📝 Task to Perform

Task No. 3 – OSCE: Internal Medicine & Geriatric Nursing

Scenario Description

You are caring for an 80-year-old woman who has been admitted to the geriatrics department. She presents with symptoms commonly associated with long-term immobility. She has been bedridden and unable to move independently for the past month, resulting in general weakness. Her daughter, who lacks the necessary knowledge and skills to provide care, has not demonstrated adequate commitment to supporting her mother at home. Your task is to provide appropriate nursing care for this patient.

Instructions for the Student

You are required to:

1. Conduct a nursing interview to assess the patient's current condition and needs.
2. Measure and record basic vital signs using the appropriate equipment and tools.
3. Perform hygiene care by changing the patient's diaper while maintaining dignity and comfort.
4. Assess and properly dress a pressure ulcer (Stage 3) on the patient's leg, following wound care protocols.

🕒 **Total Time Allowed: 40 minutes**

Step 1: Nursing Interview

Action: Knock, enter, perform hand hygiene, and approach the patient.

Say:

“Good morning. My name is [Your Name], and I’m a student nurse. I’m here to care for you today. Is that okay with you?”

- Confirm patient’s **ID wristband** for identification and ask her name.
- Close **privacy curtain**
- Ask **consent** to begin assessment.

Ask:

Ask open-ended questions:

- *“How are you feeling today?”*
- *“Are you in any pain right now?”* (Use **OLD CART** method for pain).
- *“Are you comfortable? Would you like me to adjust your position?”*

Explain everything before doing it and ask for **consent**.

Use a **privacy curtain**, lower **bed rails** when needed, and ensure the patient is **safe and comfortable**.

Step 2: Vital Signs

Action:

- Sanitize hands and wear gloves.
- Prepare equipment (BP cuff, thermometer, pulse oximeter, watch)
- Explain each step

Say:

“I’d like to check your vital signs now to assess how you're doing.”

Measure & Record:

- Temperature
- Blood pressure

- Oxygen saturation (SpO_2)

Document all values clearly.
If all are within range:

"Your vital signs are stable. There's no urgent concern at this time."

🩹 Step 3: Diaper Change

Preparation:

Collect supplies:

- Gloves (clean and sterile)
- **Disinfectant spray**
- **Gauze**, sore foam, and **adhesive dressing**
- hand sanitizer, **moisturizing cream**
- **Wipes**, clean pads, blue underpads
- All on the Trolley
- Waste bin (red)
- Wear clean gloves
- Adjust bed height
- Place blue underpad under the patient
- Ensure privacy and dignity

Say:

"I'm going to change your pad now to make sure you're clean and comfortable. Is that okay?"

Procedure:

1. Lower bed rail, roll patient gently to the side
2. Remove soiled diaper and wipe **from front to back** using disposable wipes
3. Inspect skin: *"There is some redness but no skin breakdown"* OR *"There is a Stage 3 pressure sore on the leg — I will treat it shortly."*
4. Apply **barrier cream** or moisturizer if needed
5. Place clean diaper under the patient, secure it properly
6. Reposition patient, cover them
7. Dispose of waste in **red bin**, remove gloves, perform hand hygiene

🩹 Step 4: Stage 3 Pressure Ulcer Dressing

Preparation:

- Gather materials: gloves (clean & sterile), disinfectant spray, gauze, foam dressing, plaster/tape
- Set up a clean trolley surface

Say:

"You have a pressure sore on your leg. I'm going to clean and dress it now to prevent infection and support healing."

Procedure:

1. Perform hand hygiene
2. Wear **clean gloves**
3. Remove old dressing and dispose of it in **red bin**
4. Remove gloves, disinfect hands, wear **sterile gloves**
5. Spray the wound with disinfectant
6. Clean gently with gauze **in one direction only**
7. Secure with tape or plaster
8. Remove gloves, sanitize hands

Say to patient:

"The wound is clean and dressed. I'll keep monitoring it regularly. Thank you for your cooperation."

📓 Final Step: Aftercare & Documentation (2–3 minutes)

Reposition the patient comfortably, adjust bed and rails, and tidy the area.

Say:

"You're all done. I've cleaned and dressed the wound, and you're in a dry, comfortable position now. If you need anything, just press the call bell. I'll be nearby."

Document:

- Vital signs
- Diaper care
- Pressure sore condition
- Dressing details (e.g., size, materials used, wound stage, signs of infection)
- Patient response to care