

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post-op Pain Mgt in 75 year old
Original Scenario Developer(s):	Carrie Dameron, MSN, RN (cdameron@ohlone.edu) Gale Carli, EdD, RN (gcarli@ohlone.edu)
Date - original scenario	03/07
Validation:	06/07
Pilot testing:	06/07
QSEN Revisions: Update revisions:	02/10 Marjorie Miller, MA, RN (mmiller@nurse-edconsulting.com) 12/14 Melissa Punnoose, MSN, RN-BC, CHSE (melissa.punnoose@providence.org) Heidi Traxler, MSN, RN, CHSE (Heidi.traxler@providence.org) Marjorie Miller, MA, RN, CHSE (mmiller@nurse-edconsulting.com) 4/18 Melissa Punnoose, MSN, RN-BC, CHSE, CHSOS
<u>Estimated Scenario Time:</u> 20 minutes <u>Debriefing time:</u> 40 minutes	
<u>Target group:</u> Semester 4 ADN or 3 rd /4 th year BSN students	
<u>Core case:</u> Pain Management in Post-operative geriatric patient	
<u>Brief Summary of Case:</u> 75 year old woman brought into the hospital two days ago with complaints of severe abdominal pain. Colonoscopy revealed a large tumor causing a partial intestinal obstruction. She is currently 24 hours post op following a colectomy for colon cancer. Patient has a history of smoking. Daughter is at the bedside and has called the nurse because her mother is in pain.	
<u>QSEN Competencies</u> <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)
Hoch, C.R. (2017). Postoperative care. In Lewis, S., Bucher, L., McLean, M., and Harding, M.(Eds.), Medical-surgical nursing: Assessment and management of clinical problems (10 th ed.)(pp.330-348). St. Louis, Missouri: Elsevier.
Dolansky, M.A., and Moore, S.M. (2013). Quality and safety education for nurses (QSEN): The key is systems thinking. <i>Online Journal of Issues in Nursing</i> , 18(3), Manuscript 1.
Polomano, R.C., and Fillman, M. (2017). Pain. In Lewis, S., Bucher, L., McLean, M., and Harding, M.(Eds.), Medical-surgical nursing: Assessment and management of clinical problems (10 th ed. pp.102-128). St. Louis, Missouri: Elsevier.

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Provide care to patients utilizing principles of safety
2. Apply clinical decision making based on analysis of assessment data
3. Communicate effectively with team members

Specific Learning Objectives

1. Demonstrate accurate assessment of the post-operative patient
2. Demonstrate comprehensive, accurate pain assessment
3. Select age-appropriate interventions to manage post-operative pain
4. Administer pain medications accurately and safely
5. Evaluate patient response to specific nursing interventions
6. Communicate effectively with patient and patient’s family
7. Communicate effectively with team members using SBAR and closed loop communication
8. Adapt evidence-based guidelines for the treatment of post-op pain.

Critical Learner Actions

1. Wash hands, introduce self, and identify patient using patient identifiers.
2. Perform post op assessment, including VS, wound, drains, IV’s, NG tube, Foley, etc.
3. Perform accurate pain assessment
4. Select and administer appropriate pain medication
5. Communicate with patient and family re. expected effects of medication
6. Reassess pain and vital signs after administering pain medication

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies

Knowledge	Skills/ Attitudes
<input type="checkbox"/> Post-op assessment	<input type="checkbox"/> Recognize clinical manifestations of unrelieved pain
<input type="checkbox"/> Pain assessment	<input type="checkbox"/> Recognize clinical manifestations of normal vs abnormal findings in post-operative patient
<input type="checkbox"/> Administration of IV Push medication	<input type="checkbox"/> Pharmacology of pain medications
<input type="checkbox"/> SBAR communication	<input type="checkbox"/> Expected and untoward reactions of pain medications
<input type="checkbox"/> Patient teaching of expected effects	<input type="checkbox"/> Interprofessional and interpersonal communication

