

## SECTION I: SCENARIO OVERVIEW

<b>Scenario Title:</b>	Acute Brain Attack	
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Date - original scenario	03/07	
Validation:	05/07	
Pilot testing:	05/07	
Revisions:	07/10 Marjorie Miller, MA,RN ( <a href="mailto:mmiller@Nurse-EdConsulting.com">mmiller@Nurse-EdConsulting.com</a> ) 12/14 Melissa Punnoose, MSN, RN-BA, CHSE ( <a href="mailto:Melissa.Punnoose@providence.org">Melissa.Punnoose@providence.org</a> ) Heidi Traxler, MSN, RN, CHSE ( <a href="mailto:Heidi.Traxler@providence.org">Heidi.Traxler@providence.org</a> ) Marjorie Miller, MA, RN, CHSE ( <a href="mailto:mmiller@nurse-edconsulting.com">mmiller@nurse-edconsulting.com</a> ) 4/2018 Heidi Traxler, MSN, RN, CHSE/mm	
<b>Estimated Scenario Time:</b> 20 minutes <b>Debriefing time:</b> 40 minutes		
<b>Target group:</b> Senior nursing students, new graduates, transition program participants		
<b>Core case:</b> Adult med surg CVA		
<b>Brief Summary of Case:</b> Mrs. E. Kaur, is a 75-year old East Indian woman admitted for uncontrolled atrial fibrillation 4 days ago. She is to be discharged today. Upon answering the call light, the daughter states her mother has difficulty with speech and cannot move her right side at all. Mrs. Kaur’s history is significant for hypertension and atrial fibrillation. Current medications include digoxin, aspirin and Cardizem. Learners are expected to assess the change in status, perform immediate interventions for safety, initiate the Code Stroke and communicate effectively with family and members and interprofessional team members.		
<b>QSEN Competencies</b>		
<input checked="" type="checkbox"/> Patient Centered Care <input checked="" type="checkbox"/> Patient Safety <input type="checkbox"/> Quality Improvement <input checked="" type="checkbox"/> Teamwork and Collaboration		

EVIDENCE BASE / REFERENCES (APA Format)
Dilansky M.A., Moore, S.M., (September 30, 2013) Quality and safety education for Nurses (QSEN) The Key is Systems Thinking. Online Journal of Issues in Nursing, 2013; Vol 18, No. 3, Manuscript 1.
NIH Stroke Scale (2003). Retrieved from <a href="http://www.ninds.nih.gov/doctors/nih_stroke_scale.pdf">http://www.ninds.nih.gov/doctors/nih_stroke_scale.pdf</a> on 4/13/2018.
Powers, W.J. et al, (2018) AHA/ASA Guideline: 2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2018; 49(4), pp. e1-e64.
Zomorodi, M. (2017). Stroke. In Lewis, S., Bucher, L., McLean, M., and Harding, M.(Eds.), Medical-surgical nursing: Assessment and management of clinical problems (10 <sup>th</sup> ed. pp.270-299). St. Louis, Missouri: Elsevier.

## SECTION II: CURRICULUM INTEGRATION

### A. SCENARIO LEARNING OBJECTIVES

#### Learning Outcomes

1. Provide evidence based nursing care for the patient having an acute brain attack.
2. Apply clinical decision making skills in interpreting and analyzing data in an evolving situation.
3. Prioritize interventions based on accurate interpretation of assessment data.
4. Communicate effectively with members of the interprofessional team using SBAR and closed loop communication.

#### Specific Learning Objectives

1. Recognize clinical manifestations of an acute brain attack.
2. Discuss evidence based care for acute brain attack
3. Recognize change in condition and call for help early
4. Perform NIHSS for the patient with suspected acute brain attack
5. Identify risk factors for acute brain attack
6. Utilizes agency communication protocol in delivering change of status report to interprofessional team
7. Communicates effectively to patient and family to keep informed of actions and status.
8. Responds to family members immediate report and begins focused assessment, prioritizing neurovascular assessment.

#### Critical Learner Actions

1. Introduces self and role on entering room
2. Performs hand hygiene, identifies patient.
3. Prioritizes neurovascular assessment (airway) and positions for safety.
4. Assesses vital signs: BP, HR, O2 saturation, respiratory status, Glasgow Coma Scale.
5. Initiates Code Stroke Protocol; collects critical assessment data for Code Team
6. Keeps patient and family informed of team actions and status.
7. Correctly identifies patient and introduces self and team to patient and family.
8. Applies principles of hand hygiene, infection control and personal protection
9. Responds to family member's immediate report and begins focused assessment, prioritizing neurovascular assessment.
10. Performs NIHSS according to NIH guidelines.

