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| **Multi-patient Simulation Template** |
| **Concepts:****Management of 3 patients on a med/surg unit**3 scenarios | **Student roles:** |
| **Learning Objectives:** 1. Utilize principles of prioritization and delegation in caring for multiple patients within the complex hospital environment.2. Demonstrate therapeutic communication to express respect, patience, and sensitivity to patients which is inclusive of plan of care. 3. Collaborate with interprofessional health care team to provide safe and effective patient centered care. 4. Use relevant assessment data to develop evidenced informed (based) plans of care for the patients(s).5. Use clinical reasoning processes in modifying patient care decisions.6. Provide and receive constructive feedback to/from health care team members to improve performance (patient outcomes). |
| **Psychomotor Skills:**Focused assessmentMedication administration | **Cognitive Skills:**Identify critical assessment findingsCommunicationPrioritizationDelegationOrganization |
| MCj04315860000[1] Simulation Time: 30 minutes | MCj04315860000[1] Debriefing Time: 60 minutes |

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| **Patient Set Up** |
|  | **Name** | **Name** | **Name** |
| **(Manikin/SP)** | **Fidelity** | **Fidelity** | **Fidelity** |
| **Simulation setting**All patients have ID bracelets; orders, plan of care and the following standard equipment:1 automatic BP cuff with thermometer, O2 sat, transport monitor, glucometer, for “unit”, headwall, cannulas. | Med/surg unit | Med/surg unit | Med/surg unit |
| **Preparation of manikin** | Write in as per scenario | Write in as per scenario | Write in as per scenario |
| **Medications** |  |  |  |
| **IVs** |  |  |  |
| **Bedside equipment and enhancements** |  |  |  |
| **O2** |  |  |  |
| **Report** |  |  |  |
| **Wounds/skin/other** |  |  |  |
| **Chart forms**  |  |  |  |
| **Pre-brief** |  |  |  |
| **Other roles available** |  |  |  |

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| **PATIENT CARE SIMULATION PROGRESSION** |
| ***Time*** | ***Manikin Settings and Changes*** | ***Student Action*** | ***Cue / prompt*** |
| ***0-10 min******MCj04315860000[1]*** | **Patient #1** | **Patient #1** | **Patient #1** |
| **Patient #2** | **Patient #2** | **Patient #2** |
| **Patient #3b** | **Patient #3** | **Patient #3** |
|  |  |  |  |
| ***10-20min******MCj04315860000[1]*** | **Patient #1** | **Patient #1** | **Patient #1** |
| **Patient #2** | **Patient #2** | **Patient #2** |
| **Patient #3** | **Patient #3** | **Patient #3** |
|  |  |  |  |
| ***20-30 min******MCj04315860000[1]*** | **Patient #1** | **Patient #1** |  **Patient #1** |
| **Patient #2** | **Patient #2** | **Patient #2** |
| **Patient #3** | **Patient #3** | **Patient #3** |

**Student Version**

**Student Pre-Simulation Work:**

1. Discuss delegation of tasks

2. Differentiate between assertive versus aggressive communication

3. Discuss closed loop communication

4. Identify appropriate prioritization

**Student Briefing:** Discuss the safe container and review of the objectives.

**Simulation Hospital Report**

Patient #1

Patient #2

Patient #3

**Simulation Hospital(x3)**

**Patient Information Sheet**

|  |  |  |
| --- | --- | --- |
| Patient name: | Admit Date:Today’s date | Admitting provider name: |
| DOB: | Age: | Gender: | Ht: | Wt: | Religion: |
| Dx: | Medications: |
| History of Present Illness: |
| Medical History: |
| Surgical History (Procedures & Dates): |
| Social History: |
| Support/Contact person(s): |
| Tubes/Drains: | Nutrition: |
| Wounds/Skin: pressure ulcer on R heel | Activity: |

**Simulation Hospital (x3)**

**PROVIDER ORDERS**

|  |  |
| --- | --- |
|  | **Diagnosis:**  |
| [ ] **Allergies & Sensitivities:** |
| **Date** | **Time** | **PROVIDER ORDER AND SIGNATURE** |
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|  |  |  |
| **PROVIDER SIGNATURE:** |

**SIMULATION HOSPITAL (x3)**

**MEDICATION ADMINISTRATION RECORD**

|  |
| --- |
| PatientDate of birthMRN |

|  |
| --- |
| [ ] **Allergies & Sensitivities:** |
| **Scheduled Medications** |
| **Date Ordered** | **Medication** | **0700-1859** | **1900-0659** |
|  |  |  |  |
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| **PRN Medications** |
|  |  |  |
|  |  |  |
| **IV Infusions** |
|  |  |  |  |
|  |  |  |  |
| **Signature** | **Initials** | **Signature** | **Initials** |
|  |  |  |  |

