SECTION I: SCENARIO OVERVIEW

Scenario Title:	General Safety for Elderly Patient with Syncopal Episode
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; 05/18 Jaime Hannans PhD, RN, CNE; Colleen Nevins DNP, RN, CNE
Pilot testing:	11/09 BASC Critical Thinking Study
QSEN revision:	10/12 C. O'Leary-Kelley, RN, PhD, CNE

Estimated Scenario Time: 15 minutes Debriefing time: 30 minutes

Target group: Pre-licensure Fundamental nursing students
Core case: Environment of safety; basic neurological assessment
QSEN Competencies:

- ❑ Patient Safety
- ❑ Teamwork and Collaboration
- ❑ 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 his neurological & cardiovascular status is stable.

This scenario is appropriate for beginning nursing fundamentals students. It can be made more complex with a concerned family member role at bedside; confusion and/or c/o of dizziness with greater orthostatic changes when HOB raised 90 degrees.

EVIDENCE BASE / REFERENCES (APA Format)

Craven, R., Hirnle, C., & Henshaw, C. M. (2017). *Fundamentals of Nursing: Human Health and Function* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Quality and Safety Education for Nurses (QSEN) Institute. (2018). QSEN Competencies. Retrieved May 13, 2018, from http://qsen.org/competencies/pre-licensure-ksas/#safety

The Joint Commission. (2018). Targeted Solutions Tool for Preventing Falls. Retrieved May 13, 2018, from https://www.centerfortransforminghealthcare.org/tst_pfi.aspx

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Mitchell, M. D., Lavenberg, J. G., Trotta, R. & Umscheid, C. A. (2014). Hourly rounding to improve nursing responsiveness: A systematic review. *Journal of Nursing Administration*, 44(9): 462-472. Doi: 10.1097/NNA.0000000000000101

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide nursing care that promotes safety, minimizing risk of injury.
2. Apply clinical decision making skills in interpreting and analyzing assessment data in evolving situations.
3. Prioritize interventions to provide safe, patient-centered care.
Specific Learning Objectives
1. Demonstrate accurate head-to-toe assessment of the client, with a focus on the neurological and cardiovascular system.
2. Identify and interpret significant assessment findings which require 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 measures appropriate to situation.
Critical Learner Actions
1. Wash hands, introduce self, and identify patient with two patient identifiers.
2. Demonstrate safety precautions including placing bed in low position, side rails up, and call bell within reach.
3. Perform a general survey and focused neurological and cardiovascular assessment.
4. Apply therapeutic communication with patient/family, and accurate communication with team members about assessment findings.
5. Perform orthostatic vital signs, lying and sitting only.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
❑ Normal and abnormal assessment findings in older adults	❑ Perform general survey
❑ Adult and geriatric nursing assessment practices	❑ Perform focused neurological and cardiovascular assessment
❑ National Patient Safety Goals	❑ Identify abnormal assessment findings
❑ QSEN Competencies: Patient Safety, Patient-Centered Care, and Teamwork and Collaboration	❑ Apply therapeutic communication in acute situations
❑ Hourly patient rounding	❑ Apply safety precautions for hospitalized patient, including fall risk precautions
	❑ Orthostatic vital signs

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 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 has been managed with medication. He is a retired lumber worker and reports arthritis in his hips and knees. He is admitted to evaluate if there are neurological and/or cardiovascular events leading to the syncopal episode. He is a widower and was brought to the hospital by paramedics. He manages his care at home independently. 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 from the floor, 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 but could not get the bed to work. Learners need to assess to determine if he is experiencing neurological deficits, or just needs instruction on how to operate the bed controls, and implement safety precautions including educating the patient.

C. Scenario Cast		
Patient/ Client	❑ **High fidelity simulator**	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Learner (L) or Standardized Participant (SP)
RN 1	Assigned to care for patient	Learner
RN 2	Assisting RN1 with patient care	Learner
Charge RN	Instructor	

D. Patient/Client Profile				
Last name:	Jasper		First name:	Henry
Gender: M	Age: 78	Ht: 6'0''	Wt: 75 Kg	Code Status: Full
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 acute MI 10 years ago and has been managed medically without recurrence of chest pain.

He is a widower and was brought to the hospital by paramedics. He manages his care at home independently. His adult daughter lives nearby and visits him weekly. He is alert and oriented, cooperative. Admitting vital signs are stable.

Primary Medical Diagnosis	s/p syncopal episode R/O Acute Coronary Syndrome, R/O Trans-Ischemic Attack

2. Review of Systems	
CNS	A&O x 4; denies pain; speech clear
Cardiovascular	Rate and Rhythm Regular; Normal Sinus Rhythm 80 bpm, no ectopy; skin warm, dry and no edema
Pulmonary	Lungs clear bilaterally; no dyspnea
Renal/Hepatic	No abnormalities
Gastrointestinal	Abdomen soft, non-tender; Bowel Sounds x 4 quadrants
Endocrine	No abnormalities
Heme/Coag	No bleeding abnormalities, bruising noted to left upper arm
Musculoskeletal	Moves All Extremities; 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 XL	75 mg	po	daily
	Tylenol	650 mg	po	Prn joint pain
	ASA	81 mg	po	daily

