Simulation Design Template

Jenny Brown – Simulation #1

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| **Date:** **Discipline:** Nursing**Expected Simulation Run Time:** approx. 20 minutes**Location:** Short stay acute psychiatric unit**Today’s Date:**  | **File Name:** Jenny Brown**Student Level:** **Guided Reflection Time:** Twice the amount of simulation run time**Location for Reflection:**  |

Brief Description of Patient

**Name:** Jenny Brown **Pronouns**: she/her

**Date of Birth:** 06-22-YYYY (reflect age 29) **Age**: 29

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

**Sexual Orientation:** heterosexual **Marital Status:** unmarried with partner

**Weight**: 120 lbs (54.4 kg) **Height**: 66 in

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

**Support Person:** Eric (boyfriend) **Support Phone:** 555-555-5566

**Employment Status:** college student **Insurance Status**: Insured **Veteran Status**: Veteran

**Allergies:** No known allergies **Immunizations:** Current, including influenza and Tdap

**Attending Provider/Team:** Marianne Hough, MD

**Past Medical History:** Mild intermittent, exercise-related asthma as a child - resolved

**History of Present Illness:** 18 weeks pregnant. Voluntary admission to acute adult psychiatric unit from Emergency Department for evaluation following episode of acute agitation requiring restraint and administration of repeated doses of IV benzodiazepine. Episode started in hospital Imaging Services Department where 18-week female fetus was diagnosed with cleft lip & palate on ultrasound. Now stable, awaiting further mental health evaluation and discharge teaching/planning.

**Social History:** Military Veteran whose service included deployment to combat zones in Iraq. College student studying construction management. Stable monogamous relationship with boyfriend Eric.

**Primary Medical Diagnosis:** Intrauterine pregnancy at 18 weeks; generalized anxiety disorder with panic attack, possible PTSD

**Surgeries/Procedures & Dates:** None

Psychomotor Skills Required Prior to Simulation

None

Cognitive Activities Required Prior to Simulation

Use textbooks and other faculty-directed resources to review:

* therapeutic communication techniques
* elements of effective discharge teaching and planning

Review the following tools:

* Suicide Risk Assessment Guide at <https://www.mentalhealth.va.gov/docs/VA029AssessmentGuide.pdf>
* Primary Care PTSD Screen for DSM-5 at <https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf>
* 3 Question DVBIC TBI Screening Tool at <https://www.mirecc.va.gov/docs/visn6/5_TBI_3_Question_Screening_Tool.pdf>

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. Use therapeutic communication techniques to establish rapport.
2. Perform focused mental health assessment(s) appropriate for veterans with combat-related service.
3. Report assessment findings to discharge team using SBAR or other structured communication tool.

Faculty Reference

Assessment tools:

* Suicide Risk Assessment Guide at <https://www.mentalhealth.va.gov/docs/VA029AssessmentGuide.pdf>
* Primary Care PTSD Screen for DSM-5 at <https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf>
* 3 Question DVBIC TBI Screening Tool at <https://www.mirecc.va.gov/docs/visn6/5_TBI_3_Question_Screening_Tool.pdf>

**References:**

Ganzer, C. A. (2016). Veteran Women: Mental Health-related consequences of Military Service. *American Journal of Nursing, 116*(11); 32-39.

Mankowski, M. & Evertt, J. E. (2016). Women service members, veterans and their families: What we know now. *Nurse Education Today*, 47; 23-28. doi:10.1016/j.nedt.2015.12.0017

Military Sexual Trauma: Women Veteran’s Health Care: <http://www.womenshealth.va.gov/WOMENSHEALTH/trauma.asp>

National Center for PTSD

<http://www.ptsd.va.gov/index.asp>

Prins, A., et al. (2003). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9; 9-14.

The PTSD Toolkit for Nurses from the American Nurses Foundation.

<https://www.nursingworld.org/~48e191/globalassets/foundation/the_ptsd_toolkit_for_nurses__assessment.99783.pdf>

Women Veterans Health Care FAQs:

<https://www.womenshealth.va.gov/faq.asp>

The Healthcare Simulation Standards of Best Practice™

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

Setting/Environment

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| [ ]  Emergency Department[ ]  Medical-Surgical Unit[ ]  Pediatric Unit[ ]  Maternity Unit[x]  Behavioral Health Unit | [ ]  ICU[ ]  OR / PACU[ ]  Rehabilitation Unit[ ]  Home [ ]  Outpatient Clinic[ ]  Other:  |

Equipment/Supplies

**Simulated Patient/Manikin(s) Needed:** Simulated patient recommended.

**Recommended Mode for Simulator:** Manual, if used.

**Other Props & Moulage:** Standardized patient or manikin dressed in street clothes

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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:****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[ ]  Provider (physician/advanced practice nurse)[ ]  Other healthcare professionals:  (pharmacist, respiratory therapist, etc.) | [x]  Observer(s) Any number[x]  Recorder(s) Optional[ ]  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 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:** 0700, 2 days after admission to short stay acute psychiatric unit

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

**Situation:** Jenny Brown is 29 years old, admitted two days ago for acute agitation and anxiety. She is 18 weeks pregnant with her first baby. She was voluntarily admitted from the Emergency Department where she was taken following an episode of acute agitation after ultrasound in the hospital’s Imaging Services Department. She received several doses of IV haloperidol in the ED before being transferred to our unit.

