CINHC Optimizing Health through Nursing Excellence
CALIFORNIA INSTITUTE FOR NURSING & HEALTH CARE

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 (CVSC, 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.californiasimulationalliance.org

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 at kt@cinhc.org)

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SECTION I: Scenario Overview	
Scenario Title:	**Hospice: Terminal Agitation**
Original Scenario Developer(s):	Andrea Eccard, RN; Leilani Santos, RN; Nancy Hoeck, RN; Nancy Yousef, RN; Lori Daniels, RN; Janine Sobala, RN; Carrie Edsinger, RN; Rick Becker, RN
Date---original scenario	11/4/2013
Validation:	Marjorie Miller, MA, RN, CHSE; Lillian Jones-Bell, MSN, RN, PHN; Cathryn Halford, DNP, RN, CNL, CNS
Revision Dates:	11/17/2014
Pilot testing:	November 18, 2013; November 17, 2014
QSEN revision:	Included in original scenario

Estimated Scenario Time: 15---20 minutes
Debriefing time: 30 minutes
Target group: New Graduate RN---Ambulatory Care Specialty

Core case: Assessment and Symptom management
QSEN Competencies: Patient---centered care, Safety, Teamwork and Collaboration, Evidence---based Practice, Quality Improvement, Informatics

Brief Summary of Case:

Hospice receives an after hours call from caregiver stating patient is extremely agitated. Two hospice nurses go to the home. They gather information, assess the patient, rule out possible causes and plan interventions to manage the symptoms.

EVIDENCE BASE / REFERENCES (APA Format)

Center for Disease Control (2013). Handwashing: clean hands save lives. Accessed November 1, 2014 at http://www.cdc.gov/handwashing/

Kehl, K. A. (2004). Treatment of terminal restlessness: a review of the evidence. *J Pain Palliat Care Pharmacother, 18*(1), 5---30.

Lindqvist, O., Lundquist, G., Dickman, A., Bukki, J., Lunder, U., Hagelin, C. L., . . . Furst, C. J. (2013). Four essential drugs needed for quality care of the dying: a Delphi---study based international expert consensus opinion. *J Palliat Med, 16*(1), 38---43. doi: 10.1089/jpm.2012.0205

McGlodrick, M. (2014). Bag technique: preventing and controlling infections in home care and hospice. *Home Healthcare Nurse, 32*(1), 39-45. Accessed on November 1, 2014 at http://www.nursingcenter.com/lnc/CEArticle?an=00004045.-201401000.-00006&Journal_ID=54023&Issue_ID=1645653

Travis, S. S., Conway, J., Daly, M., & Larsen, P. (2001). Terminal restlessness in the nursing facility: assessment, palliation, and symptom management. *Geriatr Nurs, 22*(6), 308---312. doi: 10.1067/mgn.2001.120996

White, C., McCann, M. A., & Jackson, N. (2007). First do no harm... Terminal restlessness or drug---induced delirium. *J Palliat Med, 10*(2), 345---351. doi: 10.1089/jpm.2006.0112

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Provide patient care that provides comfort, reduced anxiety and safety.
2. Apply nursing process in clinical decision making.
3. Integrate understanding of multiple dimensions of patient centered care.

Specific Learning Objectives

1. Correctly identify patient.
2. Correctly performs hand hygiene, nursing bag technique, and universal precautions.
3. Assess and gather relevant patient, environmental and contextual data
4. Recognize acute changes in patient condition that require immediate attention.
5. Identify patient's primary problem(s).
6. Perform nursing interventions to address patient's primary problem.
7. Evaluate effectiveness of nursing interventions.
8. Provide education to caregiver and family.
9. Communicate patient status to healthcare team.

Critical Learner Actions

1. Perform hand hygiene, correct nursing bag technique, introduce self and role, identify patient using two patient identifiers.
2. Perform general survey and thorough assessment, including mental, emotional, spiritual state of patient.
3. Rule out possible contributing factors to current situation. (bladder & bowel status, hypoxia, unrelieved pain)
4. Institute non---pharmacological interventions along with medications.
5. Evaluate patient's response to administration of new medication, Haldol.
6. Contact MD by phone regarding change in patient status.
7. Provide patient information and education to patient/family in a clear manner.
8. Report pertinent data to healthcare team using SBAR.
9. Follow up telephone call to caregiver regarding patient status a couple hours later.

