# Rules of the Game – Summary

*Aim*

The aim of the game is to safely care for four patients on an Orthopaedic rehabilitation ward by completing tasks that are required to effectively look after them within the allotted time. You will not have the resources to complete all the tasks, so must prioritise and share the workload to ensure essential actions are completed.

*The rules*

- At the start of the game, you will receive a handover for the patients who you will be looking after that day.

- You will then be randomly dealt a set of action cards, face down. Each of these action cards represents a patient related task. Each task has a points allocation that is roughly equivalent to how long that task might take. You have a total of 20 points to spend. The number of tasks you have to complete will exceed the points that are available to you, so you will have to prioritise.

- A 15-minute timer will be started. You will then turn over your cards. You will need to re-distribute the action cards between you based on who you feel is best placed to complete each task.

- Each player must then choose which tasks to prioritise. If you are planning to complete a task, you should place that action card face up in the middle of the table. The points allocation of the action cards you have played should not exceed your points allotment.

- Players can continue to re-distribute action cards between themselves, and swap the action cards they have played, until the time runs out. Once time has run out, the action cards face up on the table represent all the tasks that have been completed.

- Throughout the game, the facilitator will draw event cards every two minutes. These event cards will generate new tasks that need to be completed. One player must volunteer to claim each drawn event card. Once the event card is claimed, it must be played and included in that players points spend.

- The game ends after 15 minutes or when each player is happy with the choice of action/event cards they have played.

- At the end of each session, you will be asked to share which tasks you have completed and why you chose to complete them. We will then debrief as a whole group.

# Patient Details

## Bed 1 - Irene Adler, Age 75

*Admission details*

Irene was admitted 2 weeks ago following a fall. She was walking in icy weather, and she slipped on the ice, resulting in a fractured right neck of femur. She had a DHS inserted the day after her admission.

*Past medical history*

Osteoporosis
Rheumatoid Arthritis
Hypertension

*Progress since admission*

Irene has been medically well since her operation. She was transferred to the rehabilitation ward one week ago. Since then, she has progressed well with Physiotherapy. She is now mobilising independently with a frame. She is close to being ready for home but requires a stair assessment and a kitchen assessment to ensure she is safe for discharge. She is planned for review by Discharge to Assess after she goes home. Overnight she has been complaining of dizziness standing up, though she has not had any further falls. Her son, who lives in London has also called asking for an update from the medical team.

## Bed 2 - John Watson, Age 82

*Admission details*

John Watson was admitted six weeks ago following a fractured left neck of femur. John woke up overnight and lost his balance while he was on the way to the bathroom, resulting in the fracture. He had a hemiarthroplasty inserted the day after his admission.

*Past Medical History*

Parkinson's disease
Lewy Body Dementia
Hypercholesterolaemia

*Progress since admission*

John has had a difficult post-operative course. He was diagnosed with delirium post-operatively. He was transferred to the rehabilitation ward 4 weeks ago for ongoing rehabilitation. Since transfer he has remained more confused than his baseline, with no clear triggers for his delirium identified. There is concern that he is at his new cognitive baseline. Additionally, he has had frequent falls on the ward. He is currently mobile with a zimmer frame and the assistance of 2, though he frequently mobilises without supervision. Therefore, he has a falls alarm in place. His wife and his family are keen that he goes home with an increased package of care on discharge, though at present this seems unlikely to be feasible. A discussion about treatment escalation is also awaited. His family are visiting all day today.

John fell again early this morning. Following the fall, he has not been able to weight bear on his left leg and has been complaining of severe pain. John takes co-careldopa and entacapone for his Parkinson's disease. The ward has run out of co-careldopa as of this morning.

## Bed 3 - Martha Hudson, Age 80

*Admission details*

Martha was admitted one week ago with a fractured left neck of femur. She fractured her him following a fall due to an episode of hypoglycaemia. The following day she had a left DHS.

*Past Medical History*

Type 2 Diabetes on Humulin M3
Diabetic retinopathy
Peripheral neuropathy
Overactive bladder
Asthma

*Progress since admission*

Since the operation, Martha has been progressing well. She has had two further episodes of hypoglycaemia which have been treated with quick acting carbohydrate. Her dose of Humulin M3 has been reduced. She has now been transferred to the ward for ongoing rehabilitation and arrived on the ward yesterday afternoon. She has been reviewed by the nursing and medical teams, who have noted that her glasses have been lost at some point during her admission or discharge. Since arrival on the ward, it has been noted that Martha is struggling with pain when mobilising. This limited her mobility overnight, and she needed the assistance of one when normally she had been mobilising with supervision. Her husband has phoned as he wishes to discuss her pre-admission care needs with somebody. He will be present on the ward for most of the day. Martha has a diabetic foot ulcer that needs redressed, and she requires referral to the local podiatrist and diabetic specialist nurses.

## Bed 4 – Gregory Lestrade, Age 77

*Admission details*

Gregory was admitted to the RIE 10 days ago following a fall during which he sustained a right sided fractured neck of femur. He fell after taking his first dose of lorazepam prescribed for breathlessness related to COPD. He had a right hemiarthroplasty 9 days ago.

*Past Medical History*

COPD – exercise tolerance of roughly 50 metres
Ischaemic heart disease
Hypertension

*Progress since admission*

Since the operation, Gregory has had a hospital acquired pneumonia. Initially he had required a 40% oxygen to maintain saturations of 88-92%. However, in recent days, his chest infection has improved and prior to transfer he was on 2l of oxygen. His antibiotics were switched to oral doxycycline yesterday. He has required regular chest physiotherapy on the other ward. Due to his recent illness, he has had limited progression with his mobility. He has arrived in the ward just before handover. He currently has a NEWS of 10 due to SpO2 of 80% on 2l of oxygen, RR 26 and a pulse of 124.