**SIMULATION HOSPITAL (x3)**

## Plan of Care Worksheet

**Client Name: Client Gender: Age Admit date:** today’s date **DNR:**

**Allergies:**

**Co-Morbidities:**

**Admitting Diagnosis:**

**Current Surgery: Surgery Date:**

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|  |  |  |  |
| **Type of Bath** | Mobility | **IV Therapy** | **Therapeutic Devices** |
| Complete Assist Self Shower Other: **Skin Management**Braden/Risk Scale Skin Care Products Used:Wound Care Protocol:  | Bedrest Turn C, & DB BSC Chair BRP with assistanceAmbulation­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­Restraints Fall/Risk Score **Nutrition**Diet TPN Tube Feed FSBS  | Peripheral Site: Central line/PICC Site Primary IV Solution/Rate0.9%NSIV Additive:IV pump Gravity: PCA Pump Setting: | Elastic stockings\_\_\_\_\_\_\_\_SCDs CPM Pulse oximetry Telemetry Ice bags Cooling Device PCA pump Urinary Catheter NG Tube Ostomy Other: Drain type & site:Other: |
|  |  |  |  |
| Respiratory Care/Oxygen/ Breathing Tx | Physical Therapy | Occupational Therapy/Speech Therapy |
|  |  |  |
|  |  |  |
| **Enter Ranges****Recorded For:** | **Date:**Today’s date- | **Date:** | **Date:** | **Date:** | **Date:** |
|  **Temperature** |  |  |  |  |  |
|  **Pulse** |  |  |  |  |  |
|  **Respirations** |  |  |  |  |  |
|  **Blood pressure** |  |  |  |  |  |
|  **Pain scale** |  |  |  |  |  |
|  **FSBS** |  |  |  |  |  |
|  **Pulse Oximetry** |  |  |  |  |  |
|  **24 hour intake** |  |  |  |  |  |
|  **24 hour output** |  |  |  |  |  |
|  **Weight** |  |  |  |  |  |
| **Diet percentage** | **B L D** |  **B L D** |  **B L D** |  **B L D** |  **B L D** |

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| **\*Laboratory Values (x3)** |
| **Test** | **Normal Range** | **Date/Time****Today’s Date** | **Date/Time** | **Date/Time** |
| White blood cells-WBCs | 5,000-10,000 mm3 |  |  |  |
| Red blood cells-RBCs | M 4.7-6.1 million/mm3F 4.2-5.4 million/mm3 |  |  |  |
| Hemoglobin- Hgb | M 14-18 g/dlF 12-16 g/dl |  |  |  |
| Hematocrit- Hct | M 42-52%F 37-47% |  |  |  |
| Platelets | 150-400 |  |  |  |
| Prothrombin time-PT | 11.0-12.5 sec |  |  |  |
| INR | 2-3.5x normal |  |  |  |
| PTT | 60-70 |  |  |  |
| Sodium-Na | 135-145mEq/L |  |  |  |
| Potassium-K | 3.5-5.0 mEq/L |  |  |  |
| Chloride-Cl | 98-106mEq/L |  |  |  |
| Carbon Dioxide CO2 | 23-30 mEq/L |  |  |  |
| Glucose | 70-110 mg/dl |  |  |  |
| BUN | 10-20 mg/dl |  |  |  |
| Creatinine | M 0.5-1.2 mg/dlF 0.5-1.1mg/dl |  |  |  |
| Lactic Acid | 0.6-2.2 mmol/L |  |  |  |
| Albumin | 3.5-5.0 |  |  |  |
| Calcium-Ca | 9.0-10.5 mg/dl |  |  |  |
| Phosphate | 1.6-2.6 mEq/L |  |  |  |
| Magnesium | 1.5-2.5 mEq/L |  |  |  |

\*Customize to your institutional values.

