SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post-operative Assessment_Case B_Pain Management
Original Scenario Developer(s):	C. O'Leary-Kelley, PhD, RN, CNE
Date - original scenario	03/09
Validation:	09/09 K. Bawel-Brinkley, PhD, RN, CNE
Revision Dates:	09/12; 05/18 C. Nevins DNP, RN, CNE; J. Hannans PhD, RN, CNE
Pilot testing:	09/09 San Jose State University
QSEN revision:	09/12 C. O'Leary-Kelley, PhD, RN, CNE;

Estimated Scenario Time: 15-20 minutes Debriefing time: 30-40 minutes

Target group: Fundamentals and beginning Medical Surgical Nursing students, new grads
Core case: Post-operative management; clinical decision making in an evolving case

QSEN Competencies:

- ❑ Evidence-Based Practice
- ❑ Safety
- ❑ Patient Centered Care

Brief Summary of Case: This is the second part of a 3-part evolving case of a patient after abdominal surgery. The patient is 65-year-old female who is admitted to the medical-surgical telemetry unit from the PACU. The patient is status post total abdominal hysterectomy. The learners receive report from the RN who has been managing the patient on the medical-surgical unit for the past 8-hours. The purpose of this scenario is to validate the learners' skill in conducting a thorough pain assessment. The patient will admit to pain but will refuse the ordered medication if the learners have not done a thorough baseline assessment of the patient's pain, and provided basic education about the medication and pain management interventions.

EVIDENCE BASE / REFERENCES (APA Format)

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

Fitzgerald, S. (2017). Assessment and management of acute pain in older people: barriers and facilitators to nursing practice. *Australian Journal Of Advanced Nursing*, *35*(1), 48-57.

Ersan, T. (2015) Perioperative management of the Geriatric Patient. Retrieved from: https://emedicingmedscape.com/article/285433/overview

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

The Joint Commission (2018). National Patient Safety Goals: Hospital. Retrieved from: https://www.jointcommission.org/assets/1/6/2018_HAP_NPSG_goals_final.pdf

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide nursing care that promotes safety and minimizes risk of error or injury.
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.
4. Communicate effectively with the patient and members of the inter-professional team.
Specific Learning Objectives
1. Identify findings from a physical and psychosocial assessment that demonstrate risk of complications in a postoperative client.
2. Demonstrate a thorough assessment of client with a focus on pain, e.g., OLDCART, PQRST.
3. Identify/interpret significant assessment findings requiring immediate reporting and/or intervention.
4. Accurately prioritize immediate interventions required for a client with postoperative pain.
5. Evaluate effectiveness of interventions by reassessing critical parameters.
6. Effectively communicate patient status to physician or charge RN utilizing SBAR tool.
7. Effectively communicate with client/family throughout simulation to keep informed and relieve anxiety.
8. Apply safety and infection control measure appropriate to situation.
Critical Learner Actions
1. Wash hands, introduce self, identify client (with 2 identifiers) upon entering room.
2. Perform complete physical assessment and document findings.
3. Recognize patient pain behaviors and perform a complete pain assessment.
4. Communicate with health care team members using SBAR.
5. Administer pain medications utilizing principles of safe medication administration.
6. Instruct patient on drug action and inform them that pain will be reassessed within 30 minutes.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	Skills/ Attitudes
❑ Pain assessment and management in post-operative and older adults	❑ Perform complete, accurate pain assessment
❑ Current National Patient Safety Goals	❑ Safe administration of medication – honor six rights and 3 checks of medication administration
❑ Structured Communication Tools (SBAR)	❑ Use SBAR to give report
❑ Pharmacology of pain medications	❑ Seek and include input from patient/family
❑ Six rights and 3 checks of medication administration	❑ Initiate treatment for pain/suffering in light of patient values and preferences
❑	❑ Evaluate pain medication response in timely manner

SECTION III: SCENARIO SCRIPT

A. Case summary
This case presents a 65-year-old female, retired college professor, who is admitted on the previous shift to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy and the report received from the off-going RN is that the patient has an order to ambulate. A second on-coming RN is also present as she/he is orienting to the unit as a new staff member. The RN reports that the patient is stable, has not requested pain medication and denied pain when last assessed one hour ago. The patient's family member is at the bedside. The RNs enter the room to assess the patient and prepare her for ambulation.

