Simulation Design Template

Peggy Nelson and Daughter Bridget Simulation #1

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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:** Peggy Nelson **Pronouns**: she/her

**Caregiver**: Bridget Nelson Hardy (daughter) **Caregiver Pronouns:** she/her **Caregiver phone:** 888-888-8888

**Date of Birth:** 07-12-YYYY (reflect age 83) **Age**: 83

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

**Sexual Orientation:** heterosexual **Marital Status:** widow

**Weight**: 142 lbs. **Height**: 5’3”

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

**Employment Status:** retired **Insurance Status:** Medicare **Veteran Status:** N/A

**Allergies:** Grass, tree pollen, pet dander **Immunizations:** Up to date including influenza & pneumococcal

**Attending Provider/Team:** Tremont Orthopedic Associates PA

**Past Medical History:** Hypertension, rheumatoid arthritis, hypothyroidism. Fitted for a right ear hearing aid 2 months ago

**History of Present Illness:** Fractured left hip after a fall at home

**Social History:** Widowed 15 years ago, has 2 grown children. Lives alone in a split-level home. Retired teacher.

**Primary Medical Diagnosis:** Fractured left hip; new onset delirium

**Surgeries/Procedures & Dates:** Cataract removal 1 year ago; ORIF left hip, post-op day one

Psychomotor Skills Required of Participants Prior to Simulation

* Post-op care

Cognitive Activities Required of Participants Prior to Simulation

Use textbook and other faculty-directed resources to review:

* Care of patient following surgery for repair of hip fracture
* Use of incentive spirometer
* Dementia and delirium
* Pain management

Read/review the following:

* The Confusion Assessment Method (CAM):

<https://hign.org/sites/default/files/2020-06/Try_This_General_Assessment_13.pdf>

* FLACC Scale- Behavioral Observation Pain Rating Scale

<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-FLACC>

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. Elicit baseline information from the caregiver regarding the mental status of the patient with reliable, valid, standardized tool.
2. Assess patient’s pain and teach caregiver on how to identify when mother is in pain.
3. Develop a discharge plan with input from caregiver and other healthcare team members.

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 specific tool recommended for this scenario is the Confusion Assessment Method (CAM).

# Geriatric Nursing Education Consortium (GNEC) Webinar Series and Faculty Resources. Available at <https://hign.org/consultgeri/elearning/geriatric-nursing-education-consortium-gnec-webinar-series>

Hartford Institute for Geriatric Nursing, New York University College of Nursing, Overview of Resources. Available at [https://www.johnahartford.org/images/uploads/resources/HIGN\_Resources\_List\_03\_13(2).pdf](https://www.johnahartford.org/images/uploads/resources/HIGN_Resources_List_03_13%282%29.pdf)

**Pain Assessment Resources:**

* FLACC Scale- Behavioral Observation Pain Rating Scale: <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-FLACC>
* Pain Assessment in People with Dementia: AJN The American Journal of Nursing:

<https://journals.lww.com/ajnonline/Fulltext/2008/07000/Pain_Assessment_in_People_with_Dementia.30.asp>

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:** Simulated patient recommended for caregiver Bridget. Peggy can be either simulated patient or manikin**.**

**Recommended Mode for Simulator:** If using a manikin, no programming required

**Other Props & Moulage:** Dressing with small amount of serous draining on left hip covering surgical incision.

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| **Equipment Attached to Manikin/Simulated Patient:**[x]  ID band [x]  IV tubing with D5LR primary line fluids running at 125mL/hr[ ]  Secondary IV line running at \_\_ mL/hr[ ]  IVPB with \_\_ running at \_\_ mL/hr[x]  IV pump[ ]  PCA pump [ ]  Foley catheter with \_\_ mL output[ ]  02 [x]  Monitor attached[ ]  Other: **Other Essential Equipment:****Medications and Fluids:**[x]  Oral Meds: see chart[ ]  IV Fluids: [ ]  IVPB: [ ]  IV Push: [ ]  IM or SC:  | **Equipment Available in Room:**[ ]  Bedpan/urinal[x]  02 delivery device (type): nasal cannula[ ]  Foley kit[ ]  Straight catheter kit[x]  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: Commode chair, walker |

Roles

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| [x]  Nurse 1- Primary[x]  Nurse 2- Secondary[ ]  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 Bridget [ ]  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:** 1900

**Person providing report:** Nurse going off duty

**Situation:** Peggy Nelson is an 83-year-old female widow who lives at alone. She sustained a fracture of her left hip from a fall at home. She had an open reduction internal fixation (ORIF) of her hip yesterday.

**Background:** Bridget Hardy, Peggy’s daughter, is at the bedside. She has been her mother’s caregiver over the past 5 years. She is concerned over the acute changes in her mother’s cognitive status. Patient has a history of mild dementia.

**Assessment**: Mrs. Nelson has been restless and moaning at times. She was trying to get out of bed and appears to be hallucinating. She could not accurately report her pain level and was not able to manage the patient-controlled analgesia (PCA) so we notified Dr. Price and she switched her to oral oxycodone 7.5 mg/acetaminophen 325 mg every 4 hours prn. FLACC scale score was a 6; now a 2 after oral pain meds were given 3 hours ago. Dressing to the left hip has small amount of bloody drainage and is intact. Her urinary catheter was discontinued, and she is voiding without difficulty. She is allowed out of bed with hip precautions, using a walker to toe touch assist to the bedside commode. Physical therapist stopped by to evaluate her today and said they will return to start therapy tomorrow. She will probably be discharged in a few days to a rehabilitation center. At1600 her vitals were BP 146/84, P 86, T 37.4C, RR 16, O2 sat 92%. neuro check PERRL, alert and oriented X 2 to person and place, confused about time. She has an IV in her right forearm with D5RL running @ 125 ml/hr and her cefazolin was administered at 1600.

**Recommendation:** Continue to assess her cognitive status and monitor for signs/symptoms of delirium. Continue to assess pain using FLACC scale. Remind her to use the incentive spirometer. Please administer the Confusion Assessment Method (CAM) and discuss post-op delirium and pain assessment and treatment plan with her daughter. She is at her mother’s bedside now.

Scenario Progression Outline

**Patient Name:** Peggy Nelson **Date of Birth:** 07-12-YYYY (reflect age 83)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 min** | Vital Signs: BP 146/84, P 86, T 37.4C, RR 16, O2 sat 92%Patient is disoriented and confused, can’t answer questions appropriately. Patient is calling out loudly “Bring Pebbles to me now. My dog is going to get run over.”Caregiver Bridget: to her mom “Pebbles is safe at home mom, nothing is going to happen to her.”To the nurse: “This is not like my mom, she is saying really crazy things. What is happening to her?” | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient ID
* Verify identity of daughter and her role in caregiving
* Begin assessment, including assessment of surgical site, dressing and IV, explaining to Peggy and Bridget what they are doing during the assessment.
* Respond to caregiver questions and validate caregiver concerns.
* Provide appropriate reassurance to Bridget.
 | **Role member providing cue:** Caregiver Bridget**Cue:** If learners forget to introduce themselves or explain what they are doing, Bridget will say: “Who are you and what are you doing to my mom?” |
| **5-10 min** | Peggy’s behavior, the background and history provided by daughter Bridget indicates a positive response to questions 1 through 7.Q 8 A&B: No evidence observed.Q 9: No evidence. | **Learners are expected to:** * Administer the CAM tool
* Explain reason for administering CAM to Bridget.
 | **Role member providing cue:** Caregiver Bridget**Cue:** If learners try to ask Peggy the questions on the CAM, Caregiver Bridget says: “Can’t you see that my mom can’t answer your questions. She doesn’t even know she is in the hospital!” |

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| **10-15 min** | Caregiver Bridget: “The doctor changed the pain medication earlier as I don’t think my mom could use the one where you have to keep pressing the button. Maybe that pain medication was making her confused. I am hoping that this pain medication won’t do that too!” | **Learners are expected to:** * Assess patient’s pain with FLACC Scale
* Discuss medications and alternative pain interventions with Bridget
* Explain delirium and possible causes
 | **Role member providing cue:** Caregiver Bridget**Cue:** If learners do not assess pain, Bridget will say: “Do you think that she is in pain?” |
| **15- 20 min** | Caregiver Bridget: “I don’t know how she will be able to return home. I’m glad she will be going to rehab in a few days. What will they be able to help her with there? I know that PT has been here, but I don’t know what’s going to happen when she leaves the hospital?”Bridget: “Why are patients rushed out of the hospital so fast when it seems as if she needs this type of care?” | **Learners are expected to:*** Respond to caregiver Bridget’s questions appropriately.
* Inform Bridget that members of the team will discuss discharge plan.
* Suggest a visit to the rehabilitation center.
 | **Role member providing cue:** **Cue:** |

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:**

* Distinction between delirium and dementia and impact of patient’s behavior on caregiver and plans for discharge.
* Importance of an interdisciplinary team in caring for this patient in both acute care and rehabilitation settings.
* Post-operative pain management and how family members can be instrumental in the assessment of patient’s pain.

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).