## Simulation Design Template

Henry Williams – Simulation 3

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| **Date:**  **Discipline:** Nursing  **Expected Simulation Run Time:** 20 minutes  **Location:** Inpatient unit of rehabilitation center  **Today’s Date:** | **File Name:**  **Student Level:**  **Guided Reflection Time:** Twice the amount of time that the simulation runs  **Location for Reflection:** |

Brief Description of Patient

**Name:** Henry Williams **Pronouns:** he/him

**Date of Birth**: 01-05-YYYY (reflect age 80) **Age**: 80

**Sex Assigned at Birth:** Male **Gender Identity:** Male

**Sexual Orientation:** Heterosexual **Marital Status:** Married

**Weight:** 194 lb (88 kg) **Height:** 72 in

**Racial Group:** (Faculty can select) **Language:** English **Religion:** (Faculty can select)

**Employment Status:** Retired **Insurance:** Medicare **Veteran Status:** (Faculty can select)

**Support Person:** Ertha (wife) and Betty (daughter-in-law)

**Support Phone:** Ertha 320-222-2345; Betty 320-222-1111

**Allergies:** Penicillin **Immunizations:** Up to date; influenza and pneumonia current

**Attending Provider/Team:** KatherineNelson, MD

**Past Medical History:** Chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), asthma, hearing loss (wears hearing aids)

**History of Present Illness:** Following a 5-day hospital admission for an acute exacerbation of COPD, Mr. Williams was admitted to this rehabilitation center 15 days ago to increase his activity tolerance and achieve better management of his COPD. He is scheduled for discharge to an assisted living apartment with his wife Ertha, who has memory problems.

**Social History:** Retired engineer for transit system

**Primary Medical Diagnosis:** COPD, cardiovascular disease

**Surgeries/Procedures & Dates:** Appendectomy at age 15.

Psychomotor Skills Required of Participants Prior to Simulation

* Skills related to focused assessment

Cognitive Activities Required of Participants Prior to Simulation

Use textbook and other faculty-directed resources to review:

* Care of patient with COPD and CVD
* General care of the older adult
* Preparation for discharge
* Resources provided by assisted living facilities and available in the community

Review the Essential Nursing Actions in the ACE.S Framework at: <https://www.nln.org/education/teaching-resources/professional-development-programsteaching-resourcesace-all/ace-s/nln-ace-s-framework>

Review Katz Index of Independence in ADL’s assessment tool in the [Try This:® Series](https://hign.org/consultgeri/try-this-series) from the Hartford Institute for Geriatric Nursing (HIGN) at the NYU Rory Meyers College of Nursing.

Katz Index of Independence in Activities of Daily Living (ADL)

<https://hign.org/consultgeri/try-this-series/katz-index-independence-activities-daily-living-adl>

Simulation Learning Objectives

General Objectives (Note: The objectives listed below are general in nature and once learners have been exposed to the content, they are expected to maintain competency in these areas. Not every simulation will include all of the objectives listed.)

1. Practice standard precautions.
2. Employ strategies to reduce the risk of harm to the patient.
3. Conduct assessments appropriate for the care of patients in an organized and systematic manner.
4. Perform priority nursing actions based on assessment and clinical data*.*
5. Reassess/monitor patient status following nursing interventions.
6. Communicate with patient and family in a manner that illustrates caring, reflects cultural awareness, and addresses psychosocial needs.
7. Make clinical judgments and decisions that are evidence-based.
8. Practice within nursing scope of practice.
9. Demonstrate knowledge of legal and ethical obligations including social determinants of health, diversity, equity and inclusion.
10. Communicate appropriately with other health care team members in a timely, organized, patient-specific manner.

Simulation Scenario Objectives

At the end of the simulated learning experience, the learners will:

1. Categorize the independence of ADLs of a geriatric patient using a valid and reliable tool (Katz Index of Independence) correctly.
2. Use appropriate information obtained from patients and family members to determine patient’s readiness for discharge to assisted living facility.
3. Examine the discharge plan of care in collaboration with the patient and family.

Faculty References

The [Try This:® Series](https://hign.org/consultgeri/try-this-series) from the Hartford Institute for Geriatric Nursing (HIGN) at the NYU Rory Meyers College of Nursing contains many evidence-based assessment tools. The tool, an article about using the tool, and a video illustrating the use of the tool, are all available for your use. The Katz Index of Independence in Activities of Daily Living is the tool recommended for this simulation.