B. PRE---SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge	Skills/ Attitudes
Symptom management for Terminal Agitation specific to Palliative Care.	General survey and assessment
Structured communication tools (i.e SBAR)	Nursing interventions for Terminal Agitation
Dimensions of patient centered care	Communication using SBAR
Infection control practices including proper nursing bag technique, hand hygiene, and universal precautions in the home environment	Engage and educate patient/caregiver/family in symptom management

ALL DATA IN THIS SCENARIO IS FICTICIOUS

SECTION III: SCENARIO SCRIPT

A. Case summary
June Smith is an 85 year old woman that was admitted to hospice care on 5/22/2013. She was diagnosed with breast cancer w/mets to bone 2/15/2013. Symptoms have been controlled well with long---acting morphine along with oral morphine for break---through pain, and a bowel regimen. Learners are expected to perform the following specific learner actions: assess status and vital signs, recognize acute changes of discomfort, plan interventions to manage symptoms and report to interdisciplinary team. Learners will demonstrate incorporation of QSEN competencies throughout the scenario by including the patient/caregiver in the plan of care, evaluating patient response to nursing interventions, educating caregiver and collaborating with healthcare team.

B. Key contextual details
Home Visit in response to phone call from primary caregiver regarding extremely agitated patient. She is yelling at her daughter, trying to fight her way out of bed to go home. Learners should assess patient and situation, identify the primary problem and manage the symptoms.

C. Scenario Cast		
Patient/ Client	High fidelity simulator	
	Mid---level simulator	
	Task trainer	
	Hybrid (Blended simulator)	
	XX Standardized patient	
Role	Brief Descriptor (Optional)	Actor/Confederate (A/C) or Learner (L)
Patient		A/C
RN 1		Learner
RN 2		Learner
Daughter/CG		A/C
Narrator		A/C

D. Patient/Client Profile					
Last name:	Smith		First name: June		
Gender: F	Age: 85	Ht: 5’4”	Wt: 93 lbs	Code Status: DNR	
Spiritual Practice: none		Ethnicity white		Primary Language English	

1. History of present illness

Dx 2/2013 with breast cancer with mets to the bone. Entered hospice care 5/2013. Lives at home with daughter caregiver.

Primary Medical Dx---	Breast cancer, stage 4, bone mets

Review of Systems	
CNS	Hx of cognitive impairment/dementia
Cardiovascular	Tachycardic@ 135
Pulmonary	Lungs clear & diminished
Renal/Hepatic	Not available
Gastrointestinal	Abdomen soft, non--- distended. BS x4
Endocrine	Not available
Heme/Coag	No bruising or apparent problems
Musculoskeletal	Generalized weakness
Integument	Skin fragile, dry, intact
Developmental	Normal 85 yo female
Psychiatric Hx	Dementia
Social Hx	Denies ETOH, tobacco use
Alternative/ Complementary Medicine Hx	None

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

3. Current medications

Drug	Dose	Route	Frequency	
docusate sodium	50---100 mg	PO	PRN	QD
bisacodyl suppository	10 mg	rectal	PRN	QD
morphine ER	30 mg	PO		BID
OMS concentrate	5---20mg	PO	PRN	Q4hours
Senna---S	17mg	PO		BID

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)	
1. Initial physical appearance	
Gender: female	Attire: Nightgown

Alterations in appearance (moulage): Rapid & shallow breathing, heart rate up, very anxious and restless (a frown between the eyebrows, trying to get out of bed, picking at bedsheets, constantly changing positions, moaning, groaning, and moving head back and forth).

	ID band present, accurate information		ID band present, inaccurate information	X	ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information	X	Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:

XX	No monitor display		Monitor on, but no data displayed		Monitor on, standard display		

BP: 110/78	HR: 135	RR: 28	T: 98.6	SpO^2: 94 RA
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	$ETC0^2$:	FHR:		
Lungs: Sounds/mechanics	Left: clear, diminished		Right: clear, diminished	
Heart:	Sounds:	Regular/tachy		
	ECG rhythm:	N/A		
	Other:			
Bowel sounds:	X4		Other:	

ALL DATA IN THIS SCENARIO IS FICTICIOUS

3. Initial Intravenous line set up --- N/A							
	Saline lock #1	Site:					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 – N/A					
	NIBP		ECG First lead:		ECG Second lead:
	Pulse oximeter		Temp monitor/type		Other:

5. Initial Hemodynamic monitors set up – N/A					
	A---line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:

6. Other monitors/devices N/A					
	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)

Patient room at home: hospital bed, side table, phone

2. Equipment, supplies, monitors

(In simulation action room or available in adjacent core storage rooms)

	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:		IV fluid additives:				Blood product ABO Type: # of units:

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

4. Documentation and Order Forms							
	Health Care Provider orders		Med Admin Record		H & P		Lab Results
	Progress Notes		Graphic record		Anesthesia/PACU record		ED Record
	Medication reconciliation		Transfer orders	X	Standing (protocol) orders		ICU flow sheet
XX	Nurses' Notes		Dx test reports		Code Record		Prenatal record
	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
	Lorazepam	0.5mg	PO			Haloperidol	0.5---1.0mL	PO