SECTION III: SCENARIO SCRIPT

A. Case summary
<p>75 year old woman of Russian descent brought into the hospital by her daughter two days ago with complaints of severe abdominal pain. Colonoscopy revealed a large tumor causing a partial intestinal obstruction.</p> <p>She is currently 24 hours post op following a colon resection with anastomosis for colon cancer. Patient has a history of smoking. Daughter is at the bedside and has called the nurse because her mother is in pain.</p> <p>Learners are expected to perform an initial post-operative assessment, communicate with family and intervene to manage pain. Patient and family teaching related to expected effects of pain medications.</p>

B. Key contextual details
Beginning of shift.

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	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Primary RN		Learner
Secondary RN	If called in to help	Learner
Daughter	Anxious because mother is in pain	Standardized Participant (SP)

D. Patient/Client Profile				
Last name:	Mondoch		First name:	Ruda
Gender: Fe	Age: 74	Ht: 5'2"	Wt: 180#	Code Status: Full Code
Spiritual Practice: Russian	Ethnicity: Orthodox		Primary Language spoken:	
1. Past history				
One day post-op colectomy for colon cancer following 2 day episode of acute abdominal pain. Colonoscopy revealed colon cancer with partial intestinal obstruction. Patient has a current history of smoking.				
Primary Medical Diagnosis	Colorectal cancer			

2. Review of Systems	
CNS	complaining of pain
Cardiovascular	Normal S1-S2, no ectopy or murmurs
Pulmonary	Clear to A & P
Renal/Hepatic	Clear amber urine, WNL
Gastrointestinal	SP colon resection with anastomosis.
Endocrine	WNL
Heme/Coag	WNL
Musculoskeletal	Moves all extremities
Integument	Midline abdominal incision
Developmental Hx	Adult, geriatric female
Psychiatric Hx	Non contributory
Social Hx	Lives alone/smoker
Alternative/ Complementary Medicine Hx	None

Medication allergies:	None known	Reaction:	
Food/other allergies:	None known	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	None			

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 100	HCO3: 22	BUN: 20	Cr: 0.6
Ca: 9	Mg: 2	Phos:	Glucose:	HgA1C:	
Hgb: 11	Hct: 36	Plt: 150	WBC: 11	ABO Blood Type:	
PT 12	PTT 28	INR	Troponin:	BNP:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:	Albumin: 3.2	
CXR: Clear	ECG: NSR				

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)			
1. Initial physical appearance			
Gender: female		Attire: hospital gown	
<u>Alterations in appearance (moulage):</u> grey wig, no makeup. ABD pad to abdomen with 2" paper tape, NGT, JP with small amount of serosanguinous drainage. Foley with clear yellow urine.			
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		X Monitor on, but no data displayed		Monitor on, data displayed	
BP: 110/70	HR: 100	RR: 28	T: 98.2	SpO ₂ : 96%	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO ₂ :	FHR:			
Lungs:	Left: clear	Right: clear			
Sounds/mechanics	Heart: Sounds: S1, S2				
	ECG rhythm: sinus tachycardia				
	Other:				
Bowel sounds:	hypoactive		Other:		

3. Initial Intravenous line set up						
	Saline lock #1	Site:			IV patent (Y/N)	
	IV #1	Site:		Fluid type:	Initial rate:	Y IV patent (Y/N)
	Main	RA		D5 ½ NS w/20 mEq KCL	125/hr	
	Piggyback					
	IV #2	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main	RA				
	Piggyback					
4. Initial Non-invasive monitors set up						
X	NIBP			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:
						.
Environment, Equipment, Essential props						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Med-Surg Unit patient room N/G drainage – bile colored fluid 150cc J/P drainage – serosanguinous drainage 30-50ml Abdominal dressing – dry with J/P suction						
2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)						
	Bedpan/ Urinal			Foley catheter kit	Straight cath. kit	x Incentive spirometer
	IV Infusion pump			Feeding pump	Pressure bag	X Wall suction
X	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:	D5 ½ NS w/20meq KCL			Tubes/drains Type: JP	Blood product ABO Type: # of units:

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

4. Documentation and Order Forms							
X	Health Care Provider orders	X	Med Admin Record		H & P		Lab Results
	Progress Notes	X	Graphic record		Anesthesia/PACU record		ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	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
	Morphine Sulfate	2mg/ml 4mg/ml	IV					
	Ceftriaxone	1 Gram	IV					
	Protonix	40mg/10ml	IV					

