Simulation Design Template
Patrick Lake Simulation #1

<table>
<thead>
<tr>
<th>Date:</th>
<th>File Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline:</td>
<td>Student Level:</td>
</tr>
<tr>
<td>Expected Run Time: 20 min</td>
<td>Course in which students learn physical assessment</td>
</tr>
<tr>
<td>Location:</td>
<td>Guided Reflection Time: Twice the amount of time that the simulation runs.</td>
</tr>
<tr>
<td>Today’s Date:</td>
<td>Location for Reflection:</td>
</tr>
</tbody>
</table>

Brief Description of Client

Name: Patrick Lake

Date of Birth: 11-13-xxxx [year should reflect age of 64]

Gender: male  Age: 64

Race: Weight: Height: [Race, Weight & Height should reflect those of standardized 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.]

Religion: Catholic

Major Support: Spouse  Support Phone: 555-666-1210

Allergies: No known allergies  Immunizations: Up to date

Attending Provider/Team: Avery Smith, MD

Past Medical History: Glaucoma, hypertension, osteoarthritis, hypercholesterolemia, intermittent atrial fibrillation

History of Present Illness: Joint pain for about one month

Social History: Participates in support group related to disability

Primary Medical Diagnosis: Joint pain

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 of the musculoskeletal system (M/S) and neurological system (with a focus on level of consciousness and orientation).

Cognitive Activities Required of Participants Prior to Simulation

Use textbook, lecture notes and other assigned readings to review
- Examination of the musculoskeletal system
- Basic neurological examination
- Focused history taking

Read the following materials (supplied):
- Overview and Introduction to Disability©
- Communicating with People with Disabilities©
- Assessment of the Patient with a Disability© Checklist
- Definitions Related to Disability©

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 and physical exam related to assessment of pain of a client with attention to an elderly patient with a disability in a clinic or outpatient setting.
2. Complete vital signs, musculoskeletal and basic neurological assessment for orientation and level of consciousness.
3. Communicate effectively using appropriate strategies for a person with a physical disability.
4. Recognize the implications of the patient’s existing disability on the patient’s current and future health care needs.

For Faculty: References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used for This Scenario:

Health assessment and/or medical/surgical textbook of choice for content on musculoskeletal and neurological assessment (orientation and level of consciousness)
Setting/Environment

- Emergency Room
- Medical-Surgical Unit
- Pediatric Unit
- Maternity Unit
- Behavioral Health Unit
- ICU
- OR / PACU
- Rehabilitation Unit
- Home
- Outpatient Clinic

Equipment/Supplies

Simulated Patient/Manikin/s Needed: Use of an 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: (i.e. manual, programmed, etc.): N/A

Other Props & Moulage: Have a printed set of vital signs available in the room, as if taken by tech or UAP (on a clipboard or in large print hanging in the room).

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
- IV pump
- Foley catheter with ___mL output
- PCA pump
- IVPB with ______ running at mL/hr
- 02
- Monitor attached
- Other:

Other Props & Moulage:

Medications and Fluids:
- IV Fluids:
- Oral Meds:
- 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

| 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 identify expectations and orient participants to the environment, scenario, roles, time allotment, and objectives.

Report Students Will Receive Before Simulation

**Time:** 3 PM

**Person providing report:** Dr. Smith

**Situation:** Mr. Patrick Lake is an adult patient who reports to the clinic with joint pain in both upper and lower extremities.

**Background:** The patient has a history of glaucoma, hypertension, intermittent atrial fibrillation, osteoarthritis, hypercholesterolemia, and an above-the-knee amputation from a war injury. This is his second visit to our clinic.

**Assessment:** Has joint pain for the past month. Wife is concerned that recently he has had some wooziness and she is wondering if this or any of his medications may be the cause.

**Recommendation:** Complete a focused history and physical exam related to the patient’s chief complaints.
# Scenario Progression Outline

