## Simulation Design Template

Henry Williams – 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:** Henry Williams **Pronouns:** he/him

**Date of Birth:** 01-05-YYYY (reflect age 80) **Age:** 80

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

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

**Weight**: 194 lb (88 kg) **Height**: 72 in

**Racial Group**: (Faculty can select) **Language**: English **Religion**: (Faculty can select)

**Employment Status**: Retired **Insurance**: Medicare **Veteran Status**: (Faculty can select)

**Support Person:** Ertha (wife) and Betty (daughter-in-law)

**Support Phone:** Ertha 320-222-2345; Betty 320-222-1111

**Allergies:** Penicillin **Immunizations:** Up to date; influenza and pneumonia current

**Attending Provider/Team:** KatherineNelson, MD

**Past Medical History:** Chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), asthma, hearing loss (wears hearing aids)

**History of Present Illness:** Admitted 5 days ago with an acute exacerbation of COPD. Will be discharged today to local rehabilitation center. Wife has memory problems and will stay with daughter-in-law until new living arrangements for Henry and Ertha can be finalized.

**Social History:** Retired engineer for transit system

**Primary Medical Diagnosis:** COPD, cardiovascular disease

**Surgeries/Procedures & Dates:** Appendectomy at age 15.

Psychomotor Skills Required of Participants Prior to Simulation

* Skills related to focused assessment

Cognitive Activities Required of Participants Prior to Simulation

Use textbook and other faculty-directed resources to review:

* Care of patient with COPD
* General care of the older adult
* Preparation for discharge

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 the Geriatric Depression Scale and the Modified Caregiver Strain Index 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.

Geriatric Depression Scale

<https://hign.org/consultgeri/try-this-series/geriatric-depression-scale-gds>

Modified Caregiver Strain Index

<https://hign.org/consultgeri/try-this-series/modified-caregiver-strain-index-mcsi>

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. Conduct a focused physical assessment.
2. Implement appropriate nursing actions based on results of Geriatric Depression and Caregiver Strain tools.
3. Complete medication reconciliation form in preparation for discharge.
4. Demonstrate effective teaching with patient and family.

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 Geriatric Depression Scale and the Modified Caregiver Strain Index assessment tools are recommended for this simulation.

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>

The Healthcare Simulation Standards of Best Practice™

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

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/Manikin(s) Needed:** Manikin or simulated patient dressed in street clothes. Betty and Ertha – simulated patients.

**Recommended Mode for Simulator:** Manual

**Other Props & Moulage:** Glasses, hat, hearing aids. If no hearing aid available, can modify scenario to reflect Henry’s difficulty hearing the nurse and he can say that he left his hearing aid at home.

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| **Equipment Attached to Manikin/Simulated Patient:**[x]  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:** Blood pressure cuff, thermometer, stethoscope, telephone.**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:  |

Roles

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| [x]  Nurse 1[x]  Nurse 2[ ]  Nurse 3[x]  Provider (physician/advanced practice nurse) on telephone[ ]  Other healthcare professionals:  (pharmacist, respiratory therapist, etc.) | [x]  Observer(s) Any number of observers[ ]  Recorder(s)[x]  Family member #1 Wife Ertha[x]  Family member # 2 Daughter-in-law Betty[ ]  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

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:** 1500

**Person providing report:** Nurse ending shift

**Situation**: Henry Williams is an 80-year-old male who was admitted through the Emergency Department 5 days ago with an acute exacerbation of COPD. He is being transferred to a rehab facility today due to generalized weakness and slow progression with his pulmonary rehab.

**Background:** Mr.Williams has been living at home with his wife Ertha. Besides his COPD he has a history of cardiovascular disease and hearing loss. Since admission, he has received albuterol treatments and oral prednisone in addition to the medications he was previously taking at home. He has improved but still gets short of breath with his ADL’s. His wife Ertha is experiencing some dementia and Mr. Williams is her primary caregiver. He seems depressed and worried about her and how they will manage. Their daughter-in-law Betty has been caring for Ertha since Henry was hospitalized. After discharge from rehab, the plan is for them to move to an assisted living facility.