Review the Essential Nursing Actions in the ACE.S Framework at: <https://www.nln.org/education/teaching-resources/professional-development-programsteaching-resourcesace-all/ace-s/nln-ace-s-framework>

The Healthcare Simulation Standards of Best Practice™

<https://www.inacsl.org/healthcare-simulation-standards>

Setting/Environment

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| Emergency Department  Medical-Surgical Unit  Pediatric Unit  Maternity Unit  Behavioral Health Unit | ICU  OR / PACU  Rehabilitation Unit  Home  Outpatient Clinic  Other: |

Equipment/Supplies

**Simulated Patient/Manikin(s) Needed:** Manikin or simulated participant dressed in street clothes. Betty and Ertha – simulated participants.

**Recommended Mode for Simulator:** Manual

**Other Props & Moulage:** Glasses, hat, hearing aids. If no hearing aid is available, can modify scenario to reflect Henry’s difficulty hearing the nurse and he can say that he left his hearing aid at home.

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| **Equipment Attached to Manikin/Simulated Patient:**  ID band  IV tubing with primary line fluids running at \_\_ mL/hr  Secondary IV line running at \_\_ mL/hr  IVPB with \_\_ running at \_\_ mL/hr  IV pump  PCA pump  Foley catheter with \_\_ mL output  02  Monitor attached  Other:  **Other Essential Equipment:** Blood pressure cuff, thermometer, stethoscope, telephone.  **Medications and Fluids:**  Oral Meds:  IV Fluids:  IVPB:  IV Push:  IM or SC: | **Equipment Available in Room:**  Bedpan/urinal  02 delivery device (type)  Foley kit  Straight catheter kit  Incentive spirometer  Fluids  IV start kit  IV tubing  IVPB tubing  IV pump  Feeding pump  Crash cart with airway devices and emergency medications  Defibrillator/pacer  Suction  Other: |

Roles

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| Nurse 1  Nurse 2  Nurse 3  Provider (physician/advanced practice nurse)  Other healthcare professionals:  (pharmacist, respiratory therapist, etc.) | Observer(s) Any number of observers  Recorder(s)  Family member #1 Wife Ertha  Family member # 2 Daughter-in-law Betty  Clergy  Unlicensed assistive personnel  Other: |

Guidelines/Information Related to Roles

Learners in the role of nurse should determine which assessments and interventions each will be responsible for, or facilitator can assign nurse 1 and nurse 2 roles with related responsibilities. Learners need to be assigned roles that they are being trained for.

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from Scenario Progression Outline.

The scenario can be run without the simulated participants.

Prebriefing/Briefing

Prior to report, participants will need prebriefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

For a comprehensive checklist and information on its development, go to <http://www.nln.org/sirc/sirc-resources/sirc-tools-and-tips#simtemplate>.

Report Students Will Receive Before Simulation

**Time:** 1030

**Person providing report:** Nurse in charge of unit

**Situation**: Henry Williams is an 80-year-old male who is being discharged today after a 15-day stay for pulmonary rehab.

**Background:** Mr. Williams had an exacerbation of his COPD and was hospitalized for 5 days for treatment prior to his admission here. He also has a history of cardiovascular disease. He lived in his own home before this illness, but will be going to an assisted living facility today. His wife Ertha is experiencing some dementia and he is her primary caregiver. Their daughter-in-law Betty is here from out of town but she needs to go back to her family.

**Assessment:** Vital signs have been stable with oxygen saturations in the low 90’s. Henry was using oxygen PRN at night and with activity, but has not needed it the past 24 hours. Henry is now up in his room, dressed, and ready for discharge. He and Ertha will be going shortly to an assisted living facility that their daughter-in-law Betty found for them. Betty provided the facility with a list of services she believe he and Ertha will need and is encouraging him to take advantage of all of the services they have to offer. The facility requested that we do a Katz Index, then their staff will observe and follow up with a more extensive assessment once Henry and Ertha are on site. I returned to Henry all of the medications he came in with. Henry has talked about his wife being "forgetful" and seems to worry about her a lot.

**Recommendation:** Prepare for discharge. I would do a Katz Index when Betty and Ertha are here. It may reassure his daughter. Review meds and patient’s ability to administer on his own. Assess their need for services in their apartment like meals, nurse visits, housekeeping, or other needs.

