## Simulation Design Template

Millie Larsen – Simulation 3

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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

**Major Support:** 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:** Cataract, hypertension, osteoarthritis, stress incontinence, hypercholesterolemia.

**History of Present Illness:** Millie Larsen is an 84-year-old female admitted from home with confusion. Prior to admission, she was not taking her medications properly and as a result, had an elevated blood pressure. She was diagnosed with a urinary tract infection and dehydration. She was treated with IV fluids and antibiotics. Her antihypertensives were restarted. Her blood pressure has improved, and she is no longer confused. She is awaiting discharge today.

**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 head-to-toe assessment
* IV fluid and line management

## 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 Katz Index of Independence in Activities of Daily Living tool in the *Try This:* ® *Series* available at <https://hign.org/consultgeri/try-this-series>.

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. Collaborate 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 level of independence using valid and reliable instruments such as the Katz Index of Independence in Activities of Daily Living
2. Provide the patient and family information on at least two resources that can assist in maintaining independence.
3. Evaluate the patient and family’s knowledge of medications after discharge by conducting a teach-back session.
4. Educate the patient and family on the prevention of urinary tract infections and the importance of antibiotic therapy completion by implementing a teaching plan with teach-back activity.

Faculty Reference

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 tool is recommended for this scenario:

Katz Index of Independence in Activities of Daily Living: <https://www.alz.org/careplanning/downloads/katz-adl.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>

Resources Locator for Maintaining ADLs of the elderly: <https://www.nia.nih.gov/health/caregiving/services-older-adults-living-home>

The Healthcare Simulation Standards of Best Practice™

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

IPEC Core Competencies for Interprofessional Collaborative Practice: Version 3. Interprofessional Education Collaborative. <https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_Version_3_2023.pdf>

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/.45NaCl with 20 mEq KCL 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:  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: Saline lock and saline flush for IV |

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 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. The learners need to be assigned roles they are being educated 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 2 days ago. She has been on IV antibiotics since admission. She is scheduled for discharge today.

**Background:** Prior to admission, Millie’s daughter stopped in to see her at home and found that she was not making sense. 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. 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. She was rehydrated with IVF, and it is currently saline-locked.

**Assessment:** She had a near fall yesterday morning just after admission but did not sustain any injuries. Millie’s last vital signs were temperature 98.6, heart rate 78, respirations 14, and her blood pressure was 148/85. Dr. Lund ordered her IV fluids discontinued. On rounds. Her confusion has resolved.

**Recommendation:** They may discharge her later today. Dr. Lund ordered us to discontinue her IV fluids and saline lock her IV, so please do that now. She lives alone so please do a Katz Index of Independence. Dr. Lund will want those results when he comes in to help him with her discharge plans.

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. Oriented x 3.  VS: BP 142/86, P 80, R 16; T -98.6  Millie: “I’m so excited about going home. I can’t wait to see my Snuggles. Dina wants me to go to her house for a while, but I want to be in my own bed at my own house. Dina just doesn’t seem to understand that. I know I was out of my head for a few days, but I’m fine now. They said maybe someone could come in a few times a week. That would be OK, or maybe my granddaughter Jessica can help if she’s not too busy.”  Dina arrives: “I really wish you would come home with me for a while, until you get your strength back. You might fall and no one would be there.”  Dina asks learners: “Do you think she should go home alone?” | **Learners should begin by:**   * Performing hand hygiene * Introducing selves * Confirming patient ID   Assess saline lock IV  Learners should explain that they are going to ask some questions that can help determine Millie’s ability to be safe and care for herself. | **Role member providing cue:**  **Cue:** |
| **5-10 min** | Millie’s responses indicate that she earns 1 point for all activities except continence. | **Learners are expected to:**   * Administer Katz tool | **Role member providing cue:**  Dina  **Cue:** During any of the assessments, if learners direct questions to Dina, Millie will say: “Don’t ask her those questions, ask ME!” |
| **10-15 min** | Dina: “I work and must drive the grandkids to their activities after school. Bool. Before Mom was hospitalized, I used to stop by in the evenings about 3 times a week. I will worry about her being alone, but I can’t visit much more than that.”  Millie: “I’ll be just fine – just like I was before. Stop making such a big fuss over nothing.” | **Learners are expected to:**   * Discuss plans for Millie at home including such things as current home layout, location of bathroom, home health aides, friends from church who may be able to stop by, medical alert pendants, etc. | **Role member providing cue:**  **Cue:** |
| **15-20 min** | Millie: “I have been taking most of these medications at home before. I can manage another one.” | **Learners are expected to:**   * Learners are expected to review medications and teach as needed. | **Role member providing cue:** Dina  **Cue: If learners do not provide instructions in writing, Dina will say: “**How is Mom going to remember all of this?” |

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:**

* Interpret results of Katz Index
* Millie’s ability to manage independently at home vs family 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 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).