**Background:** While she was in Imaging for a routine ultrasound, Jenny had to be restrained. Apparently she became extremely agitated when the perinatologist told her that the fetus, a girl, has a cleft lip and palate. She was transferred to the Emergency Department and given three 2 mg doses of IV haloperidol over approximately 4 hours. Her suicide assessment was negative but she doubted her ability to safely care for herself at home and she agreed to admission for evaluation. On the first day of admission, she received 2 mg oral haloperidol regularly, every 4 hours. Yesterday she only had two doses and seemed much more stable. She still had difficulty sleeping and woke screaming from nightmares the first night. Last night she refused the haloperidol and slept on and off but there were no nightmares.

**Assessment:** Vital signs: T: 98.6, Pulse: 76, regular; Respirations: 16, BP: 112/74. Admitting diagnosis was panic attack with underlying generalized anxiety disorder and possible PTSD. She has no psychotic behaviors and is well oriented X3. Her prenatal admission assessment was done per protocol and everything looks good. Fetal heart rate is in the 130s. She’s also had the full psychiatric intake exam. Last night she slept poorly. She cries from time to time and is worried about her baby. Her vital signs have been stable. She has suicide checks ordered every 12 hours but so far those are all negative. She says she won’t harm herself because of the baby. She has showered and is well groomed with a normal train of thought and full vocabulary. She maintains eye contact when speaking. She has rapid, pressured speech at times. She is sometimes fidgety when seated and paces to calm herself. She’s been talking on the phone with her boyfriend from time to time all night – this seems to help calm her.

**Recommendation:** There will be a care conference later today to plan for discharge and follow-up care. The team is asking for three additional assessment to be done: a suicide risk assessment, PTSD assessment and a TBI screen. The forms are on the chart.

Scenario Progression Outline

**Patient Name:** Jenny Brown **Date of Birth:** 06-22-YYYY (reflect age 29)

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| **Timing (approx.)** | **Manikin/SP Actions** | **Expected Interventions** | **May Use the Following Cues** |
| **0-10 min** | Sitting comfortably in chair; alert and oriented; answers all questions.“I feel awful about how I acted in the ultrasound room.”“I feel much better now but I’m still so worried about my baby and how she will do with… her problem. I don’t know if I’ll be able to take care of her. I’m worried about Eric, my boyfriend, because I really need his help and support now, but he’s got to be freaked out by all of this too. I have to be able to go back to school because we are really counting on my graduation. Everybody’s counting on me… my folks, Eric… and I want to be a really good mom. I wish my mom lived close, but she’s 500 miles away.” | **Learners should begin by:*** Performing hand hygiene
* Introducing selves
* Confirming patient ID
* Using therapeutic communication (interest and concern)
* Verifying reason for admission from patient perspective
 | **Role member providing cue:** Patient**Cue:** If learners do not ask about why she was admitted, Jenny can say “Do you want to hear about what happened and why I freaked out?” |
| **10-20 min** | “I will answer any questions you have, really. Everyone here has been so nice. I wish I could take you all home with me so I could ask you things and get help when I need it. I think I’m going to need a lot of help.”**Responses to Suicide Risk Assessment:**Q 1: Feeling hopeless - NoQ 2: Thought about taking your life - YesQ 3: When? Right after I found out about the baby’s problem (cleft lip & palate).Have a plan? No. I realized right away that I would never hurt myself or my baby. I’d never hurt a fly. I want to be the best mom possible. I need help but I’m not crazy.Q 4: Had a suicide attempt? No, never. I would never hurt myself or anyone else.**Responses to Primary Care PTSD Screen:** Q 1: YesQ 2: YesQ 3: YesQ 4: YesQ 5: Sometimes**Responses to 3 Question TBI Screen:**Q 1: Yes, an IED exploded and the truck I was riding in crashed into another truck in our convoy.Q 2: No, never had any of those things happen.Q 3: The only thing I get is headaches and I’m kind of crabby a lot, but I don’t think it’s from the crash. I was fine right away after it happened and never had any problems. | **Learners are expected to:*** Explain purpose of assessment tools and encourage Jenny to answer the questions and add any details that she feels are important.
* Administer assessment tools in any order:
	+ Suicide Risk Assessment
	+ Primary Care PTSD Screen
	+ 3 Question TBI Screen
* Report findings of assessments to discharge team using SBAR or another structured communication tool.
 | **Role member providing cue:** Patient**Cue:** If learners do not initiate assessments, Jenny can say: “They told me you had some questions to ask me…” |

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 therapeutic communication
* Use of focused mental health assessment(s) appropriate for veterans with combat-related service.
* Support Jenny will need during pregnancy and post-partum

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).