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario : bedside handoff report shift to shift

Ruda Mondoch is a 75 year old female who is POD 1 following a colon resection with anastomosis for colon cancer. Her abdominal dressing is clean, dry, and intact. Her JP drain put out 50ml of serosanguinous drainage on my shift. NGT to LIS. I dc'd her Foley 2 hours ago. She has not voided yet. Order for bladder scan if no void within 6 hours. Bowel sounds normoactive and she is passing gas. I/Os are balanced. SCDs on. She has been using her incentive spirometer. Her pain has been well managed on IV morphine. She can have 2-4mg every 4 hours as needed. I gave her 2mg 3 hours ago. She is getting D5 1/2NS with 20mEq KCL at 100ml/hr via RFA SL #20 placed yesterday. Most recent VS were 118/76, HR 84, RR 18, O2 Sat 97% RA, temp 98.2. Her daughter is at her bedside.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Pt. lying in low fowler's position; grimacing in pain. Daughter at bedside in distress due to mother's pain. Asks "Is she supposed to have so much pain? Can you get her something to help with the pain?"</p>	<p>Operator</p> <p>BP 110/70 HR 90 RR 22 O2 Sats 96% RA Show when taken by learners</p> <p>Triggers: Learner Actions complete or 7 minutes elapsed.</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Enter room, wash hands, introduce self to patient & daughter, identify patient 2. Performs pain assessment 3. Performs post-op assessment 4. Checks integrity of IV's & tubes 5. Assesses wound drainage 6. Communicates with patient and daughter re. nursing actions 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Standard Precautions <input type="checkbox"/> Integrity of drainage tubes <input type="checkbox"/> Post-op assessment <input type="checkbox"/> Pain assessment

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>Patient reports pain 7/10. Continues to moan/grimace</p>	<p>Operator:</p> <p>No change in VS. If VS have not been taken, daughter cues.</p> <p>Triggers: Learner Actions completed or 7 minutes elapsed</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Refers to MD order sheet 2. Recognize time for medication 3. Select appropriate pain medication and non-pharmacologic interventions for pain. 4. Prepares and administers medications implementing 6 rights 5. Informs patient and daughter of anticipated effects of medication – time frames 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Safe administration of Morphine Sulfate <input type="checkbox"/> Range orders for PRN <input type="checkbox"/> Patient teaching
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3.</p> <p>Daughter less anxious and supports mother with calming words.</p> <p>Patient reports adequate pain relief 2/10</p>	<p>Operator:</p> <p>BP: 110/70 HR: 80 O₂ sats: 96%</p> <p>Triggers: Learner Actions complete</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Demonstrates and asks patient to return demo on Incentive Spirometer 2. Reassess O₂ sats , RR 3. Leaves call bell in reach 4. Evaluate patient response to specific nursing interventions. 	<p>Debriefing Points:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Value active partnership with patient/families in planning, implementing, and evaluating care. <input type="checkbox"/> Importance of patient teaching/communication as part of intervention <input type="checkbox"/> non-pharmacologic pain management techniques <input type="checkbox"/> Reassessment
<p>Scenario End Point: Patient is relaxed and pain is at an acceptable level. RR- 16, O₂ sats – 96%; Pain 2/10</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Ruda Mondoch DOB: Age: 74 MR#: 123456		Diagnosis: Colorectal Cancer
†No Known Allergies †Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
yesterday		Strict NPO
		NGT to LIS
		Vital signs – Adult per unit routine
		IS every hour while awake
		Activity as tolerated
		Place sequential compression device bilateral lower extremities
		Ceftriaxone 1g IV Q8 hours x 24hours
		Morphine sulfate 2-4 mg IV q4 hours PRN pain
		Tylenol 650mg PR Q6 hours PRN temp >101 or pain
		Protonix 40mg IV daily
		Lovenox 30mg subcutaneous daily
		Remove indwelling urinary catheter POD #1
		Perform bladder scan when: inability to void in 6 hours; Straight cath if PVR>300 PRN
		D5 1/2NS with KCL 20mEq/L infusion 100ml/hr intravenous: Continuous
Signature		

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:			