Simulation Design Template

Phil and Lois Gardner – Simulation #1

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| **Date:** **Discipline:** Nursing**Expected Simulation Run Time:** 20 minutes**Location:** Acute care unit**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:** Lois Gardner **Pronouns**: she/her

**Caregiver:** Phil Gardner, husband **Caregiver Pronouns**: he/him **Caregiver Phone**: 888-202-2222

**Date of Birth:** 02-12-YYYY (reflect age 75) **Age**: 75

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

**Sexual Orientation**: heterosexual **Marital Status**: married

**Weight**: 132 lbs. (59.9 kg) **Height**: 5’4”

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

**Employment Status**: retired **Insurance Status**: Medicare **Veteran Status**: N/A

**Allergies:** Penicillin **Immunizations:** Current including influenza

**Attending Provider/Team:** Jenna Wong, MD

**Past Medical History:** chronic obstructive pulmonary disease (COPD), heart failure (HF), myocardial infarction (MI) age 51

**History of Present Illness:** Diagnosed with pneumonia 3 days ago. Was admitted to inpatient medical unit from the emergency department (ED). Mrs. Gardner was dehydrated and had low oxygen saturation. She was admitted for oxygen therapy, IV fluids, and antibiotics.

**Social History:** Married to Phil Gardner since age 49. Both are retired. Lois has a sister Dorothy who lives with her husband a few hours away, and Phil has two grown children from a previous marriage. Lois has shown some signs of memory loss over the past year or two. She is on Medicare and supplemental insurance.

**Primary Medical Diagnosis:** Pneumonia

**Surgeries/Procedures & Dates:** MI, had cardiac catheterization and stent placed at age 51.

Psychomotor Skills Required of Participants Prior to Simulation

Oxygen therapy

Cognitive Activities Required of Participants Prior to Simulation

Use textbook and other faculty-directed resources to review:

* General care of the older adult
* Confusion in older adults
* Pneumonia

Read/review the following:

* Powell-Cope, G., Thomason, S., Bulat, T., Pippins, K., & Young, H. (2018). Preventing Falls and Fall Related Injuries at Home. *American Journal of Nursing*, 118(1), 58-61. doi: 10.1097/01.NAJ.0000529720.67793.60
* Nursing Standard of Practice Protocol: Assessing Cognitive Functions <https://hign.org/consultgeri/resources/protocols/assessing-cognition>
* The Mental Status Assessment of Older Adults: The Mini-Cog™ <https://hign.org/consultgeri/try-this-series/mental-status-assessment-older-adults-mini-cog>

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 risk of harm to the patient.
3. Conduct assessments appropriate for care of patient 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. Communicate appropriately with other health care team members in a timely, organized, patient-specific manner.
8. Make clinical judgments and decisions that are evidence-based.
9. Practice within nursing scope of practice.
10. Demonstrate knowledge of legal and ethical obligations.

Simulation Scenario Objectives

Objectives:

1. Assess respiratory status, teaching caregiver Phil how to recognize respiratory distress.
2. Assess patient’s abilities to participate in her own care using reliable, valid, standardized tool.
3. Address patient/caregiver concerns regarding medications and safety using walker.
4. Initiate discharge teaching.

Faculty References

Nursing Standard of Practice Protocol: Assessing Cognitive Functions

<https://hign.org/consultgeri/resources/protocols/assessing-cognition>

Powell-Cope, G., Thomason, S., Bulat, T., Pippins, K., & Young, H. (2018). Preventing Falls and Fall Related Injuries at Home. *American Journal of Nursing*, 118(1), 58-61. doi: 10.1097/01.NAJ.0000529720.67793.60

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 recommended for this scenario is the Mental Status Assessment of Older Adults: The Mini-Cog: <https://hign.org/consultgeri/try-this-series/mental-status-assessment-older-adults-mini-cog>.

The Healthcare Simulation Standards of Best Practice™

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

Setting/Environment

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| [ ]  Emergency Department[x]  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:** Simulated patient recommended for both roles, but manikin may be used for Lois.

**Recommended Mode for Simulator:** If manikin is used, manual mode.

**Other Props & Moulage:**

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| **Equipment Attached to Manikin/Simulated Patient:**[x]  ID band [x]  IV tubing with Dextrose 5% 1/2NS fluids running at 30 mL/hr[ ]  Secondary IV line running at \_\_ mL/hr[ ]  IVPB with \_\_ running at \_\_ mL/hr[ ]  IV pump[ ]  PCA pump [ ]  Foley catheter with \_\_ mL output[x]  02 [ ]  Monitor attached[ ]  Other: **Other Essential Equipment:****Medications and Fluids:**[ ]  Oral Meds: [ ]  IV Fluids: [ ]  IVPB: [ ]  IV Push: [ ]  IM or SC:  | **Equipment Available in Room:**[ ]  Bedpan/urinal[x]  02 delivery device (type) nasal canula[ ]  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 [x]  Other: nasal canula out of nose, lying on bed. |

Roles

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| [x]  Nurse 1[x]  Nurse 2[ ]  Nurse 3[ ]  Provider (physician/advanced practice nurse)[ ]  Other healthcare professionals:  (pharmacist, respiratory therapist, etc.) | [x]  Observer(s) (Any number of observers)[ ]  Recorder(s)[x]  Family member #1: Caregiver, husband Phil[ ]  Family member #2[ ]  Clergy[ ]  Unlicensed assistive personnel [ ]  Other: |

Guidelines/Information Related to Roles

Learners in 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.

