



California Simulation Alliance (CSA) Simulation Scenario Template

The California Simulation Alliance (CSA) is comprised of simulation users from all disciplines from throughout the state. Several regional collaboratives have formed totaling 7 as of March, 2011: The Rural North Area Simulation Collaborative (RNASC), the Capital Area Simulation Collaborative (CASC), the Bay Area Simulation Collaborative (BASC), the Central Valley Simulation Collaborative (CVBSC), the Southern California Simulation Collaborative (SCSC), the Inland Empire Simulation Collaborative (IESC), and the San Diego Simulation Collaborative (SDSC). The CINHC, a non-profit organization focused on workforce development in healthcare provides leadership for the CSA.

The purpose of the California Simulation Alliance (CSA) is to become a cohesive voice for simulation in healthcare education in the state, to provide for inter-organizational research on simulation, to disseminate information to stakeholders, to create a common language for simulation, and to provide simulation educational courses. The goals of the alliance will include providing a home within the CINHC for best practice identification, information sharing, faculty development, equipment/vendor pricing agreements, scenario development, sharing and partnership models. More information can be found on the CSA website at www.cinhc.org/programs.

All scenarios have been validated by subject matter experts, pilot tested and approved by the CSA before they were published online. All scenarios are the property of the CINHC/CSA. The writers have agreed to release authorship and waive any and all of their individual intellectual property (I.P.) rights surrounding all scenarios. I.P. release forms can be found at www.bayareanrc.org/rsc and click documents. (Please send signed I.P. release forms to kt@cinhc.org)

TABLE OF CONTENTS

SECTION I SCENARIO OVERVIEW

- A. Title
- B. Summary
- C. Evidence Base

SECTION II CURRICULUM INTEGRATION

- A. Learning Objectives
 - 1. Primary
 - 2. Secondary
 - 3. Critical Elements
- B. Pre-scenario learner activities

SECTION III SCENARIO SCRIPT

- A. Case Summary
- B. Key Contextual Details
- C. Scenario Cast
- D. Patient/Client Profile
- E. Baseline patient/client simulator state
- F. Environment / equipment / essential props
- G. Case flow /triggers / scenario development

SECTION IV APPENDICES

- A. Health Care Provider Orders
- B. Digital Images of Manikin / Milieu
- C. Debriefing Guide

SECTION I: SCENARIO OVERVIEW

Scenario Title:	General Safety for confused elderly patient	
Original Scenario Developer(s):	C. O'Leary-Kelley, RN, PhD, CNE	
Date - original scenario	10/05/09	
Validation:	L. Sweeney, RN, MS	
Revision Dates:	07/12	
Pilot testing:	11/09 BASC Critical Thinking Study	
QSEN revision:	10/12 C. O'Leary-Kelley, RN, PhD, CNE	
Estimated Scenario Time: 15-20 minutes Debriefing time: 30-40 minutes		
Target group: Nursing fundamentals students		
Core case: Environment of safety; basic neurological assessment		
QSEN Competencies:		
<input type="checkbox"/> Patient Safety <input type="checkbox"/> Teamwork and Collaboration <input type="checkbox"/> Patient Centered Care		
Brief Summary of Case: The elderly patient was admitted to the medical-surgical / telemetry unit for observation following a syncopal episode earlier this morning. He has a history of hypertension and cardiac disease. He was admitted to rule out heart attack, CVA, or to determine if his blood pressure medications need to be adjusted.		
Learners need to provide for patient safety in the environment and determine if he is stable neurologically.		

EVIDENCE BASE / REFERENCES (APA Format)

- Beland, D. K. & Avanecean, D. M. (2013). Nursing Assessment: Neurologic Function. In L. H. Pellico (Ed.), Focus on adult health: Medical - surgical nursing. (pp. 1150-1174). Philadelphia: Lippincott Williams & Wilkins.
- Cronenwett, L., Sherwood, G., Barnsteiner, J. et al. (2007). Quality and safety education for nurses. Nursing Outlook, 55(3), 122-131. doi:10.1016/j.outlook.2007.02.006
- 2012 National Patient Safety Goals (Hospital) retrieved from:
http://www.jointcommission.org/assets/1/6/2012_NPSG_HAP.pdf

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Provide nursing care that promotes safety and minimizes risk of error.
2. Apply clinical decision making skills in interpreting and analyzing data in evolving situations.
3. Prioritize interventions to provide care that is safe and patient-centered.

Specific Learning Objectives

1. Demonstrate accurate assessment of the client with a focus on the neurological system.
2. Identify and interpret significant assessment findings requiring immediate reporting and/or intervention.
3. Accurately prioritize immediate interventions required to maintain a safe environment.
4. Effectively communicate with client/family to keep them informed and relieve anxiety.
5. Apply safety and infection control measure appropriate to situation.