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| **Multi-Patient Simulation Template (Exemplar)** |
| Disclaimer: The exemplars were solely developed by the authors of the toolkit as an illustration for completing the template. |
| **Concepts:** **Management of 3 patients on a med/surg unit**3 scenarios | **Student roles:**Night NurseCharge NurseBedside NurseStudent Nurse |
| **Learning Objectives:** 1. Utilize principles of prioritization and delegation in caring for multiple patients within a complex environment.2. Demonstrate therapeutic communication to express respect, patience, and sensitivity to patients, inclusive of plan of care. 3. Collaborate with interprofessional health care team to provide safe and effective patient centered care. 4. Utilize relevant assessment data to develop evidenced informed (based) plans of care for the patients(s).5. Use clinical reasoning processes in modifying patient care decisions.6. Provide and receive constructive feedback to/from health care team members to improve performance (patient outcomes). |
| **Psychomotor Skills:**Focused assessmentMedication administration | **Cognitive Skills:**Identify critical assessment findingsCommunicationPrioritizationDelegationOrganization |
| MCj04315860000[1] Simulation Time: 30 minutes | MCj04315860000[1] Debriefing Time: 60 minutes |

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| **Patient Set Up** |
| **Patient** | **Virginia Kramer #1** | **Kevin Stevens #2** | **Annie Wilson #3** |
| **(Manikin/SP)** | **High fidelity** | **Low or high fidelity** | **Low or high fidelity** |
| **Simulation setting**All patients have ID bracelets; orders, plan of care and the following standard equipment:1 automatic BP cuff with thermometer, O2 sat, transport monitor, glucometer, for “unit”, headwall, cannulas. | Med/surg unitVirginia KramerDOB – 4/3/1956MR # 313122Dr. Stone Right knee replacement, spouse at bedside | Med/surg unitKevin StevensDOB – 11/3/1954MR # 777998Dr. FenskeGI study, spouse at bedside. | Med/surg unitAnnie M. WilsonDOB – 6/10/1932MR # 7654321Dr. CollinsStatus post UTI, DC home today. |
| **Preparation of manikin** | Adult, female, fresh post –op right knee replacement with dressing and ACE wrap. Pale, diaphoretic. IV access. All pulses present. Lung and heart sounds WNL. Bowel sounds – hypoactive. Alert and oriented X3. | Adult male, general appearance. IV access. Lung and Heart sounds WNL, bowel sounds hyperactive. Alert and oriented X3. Skin warm and dry. | Female, elderly appearance. IV access. Urinary catheter in place. Lung, bowel, and heart sounds WNL. Skin warm and dry. Confused as to person and place.  |
| **Medications** | morphine sulfate 2mg IVP every 2-4 hours as needed for pain. hydromorphone 0.2 mg to 1 mg IVP every 4 hours as needed for pain.ondansetron 4 mg IVP every 6 hours as needed for nausea and vomiting.losartan 50 mg PO BIDtoradol 30 mg IVP once per day.bisacodyl 5 mg tablets PO as needed for constipation.zolpidem 5 mg tablet PO as needed for sleep. | Only bowel prep, take as directed. | acetyl salicylic acid 81 mg POtriamterene 50 mg POregular insulin |
| **IVs** | Normal Saline at 100 ml/hour | Capped with normal saline for flush | Capped with normal saline for flush |
| **Bedside equipment and enhancements** | Bedpan, basin, table, personal care, walker, c-pap | Bedpan, basin, table, personal care, | Bedpan, basin, table, personal care, walker, family pictures, flowers, glasses, robe. |
| **O2** | Titrate as needed, CPAP and or cannula at 02. | Nasal Cannula PRN | Nasal Cannula PRN |
| **Report** | Yes | yes | Yes |
| **Wounds/skin/other** | Right knee surgery with dressing and ACE wrap in place.6 inch incision closed with cyanocrylate adhesive.Compression stockings. Cold therapy machine.  | None | Indwelling urinary catheter, urine color is yellow and clear, 200 ml in Foley bag.  |
| **Chart forms**  | Surgical report, MAR, provider orders, lab values, History. | Provider orders, MAR, history, lab values, consent for colonoscopy.  | Provider orders, MAR, nursing documentation, history, discharge orders.  |
| **Pre-brief** | Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report.  | Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report. | Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report. |
| **Other roles available** | UAP, MD, Anesthesiologist, Pharmacist, other RN, PACU nurse | MD, GI Lab RN | UAP, Daughter, MD, other RN |

