Simulation Design Template

Phil and Lois Gardner – Simulation #2

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| **Date:** **Discipline:** Nursing**Expected Simulation Run Time:** 20 minutes**Location:** Gardner home**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:** 126 lbs. (57.2 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. Hospitalized for pneumonia 6 months ago. Following discharge, evaluated by neurologist and diagnosed with dementia.

**History of Present Illness:** Lois was seen in the emergency department (ED) a week ago for an episode of angina, which was treated with nitroglycerin. There was no inpatient admission. She is now having monthly home visits for assessment of COPD/HF and medication management. This is the first home visit.

**Social History:** Married to Phil Gardner since age 49. Lois has a sister Dorothy who lives with her husband a few hours away. Lois has had signs of confusion and memory loss for over a year and was officially diagnosed with dementia by her neurologist after her hospitalization 6 months ago. She is on Medicare and supplemental insurance. Husband Phil is Lois’s caregiver. He has not had help from others in caring for Lois. Phil is now responsible for cooking and most of the household duties. Lois helps as able with tasks like washing dishes and folding laundry. Phil is mostly confined to the house, though he will occasionally leave for an hour or two to shop, run errands, and meet friends for coffee or lunch. Lois is able to accompany him to the store and does that at times. Otherwise she has few interests and spends her time watching TV or looking out the window.

**Primary Medical Diagnosis:** COPD, HF, post MI

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

Psychomotor Skills Required of Participants Prior to Simulation

none

Cognitive Activities Required of Participants Prior to Simulation

Use textbook and other faculty-directed resources to review:

* General care of the older adult
* Dementia
* Caregiver strain

Read/review the following:

Nursing Standard of Practice Protocol: Family Caregiving

<https://hign.org/consultgeri/resources/protocols/family-caregiving>

The Modified Caregiver Strain Index

<https://hign.org/sites/default/files/2020-06/Try_This_General_Assessment_14.pdf>

Research available resources for older adults and caregivers in your community

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. Assess patient’s safety and well-being in the home.
2. Assess caregiver strain using reliable, valid, standardized tool.
3. Explain how to access resources such as adult day care and respite care.
4. Assist caregiver in asking other family members for help with Lois’s care.

Faculty References

Nursing Standard of Practice Protocol: Family Caregiving

<https://hign.org/consultgeri/resources/protocols/family-caregiving>

The Modified Caregiver Strain Index

<https://hign.org/sites/default/files/2020-06/Try_This_General_Assessment_14.pdf>

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[x]  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:**[ ]  ID band [ ]  IV tubing with primary line fluids running at \_\_ 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:****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 [x]  Other: Living room set up. Walker should be in room. Phil has a med dispenser filled appropriately with oral meds, a bottle of nitroglycerin, and all the inhalers. He also has bottles of the meds with appropriate labels and sufficient amounts for at least a month. |

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:** 1200

**Person providing report:** RNcase manager from home care agency

**Situation:** Lois Gardner is a 75-year-old female we will be seeing monthly for assessment and medication management. She lives in retirement housing with her husband Phil, who is her caregiver. This will be our first visit.

**Background:** Mrs. Gardner is a previous smoker and has a history of COPD and HF. She had an MI at age 51 and was hospitalized for pneumonia 6 months ago. She was seen in the ED last week for an episode of angina, treated with nitroglycerin. Her ECG was normal, and she was sent home. Her home medications include metoprolol, atorvastatin, aspirin, and her inhalers – albuterol, salmeterol, and tiotropium bromide. Nitroglycerin is as needed for chest pain.

Her husband reports that she has become extremely confused and forgetful over the past year and a half and requires help with medications and other tasks. This seems to have worsened since her hospitalization for pneumonia 6 months ago. Dr. Wong referred Lois to neurology after that hospitalization and she was diagnosed with “non-specific dementia,” probably vascular. Her husband takes care of most of the household duties. The ED nurses reported that he seemed overwhelmed with his responsibilities, and with determining the extent of her chest pain. She was unable to describe to him exactly what was going on and how severe it was.

