Simulation Design Template

Patrick Lake Simulation #2

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| **Date:**  **Discipline:** Nursing  **Expected Simulation Run Time:** 20 min  **Location:** Medical Surgical/Telemetry Unit  **Today’s Date:** | **File Name:**  **Student Level:** Course in which students learn care of patient with heart failure (HF)  **Guided Reflection Time:** Twice the amount of time that the simulation runs.  **Location for Reflection:** |

Brief Description of Patient

**Name:** Patrick Lake **Pronouns:** He/him

**Date of Birth:** 11-13-YYYY (reflect age 64) **Age**: 64

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

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

**Racial Group**: [Race of simulated patient] **Language**: English **Religion:** Catholic

**Employment Status:** Retired **Insurance:** VA benefits **Veteran Status**: Army vet

**Weight:** [weighted of simulated patient] **Height**: [height of simulated patient]

*Since weight gain or loss is important data to collect, it has been highlighted in yellow in template and chart materials so you can insert actual weights.*

**Support Person:** Wife Gloria **Support Phone:** 555-666-1210

**Allergies:** No known allergies **Immunizations:** Up to date

**Attending Provider/Team:** James Webber, MD; PCP at Wellness Clinic is Avery Smith, MD

**Past Medical History:** Glaucoma, hypertension, osteoarthritis, hypercholesterolemia, intermittent atrial fibrillation. Last seen in Wellness Clinic 4 months ago.

**History of Present Illness:** Admitted to the hospital 5 days ago with shortness of breath and heart rate of 130. Diagnosed as new onset of heart failure (HF).

**Social History:** Participates in support group related to disability.

**Primary Medical Diagnosis:** Tachycardia and new onset heart failure.

**Surgeries/Procedures & Dates:** Above-the-knee amputation related to injury sustained during war. (Note: right or left leg can be selected; and this can be changed if the SP has a below-the-knee amputation [BKA])

Psychomotor Skills Required of Participants Prior to Simulation

Physical assessment with a focus on the cardiopulmonary system

Cognitive Activities Required of Participants Prior to Simulation

Use textbook, lecture notes and other assigned readings to review

* Basic physical and psychosocial assessment
* Focused history taking
* Care of a client with an above-the-knee amputation, heart failure, hypertension, hypercholesterolemia, atrial fibrillation who is receiving anticoagulants and diuretics

Read the following materials (supplied):

* [Overview and Introduction to Disability©](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/overview-and-introduction-to-disability)
* [Communicating with People with Disabilities©](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/communicating-with-people-with-disabilities)
* [Assessment of the Patient with a Disability© Checklist](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/assessment-of-a-person-with-disability)
* [Definitions Related to Disability©](https://www.nln.org/docs/default-source/uploadedfiles/professional-development-programs/ace-series/definitions-related-to-disability-7-20-17.pdf?sfvrsn=a0b2a80d_0)

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 in a manner that illustrates caring for patient’s overall well-being, reflects cultural awareness and psychosocial needs.
7. Communicate appropriately with other healthcare 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. Complete a focused history, physical, and psychosocial assessment of the client with attention to an elderly patient with a disability.
2. Implement appropriate nursing actions for care of a patient with heart failure who is receiving anticoagulants and diuretics.
3. Complete fall risk assessment.
4. Identify patient teaching needs and begin teaching.
5. Communicate effectively using appropriate strategies for a person with a physical disability.
6. Recognize the implications of the patient’s existing disability on the patient’s current and future health care needs.

Faculty Reference

The Healthcare Simulation Standards of Best Practice™

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

Medical/surgical textbook of choice for content on heart failure and atrial fibrillation.

Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model

https://hign.org/sites/default/files/2022-11/Hendrich%20II%20Fall%20Risk%20Model.pdf

Setting/Environment

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

Equipment/Supplies

**Simulated Patient/Manikin(s) Needed:** Use of a simulated patient (SP) with disability is ideal for authenticity of the experience. Another SP or faculty member who is educated to simulate the disability is the alternative. Simulate the disability by covering the SP’s leg with a skin-colored sheath and have the SP simulate not being able to stand without an assistive device.

**Recommended Mode for Simulator:** (e.g. manual, programmed, etc.): N/A

**Other Props & Moulage:** Have a printed set of vital signs available in the room (on a clipboard or in large print hanging in the room), as if taken by tech or unlicensed assistive personnel (UAP). Prosthetic leg next to bed.

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| **Equipment Attached to Manikin/Simulated Patient:**  ID band  IV tubing with primary line fluids: 250 ml of 0.9 NS with 25,000 units of heparin running at 800 units/hour  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 Props & Moulage:** Prosthetic leg  **Medications and Fluids:**  Oral Meds:  IV Fluids: 250 ml of 0.9 NS with 25,000 units of heparin running at 800 units/hour  IVPB:  IV Push:  IM or SC: | **Equipment Available in Room:**  Bedpan/urinal  02 delivery device (type): nasal cannula  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)  Recorder(s)  Family member #1  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 needed for some roles.

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 ending shift

**Situation:** Mr. Patrick Lake was admitted from the emergency department to the cardiac care unit 5 days ago with heart failure (HF). His condition improved with treatment and he was transferred to this medical surgical/telemetry unit last night. He will likely be discharged within the next two days.

**Background:** Prior to admission, Mr. Lake told his wife his heart was racing and he had shortness of breath. His wife called his primary care physician, who instructed her to call 911 and take him to the emergency department. When he arrived at the hospital he was placed on a cardiac monitor and his heart rate was 130. His other vital signs were: respirations 30, blood pressure 100/60, and O2 SAT 94%. He had +2 pitting edema in the leg without the amputation, and he reported that the prosthesis he uses for his above-the-knee amputation from a war injury in his 20s was snug and rubbing. With treatment he returned to a normal sinus rhythm. He is still on a heparin drip for another 24 hours. It will be discontinued in 24 hours and he will be transitioned back to his apixaban.

