handoff ▪ Team member 4 adds 10 pumps to BP cuff while Team member 3 finished Handoff in anteroom ○ Attending – Team member 2 sets up DVE with JCP CAC
Charge Nurse – Team member 3
Respiratory therapist (RT) – Team member 1
0700 – Simulation starts (Team member 1 in sim room/Team member 2 outside sim room as comma with engineer in DVE to support, Team member 3 is runner:)
0700-Rounds <ul style="list-style-type: none"> • Resident Pre-Rounds • Nursing care • Attending pre-rounds or other
~0800- Rounds
0830 – Family member calls
0930 – Liaison Calls
Post rounds – Rounds plans implemented, patient declines, decisions made.

Goals and Concepts

- Patient is doing OK and plans should be to advance care (feeds, rehab, sedation holiday, vent weaning, prep-for OR tomorrow).
- Patient's condition gets worse as the morning goes on.
- The team should identify why and make decisions about how to manage (bedside DPL/mini-lap vs. go to OR, vs. transition to comfort care.
- First residuals whenever they are checked will be 300.
- By 1-2 hrs after rounds HR increases to 130s levo 10, abdomen more distended (may not be apparent)
- Fluid challenges result in transient improvements in HR/MAP
- Next residual check 600mL, abdomen is more distended. Some grimacing on abdominal exam in the RUQ > other locations.
- If Tilt tried, HR goes up, MAP drops, sats drop, generally does not tolerate.
- Ultimately HR 150s Levo 10-25mcg/min
- If CT considered/attempted, VS decline faster.

Outcomes

End state (Primary decision) is decision for emergent/urgent ex-lap or not. If bedside DPL/mini-lap pursued (simulated), then findings are murky, brown fluid in abdomen.

Other key outcomes:

- Time to complete pre-rounds by resident
- Time for oncoming nurse to say he/she feel's "comfortable" (i.e. feels like he/she knows what is going on with the patient and starts documenting their assessment)
- Time to ordering cultures and antibiotics
- Time to calling family to discuss ex-lap
- Time to deciding to perform ex-lap or not

Other items to note:

- Should note lack of DVT and GI prophylaxis and should start them
- Should identify need to feed patient not fed X 4 days (consider TPN)
- Should note no type and screen and should order for OR tomorrow or pre-op today.

Room Set-up

- Call cards for Resident, Nurse, and Attending
- Bedside silver tray – for monitor
- Hospital bed
- New room set up
 - Bedside tables with new admission supplies
 - RT table and back table
- 2 IV pumps stands
- Kangaroo Pump (available, not in room)
- Fill out white board
- Wet down bottles
- Ventilator settings flow sheet attached to the ventilator
- Chux
- NGT to bag with 300mL bilious fluid set up
- Second bag of 600mL stool colored fluid available.
- New paper insulin protocol
- L&B in anteroom folder
- Hard chart/consents/labels in room

Patient / Miscellaneous

- 3G Mannequin
 - Triple lumen CVC in right femoral vein
 - Arterial catheter in left femoral artery with blood bag attached
 - 8.0 ETT at 24cm at the lip with bite block in place – tied to the face
 - Nasogastric tube with NGT Ties
 - Foley catheter hooked up to IV tube for output
 - Urimeter with additional urine to input over time with cards displaying urine output
 - Bandages over everything except feet/distal legs
 - Distended abdomen – BP Cuff in Manikin filled to 10 pumps (**Team member 3**)
 - Arm band with patient name
 - Allergy Band with PCN
 - Falls band
 - Eyes closed
 - HOB up 30 degrees
 - Arms on towels for elevation
 - Sim draws Blood bag for blood draws
- Ventilator with flow sheets– VDR - HFPV. FiO2 50%, PEEP 5, PIP 20, RR – set 15, Hz 550, MAP 17

- Room hot
- Simulated medications/blood products (all boxed and outside with sim team)
 - *Enoxaparin syringe
 - *Protonix IV push or piggyback
 - *Albuterol (saline neb) – get from RT
 - *Fentanyl drip
 - *Ketamine drip
 - *Propofol drip
 - * LR bags x 2
 - *Albumin
 - *PRBCs x1
 - *Vasopressin drip
 - *Levophed drip
 - *Enteral feeding
 - Blood bag for blood draws
- Extension tubing/primary tubing for all drips x 4-6 sets
- Foley/reservoir bag for medications to drain
- Stethoscope

Physician Handoff

34 yo Active Duty E5 with 85% TBSA now post injury day 4. Thermal injury occurred in Afghanistan after his cloths caught on fire while he was checking the fuel level of his truck with a lighter. Initial resuscitation was c/b hypotension. high volume infusion rates (2L/hr x 3 hours, early albumin administration at 8 hours post burn), and vasopressor usage (vasopressin/levophed highest 30 mcg/min). 266mL/kg 24 hr resus. (see burn flow sheet).