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| **PATIENT CARE SIMULATION PROGRESSION** |
| ***Time*** | ***Manikin Settings and Changes*** | ***Student Action*** | ***Cue / prompt*** |
| **0-10 min****MCj04315860000[1]** | **Patient #1:** Pale, diaphoretic. Moans when awake, but answers questions. Nauseated from morphine IV. V/S. Pain level. | **Patient #1**: Receive bedside report from PACU nurse. Assess patient’s leg, V/S and pain. Discuss with spouse.  | **Patient #1**: Patient voices acute discomfort.  |
| **Patient #2**Going for mid-morning GI diagnostic test. Awake and alert. No discomfort.  | **Patient #2**Finish patient GI preparation, ensuring consent and patient teaching is finished. V/S taken. | **Patient #2** Patient asking questions as to what the test entails.  |
| **Patient #3**: Normal patient, v/s within normal limits. | **Patient #3:**Receive report, does initial contact/ assessment. | **Patient #3:**Patient asleep |
|  |  |  |  |
| **10-20min****MCj04315860000[1]** | **Patient #1:** Remains unchanged. Patient c/o increased pain and nausea.  | **Patient #1:** Assess for pain and nausea. Assess respiratory status, mentation and peripheral vascular. Identifies need to administer medications. (Can give ondansetron for nausea, hyrdomorphone IVP for pain after assessment.) | **Patient #1:** C/O severe nausea, and pain increasing to a level 8/10. If not recognized. |
| **Patient #2** Patient appears anxious. Wife at bedside. Pain free.  | **Patient #2** Assess any patient teaching issues. Physical assessment. | **Patient #2** Anxiety, asking several questions regarding procedure.  |
| **Patient #3:**Normal patient, v/s within normal limits. Lung, heart and bowel sounds within normal limits. Skin WNL. Can ID self.  | **Patient #3:**Responds to patient’s calls. Gets blood sugar, calls for tray. Uses therapeutic communication to establish rapport and reduce patient anxiety. | **Patient #3:**Patient calling out, “I am hungry”.  |
| **20-30 min****MCj04315860000[1]** | **Patient #1** Patient sleeping at times, arouses easily. C-PAP on. Denies pain, if meds were given. Peripheral pulses intact.  | **Patient #1** Continue the assessment, address any changes. Give the pain meds and ondansetron, if not done. |  **Patient #1**Moans upon initial arousal. If meds, not given spouse verbalizes C/O’s |
| **Patient #2**Patient appears scared. BP 148/90, HR 90, RR 22, T 98.6  | **Patient #2** Therapeutic communication with patient. Gives report to GI lab nurse.  | **Patient #2** “What are they going to find? What if it is cancerous?” |
| **Patient #3:** Patient unchanged.  | **Patient #3:** Call for help with tray, and contacting daughter.  | **Patient #3:** Tray arrived, patient needs help with tray. Patient states, “When can I go home? Where is my daughter, can you call her?” |

**Student Version**

**Student Pre-Simulation Work:**

1. Discuss delegation of tasks

2. Differentiate between assertive versus aggressive communication

3. Discuss closed loop communication

4. Identify appropriate prioritization

**tudent Briefing:** Discuss the safe container and review of the objectives.

**Simulation Hospital Report**

**Patient #1** Virginia Kramer

PACU Nurse to Med-Surg: 59 y/o female who was Dr. Stone’s 1st knee replacement this morning, Right knee. Pressure dressing and elastic wrap are clean, dry and intact. A&O X3 when awake. Lungs clear, able to cough and deep breathe when cued. Patient is a nurse. IV is NS at 100 ml/hour in left forearm. The anesthesiologist ordered morphine sulfate 2-4 mg every 2 hours for immediate post-op pain once she was awake. I gave the patient 6 mg in 2 hours and there was no pain relief, but she became nauseated and threw up. Order added for ondansetron 4mg IV, which was not given. Spouse in the room.

**Patient #2** Kevin Stevens

RN Night to day shift report. Patient finished bowel prep this morning with good results. Scheduled to go to GI lab at 10 AM for colonoscopy for changes in bowel habits. Patient has several questions and repeats them often. He has colon cancer history in family. Wife is here, seems to be calming for him. Take a second look at paperwork, I think everything is all done. I have not had time to talk to him. Awake and alert. No pain. BP 120/70 HR 78 RR 18 SP02 98% room air. Just quit smoking 3 months ago. Up without difficulty. No past medical hx.

**Patient #3** – Anne M. Wilson

RN Night to day shift: Mrs. Wilson had a difficult night, she had trouble sleeping, could not get comfortable, and was up in the chair at times. Gets afraid and disoriented at night. Finally fell asleep at 0400. I let her sleep this morning, so did not get a blood sugar. She is to be discharged home today with her daughter Betty. Was admitted with a UTI, on antibiotics, has hx of diabetes (2) which really is not a problem, except poor eater. No pain, last V/S at 0300, T-98.0 BP 110/70, HR 70 RR 16 SP02 98% RA. No open areas or redness on skin. Lungs clear. Urinary catheter is draining clear yellow urine, which needs to be removed. Daughter taking her home today.