Simulation Design Template

Millie Larsen – Simulation 1

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| **Date:**  **Discipline:** Nursing  **Expected Simulation Run Time:** 20 minutes  **Location:** Inpatient 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:** Millie Larsen **Pronouns:** she/her

**Date of Birth:** 01-23-YYYY (reflect age 84) **Age**: 84

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

**Sexual Orientation:** heterosexual **Marital Status:** widow

**Weight:** 106 lbs. (48 kg) **Height**: 61 inches

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

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

**Support Person:** Dina (daughter) **Support Phone:** 456-555-1210

**Allergies:** No known allergies **Immunizations:** Influenza & pneumonia (2 years ago)

**Attending Provider/Team:** Eric Lund, MD

**Past Medical History:** Glaucoma, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia.

**History of Present Illness:** Millie’s daughter Dina became concerned yesterday when she stopped over to check on her and found her still in her bathrobe at 1800. The house was very unkempt, and Millie couldn’t remember her daughter’s name. Dina stayed with her for a few hours, but when Millie became more confused she decided to bring her to the emergency department. They arrived in the emergency department at 0015.

**Social History:** Widow for one year; involved in church activities and gardening. Daughter and grandchildren live nearby.

**Primary Medical Diagnosis:** Dehydration, probable urinary tract infection

**Surgeries/Procedures & Dates:** Cholecystectomy at age 30

Psychomotor Skills Required of Participants Prior to Simulation

* General head-to-toe assessment
* IV assessment skills

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
* Geriatric syndromes
* Atypical presentation of signs of illness in older adults

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 SPICES and CAM assessment tools 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.

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

1. Conduct a head-to-toe physical assessment.
2. Notify provider of abnormal vital signs.
3. Assess cognitive status using the Confusion Assessment Method (CAM) tool.
4. Assess the patient for common syndromes of the elderly using the SPICES tool.

Faculty Reference

Essential Nursing Actions in the [ACE.S Framework](file://nln-fileserver/albrowning$/ACE%20sim%20updates/Millie/ACE.S%20Framework) at:<https://www.nln.org/education/teaching-resources/professional-development-programsteaching-resourcesace-all/ace-s/nln-ace-s-framework>

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 SPICES and CAM assessment tools are recommended for this scenario.

**Geriatric syndromes:** The HealthinAging.org website, created by the American Geriatrics Society's Health in Aging Foundation, provides consumers and caregivers with up-to-date information on health and aging. <http://www.healthinaging.org>.

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:** Millie - manikin or simulated patient. Dina – simulated patient.

**Recommended Mode for Simulator:** Manual

**Other Props & Moulage:** Adult diapers

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| **Equipment Attached to Manikin/Simulated Patient:**  ID band  IV tubing with primary line fluids D5/0.45%NaCl with 20 mEq KCL per liter running at 60 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 or method to contact provider  **Medications and Fluids:**  Oral Meds:  IV Fluids: D5/0.45/% NaCl with 20 mEq KCL per liter running at 60 mL/hr  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) on telephone  Other healthcare professionals:  (pharmacist, respiratory therapist, etc.) | Observer(s) Any number of observers  Recorder(s)  Family member #1 Daughter Dina  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

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:** 0700

**Person providing report:** Nurse going off shift

**Situation:** Millie Larsen is an 84-year-old female brought to the ED by her daughter with confusion.

**Background:** When Millie’s daughter stopped in to see her yesterday evening, she found that she was not making sense or acting right. She brought her to the ED and a decision was made to admit her, but she remained in the ED all night until a bed became available an hour ago. Mrs. Larsen has a history of hypertension, glaucoma, osteoporosis, arthritis, elevated cholesterol, and stress incontinence. It is unclear whether she has taken her medications properly the past few days; her daughter couldn't tell from looking at her medication box.

**Assessment:** Millie’s last vital signs at 0230 were: temperature 98.4, heart rate 76, respirations 14, BP 170/90. She is not oriented to time or place and seems quite confused. She has an IV of D5 0.45% NaCl with 20 mEq KCL per liter at 60 mL’s per hour.

Her labs were drawn in the ED. She has 12000 WBC’s, an elevated sodium, and a urine specific gravity of 1.050, with some signs of a UTI. Urine culture is being done. Her primary physician Dr. Lund was notified of her admission and wrote orders for her meds. I just gave her AM meds about 15 minutes ago. I gave captopril, metoprolol, furosemide, pilocarpine drops, ciprofloxacin, and celecoxib. She takes her atorvastatin before dinner so that will be with her 1600 meds. She says she is not experiencing any pain.

**Recommendation:** Please do vital signs and head to toe assessment and administer the CAM and SPICES tools.

Scenario Progression Outline

**Patient Name:** Millie Larsen **Date of Birth:** 01-23-YYYY (reflect age 84)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-10 min** | Disoriented and confused, can't answer questions appropriately.  VS - BP 200/110, P - 80  R - 16; T - 98.4  Millie: “My daughter dropped me off and left me here. I’m not quite sure where I am or why I’m here. I feel ok. I can’t believe how my life has changed in the past couple of weeks now. Harold died a couple of weeks, no months ago. I can’t remember. Why can’t I remember? Things have changed. I don’t like that; I’ve always been a strong woman. I feel ok and I take a lot of pills – not sure what they all are. Look on the kitchen counter or ask my daughter what they are. Where is Dina? I haven’t seen her in 6 years; no one ever comes to see me.”  Dina: “I’m right here mom. I don’t think she has been taking her medicine. I never saw her like this before. Will she be OK?” | **Learners should begin by:**   * Performing hand hygiene * Introducing selves * Confirming patient ID   Conduct a head-to-toe physical assessment.  Assess IV.  Explain to Millie and Dina what you are doing during the assessment.  Provide appropriate reassurance to Dina. | **Role member providing cue:**  **Cue:** |
|  | Dina continues to support Millie and stay at her side  Dr. Lund: Has she had her AM meds yet?” (YES). “Monitor her blood pressure every 15 minutes for an hour. If it is not going down please call me back. I plan to be on the unit again this afternoon and will stop in.” | **Learners are expected to:**   * Call provider with elevated BP | **Role member providing cue:** Dina  **Cue:** If students don’t report elevated BP, “Her blood pressure is never that high. Does Dr. Lund know about that?” |
| **10-20 min** | Dina’s responses:  **Sleep:** “She hasn’t complained to me about not sleeping.”  **Problems Eating/Feeding**: “She doesn’t cook much. I bring her food that she can heat up. Her appetite has been good.”  **Incontinence:** “She loses control of urine sometimes so she wears adult diapers.”  **Confusion:** “She is very confused right now, but I never saw her like this before.”  **Evidence of Falls**: “Not that I’m aware of.”  **Skin Breakdown:** “No.” | **Learners are expected to:**   * Administer SPICES tool | **Role member providing cue:** Dina  **Cue:** If learner’s direct questions to Millie, Dina will say: “I don’t think she is able to answer your questions, but I may be able to answer some of them.” |
|  | Millie’s behavior and the history provided by Dina indicates a positive response to questions 1 through 6.  Q 7: Dina: “I have not seen any evidence that she is having hallucinations.”  Q 8 A&B: No evidence observed.  Q 9: No evidence. | **Learners are expected to:**   * Administer CAM tool | **Role member providing cue:** Dina  **Cue:** If learners try to ask Millie the questions on the CAM, Dina says: “Can’t you see that she is in no shape to answer your questions!” |

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:**

* Value of assessment tools like CAM and SPICES
* Possible atypical presentations of illness seen in older adults
* Geriatric syndromes
* 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).