The burn flight team picked the patient up in LRMC yesterday and arrived this morning at 0330.

Plan is for excision tomorrow morning.

HD stable since admission. HR 120's 115/67 99% FiO2 50% VDR 550 15 5/5 24 ABG 7.38/35/110/23/98%/lactate 1.2

Chemistry 130/3.4/110/24/45/0.7/175/ PO4 1.2 Ca 9.5

CBC 12>7.3/23<110

LFTs 6.8/3.3/4.0/101/160/134

N: Sedated on Fentanyl drip, Ketamine drip, Propofol drip, GCS prior to flight 9T. Dr. ____ suggested a sedation holiday to get another neuro exam. (M6E2/V1T)

P: VDR 550 15 5/5 24 ABG 7.38/35/110/23/98% CXR clear except b/l Basilar infiltrates prior to flight

C: No issues. HR 130 115/67, pulses in all extremities, currently on vasopressin and levophed 2mcg/min

R: UOP has been fine, 30-60mL/hr IVF 200mL/hr LR

GI: No real issues, mildly distended. No BS, soft, no tenderness, mild distended Dr. ____ suggested starting feeding today.

Wounds: 85% TBSA. Pretty edematous. escharotomies everywhere (all extremities, chest/abdomen), Dressings were changed this morning to 5% throughout, face in baci, ears sulfa.

SBAR Report Nursing

SITUATION: Admit/Burn Date: Admitted this morning at 0330 TBSA:	Doctor: (Name)
BACKGROUND: History: 34 yo Active Duty E5 with 80% TBSA now post injury day 4. Thermal injury occurred in Afghanistan after his cloths caught on fire while he was checking the fuel level of his truck with a lighter. Initial resuscitation was c/b hypotension. high volume infusion rates (2L/hr x 3 hours, early albumin administration at 8 hours post burn), and vasopressor usage (vasopressin/levophed highest 30 mcg/min). 266mL/kr 24 hr resus. The burn flight team picked the patient up in LPMC yesterday and arrived this morning at 0330 . Plan is for excision tomorrow morning. Last Vitals: HR 115, MAP 57, 92/40, R 15, CVP 15, SpO2: 99% Wt: 104 LR at 200, Propofol 50, Ketamine 20 mcg, Fentanyl 100 mcg	Code Status: Full Allergies: ????
ASSESSMENT: Neuro/Pain: Sedated, GCS prior to flight 9T (M3E2V1T) Respiratory: VDR 550 15 5/5 24 ABG 7.38/35/110/23/98% CXR clear except b/l Basilar infiltrates prior to flight Cardiac: HR 130 115/67, pulses in all extremities, currently on vasopressin GI: No BS, soft, no tenderness, mild distended GU: UOP 30-60mL/hr IVF 200mL/hr LR In- 235, UOP 55 Skin/Wounds: Wounds: 85% TBSA. Edema all extremities, escharotomies all extremities, chest/abdomen, 5% throughout, face in baci, ears sulfa Lines: Left Fem a line, Right Fem CVC Infx: Labs: glucose 168, lactate 1.2	
RECOMMENDATIONS: Goals: Burn surgeon will look at wounds tomorrow; need consents signed! Tests/Treatments: none	

WBC	12	BUN	45
Hgb	7.3	Cr	0.7
HCT	23	Glu	175
PLTs	110	iCa	1
INR	1.2	Mag	2.4
PT	13.1	Phos	1.2
PTT	24	TP	6
Na	134	Albumin	2.2
K	3.4		
CL	102		
HCO3	22		
Gap	10		

RT Handoff

H & P: 34 yo Active Duty E5 with 80% TBSA now post injury day 4. The burn flight team picked the patient up in LRMC yesterday and arrived this morning at 0330 .

Thermal injury occurred in Afghanistan after his cloths caught on fire while he was checking the fuel level of his truck with a lighter. Initial resuscitation was c/b hypotension. high volume infusion rates (2L/hr x 3 hours, early albumin administration at 8 hours post burn), and vasopressor usage (vasopressin/levophed highest 30 mcg/min). 266mL/kr 24 hr resus.

CXR clear except b/l Basilar infiltrates prior to flight

Sedated, GCS prior to flight 9T (M6E2V1T)

+/- Inhalation: negative

Recent ABG: ABG 7.38/35/110/23/98%

Vent Settings: Mode: VDR—PIP: 26 PF: 550 R: 15 OCPeep: 5 DemPeep: 5 FiO2: 100%

Treatments:

ETT size/placement: 8/ 25T

Plan today: ?