The patient has a history of hypercholesterolemia for 15 years, which has been treated with atorvastatin 40 mg PO daily; he has been hypertensive for 10 years, treated with lisinopril 20 mg; he has had intermittent atrial fibrillation and was taking metoprolol 50 mg twice a day, as well as apixaban 5 mg twice a day for anticoagulation prophylaxis for the atrial fibrillation. He also has had glaucoma for 2 years, treated with timolol 0.25% one drop twice a day to both eyes. He has had osteoarthritis for 10 years and takes acetaminophen PO about every 8 hrs prn for his joint pain. He is on a low-fat, low-sodium diet.

**Assessment:** This morning Patrick is alert and oriented x 3. His vital signs at 0400 were: heart rate 82 and regular, blood pressure 132/84, respirations 18 and a temperature of 98.6. His lungs are clear with the exception of diminished breath sounds in the bases with fine crackles. All peripheral pulses are palpable and +3. He has trace edema in the foot without the amputation and some general swelling of stump. Patrick says his prosthetic leg feels a little snug and the stump is a little sore, but there is no evidence of skin breakdown on his stump or elsewhere on his body. His weight this morning was xxx lbs. On admission it was xxx (+ 8 lbs). Two days ago, it had dropped to xxx lbs (-5 lbs.). The heparin drip with 25,000 units of heparin in 250 ml of 0.9 NS is running at 800 units/hour and is infusing well via a 22-gauge needle into his left anterior forearm. There is no redness, drainage, tenderness, or swelling at the site.

**Recommendation:** Please complete his morning assessment with a focus on cardiopulmonary system and see if he has any pain. Do a repeat fall assessment. A fall risk assessment was done on admission with a score of 5. Begin teaching about his heart failure and the importance of weight management and reporting any increase in weight. See if he needs any dietary teaching or other teaching needs concerning his new or current medications. The case manager will be calling to request a meeting with the patient and his wife to work on a home plan of care. Since Patrick is going home soon, please call the healthcare provider to request a transition back to apixaban prior to Heparin being discontinued.

Scenario Progression Outline

**Patient Name:** Patrick Lake **Date of Birth:** 11-13-YYYY (reflect age 64)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 minutes** | **SP is sitting in bed or chair:**  **Cardiac monitor:** displays normal sinus rhythm  **Vital signs** are: BP 148/84; HR 88;R 18; Temp. 98.4.  SP can handlearner a card with vital signs or can be on clipboard in room.  **Questions about ID and orientation:** SP answers correctly to all.  **Questions about general well-being:** “I am feeling much better than when I first came in, but I am nervous about the new medications and worried that my heart will start racing again. Can you tell me what it is right now?” | **Learners should begin by:**   * Performing hand hygiene * Introducing selves * Confirming patient ID * Taking vital signs * Providing privacy * Asking questions to determine orientation * Asking question about general well-being | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |
| **5-10 minutes** | **Cardiopulmonary assessment:**  **Pain:** “I still have pain in my back and legs, but no chest pain or shortness of breath.”  **Stump:** “It is still sore and the prosthesis is snug, so I haven’t been putting the leg on all the time – I just use a walker.”  **IV site:** “Feels fine.” | **Learners are expected to:**   * Complete focused cardiopulmonary and peripheral vascular assessment, asking appropriate questions about shortness of breath, chest pain, etc. * Assess stump * Assess IV site | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |
| **10-15 minutes** | **Fall Risk Assessment Responses:**  **Depression:** “I’m disappointed and concerned to have this new health problem, but I wouldn’t say I am depressed.”  **Dizziness:** “I’m not feeling dizzy.”  **Ability to rise from bed/chair**: “I need to put my leg on to get up, so I need assistance.” | **Complete Fall Risk Assessment**  Assessment tool provided in chart | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |
| **15-20 minutes** | **Medications:** Patrick is knowledgeable about all medications taken at home prior to admission.  **SP:** “The nurse said my weight today is xxx lbs. I am losing weight every day. I don’t want to lose too much weight.”  **SP:** “So will I have to weigh myself at home, then? How often? Do I keep my prosthesis on or off?”  **SP:** “How will I manage all of this at home?” | **Learners are expected to:**   * Assess what Patrick knows about his meds. * Assess his diet at home. * Teach about significance of weight and HF. * Ask if Patrick has any other questions related to his HF, medications, diet, etc. * Teach how to weigh himself safely. * Provide appropriate reassurance that case manager will discuss home visits. | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |

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:**

* Communication with a person with a disability
* Caring for a person with a disability in the hospital environment
* Management of care for a patient with heart failure who also has an existing leg stump.

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).

Important Note

If you can recruit an SP with a real disability, then include the SP in the debriefing and ask SP to provide feedback regarding their feelings as the patient in the scenario, focusing on interpersonal skills:

Did the learners:

* Talk to me as a person?
* Demonstrate active listening/make eye contact?
* Sit at eye level?
* Treat me as an adult and with respect?
* Ask about my disability and its impact on my current situation?

The authors have created an Observation Tool and Critical Elements for assessing learners in this simulation. Access the [Observation Tool and Critical Elements for Patrick Lake Simulation #2](https://www.nln.org/docs/default-source/uploadedfiles/professional-development-programs/ace-series/p-lake-sim-2-observation-tool-and-critical-elements-bam.pdf?sfvrsn=acafa80d_0).