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.

Pre-briefing/Briefing

Please remind learners that this simulation is somewhat different than those they may have experienced in the past. While they will be caring for both the patient and the caregiver, the focus of the simulation is the caregiver.

Prior to report, participants will need pre-briefing/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:** 0730

**Person providing report:** Night shift RN going off duty

**Situation:** Lois Gardner is a 75-year-old female admitted to the unit from the Emergency Department 3 days ago. Her husband Phil Gardner brought her in with a severe cough and weakness. She was dehydrated, dyspneic, and required oxygen support.

**Background:** Mrs. Gardner is a previous smoker and has a history of chronic obstructive pulmonary disease (COPD) and heart failure (HF), which she developed after a myocardial infarction (MI) at age 51. Her husband reported a 3-day history of an upper respiratory infection which worsened to the point where his wife was unable to eat or carry out her normal activities. He brought her to the ED where she was started on IV fluids, antibiotics, and oxygen at 4 liters per minute via nasal canula.

Prior to admission, Mrs. Gardner’s home medications were metoprolol, atorvastatin, aspirin, and her inhalers – albuterol, salmeterol, and tiotropium bromide.

Mrs. Gardner’s husband and caregiver reports that she seems increasingly forgetful over the past year or two, particularly the past few months, causing him some concern. Her respiratory status has improved over the past few days and she is now on oxygen at 1-2 liters. Her oxygen saturation has been 95-96% for 6 hours. She is going to be discharged later this morning on oral antibiotics. She will also need a walker at least temporarily due to weakness.

**Assessment:** Admission oxygen saturation was 82% on room air. Mrs. Gardner’s sat is currently 95% on 1-2 liters O2 by nasal canula. Pulse is 92, RR 20, BP 122/70. Lungs have course rales but clear with coughing. She has a productive cough that has improved over the past 24 hours. She has an IV of D5 1/2NS at 30 mL/hour. She is able to answer some questions, and she slept well last night. Her husband Phil has been here during the day but goes home at night. He answers most questions for her. He seems really tired and a little frustrated with her at times but seems very caring and competent.

**Recommendation:** Due for vital signs and focused respiratory assessment. Please be sure her husband knows the signs of increasing respiratory distress. You can wean her off oxygen if her saturation is above 94%, which it has been through the night. Her discharge teaching form is ready and includes her home medications, so please review that. I recommend doing a Mini-Cog on Mrs. Gardner to determine her ability to comprehend what’s going on and assist with her own care.

Scenario Progression Outline

**Patient Name:** Lois Gardner **Date of Birth:** 02-12-YYYY (reflect age 75)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 min** | Lois: “Can I go home? Phil can you take me home?”Phil: “Honey can you be quiet for just a minute so the nurse can assess you? We will be going home.”Pulse - 94, RR - 18, BP- 128/72, oxygen saturation 95%, nasal canula is out of nose, lying on bed.Lung sounds normal, except for occasional coarse rales. | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient ID
* Perform a respiratory assessment
* Explain to Lois and Phil what is happening during the assessment and what to watch for at home
* Discontinue oxygen
 | **Role member providing cue:** Phil**Cue:** If lungs not auscultated, Phil will say: “How does her breathing sound this morning? When should I worry?” |
| **5-10 min** | Phil: “I’m going to need to do a lot for her at home. I’m not sure how much of this she can handle by herself.”Responses to Mini-CogLois – draws clock but abnormal, does not give correct time as directed (0 points),Lois remembers 2 of the 3 words (2 points)Total: 2 points | **Learners are expected to**:* Perform Mini-Cog assessment

Nurses should clarify that Lois and not Phil needs to answer the Mini-Cog questions.* Learner states 3 words
* Learner instructs Lois to draw face of a clock and give a specific time
* Learner asks Lois to repeat the 3 words
 | **Role member providing cue:** Phil**Cue:** If learner does not explain purpose of Mini-Cog, Phil will ask: “What are you doing and why are you asking her these things?” |

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| **10-20 min** | Phil: “I’ll need to be there to help her pretty much all the time, at least for awhile. We might need to go over her medications. I hope she won’t always need a walker, but I guess she needs it for a while.”Lois: “I’m OK. I’ll be OK. Don’t fuss over me.” | **Learners are expected to:*** Explain implications of assessments to Phil and Lois
* Assess Phil’s understanding of need for care at home
* Provide emotional support for Phil
* Review orders for home meds with Phil
* Discuss home safety with walker (stairs, lighting, throw rugs, etc.)
 | **Role member providing cue:** Phil**Cue:** (If nurses don’t address) Do I need to know anything special about Lois having a walker at home? She never had problems getting around before. This is different for us. |

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:**

* Use of tools for assessing cognition
* Discharge teaching for caregiver
* Assessing and supporting caregiver abilities and frustrations

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).