Plan is for excision tomorrow morning.

71 Inches, IBW 75.6

Family Member Script (Questions/Answers/Cue's)

****Bold denotes KEY Messages to convey.**

- Hi, my name's TBD, I'm calling about my husband SGT XXXXX..... Is my husband OK?
- The rear detachment commander and his wife came over three days ago and have been helping me get my things together so I can come down to see him. They said he was pretty bad, (Crying/Sad) burns over 80% of his body.... (More Crying/sad)... They said his truck exploded, how does that even happen? Will he be OK?
- Can I talk to him? I just want to hear his voice. They said he couldn't talk to me when he was in Landstuhl because of the tubes. Is he on machines? He said he would never want to live on machines.
- I'm at the airport. My flight leaves in 30 min. I should get in tonight around 11... Can I come visit then? I want to see him right away. Will they let me stay with him?
- We're stationed at Fort Drum in New York.
- It's just me up here alone. I've been keeping a secret from him, we are about to have our first baby. I wanted to wait until I was further along to tell him....now I wish he had known.
- His parents live in Phoenix. (Insert Names) They should be driving there now.
- No, no brothers or sisters.
- A Company, 2nd BN, 87th INF Regiment.
- Password = Buttercup (because that's what he calls me....)
- My phone number XXX-XXXX (give actual personal cell for phone call)
- Tom's number is XXX-XXXX.
- Betty's number is XXX-XXXX (yes, they just moved from San Antonio – Tom was in the Air Force).
- Yeah, he's old for an E5... I'd rather not talk about it.

Military Liaison Script

- Hi, my name's MAJ (NAME).
- Just checking up on SGT TBD.
- **He's with the A Co. 2/87**
- CO is CPT (NAME). Rear detachment POC is SFC (NAME).
- Just need to know his current status?
- Any information you need? (Anything they ask you just say you'll work on getting it)

Scenario 1

	Hour	3:30	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
Vital Signs														
	Weight (kg)	104												
	HR	115	118	113	109	120	122	127	137	145	136	132	157	155
	MAP	57	69	65	71	68	67	68	62	45	59	62	60	59
	SBP	92	109	105	107	105	106	104	102	70	91	92	90	88
	DBP	40	49	45	53	49	48	50	42	32	43	47	45	45
	RR	15	15	15	15	15	15	15	15	15	15	15	15	15
	CVP	15	18	12	14	16	12	11	8	6	5	10	15	14
	Temp	101.4	101.6	101.8	102.1	102.2	102.4	102.2	102.6	103.2	104	103	102.5	102.3
	SpO2	99	97	98	99	98	99	97	100	95	92	96	95	94
	CO					-						11.1	14.1	12.2
	SV											84	90	79
	SVV					-						7%	6%	8%
	SVR					-						300	364	340
	ABD Pressure						18					22		
	RASS	-3	-3	-3	-3	-3								
	FSGlucose	168					195	230	250					
Inputs														
	LR	200	200	200	200	200								
	Albumin													
	vasopressin	0	2.4	2.4	2.4	2.4	2.4							
	Levo													
	Promote	0	0	0	0	0	0							
	Insulin	0	0	0	0	0	0							
	Propofol (mcg/kg/min)	50	50	50	50	50	50							
	Ketamine (mcg/kg/min)	20	20	20	20	20	20							
	Fentanyl (mcg/hr)	100	100	100	100	100	100							
	Ins													
Outputs														
	UOP/Foley	55	50	75	60	40	45	35	50	20	5	5	0	0
	CRRT UF													
	Residuals							300		600				
	Stool													
	Net Ins/Outs	0	0	0	0	0	0	0	0	0	0	0	0	0
Labs														
	WBC	12								20				
	Hgb	7.3								6.8				
	HCT	23								20.2				
	PLTs	110								105				
	INR	1.2												
	PT	13.1												
	PTT	24												
	Na	134								133				
	K	3.4								4.2				
	CL	102								101				
	HCO3	22								18				
	Gap	10								14				
	BUN	45								56				
	Cr	0.7								1				
	Glu	175								236				
	Mag	2.4								3				
	Phos	1.2								2.1				
	TP	6												
	Albumin	2.2												
	Tbili	1.2												
	Dbili	0.8												
	Alk Phos	64												
	AST	95												
	ALT	54												
	HCG	Neg												
	EtOH	< 0.03												
	CK	1104												
	Troponin	< 0.01												
	T&S				A+									
	A1C	5.5												
	Arterial pH	7.37	7.38				7.34		7.35	7.32	7.27	7.2	7.14	
	Arterial PaCO2	34	35				38		35	35	30	28	26	
	Arterial PaO2	125	110				115		100	94	90	93	95	