### B. PRE-SCENARIO LEARNER ACTIVITIES

#### Prerequisite Competencies

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Neurovascular assessment, NIHSS	<input type="checkbox"/> Keep patient/family well informed throughout care
<input type="checkbox"/> S/S of CVA and treatment priorities	<input type="checkbox"/> Maintain patient safety, call for help early
<input type="checkbox"/> EBP for treatment of stroke	<input type="checkbox"/> Perform NIHSS
<input type="checkbox"/> Awareness of "Code Stroke Protocol" and what it might include	<input type="checkbox"/> Insert second IV, maintain NPO
<input type="checkbox"/>	<input type="checkbox"/> Communicate with team members using SBAR and closed loop communication

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

Mrs. Kaur, a 75-year old East Indian woman lives with her large family. She was admitted for uncontrolled atrial fibrillation 4 days ago. Her Cardizem drip was DC'd yesterday. Her HR is stable and she will be going home today. Upon answering the call light, the daughter states her mother has difficulty with speech and cannot mover her right side at all.

Mrs. Kaur's history is significant for hypertension and atrial fibrillation. She takes digoxin, aspirin and Cardizem

#### B. Key contextual details

Shift change at 7am telemetry unit. Daughter is very concerned about mother's sudden change in condition.

#### C. Scenario Cast

Patient/ Client	<input checked="" type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input checked="" type="checkbox"/> Standardized patient      SP a great option for this scenario.	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Primary RN		L
Secondary RN		L
Daughter	Very concerned at the bedside	SP
Charge RN		Faculty
Code Stroke RN		Faculty

D. Patient/Client Profile				
Last name:	Kaur		First name:	Smita
Gender:	Age: 75	Ht: 5'3"	Wt: 110	Code Status: full
Spiritual Practice: Muslim	Ethnicity: East Indian		Primary Language spoken: English	
1. Past history				
History of hypertension and a fib, which was previously well controlled. Admitted from doctor's office after routine follow-up visit.				
<b>Primary Medical Diagnosis</b>	Uncontrolled Atrial Fibrillation			

2. Review of Systems	
CNS	PERLLA, alert and responsive to person, place, time and situation
Cardiovascular	Atrial fibrillation, S1/S2,
Pulmonary	WNL
Renal/Hepatic	WNL
Gastrointestinal	WNL
Endocrine	WNL
Heme/Coag	Superficial bruising
Musculoskeletal	WNL
Integument	Skin CDI with superficial bruising
Developmental Hx	Adult, senior
Psychiatric Hx	None stated
Social Hx	Widow, lives in apartment behind daughter's residence
Alternative/ Complementary Medicine Hx	

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

3. Current medications	Drug	Dose	Route	Frequency
	Digoxin	0.25mg	PO	Daily
	Cardizem	120mg	PO	BID
	ASA	81mg	PO	daily

4. Laboratory, Diagnostic Study Results					
Na: 145	K: 3.5	Cl: 104	HCO3: 30	BUN: 23	Cr: 0.8
Ca:	Mg:	Phos:	Glucose: 80	HgA1C:	
Hgb: 14.5	Hct: 49	Plt: 450	WBC: 6,000	ABO Blood Type:	
PT 15 sec	PTT	INR 2.6	Troponin:	BNP:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR:	ECG:				

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)			
1. Initial physical appearance			
Gender: female		Attire: patient gown	
<u>Alterations in appearance (moulage):</u> black/gray wig in bun, small bruises on arms			
x	ID band present, accurate	ID band present, inaccurate	ID band absent or not applicable
	Allergy band present, accurate	Allergy band inaccurate	x Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:					
No monitor display		Monitor on, but no data displayed		Monitor on, data displayed <b>x</b>	
BP: 160/102	HR: 109 a fib	RR: 22	T: 98.6	SpO <sub>2</sub> : 92% RA	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO <sub>2</sub> :	FHR:			
Lungs: Sounds/mechanics	Left:	Right:	Clear Bilaterally		
Heart:	Sounds:	S1S2			
	ECG rhythm:	A fib			
	Other:				
Bowel sounds:	WNL			Other:	

3. Initial Intravenous line set up					
X	Saline lock #1	Site:	RA		IV patent (Yes)
	IV #1	Site:		Fluid type:	Initial rate:
	Main	RA			IV patent (Y/N)
	Piggyback	PIL			
	IV #2	Site:		Fluid type:	Initial rate:
	Main	RA			IV patent (Y/N)
	Piggyback				
4. Initial Non-invasive monitors set up					
x	NIBP		x	ECG First lead:	ECG Second lead:
x	Pulse oximeter		x	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:
<b>Environment, Equipment, Essential props</b>					
1. Scenario setting: (example: patient room, home, ED, lobby)					
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
x	IV Infusion pump		Feeding pump	Pressure bag	Wall suction
	Nasogastric tube		ETT suction catheters	Oral suction catheters	Chest tube kit
	Defibrillator		Code Cart	12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump	Central line Insertion Kit	Dressing Δ equipment
x	IV fluid Type:		IV fluid additives:	IV Piggy back	Blood product ABO Type: # of units:

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

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
x	Progress Notes	x	Graphic record		Anesthesia/PACU record		ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	Nurses' Notes	x	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**

**Initiation of Scenario :**

Change of shift report at 7am. Mrs. Smita Kaur is a 75-year old East Indian woman lives with her large family. She was admitted 4 days ago from her PMD’s office for uncontrolled atrial fibrillation. Her Cardizem drip was DC’d yesterday. Her heart rate has been stable between 90’s – 110’s. The plan today is for discharge home on PO antiarrhythmics. She has a history of hypertension. BP has been running 140s/80s. She has had her morning meds. She is afebrile and her vital signs have been stable at: BP- 145/90, HR- 101, irregular, RR-16, O2 sats- 96% on room air.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b></p> <p>Initially patient able to answer questions.</p> <p>After a few minutes: Patient trying to speak, but speech is garbled. Patient’s speech pattern is rapid and demonstrates anxiety.</p> <p>Family member says that patient cannot move her right arm and is very upset</p>	<p><b>Operator</b></p> <p>Once off-going RN leaves and RN starts to assess patient, speech becomes slurred etc.</p> <p>VS: 160/102, 104 irregular, 22, 93% room air</p> <p><b>Triggers:</b> 1-2 minutes into assessment patient has stroke symptoms</p>	<p><b>Learner Actions</b></p> <ol style="list-style-type: none"> <li>1. Introduces self and role to patient and family member</li> <li>2. Identifies patient using 2 patient identifiers</li> <li>3. note onset time of symptoms, perform FAST assessment</li> <li>4. Assesses airway and positions for safety/prevent injury.</li> <li>5. Recognize change in condition and calls charge RN</li> <li>6. Communicates with patient and family to keep them informed and help them stay calm</li> </ol>	<p><b>Debriefing Points</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> How to provide for during a stroke</li> <li><input type="checkbox"/> S/S of acute brain attack</li> <li><input type="checkbox"/> Evidence based care for acute brain attack</li> </ul>



STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2. Garbled speech. Cooperates with assessment. Tries to verbalize that she can't move right arm. Responds to daughters directions and RNs questions as best able.</p>	<p><b>Operator:</b> No change in VS except for: O<sub>2</sub> sat: 90% room air Pupils: PERRLA <b>NIHSS: 12</b> LOC: 0, 0, 0 Horiz eye movement: 0 Visual fields: 0 Face palsy: 1 Arm motor: 3 Leg motor: 3 Ataxia: 1 Sensory: 2 Language: 1 Speech: 1 Extinction; 0</p> <p><b>Triggers:</b> If O<sub>2</sub> applied sat goes up to 93%</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. Assesses vital signs/monitor</li> <li>2. Perform NIHSS</li> <li>3. Apply O<sub>2</sub> at 2L via NC</li> <li>4. Give SBAR to charge.</li> <li>5. Charge recommends call Code Stroke.</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Components of GCS/FAST/NIHSS;</li> <li><input type="checkbox"/> significance of assessment findings/score</li> <li><input type="checkbox"/> Relevance of ↓ O<sub>2</sub> sats in acute brain attack patient</li> <li><input type="checkbox"/> Significance of ↓ neuro status</li> <li><input type="checkbox"/> Essentials of taking telephone orders (RBV- if EMR is used, must verify in EMR before initiating orders.</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>3.</b> Daughter becomes concerned,” Why are you doing those things?”</p> <p>My mom is here for a heart problem? Why can’t she move her right side? Why can’t she talk?</p>	<p><b>Operator:</b> No change in patient status</p> <p><b>Triggers:</b> As RN increases O<sub>2</sub>, sat will rise to 96%</p> <p><b>MD Orders/Code Stroke Orders:</b> O<sub>2</sub> via NC to keep sat &gt;95% Non contrast head CT Stat, neuro evaluation, NIHSS, Check blood glucose, PT, INR Seizure precautions Start a second IV, NS@20ml/hr NPO, Swallow eval</p>	<p><b>Learner Actions:</b></p> <ol style="list-style-type: none"> <li>1. ↑ HOB to 30° if not done previously</li> <li>2. Administers supplemental O<sub>2</sub>@ 2L/NC if not done previously</li> <li>3. Communicates to Code Stroke team utilizing SBAR and receives orders</li> <li>4. Communicates plan of care calmly to patient and family member.</li> <li>5. Determines last recorded weight from chart.</li> <li>6. Delegates tasks to team members</li> <li>7. Call MD and notify of change in condition using SBAR</li> <li>8. Perform frequent neuro checks</li> </ol>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>❑ Rationale for interventions of O<sub>2</sub> and HOB elevation</li> <li>❑ SBAR communication</li> <li>❑ Data collection for responding team</li> <li>❑ Teamwork behaviors: communication, teamwork and collaboration strategies. (closed loop communication, call-outs, situation awareness)</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>4.</b> Patient and daughter still concerned. Daughter tearful, but not hysterical. Wants to know what is going to happen next and what is being done for her mother.</p>	<p><b>Operator:</b> Eyes: open spontaneously 4 Verbal response: 3 Motor response: 1 Pupils: PERRLA  HR: 122, irregular BP: 160/90 HR: 22 shallow Pulse: irregular O<sub>2</sub> sat: 94% 2L/nc Speech: garbled</p>	<p><b>Learner Action</b></p> <ol style="list-style-type: none"> <li>1. Communicates with daughter to keep her informed of plan of care and immediate interventions</li> <li>2. Scenario ends with pt leaving for CT</li> </ol>	<p><b>Debriefing Points</b></p> <ul style="list-style-type: none"> <li>❑ Communication skills for families and patients in rapidly evolving situations</li> <li>❑ Rationale for IV at 20 mL/hr</li> <li>❑ Anticipation of the next several hours of nursing care for Mrs. Kaur</li> </ul>
<p>Scenario End Point: Transport team arrives to transport patient to CT scanner. Primary nurse gives SBAR to transport team            Decrease complexity: No family member and charge RN assists with components of GCS/FAST/NIHSS assessment            Increase complexity: Obtain results of head CT and initiation of patient on thrombolysis and/or anticoagulants</p>			

**APPENDIX A: HEALTH CARE PROVIDER ORDERS**

<b>Patient Name: Smita Kaur</b>  <b>DOB:</b>  <b>Age: 75</b>  <b>MR#: 372924</b>		<b>Diagnosis: Uncontrolled Afib</b>
†No Known Allergies †Allergies & Sensitivities		
Date	Time	<b>HEALTH CARE PROVIDER ORDERS AND SIGNATURE</b>
yesterday		DC IV fluids
		DC Cardizem drip
		Digoxin 0.25mg PO Daily Cardizem 120mg PO BID ASA 81mg PO daily
		A fib education by nursing
		CBC, Chem 7 in am
		DC planning for discharge tomorrow
		<b><i>MD Orders during scenario</i></b> O <sub>2</sub> via NC to keep sat >95% Non contrast head CT Stat Check blood glucose, PT, INR Neuro evaluation Seizure precautions Start a second IV, NS@20ml/hr NPO, Swallow eval
<b>Signature</b>		

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

<p><b>Insert digital photo here</b></p>	<p><b>Insert digital photo here</b></p>
<p><b>Insert digital photo here</b></p>	<p><b>Insert digital photo here</b></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"> <li>1. How did the experience of caring for this patient feel for you and the team?</li> <li>2. Did you have the knowledge and skills to meet the learning objectives of the scenario?</li> <li>3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?</li> <li>4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?</li> <li>5. How would you handle the scenario differently if you could?</li> <li>6. In what ways did you check feel the need to check ACCURACY of the data you were given?</li> <li>7. In what ways did you perform well?</li> <li>8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?</li> <li>9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?</li> <li>10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?</li> <li>11. Discuss actual experiences with diverse patient populations.</li> <li>12. Discuss roles and responsibilities during a crisis.</li> <li>13. Discuss how current nursing practice continues to evolve in light of new evidence.</li> <li>14. Consider potential safety risks and how to avoid them.</li> <li>15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.</li> </ol>			
<b>Notes for future sessions:</b>			