ALL DATA IN THIS SCENARIO IS FICTITIOUS

4. Laboratory, Diagnostic Study Results					
Na: 143	K: 4.2	Cl: 101	HCO3: 24	BUN: 18	Cr: 1.0
Ca:	Mg:	Phos:	Glucose: 90	HgA1C:	
Hgb: 13.5	Hct: 39.0	Plt: 331	WBC: 7.6	ABO Blood Type: O+	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR: clear; no infiltrates		ECG: NSR 70 - 80 bpm			
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, and bruising to left upper arm					
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: 126/84	HR: 80	RR: 16	T: 37.0 C	SpO2: 97%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left: clear		Right: clear	
Heart:	Sounds:			
	ECG rhythm:	NSR 80 bpm, no ectopy		
	Other:			
Bowel sounds:	Present		Other:	

ALL DATA IN THIS SCENARIO IS FICTITIOUS

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:

ALL DATA IN THIS SCENARIO IS FICTITIOUS

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
	Progress Notes	x	Graphic record		Anesthesia/PACU record	x	ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
x	Nurses' Notes		Dx test reports		Code Record		Prenatal record
x	Actual medical record binder or electronic record, 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: Learners receive report from the dayshift nurse. Mr. Jasper was just admitted to the medical-surgical telemetry unit from the ED after a witnessed syncopal episode earlier this morning. He has been stable on telemetry and admission orders have been written. He had a head CT earlier which was negative, and is scheduled for a MRI tomorrow morning. The RNs are to assess the patient's neurological and cardiovascular status, report any abnormal findings, and document.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient is lying flat in bed. The bed is in high position and only 1 side rail is up. Call light is not within reach. Patient is alert and responds appropriately when questioned.	**Operator** B/P: 130/84 HR: 80 SR RR: 16 Temp: 37.0 C Sp02 = 97% (when checked by the learner) **Trigger:** Completes general survey, provides safety measures, and obtains vital signs in 5 minutes	**Learner Actions** Wash hands / introduce self/ identify patient w/ 2 identifiers Notice safety issues; Raise HOB; lower bed position; raise side rail; reposition call light in reach; instruct patient on fall risk and bed controls Perform general survey and obtains vital signs	**Debriefing Points:** • NPSG – infection control specific to hand washing/standard prec. • Recognize safety hazards in pt. environment & take measures to avoid injury • Provide means for patient to call for assistance • Assessment of neuro status in a patient after fall • Differentiate confusion versus lacks information/ability to manage bed controls • Integrate QSEN competencies
STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
2. **Assessment** Pt. remains stable / alert and oriented; answers questions appropriately "The doctor said I needed to have tests done." "When will I have the tests?"	**Operator:** Alert & orient x 4, no neuro deficits, S1, S2 VS unchanged, unless orthostatic vital signs are taken (refer to state 3) **Triggers:** Completes focused neuro and cardiovascular assessment	**Learner Actions:** Performs a focused neurological and cardiovascular assessment Respond to patient questions; educates patient re plan of care, e.g., orders	**Debriefing Points:** • Assessment of neuro/cardio findings related to syncope • Effective patient communication; explanation of planned procedures

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
3. Orthostatic Assessment Pt. remains stable / alert and oriented; answers questions appropriately "Have you found anything unusual?"	**Operator:** Orthostatic VS: Lying: BP 126/82, HR 78 Sitting up in bed: BP 110/65, HR 95 **Triggers:** Provide for safe environment and inform patient when RN will return	**Learner Actions:** Complete orthostatic vital signs lying and "sitting" Document VS and assessment on flowsheet or electronic record at bedside Respond to patient questions; informs patient of orthostatic findings and educate a ways to avoid falls or syncope Places call light, bed controls, bedside table, water, and urinal within reach of patient Communicate the assessment findings to the team	**Debriefing Points:** • Discuss evaluation of orthostatic vital signs and significance to assessment, including possible reasons such as medications, hydration, neuro or cardiovascular • Effective patient communication; explanation of orthostatic changes and measures to avoid injury
Scenario End Point: 15 minutes Patient is made comfortable. Patient needs related to hourly rounds are addressed including hygiene, toileting, pain/comfort, bedside table and call light within reach. Learners are asked to give report to Charge RN after completing tasks.			
Suggestions to decrease complexity: Focus on assessment, vital signs, and fall risk; remove orthostatic vital signs Suggestions to increase complexity: Concerned family member role at bedside; confusion and/or c/o of dizziness with greater orthostatic changes when HOB raised 90 degrees.			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Jasper, Henry **DOB: XX/xx/XX** **Age: 78** **MR#: 55641**	**Diagnosis: Syncopal episode**

† No Known Allergies
† Allergies & Sensitivities

Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
		Admit to Medical-Surgical Telemetry, on telemetry
		Vital Signs every 4 hours with neuro checks and orthostatic vital signs
		Out of bed with assist only
		Saline lock, flush per protocol
		Titrate O2 2 – 6 L nasal cannula to maintain 02 sat ≥ 93%
		Cardiac diet
		MRI Head with contrast in am
		CBC, Basic Metabolic Panel, UA in AM
		Fall risk precautions
Signature		*J. Jeffries MD*

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

Sample 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. Was there any RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. The main objectives of the simulation was to recognize the neurological and cardiovascular assessment required for a patient after a syncopal episode, inclusive of safety precautions and appropriately intervene.
    a. With that in mind, can you identify aspects of your nursing care where you addressed the objectives?
    b. Are there any aspects of your care that you would handle differently if you could?
6. In what ways did you feel the need to check ACCURACY of the data you were given?
7. In what ways did prioritization affect your performance?
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 when addressing acute needs of patients or during a crisis, such as syncope or fall.
13. Discuss how each of the QSEN competencies for patient-centered care, safety, and teamwork & collaboration impacted your care of the patient.
14. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.

Notes for future sessions: