Simulation Design Template

Patrick Lake Simulation #3

|  |  |
| --- | --- |
| **Date:**  **Discipline:** Nursing  **Expected Simulation Run Time:** 20 min  **Location:** Patrick Lake’s home  **Today’s Date**: | **File Name:**  **Student Level:** Course in which home health is taught  **Guided Reflection Time:** Twice the amount of time that the simulation runs.  **Location for Reflection:** |

Brief Description of Patient

**Name:** Patrick Lake **Pronouns:** He/him

**Date of Birth:** 11-13-YYYY (reflect age 64) **Age**: 64

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

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

**Racial Group**: [Race of simulated patient] **Language**: English **Religion:** Catholic

**Employment Status:** Retired **Insurance:** VA benefits **Veteran Status**: Army vet

**Weight:** [weighted of simulated patient] **Height**: [height of simulated 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.*

**Support Person:** Wife Gloria **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:** Admitted to hospital cardiac care unit 9 days ago with shortness of breath and heart rate of 130. He was diagnosed with new onset of heart failure (HF). Responded to treatment and was discharged from the hospital 3 days ago and referred to the home health agency for follow-up.

**Social History:** Participates in support group related to disability.

**Primary Medical Diagnosis:** New onset of heart failure (HF).

**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 with a focus on the cardiopulmonary system

Cognitive Activities Required of Participants Prior to Simulation

Use textbook, lecture notes and other assigned readings to review

* Focused history taking including physical, psychosocial, home environment
* Essential elements of a home visit
* Care of a client with an above-the-knee amputation, heart failure, hypertension, hypercholesterolemia, atrial fibrillation

Read the following materials (supplied):

* [Overview and Introduction to Disability©](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/overview-and-introduction-to-disability)
* [Communicating with People with Disabilities©](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/communicating-with-people-with-disabilities)
* [Assessment of the Patient with a Disability© Checklist](http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/assessment-of-a-person-with-disability)
* [Definitions Related to Disability©](https://www.nln.org/docs/default-source/uploadedfiles/professional-development-programs/ace-series/definitions-related-to-disability-7-20-17.pdf?sfvrsn=a0b2a80d_0)

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, physical, and psychosocial assessment of the client with attention to an elderly patient with a disability in the home setting.
2. Implement appropriate home health nursing actions based on priority problems.
3. Identify patient teaching needs and begin teaching.
4. Communicate effectively using appropriate strategies for a person with a physical disability.
5. Recognize the implications of the patient’s existing disability on the patient’s current and future health care needs.
6. Use SBAR to communicate assessment findings with other members of the health care team.

Faculty Reference

The Healthcare Simulation Standards of Best Practice™

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

Medical/surgical textbook of choice for content on heart failure and atrial fibrillation.

Community health textbook on choice on essentials of a home visit.

Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model

https://hign.org/sites/default/files/2022-11/Hendrich%20II%20Fall%20Risk%20Model.pdf

Setting/Environment

|  |  |
| --- | --- |
| Emergency Department  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:** Use of a simulated patient (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:** (e.g. manual, programmed, etc.): N/A

**Other Props & Moulage:** Printed set of vital signs (to give to learner at appropriate point in scenario) Prosthetic leg next to bed.

|  |  |
| --- | --- |
| **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 Props & Moulage:** Prosthetic leg  **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

|  |  |
| --- | --- |
| Nurse 1  Nurse 2  Nurse 3  Provider (physician/advanced practice nurse)  Other healthcare professionals:  Dr. Avery Smith responds to phone call at end of scenario | Observer(s)  Recorder(s)  Family member #1: Wife  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 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:** 0900

**Person providing report:** Manager at home health agency

**Situation:** This will be Mr. Patrick Lake’s second home health visit since he was discharged from the hospital 3 days ago.

**Background:** Mr. Lake was admitted to hospital cardiac care unit 9 days ago with shortness of breath and heart rate of 130. He was diagnosed with new onset of heart failure. He responded to treatment and was discharged from the hospital 3 days ago and referred to the home health agency for follow-up. The client also has a past history of glaucoma, hypertension, osteoarthritis, hypercholesterolemia, atrial fibrillation, and an above-the-knee amputation from a war injury. Client is supposed to follow a low-fat, low-sodium diet.

**Assessment:** The nurse who conducted the first home health visit to Mr. Lake yesterday reported that he was alert and oriented x 3. His vital signs were: BP 128/84; heart rate 68 and regular; respirations 18 and temp of 98.9. His lungs were clear, but there were diminished breath sounds in the bases. He had trace edema in his foot and some general swelling of stump. All other peripheral pulses are palpable and +3. His weight was xxx lbs. Client complained his prosthetic leg was a little snug and he thought the stump was a little sore; however, there was no skin breakdown.