CSA REV template (12/15/08; 5/09; 12/09; 4/11)

ALL DATA IN THIS SCENARIO IS FICTICIOUS

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: Caregiver (daughter) calls hospice to report that patient is agitated (restless, crying out, trying to get out of bed). Hospice sends two nurses to patient's home.			
State/Patient Status	**Desired Learner Actions & Triggers to Move to Next State**		
Baseline: Patient restless, picking at clothing, wants to get out of bed	**Operator:** T: 98.6 HR: 135 RR: 28 BP: 110/78 02: 94% RA **Triggers:** ID primary problem, complete assessment	**Learner Actions:** . Hand hygiene . Introduction . Recognize acute changes . General assessment . Identify primary problem	**Debriefing points:** What were the acute changes noted? What was the primary problem, and what part of the assessment lead you to this conclusion? What was done well, and what would the team do differently next time?
State/Patient Status	**Desired Actions & Triggers to Move To Next State**		
Next State: Patient restless, picking at clothes, trying to get up "to go home"	**Operator:** Vital signs: HR/RR may be increased d/t agitation **Trigger:** Administer Haldol	**Learner Actions:** Checks standing orders Institutes non---pharmacological interventions (soft music, low lights) Determines which comfort med to administer	**Debriefing Points:** How did you determine which comfort medication to administer (or which medication should have been given)? What other non---pharmacological interventions could have been used? What was done well, and what would the team do differently next time?

<table>
<tr><td>State/Patient status</td><td colspan="3">Desired Actions & Triggers to Move to Next State</td></tr>
<tr><td>Next State:

Patient resting quietly</td><td>Operator:

HR: 80
RR: 16
Patient calming, regular respirations</td><td>Learner Actions:

Assess patient reaction to Haldol

Caregiver/family education</td><td>Debriefing Points:

What are the adverse reactions to Haldol?

What would you have done if the Haldol had no effect?

What was done well, and what would the team do differently next time?</td></tr>
<tr><td colspan="4">Triggers: Haldol given, teaching w/teach back complete</td></tr>
<tr><td colspan="4">Scenario End Point: Patient is resting comfortably. Caregiver reassured, understands change in patient status and is able to administer meds appropriately.</td></tr>
<tr><td colspan="4">Suggestions to <u>decrease</u> complexity:

Suggestions to <u>increase</u> complexity: Patient has bad reaction to medication. Patient sustains fall while agitated.</td></tr>
</table>

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: **Smith, June** **DOB:** **8/17/28** **Age: 85** **MR#:** **99582**	**Diagnosis: Stage 4 Breast Cancer, bone mets**
No Known Allergies Allergies & Sensitivities	

Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
5/22/201	1000	Docusate Sodium 50-100 mg QD PO PRN
5/22/201	1000	Bisacodyl suppository 10 mg QD rectal PRN
5/22/201	1000	Morphine ER 30 mg PO BID
5/22/201	1000	OMS Concentrate 5-20 mg PO Q4H PRN
5/22/201	1000	Senna-S 17 mg PO BID
8/5/2013	1100	Lorazepam 0.5mg: 1-2 tabs (0.5-1mg) PO/SL Q4h PRN anxiety
8/5/2013	1100	Haloperidol 2mg/mL: 0.5-11.0mL (1-2mg) PO Q6h PRN agitation or confusion
Signature		Dr. Van Fogle MD

Nurses Notes:

11/2/13: Routine check visit. Patient is arousable to speech but otherwise unresponsive. HR 130, T 98.3, R 30. Patient appears to be resting comfortably. Caregiver present. Discussed likelihood of impending death. Reviewed comfort plan of care. Caregiver grieving but accepting.

10/31/13: Routine check visit. Patient is awake, lethargic, able to respond to questions. Denies pain and/or discomfort at this time. Per caregiver, patient is accepting sips of liquids, but refuses any other food. HR 86, T 98.7, R 18. Last BM yesterday. Caregiver is continuing OMS and bowel care regimen.

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

Insert digital photo here	**Insert digital photo here**
Insert digital photo here	**Insert digital photo here**

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
■ Individual	■ Group	■ With Video	■ Without Video
Debriefing Materials			
■ Debriefing Guide	■ Objectives	■ Debriefing Points	■ QSEN

QSEN Competencies to consider for debriefing scenarios		
■ Patient Centered Care	■ Teamwork/Collaboration	■ Evidence---based Practice
■ Safety	■ Quality Improvement	■ Informatics

Questions for Debriefing

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: