Scenario Title: Diabetes and Skin Breakdown-Makeup Scenario

Scenario Overview:

Brief Description: Students will care for a 58-year-old male with Type 2 Diabetes which is poorly controlled. He has been admitted for Foot Wound + Elevated Blood Glucose Levels

Setting: Med Surg

Course Number and/or Student Grade Level: NRS 122 1st Semester LPN Students

Patient Background:

Name:	Robert Jenkins
Age:	58
DOB:	08/01/19
Height:	187 cm
Weight:	131.5 kg
Code Status:	Full Code
Gender:	Male
Medical History:	Type 2 diabetes (poorly controlled)
Social/Family History:	Patient brought himself to the ER after speaking to his daughter on the phone. Daughter voiced concern for blood sugar levels so patient brought himself into the hospital. He is being admitted for elevated uncontrolled blood glucose plus % numbness in feet and non-healing wound to R. foot. Patient worked in construction until last year when his legs became too numb/painful. He is divorced and has one daughter who lives in Wyoming.
Diagnosis	T2DM, Foot Wound
Current Medications:	Metformin-1000mg PO Daily

	Lisinopril-10 mg PO Daily Insulin Lispro (Humalog)-Sliding Scale SQ BID Insulin Glargine (Lantus)-20 units SQ Daily
Allergies:	NKDA
Vital Signs (baseline):	HR: 88 BP: 138/84 RR: 18 SpO2:97% on room air Temp: 37.2 C

Learning Objectives:

1. Students will apply knowledge of blood glucose monitoring and insulin administration to safely manage a patient with diabetes.

2. Students will analyze patient data to differentiate between hypoglycemia and hyperglycemia and identify appropriate interventions.

3. Students will evaluate the effectiveness of interventions and determine the need for escalation of care.

4. Students will develop and deliver patient-centered education related to diabetes management and foot care.

Learning Outcomes:

1. Students will perform blood glucose checks prior to insulin administration. Students will accurately determine insulin dose using the provided sliding scale. Students will correctly administer insulin with the correct technique and timing.

2. Students will correctly interpret blood glucose values. Students will identify the signs and symptoms of hypo vs hyperglycemia. Students will appropriately intervene based on patient condition.

3. Students will reassess the patient after insulin or hypoglycemia treatment. The students will determine if the patient's condition is improving or worsening. The students will communicate needs to notify the provider based on clinical findings.

4. Students will provide at least 2-3 appropriate teaching points (e.g., foot care, glucose monitoring, and medication adherence) Students will use clear, patient-friendly language. Students will address risk factors such as neuropathy and wound care.

Handoff Report to Students (ISBARRQ Format)

Identify	Robert Jenkins, 58-year-old male patient.
Situation	Robert is a male patient with T2DM which is poorly managed. He came into the ED today at his daughter's urging for a high blood glucose reading. He is also reporting numbness in his feet. He doesn't know what his last blood sugar was, but that it was high.
Background	Robert is a 58 year old male patient who appears to be stated age. He has poor hygiene noted to feet, but is otherwise clean and well-nourished. The patient is medically classified as obese per BMI guidelines. He was diagnosed with T2DM approximately 5 years ago. He was also diagnosed with mild HTN at the same time and takes medication for it, but the patient is unsure what one. Patient is a somewhat reliable historian, but does not have many details about diagnosis, condition, and medications.

Assessment	Vitals: HR: 89 BP: 140/87 RR: 18 SpO2: upper 90s on room air Temp: 37.2 C General Appearance: Awake and oriented x3, appears fatigued and mildly uncomfortable. Overweight, poor hygiene noted to feet, frequently thirsty (asks for water). Cardiovascular: HR 89 BP 140/87, Peripheral Pulse 2+, but slightly diminished in feet, Cap Refill: 2-3 seconds, No chest pain reported Respiratory: RR 18, non-labored, lung sounds are clear bilaterally, SpO2: 97 ORA GI: Abdomen soft, non-tender, bowel sounds present in all quadrants, reports increased hunger, complains of dry mouth GU: Reports frequent urination, urine clear, light yellow, no pain with urination. Uses male urinal at bedside independently. Extremities: Full ROM, decreased sensation in bilateral feet. Reports “feet feel numb sometimes” “I don’t always notice when I step on things” Skin: Warm slightly dry. Right Foot Wound, haven’t had time to do a full assessment on the wound. Feet are dry and cracking with poor nail care Neurological: Alert and oriented x3. Clear speech IVs: Peripheral IV in L forearm, 20 gauge, Saline Lock, Site clean, dry, intact. Labs:Labs were ordered and should be in the chart. Fall Risk: Moderate –non-slip footwear, assist x1 w/ambulation