Critical Learner Actions

1. Wash hands / introduce self / identify patient w/ 2 patient identifiers.
2. Place bed in low position / put side rail up / place call bell within reach.
3. Perform a general survey and focused neuro assessment.
4. Document vital signs on flowsheet.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies

Required prior to participating in the scenario

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Normal and abnormal assessment findings in older adults	<input type="checkbox"/> Focused neurological assessment
<input type="checkbox"/> Geriatric syndromes	<input type="checkbox"/> Ability to perform general survey
<input type="checkbox"/> Current National Patient Safety Goals	<input type="checkbox"/> Significance of abnormal assessment findings
<input type="checkbox"/>	<input type="checkbox"/> Therapeutic communication in acute situations
<input type="checkbox"/>	<input type="checkbox"/> Safety precautions for hospitalized patient
<input type="checkbox"/>	<input type="checkbox"/>

SECTION III: SCENARIO SCRIPT

A. Case summary

Mr. Jasper is a 78-year old man admitted to the medical-surgical / telemetry unit this afternoon for observation after a syncopal episode ('passed out') in the grocery store earlier this morning. Mr. Jasper has a history of hypertension and cardiac disease. He had a heart attack 10 years ago but gets along well with medication. He is a retired lumber worker and has some arthritis in his hips and knees.

Health care providers are uncertain if he suffered another heart attack, small stroke, or if his blood pressure medications may have caused his syncope. He is admitted for CT scan and observation.

He is a widower and was brought to the hospital by paramedics. He manages his care at home without difficulty. His adult daughter lives nearby and visits him weekly. He is alert and oriented, cooperative. Admitting vital signs are stable.

B. Key contextual details

The patient was admitted to the medical-surgical telemetry unit at the end of dayshift. After receiving report, the learners enter the room to find the patient flat in bed which is elevated in high position, only one side rail is up and the call light is not within reach. The patient states he was trying to adjust the bed controls. Learners need to determine if he is experiencing neurological deficits or just needs instruction on how to operate the bed controls.

C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Confederate (C) or Learner (L)
RN		Learner
RN		Learner
Charge RN		Learner or Confederate

D. Patient/Client Profile

Last name:	Jasper	First name:	Henry
Gender: M	Age: 78	Ht: 6'0"	Wt: 75 Kg
Spiritual Practice: Protestant	Ethnicity: Caucasian		Primary Language spoken: English
1. History of present illness			
78 –year old male sustained a syncopal episode earlier today. He has a history of hypertension and cardiac disease. He had an AWMI 10 years ago and has been managed medically without recurrence of chest pain.			
Primary Medical Diagnosis	s/p syncopal episode R/O cardiovascular event		

2. Review of Systems	
CNS	A&O x 4; denies pain; speech clear
Cardiovascular	RRR; NSR 80s no ectopics; skin warm, dry no edema
Pulmonary	Lungs CTA; no dyspnea
Renal/Hepatic	No abnormalities
Gastrointestinal	Abdomen soft, non-tender; BS x 4 quadrants
Endocrine	No abnormalities
Heme/Coag	No bleeding abnormalities
Musculoskeletal	MAE; osteoarthritis to hip joints bilaterally; ambulatory
Integument	Skin clear, no lesions
Developmental Hx	Normal elderly male
Psychiatric Hx	None
Social Hx	Non-smoker; no ETOH
Alternative/ Complementary Medicine Hx	none

Medication allergies:	NKDA	Reaction:	
Food/other allergies:		Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Metoprolol	75 mg	po	daily
Tylenol	650 mg	po	Prn joint pain	
ASA	81 mg	po	daily	

4. Laboratory, Diagnostic Study Results					
Na: 137	K: 4.2	Cl: 101	HCO ₃ : 24	BUN: 12	Cr: 0.4
Ca:	Mg:	Phos:	Glucose: 90	HgA1C:	
Hgb: 14.5	Hct: 40.0	Plt: 331	WBC: 7.6	ABO Blood Type: O+	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO ₂ :	paCO ₂ :	HCO ₃ /BE:	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR: clear; no infiltrates		ECG: NSR 80			
CT: negative		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: male		Attire: patient gown			
Alterations in appearance (moulage): Glasses; may have a bandage to elbow					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:					
	No monitor display	X	Monitor on, but no data displayed		Monitor on, standard display

BP: 130/84	HR: 80	RR: 16	T: 37.0 C	SpO ₂ : 97%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETCO ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: clear		Right: clear	
Heart:	Sounds:			
	ECG rhythm:	NSR 80 no ectopy		
	Other:			
Bowel sounds:	hypoactive		Other:	