**Recommendation:** Complete a focused history and physical psychosocial exam and home health assessment according to the agency’s plan of care. Conduct any client or family teaching as needed. At the conclusion of your visit, if there are any significant findings, such as weight gain or shortness of breath, his primary care physician wants to be called.

Scenario Progression Outline

**Patient Name:** Patrick Lake **Date of Birth:** 11-13-YYYY (reflect age 64)

|  |  |  |  |
| --- | --- | --- | --- |
| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-5 minutes** | **Patrick Lake is sitting in chair. Wife is sitting next to him.**  **Vital signs:** 97.8; BP 150/90, heart rate - 90; respirations - 26 with crackles in bases (SP can handlearner a card with vital signs.)  **Questions about ID and orientation:** SP answers correctly to all.  **Pain:** “I have not really been feeling all that great. No real pain, but I’m kind of achy.”  **Stump:** “Stump is OK, but maybe a little sore, and the prosthesis is snug, so I haven’t been putting it on.” | **Learners should begin by:**   * Performing hand hygiene * Introducing selves * Confirming patient ID * Taking vital signs * Providing privacy * Asking question about general well-being   **Complete focused physical exam:**   * Cardiopulmonary and peripheral vascular assessment * Assess stump | **Role member providing cue:**  Simulated patient or wife  **Cues:** Throughout the scenario, if learners do not ask appropriate questions, SP or wife can volunteer information listed in SP Actions column. (Example: If learners do not ask about pain, SP can say “I have not really been feeling all that great. I’m kind of achy.”)  **If learner does not assess stump:**  SP Cue: “Do you think my stump will ever fit right again?” |
| **5-15 minutes** | **If/when asked, the SP will respond as follows:**  **General:** “I’m OK – a little tired and achy. And I get a little winded sometimes. No other symptoms. I think I’m doing pretty well.”  **Cardiac:** no symptoms  **Respiratory:** no symptoms   * **Medications**: provides accurate list: * lisinopril 20 mg daily * metoprolol 100 mg twice a day * apixaban 5 mg twice per day * furosemide 40 mg * potassium chloride 20mEq daily * atorvastatin 40 mg * my timolol eye drops twice a day – one drop in each eye * “I take them all, along with some acetaminophen for my aches and pains when I need it.”   **Nutrition:** Wife answers for client: (concerned)   * Yesterday dinner: steak, baked potato, and veggie * Today breakfast: eggs, bacon and toast, juice and coffee * Lunch will be: soup, cheese, crackers, apple   **Weight: “**xxx lbs. today. I was down to xxx (5 lbs. lighter) when I left the hospital.” | **Learners are expected to:**  Ask appropriate questions   * **General:** How has patient been feeling? Symptoms since last visit? * **Cardiac:** Chest pain/pressure/tightness? * **Respiratory:** Shortness of breath? Dyspnea? Orthopnea? Cough? Wheezing? * **Medications:** Ask what meds he is taking and has he taken them all today. * **Nutrition:** 24-hour food intake recall * **Weight:** What was your weight today? | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column.  **If nurse does not ask about diet:**  SPCue: “I like my wife’s cooking. And she’s been making my favorite foods.” |
| **15-20 minutes** | **If/when asked:**  **Weight: “**I can’t seem to keep the weight off. My wife helps when I weigh myself. I have my prosthesis on when I do my weight so I don’t fall over.”  **Activity**: “I haven’t been feeling so great and am still recovering from my hospitalization, so haven’t been doing much. Right now, I can hardly get up to shower or brush my teeth alone.” | **Learners are expected to discuss/teach about:**   * Diet (issues noted in 24 hour recall; improved choices to prevent weight gain) * Medications * Activity/exercise/activities of daily living * Daily weight, subtracting weight of prosthesis.   Learner should call Dr. Smith to report relevant findings (weight gain and sore stump) using SBAR.  Dr. Smith will respond: “Have him take an extra furosemide 40 mg PO today. Please revisit him tomorrow and call me after you see him.”  Learner should relay information to patient. | **Role member providing cue:**  Simulated patient  **Cues:** Throughout the scenario, if students do not ask appropriate questions, SP can volunteer information listed in SP Actions column. |

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:**

* Communication with a person with a disability
* Home care management of a patient with heart failure
* Patient education for the patient and his family to prevent re-hospitalization.

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.

|  |  |
| --- | --- |
| **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).

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 their feelings as the patient 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. Access the [Observation Tool and Critical Elements for Patrick Lake Simulation #3](https://www.nln.org/docs/default-source/uploadedfiles/professional-development-programs/ace-series/p-lake-sim-3-observation-tool-and-critical-elements-bam.pdf?sfvrsn=beafa80d_0).