Scenario Progression Outline

**Patient Name:** Henry Williams **Date of Birth:** 01-05-YYYY (reflect age 80)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 min** | Henry is in the chair, dressed and waiting for discharge. “I’m ready to get out of here. Betty should be here any minute. She’s so worried about whether I can manage.”  VS, O2 sat-92% on room air, pulse-88, RR-18, BP-130/82  Betty and Ertha arrive.  **Betty**: “I sure hope you can take care of yourself, and mom.” | **Learners should begin by:**   * Performing hand hygiene * Introducing selves * Confirming patient ID | **Role member providing cue:**  **Cue:** |
| **5-10 min** | **Henry**: “Betty, I am much better, and Ertha will be fine with me… Why are you so upset?” “Maybe the nurses can reassure you.”  Answers to Katz:  Henry answers that he is independent in every area = 6 points | **Learners are expected to**:   * Include family members in discharge plan * Administer Katz Index | **Role member providing cue:** Betty  **Cue:** If nurses don’t begin Katz:“Do you think this will work? Is there any test you can do to be sure they will be okay?” |
| **10-20 min** | **Betty:** “What about mom?I have had to give her diphenhydramine at night to get her to sleep and not wander.”  **Henry:** “Betty, your mother doesn't need things to help her sleep…it just makes her more confused.”  **Betty:** “I realize she is getting more confused.”  **Henry**: “I can do my own meds. I always have.” (Henry answers any medication questions correctly)  **Henry:** “Betty, you need to get back to your family. Thanks for all your help these past weeks. Get some rest and come visit us. We will love the new apartment. Thanks for bringing some of Ertha's favorite things over there…”  **Betty:** “OK, but remember, you can get more help if you need it. | **Learners are expected to**:   * Teach about caution with over-the-counter meds for sleep * Assess whether Ertha been evaluated for her memory lapses, and wandering? * Encourage follow-up for Ertha, for evaluation of her mental status. * Evaluate Henry’s ability to take his medications on his own. * Assess the need for assistance with meals, respite care for Ertha, housekeeping, transportation, finances, and other areas. * Discuss referrals in needed areas. | **Role member providing cue:** |

Debriefing/Guided Reflection

Note to Faculty

We recognize that faculty will implement the materials we have provided in many ways and venues. Some may use them exactly as written, and others will adapt and modify extensively. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

**Themes for this scenario:**

* What does “readiness for discharge mean?”
* Determining availability and need for assistance services.
* Changing family roles and concerns.
* Selected Essential Nursing Actions from ACE.S Framework

We do not expect you to introduce all of the questions listed below. The questions are presented only to suggest topics that may inspire the learning conversation. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). The debriefing questions for consideration are organized into the phases of debriefing, as recommended by the Healthcare Simulation Standard of Best Practice™ The Debriefing Process. The following phases are included below: Reactions/Defuse, Analysis/Discovery and Summary/Application. Remember to also identify important concepts or curricular threads that are specific to your program.

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| **Debriefing Phase** | **Debriefing Questions for Consideration** |
| Reactions/ Defuse | How did you feel throughout the simulation experience? |
| Give a brief summary of this patient and what happened in the simulation. |
| What were the main problems that you identified? |
| Analysis/ Discovery | Discuss the knowledge guiding your thinking surrounding these main problems. |
| What were the key assessment and interventions for this patient? |
| Discuss how you identified these key assessments and interventions. |
| Discuss the information resources you used to assess this patient. How did this guide your care planning? |
| Discuss the clinical manifestations evidenced during your assessment. How would you explain these manifestations? |
| Explain the nursing management considerations for this patient. Discuss the knowledge guiding your thinking. |
| What information and information management tools did you use to monitor this patient’s outcomes? Explain your thinking. |
| How did you communicate with the patient? |
| What specific issues would you want to take into consideration to provide for this patient’s unique care needs? |
| Discuss the safety issues you considered when implementing care for this patient. |
| What measures did you implement to ensure safe patient care? |
| What other members of the care team should you consider important to achieving good care outcomes? |
| How would you assess the quality of care provided? |
| What could you do improve the quality of care for this patient? |
| Summary/ Application | If you were able to do this again, how would you handle the situation differently? |
| What did you learn from this experience? |
| How will you apply what you learned today to your clinical practice? |
| Is there anything else you would like to discuss? |

Guided Debriefing Tool

The NLN created a Guided Debriefing Tool to provide structure from which facilitator observations can make objective notes of learner behaviors in simulation in direct relationship to the learning outcomes. [Download the NLN Guided Debriefing Tool](https://www.nln.org/docs/default-source/uploadedfiles/professional-development-programs/sirc/guided-debriefing-tool.docx?sfvrsn=f659d27e_3).