**Patient Name:** Patrick Lake  
**Date of Birth:** 11-13-xxxx [year should reflect age (64)]

<table>
<thead>
<tr>
<th>Timing (approx.)</th>
<th>SP Actions</th>
<th>Expected Interventions</th>
<th>May Use the Following Cues</th>
</tr>
</thead>
</table>
| 0-5 minutes      | Patrick Lake is in exam room. Vital signs: Temp - 97.8; BP 150/90; heart rate - 80; respirations – 16  
SP can hand learner a card with vital signs or can be on clipboard in room  
**Information provided by SP:**  
"I've been having pain in all my joints."  
"I've had osteoarthritis for 10 years. I take acetaminophen 650 mg about 3 times a day, but it does not provide full relief."  
"Pain is different and worse than before, and I can’t exercise because of the pain."  
"I don’t have any swelling, redness, or lack of sensation in my joints, but they hurt and I am really stiff, especially in the morning. I can do everyday things, but can’t do many of the chores in the house and garden anymore."  
"I also get dizzy sometimes and am wondering if my drugs are causing it."  
**Level of pain:** 5 | Learners should begin by:  
• Performing hand hygiene  
• Introducing selves  
• Confirming patient ID  
• Taking vital signs  
• Providing privacy  
• Asking what brings patient to outpatient center  
• Assessing pain (0-10 scale) | Role member providing cue: Standardized patient  
**Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |
### 5-15 minutes

<table>
<thead>
<tr>
<th>SP responses to questions about medications:</th>
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<tbody>
<tr>
<td>“Besides the acetaminophen 650 mg that I take about 3 times a day for the joint pain, I also take</td>
</tr>
<tr>
<td>• 2 pills for hypertension - lisinopril 20 mg once a day and metoprolol 50 mg twice a day; the metoprolol is also for my atrial fibrillation, along with warfarin to prevent blood clots from my atrial fibrillation.</td>
</tr>
<tr>
<td>• For my high cholesterol, I take 1 atorvastatin 40 mg every day</td>
</tr>
<tr>
<td>I have glaucoma, so twice a day I put one drop of timolol in each eye.”</td>
</tr>
<tr>
<td>During musculoskeletal assessment: SP should indicate that he has pain in all joints in arms and legs, and it is sometimes worse in knees and wrists.</td>
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<tr>
<td>If asked questions about orientation: SP answers correctly to person/place/time.</td>
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</tbody>
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<tr>
<th>Learners are expected to:</th>
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<tr>
<td>• Take medication history</td>
</tr>
<tr>
<td>• Complete musculoskeletal assessment (assesses for temperature, redness, swelling, range of motion)</td>
</tr>
<tr>
<td>• Assess stump</td>
</tr>
<tr>
<td>• Do basic neuro assessment for level of consciousness and orientation</td>
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<tr>
<td>Standardized patient</td>
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If learner does NOT ask about medications SP should say: “What about all these pills I take, do you need to know about them? Sometimes they make me fuzzy.”

### 15-20 minutes

<table>
<thead>
<tr>
<th>SP states:</th>
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<tbody>
<tr>
<td>“So what do you think? Can anything be done about my pain so I can get more active again?”</td>
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<th>Learners are expected to:</th>
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<tr>
<td>• Discuss impact of pain and disability on activities of daily living.</td>
</tr>
<tr>
<td>• Tell Mr. Lake that s/he will report findings to Dr. Smith, who will be in to see him shortly.</td>
</tr>
</tbody>
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<td>Standardized patient</td>
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Cues: Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column.
Debriefing/Guided Reflection

The following 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 (Debriefing with Good Judgement, Debriefing for Meaningful Learning, PEARLS, etc.) Remember to also identify important concepts or curricular threads that are specific to your program.

1. How did you feel throughout the simulation experience?
2. Give a brief summary of this patient and what happened in the simulation.
3. What were the main problems that you identified?
4. Discuss the knowledge guiding your thinking surrounding these main problems.
5. What were the key assessment and interventions for this patient?
6. Discuss how you identified these key assessments and interventions.
7. Discuss the information resources you used to assess this patient. How did this guide your care planning?
8. Discuss the clinical manifestations evidenced during your assessment. How would you explain these manifestations?
9. Explain the nursing management considerations for this patient. Discuss the knowledge guiding your thinking.
10. What information and information management tools did you use to monitor this patient’s outcomes? Explain your thinking.
11. How did you communicate with the patient?
12. What specific issues would you want to take into consideration to provide for this patient’s unique care needs?
13. Discuss the safety issues you considered when implementing care for this patient.
14. What measures did you implement to ensure safe patient care?
15. What other members of the care team should you consider important to achieving good care outcomes?
16. How would you assess the quality of care provided?
17. What could you do improve the quality of care for this patient?
18. If you were able to do this again, how would you handle the situation differently?
19. What did you learn from this experience?
20. How will you apply what you learned today to your clinical practice?
21. Is there anything else you would like to discuss?

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 his/her feelings as the client 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. Click here to access their tool.