## Simulation Design Template

Millie Larsen – Simulation 2

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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 Group**: (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**: Cataracts, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia.

**History of Present Illness:** Millie Larsen is an 84-year-old female admitted from home with confusion about 36 hours ago with a diagnosis of dehydration and urinary tract infection. She has been receiving IV fluids and antibiotics. Prior to admission she was not taking her medications properly and as a result had an elevated blood pressure yesterday morning. Her blood pressure has improved.

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

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

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

Psychomotor Skills Required Prior to Simulation

* General care of older adult

## Cognitive Activities Required Prior to Simulation

Use textbook and other faculty-directed resources to review:

* General care of the older adult
* Confusion in older adults
* Geriatric syndromes

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 Confusion Assessment Method (CAM) and Hendrich II Fall Risk Model 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

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 experience, the learners will be able to:

1. Assess the patient’s cognitive status using the Confusion Assessment Method (CAM).
2. Determine the patient’s fall risk using valid and reliable instruments such as the Hendrich II Fall Risk Model.
3. Administer antibacterial therapy using the “rights of medication administration” in collaboration with the interprofessional healthcare team.

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 following tools are recommended for this scenario:

* Confusion Assessment Method (CAM). <https://hign.org/consultgeri/try-this-series/confusion-assessment-method-cam>
* Hendrich II Fall Risk Model. <https://hign.org/sites/default/files/2020-06/Try_This_General_Assessment_8.pdf>

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>

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 or Participant/Manikin(s) Needed:** Millie - manikin or simulated participant. Dina – simulated patient.

**Recommended Mode for Simulator:** Manual

**Other Props & Moulage:** Adult diapers

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| **Equipment Attached to Manikin/Simulated Patient:**[x]  ID band[x]  IV tubing with primary line fluids D5/.45NaCl with 20 mEq KCL running at 60 mL/hr.[ ]  Secondary IV line running at \_\_ mL/hr[ ]  IVPB with \_\_ running at mL/hr[x]  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: [x]  IV Fluids: D5/.45NaCl with 20 mEq KCL 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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| [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 Daughter Dina[ ]  Family member #2[ ]  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 the facilitator can assign nurse 1 and nurse 2 roles with related responsibilities. Learners need to be assigned roles 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.

Prebriefing/Briefing

Prior to the report, participants will need a 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, objectives and subsequent debriefing process.

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 ending shift

**Situation:** Millie Larsen was brought to the ED by her daughter with confusion. She was diagnosed with a urinary tract infection and dehydration and transferred to our unit yesterday. She had a near fall about 0600 this morning. She said she was trying to go to the bathroom.

**Background:** Prior to admission, Millie’s daughter stopped in to see her at home and found that she was disheveled and confused. 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 about 0600 yesterday. Mrs. Larsen has a history of hypertension, cataracts, 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. Her blood pressure was very elevated yesterday, but once we restarted her meds it started coming down.

**Assessment:** Checked Millie over from head to toe. She did not hit her head. She says she is OK and has no visible injuries. Her primary care provider and her daughter have been notified. Her daughter is on her way in. She is currently oriented to person and place. Millie’s last vital signs were: temperature 98.6, heart rate 78, respirations 14, and blood pressure 160/92. She has had 450 cc of amber urine out and she had no pain during the night.

**Recommendation:** Please administer her 0800 medications, do a repeat CAM and a Hendrich II Fall Risk Assessment. Dr. Lund will want those results when he comes in to help him develop a discharge plan.

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** |
| **0-5 min** | Millie is resting in bed. Dina arrives and is visibly upset.VS: BP 160/92; P 78; R 14; T 98.6Dina: “Mom, they called and told me you tried to go to the bathroom by yourself last night and almost fell. Why didn’t you call for help? Are you OK?”Millie: “I just needed to go to the bathroom. They are all so busy here. I didn’t want to bother anybody. I forgot I had this thing attached to my arm (points to IV and pump), and I tripped on it. I’m OK, but everyone is treating me like a child. They call me ‘honey’ and ‘sweetheart.’ My name is Millie. Why can’t they call me by my name? I am OK now and I want to go home.”Dina: “Come home with me for a while, until you get your strength back. I would worry if you are alone. You might fall and no one would be there.”Millie: “I can take care of myself, and I need to take care of Snuggles. Did you feed her since I’ve been here?”Dina: “Yes I did Mom.” | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient ID

Explain that they are going to ask some questions that can help determine if Millie’s confusion is clearing and if she is at risk for falling. | **Role member providing cue:****Cue:** |

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| **5-10 min** | Millie’s responses to questions indicate that * she is no longer confused or disoriented,
* is not depressed,
* has no problems with elimination.

She is not taking any anticonvulsant or benzodiazepine medications.On “Rising from a chair” test, she can rise on first attempt with no loss of balance. | **Learners are expected to:**(Note: The CAM and Fall Risk Assessment tools can be administered in any order)* Administer Hendrich II Fall Assessment
 | **Role member providing cue:**Dina**Cue:** During any of the assessments, if the learners direct their questions to Dina, Millie will say: “Don’t ask her those questions, ask ME!” |
| **10-15 min** | Millie’s behavior and answers to questions should indicate that she is no longer confused, is attentive and oriented, and her memory has returned. | **Learners are expected to:*** Administer CAM tool
* Learners should pose appropriate questions to Millie to assess her confusion.
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| **15-20 min** | Millie will answer questions to demonstrate that she is oriented to person, time and place when learners administer medications | **Learners are expected to:*** Administer antibiotics as prescribed by the licensed provider
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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:**

* Compare and discuss CAM results from yesterday and today
* Impact of falls on individual patients and specific populations
* Geriatric syndromes
* Selected Essential Nursing Actions from ACE.S Framework
* Safe medication administration

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 assessments 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 to 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).