3. Initial Intravenous line set up						
X	Saline lock #1	Site:	RA			IV patent (Y/N)
	IV #1	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main					
	Piggyback					
	IV #2	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main					
	Piggyback					
4. Initial Non-invasive monitors set up						
x	NIBP	x	ECG First lead: II		ECG Second lead:	
x	Pulse oximeter		Temp monitor/type		Other:	
5. Initial Hemodynamic monitors set up						
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:	
6. Other monitors/devices						
	Foley catheter	Amount:		Appearance of urine:		
	Epidural catheter		Infusion pump:	Pump settings:		
	Fetal Heart rate monitor/tocometer			Internal	External	
Environment, Equipment, Essential props						
Recommend standardized set ups for each commonly simulated environment						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Medical-surgical /telemetry patient room						

2. Equipment, supplies, monitors						
(In simulation action room or available in adjacent core storage rooms)						
x	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit	Incentive spirometer
	IV Infusion pump		Feeding pump		Pressure bag	Wall suction
	Nasogastric tube		ETT suction catheters		Oral suction catheters	Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	Dressing Δ equipment
	IV fluid Type:				Tubes/drains Type:	Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent		Simple Face Mask		Non rebreather mask
	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders		Med Admin Record	x	H & P		Lab Results
x	Progress Notes	x	Graphic record		Anesthesia/PACU record	x	ED Record
	Medication reconciliation	x	Transfer orders		Standing (protocol) orders		ICU flow sheet
x	Nurses' Notes		Dx test reports		Code Record		Prenatal record
x	Actual medical record binder, constructed per institutional guidelines				Other Describe:		

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
<p>Initiation of Scenario: Learners receive report from the dayshift nurse. Mr. Jasper was admitted to the medical-surgical telemetry unit from the ED after a syncopal episode earlier this morning. He has been stable and admission orders have been written. He had a head CT earlier and is scheduled for a repeat CT scan later today. The RNs are to assess the patient and document his vital signs.</p>			
STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline Pt is lying flat in bed. The bed is in high position and only 1 side rail is up. Call light is not within reach.</p> <p>Pt is alert and responds when questioned.</p>	<p>Operator B/P: 130/84 HR: 80 SR RR: 16 Temp: 37.0 SpO2 = 97% (when checked by the learner) Trigger: Completes general survey and focused neuro assessment in 3-5 mins</p>	<p>Learner Actions Wash hands / introduce self/ identify pt w/ 2 identifiers</p> <p>Notice safety issues - Raise HOB; lower bed position; raise side rail</p> <p>Perform general survey/focused neuro assessment</p>	<p>Debriefing Points:</p> <ul style="list-style-type: none"> National Patient Safety Goals – infection control Recognition of safety hazards in patient environment Assessment of neuro status in a patient after fall Differentiate confusion versus lacks information/ability to manage bed controls.
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>Pt. remains stable / alert and oriented; answers questions appropriately</p> <p>“The doctor said I needed to have tests done.” “When will I have the tests?”</p>	<p>Operator: VS unchanged</p> <p>Triggers: Provide for safe environment and inform patient when RN will return</p>	<p>Learner Actions: Document VS on flowsheet at bedside</p> <p>Respond to patient questions</p> <p>Place call bell within reach</p>	<p>Debriefing Points: Provide means for patient to call for assistance</p> <p>Effective patient communication; explanation of planned procedures</p>
<p>Scenario End Point: Patient is made comfortable. Learners are called to another room by Charge RN after completing tasks.</p>			
<p>Suggestions to <u>decrease</u> complexity: Concerned family member role can be added</p> <p>Suggestions to <u>increase</u> complexity:</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Jasper, Henry		Diagnosis: Syncopal episode
DOB: XX/xx/XX		
Age: 78		
MR#: 55641		
†No Known Allergies		
†Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to Medical-Surgical Telemetry
		Vital Signs Q 4 with neuro checks
		Bedrest x 8 hours
		Saline lock flush per protocol
		O2 2 – 4 L nasal cannula to maintain O2 sat \geq 94%
		Cardiac diet
		Repeat CT w/contrast
		CBC, Chem 7, PT, aPTT, INR, UA in AM
Signature	<i>J. Jeffries MD</i>	

APPENDIX B: Digital images of manikin and/or scenario milieu

<p>Insert digital photo here</p>	<p>Insert digital photo here</p>
<p>Insert digital photo here</p>	<p>Insert digital photo here</p>

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input type="checkbox"/> Objectives	<input type="checkbox"/> Debriefing Points	<input type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork/Collaboration	<input type="checkbox"/> Evidence-based Practice	
<input type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 5. How would you handle the scenario differently if you could? 6. In what ways did you check feel the need to check ACCURACY of the data you were given? 7. In what ways did you perform well? 8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 11. Discuss actual experiences with diverse patient populations. 12. Discuss roles and responsibilities during a crisis. 13. Discuss how current nursing practice continues to evolve in light of new evidence. 14. Consider potential safety risks and how to avoid them. 15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			