**Assessment:** Vital signs stable with oxygen saturation in low 90’s. He uses 2 liters per nasal cannula PRN at night and for shortness of breath with activity. Transfer forms have been faxed to the rehab facility. His AM meds were given and the rest are not due until 2000.

**Recommendation:** Check discharge orders and prepare for discharge to rehab facility. He needs vital signs and a focused assessment and completion of his medication reconciliation form. And please administer the Geriatric Depression Scale and Caregiver Strain Index before his family arrives. When the family arrives assess need for teaching about medications. Call the rehab facility and give them a report when you have completed all your assessments.

Scenario Progression Outline

**Patient Name:** Henry Williams **Date of Birth:** 01-05-YYYY (reflect age 80)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 min** | Henry is in the chair, dressed and waiting for discharge. He appears withdrawn and sad.VS, O2 sat-90% on room air, pulse-88, RR-18, BP-130/82“I am afraid of going to that rehabilitation center. I hear people never go home…. Well, it’s time to leave the hospital today and I am worried about everything! The nurses keep talking to me about the rehabilitation center like it will be a great place for me, but I won’t have Ertha and I won’t be home so what is so good about this? I know it’s temporary and I need the rehab but still, it seems so permanent and I won’t probably see our home again. Betty is arranging for us to go to an assisted living apartment when there is an opening. Poor Betty, she doesn’t even live close by.” | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient ID
* Taking vital signs
* Completing a focused respiratory assessment
* Responding to Henry’s concerns using therapeutic communication
 | **Role member providing cue:** **Cue:** |
| **5-15 min** | **Geriatric Depression Scale: Henry’s answers:**1. Satisfied with life? NO, not right now2. Dropped activities? YES3. Life is empty? NO4. Get bored? NO5. Good spirits most of the time? NO, not right now.6. Afraid that something bad is going to happen to you? NO7. Happy most of time? NO8. Feel helpless? NO9. Prefer to stay at home? NO10. Problems with memory than most? NO11. Wonderful to be alive now? Not sure12. Feel worthless? NO13. Feel full of energy? NO14. Feel situation is hopeless? NO15. Do you think that most people are better off than you are? NO | **Learners are expected to**:* Select one or both assessment tools and administer them prior to family’s arrival
 | **Role member providing cue:** Henry**Cue:** If learners do not administer assessment tools before family arrives, Henry will refuse to answer questions saying “My family is here now. I am not answering your questions now.” |
|  | **Modified Caregiver Strain Index: Henry’s answers:**Sleep disturbed: SometimesCaregiving inconvenient: NoPhysical strain: YesConfining: SometimesFamily adjustments: SometimesChanges in plans: YesDemands on time: SometimesEmotional adjustments: NoBehavior upsetting: YesPerson changed: YesWork adjustments: NoFinancial strain: YesOverwhelmed: Sometimes |  |  |
| **15-20 min** | Betty and Ertha arrive:When Ertha and Betty come into the room, Henry’s anxiety increases.Betty: “Dad we are here to take you to rehab. Are you breathing OK?”Betty: “Can we get his medications straightened out? I don’t want any problems after we leave.”Ertha (wandering in room) “Henry take me home.”Henry can answer questions about his medications without difficulty.  | **Learners are expected to:*** Complete medication reconciliation form
* Assess knowledge of medications and teach appropriately
 | **Role member providing cue:** Betty**Cue:** If nurses don’t intervene to calm Ertha, Betty can say: “Can’t you please get mom to sit down somewhere.” |
|  | Henry is calmer after Ertha is seated and meds are reviewed. | **Learners are expected to:*** Call rehab facility and provide a report.
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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:**

* Use of assessment tools
* Skills required for teaching about medications
* Transitions in family roles and relationships in older adults
* 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 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).