	Pain: Rates pain 2/10 “states it doesn’t hurt, can barely feel it”
Recommendations	Review labs, call provider if needed, assess wound, frequent blood glucose checks. Educate patient on foot care and T2DM management.
Repeat Back	
Questions	

Room Setup:

Room number	Med Surg
Manikin (male, female, pediatric, etc)	Adult Male High-Fidelity Manikin
Moulage (bruising, IV, NG, etc)	IV L. Forearm-saline lock, Wound to foot-plantar surface ~2 cm, redness around edges, mild swelling, small amount of serous drainage. Skin on feet is dry, with cracked heels, poor nail care.
Equipment (spirometer, IV Pump, etc)	Glucometer, strips, wound care supplies(NS and sterile dressings), juice, vitals monitor, insulin
Staging (loud music, tangled sheets, etc)	Water cup and male urinal. Add urine to urinal between states.
Medications	Metformin 1000 mg PO Lisinopril 10 mg PO Insulin Lispro (Humalog) SQ Insulin Glargine (Lantus) SQ Cephalexin 500 mg PO
Other	

Baseline Patient Condition

Pre-Programmed Scenario: Yes or No

Baseline Vitals:

HR: 88

BP: 138/84

RR: 18

SpO2: 97%

Temp: 37.1

Baseline Sounds (lungs, heart, bowels, speech): clear lungs, bowel sounds all quadrants

Start of Scenario (State #1)

Baseline Vitals:

HR: 88

BP: 138/84

RR:18

SpO2: 97

Temp: 37.1

Baseline Sounds: None

Triggering event(s): Students enter the patient room

In this state: The students meet Robert on the Med Surg floor. The patient is awake, but slightly fatigued. The patient will complain that his foot just wont heal, but he isn't bothered by it too much because he really doesn't feel it anymore. He asks why his foot wont heal and why he doesn't have any feeling in his foot. He will ask for water frequently.

In this state, the students are expected to: Students should perform a full assessment and assess the wound. Students should ask Robert about how he manages his diabetes. Students

should perform a glucose check. His blood sugar will be 110 if students check glucose. Students should review labs and call the provider to inform the updates. Students will receive an order for Cephalexin BID 500 mg for the elevated WBC and temp related to the wound. Students will also receive a wound care order that should be completed as well.

Orders in this state:

Start Cephalexin 500 mg BID PO for 10 days for wound infection

Start daily wound care-cleanse with NS, apply dry sterile dressing. Assess for redness drainage and odor

Estimated time in this state: 30 minutes

State 2

Baseline Vitals:

HR: 95

BP: 140/90

RR: 20s

SpO2: mid 90s on room air

Temp: 37.1C

Baseline Sounds:

Triggering event(s): Patient is showing signs of confusion and increased fatigue and confusion.

In this state: Students enter the room to find that Robert is very fatigued. He is consistently asking for water and complains of frequent urination. He is exhibiting signs of confusion. Students should check blood glucose level. If checked, level will be 312. Students should take appropriate actions to correct the blood glucose level. Students should complete a full assessment of the patient and report any other findings to the provider.

In this state, the students are expected to: Students should recognize need to take blood glucose level. Students should recognize hyperglycemia. The students should administer correct insulin dosage based on sliding scale. The students should encourage fluids for the

patient. Students should notify provider of acute patient changes. Students should reassess blood glucose 15 minutes after insulin administration.

Orders in this state: No new orders

Estimated time in this state: 5 minutes

Briefing:

Prebriefing questions and points of discussion:

1. Blood Glucose Basics

- Normal ranges (fasting vs random)
- Hypoglycemia (<70 mg/dL): signs, urgency
- Hyperglycemia (>180–250 mg/dL): signs, risks

2. Insulin Fundamentals

- Short-acting vs long-acting (keep it simple)
- Timing with meals
- Safety: “check glucose before you give insulin”

3. Glucometer Skills

- When to check
- Proper technique
- Documentation

4. Diabetic Foot & Wound Care

- Daily foot checks
- Neuropathy risks
- Why wounds get bad fast

5. Communication + Escalation

- When to call provider
- Reporting abnormal findings

Debriefing questions and points of discussion:

1. Reaction Phase

- “What felt hardest?”
- “What caught you off guard?”

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2. Analysis Phase (

Blood Glucose Management

- Did you check before insulin?
- Did you interpret correctly?

Clinical Judgment

- What made you think hyper vs hypo?
- What cues did you miss?

Skills

- Insulin administration safety
- Glucometer technique

Wound Care

- What concerned you about the wound?
- Infection risk?

Teaching

- What did you tell the patient?
- What *should* they know before discharge?

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3. Application Phase

- “What will you do differently next time?”
- “What’s one thing you’ll never skip again?”