**Assessment:** Mrs. Gardner was stable upon discharge from the ED. She is continued on her home meds, which include nitroglycerin PRN for chest pain. Her husband needs support and encouragement. He has not sought any assistance from family members or outside agencies.

**Recommendation:** Assess safety of the home. Review medication administration and management. Assess how Phil is dealing with his increased caregiving role using the Modified Caregiver Strain Index. Discuss with Phil options for assistance with his wife’s 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** | Phil: “Welcome, come in. This is new for me, we’ve never had nurses in our home before.”Lois: Smiles but not talkative. Looks to Phil for reassurance. | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient and caregiver ID
* Explain reason for visit
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| **5-10 min** | Phil: “I’ve been doing everything I can to take good care of Lois.” | **Learners are expected to**:* Assess home environment with attention to safety issues such as general cleanliness, throw rugs, availability of medications
* Review med orders and verify that they are being administered correctly
 | **Role member providing cue: Phil****Cue:** If learners don’t mention environment or meds, Phil will say: “I got rid of the rugs so Lois can use her walker safely. I’ve got her meds out so we can go over them. Can you look at this list? I’m never sure about the nitroglycerin.” |
| **10-15 min** | Phil: “I don’t want to complain but this is getting harder. I’ve got no help and I can barely leave the house anymore.”Answers to questions:**My sleep is disturbed**(For example: the person I care for is in and out of bed or wanders around at night)SOMETIMES: 1**Caregiving is inconvenient** (For example: helping takes so much time or it’s a long drive over to help)NO: 0**Caregiving is a physical strain** (For example: lifting in or out of a chair; effort or concentration is required)NO: 0**Caregiving is confining** (For example: helping restricts free time or I cannot go visiting) Phil: “Well, I don’t want to complain, but, yes, this is true.”YES: 2**There have been family adjustments** (For example: helping has disrupted my routine; there is no privacy) SOMETIMES: 1**There have been changes in personal plans** (For example: I had to turn down a job; I could not go on vacation) YES: 2**There have been other demands on my time** (For example: other family members need me)NO: 0**There have been emotional adjustments** (For example: severe arguments about caregiving) Phil: “Well, we don’t argue, but it’s hard having no one to discuss things with, like we used to.”SOMETIMES: 1**Some behavior is upsetting** (For example: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things) Phil: “It is sad that she has forgotten so many things. And sometimes she just doesn’t make sense.”YES: 2**It is upsetting to find the person I care for has changed so much from his/her former self**(For example: he/she is a different person than he/she used to be) YES: 2**There have been work adjustments** (For example: I have to take time off for caregiving duties)NO: 0**Caregiving is a financial strain** Phil: “Well I can’t afford the $35/hour for a caregiver very often. I’ve done it a few times.”SOMETIMES: 1**I feel completely overwhelmed** (For example: I worry about the person I care for; I have concerns about how I will manage) SOMETIMES: 1**TOTAL = 13 POINTS** | **Learners are expected to:*** Explain and administer Modified Caregiver Strain Index
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| **15-20 min** | Phil: “What am I supposed to do? It’s not like I can leave Lois alone. So, I’m stressed. There’s not much anyone can do.”“How do I even go about finding any assistance. What’s out there anyways?”“My daughter Kara lives an hour away. She said she wouldn’t mind coming over to sit with Lois so I could get out. They always got along. I hate to ask her though.”“And Lois’s sister Dorothy offered to visit. But she lives a few hours away. Not sure if she’d be any help at all.” | **Learners are expected to:*** Explain implications of score
* Provide resources available in the community such as adult day care and respite care through assisted living facility or home care agency
* Encourage Phil to ask Kara and Dorothy to visit and help out, reassuring him that it is OK to reach out to Dorothy and to accept Kara’s offer.
 | **Role member providing cue: Phil****Cue:** If leaners do not explain score, Phil will say: “So what do all my answers tell you?” |

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:**

* Determining safety of home
* Assessing caregiver strain
* Helping caregiver find and use respite services for caregiving

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).