B. Key contextual details
The RN apologizes that she has not had time to ambulate the patient. The learners will enter the room, complete a physical assessment, and the patient will admit to pain when told she must ambulate. The learners should proceed with a thorough pain assessment and administer pain medication as ordered. The learners should provide basic education about pain management and the medication planned for administration. If they do not obtain a full description of the pain; or, if they attempt to get the patient up without managing her pain – the patient will refuse which will require the RNs to notify charge nurse/ or MD.

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
RN 1	Assigned to care for patient	Learner
RN 2	Newly RN orienting to unit	Learner
Charge RN/ MD		Standardized Participant
Family member	(optional role)	Learner or Standardized Participant

D. Patient/Client Profile				
Last name:	Phillips		First name:	Anastasia
Gender: F	Age: 65	Ht: 66 in	Wt: 150 #	Code Status: Full
Spiritual Practice: Protestant		Ethnicity: White		Primary Language spoken: English

1. History of present illness

Anastasia Phillips is a 65-year-old retired college professor with a diagnosis of dysfunctional uterine bleeding x 6 months. The patient has NKA. Medical history includes hypertension x 10 years and arthritis. She has no prior history of surgery. She is post-menopausal with last menses at age 52. Patient elected for a vaginal hysterectomy, possible total abdominal hysterectomy (TAH). She had a TAH approximately 8 -9 hours prior to change of shift.

Primary Medical Diagnosis	Post-menopausal uterine bleeding

2. Review of Systems	
CNS	A & O x4
Cardiovascular	Regular Rate and Rhythm; S1, S2; hx of hypertension: BP 120 - 130/80 -90
Pulmonary	Lungs clear to auscultation
Renal/Hepatic	Labs normal
Gastrointestinal	Abdomen soft, round, distended; bowel sounds hypoactive
Endocrine	No noted history
Heme/Coag	Labs normal other than Hgb 10.0 and HCT 32.0
Musculoskeletal	Moves all extremities; arthritis in hands bilaterally
Integument	Intact, no lesions
Developmental Hx	Normal for age
Psychiatric Hx	none
Social Hx	One glass red wine per day; no illicit drugs, married with grown children
Alternative/ Complementary Medicine Hx	

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

3. Curre	Drug	Dose	Route	Frequency
	Lisinopril	10 mg	PO	Daily in a.m.
	Ibuprofen	200 mg	PO	Q6h prn for pain

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 102	HCO3: 23	BUN: 26	Cr: 0.9
Ca:	Mg:	Phos:	Glucose: 96	HgA1C:	
Hgb: 10	Hct: 32	Plt: 200,000	WBC: 8000	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 80 bpm; no ectopy			
CT:		MRI:			
Other:					

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			
Alterations in appearance (moulage): Grey wig; glasses; abdominal dressing;					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
X	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: 120/80	HR: 80	RR: 14	T: 37 C (98.6 F)	SpO2: 97% on RA
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left: clear		Right: clear	
Heart:	Sounds:	S1 S2		
	ECG rhythm:	NSR		
	Other:			
Bowel sounds:	hypoactive		Other:	

ALL DATA IN THIS SCENARIO IS FICTITIOUS

3. Initial Intravenous line set up							
	Saline lock #1	Site:	RA				IV patent (Y/N)
X	**IV #1**	Site:	RA	Fluid type: LR	Initial rate: 100ml/hr		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	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				
x	Foley catheter	Amount: ~150		Appearance of urine: clear yellow
	Epidural catheter	x	Infusion pump:	Pump settings: 100ml/hr

Environment, Equipment, Essential props

Recommend standardized set ups for each commonly Standardized environment

1. Scenario setting: (example: patient room, home, ED, lobby)

Medical-surgical telemetry room

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
x	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 Low abd transverse drsg
x	IV fluid Type: LR				Tubes/drains Type:		Blood product ABO Type: # of units:

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

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
	Progress Notes		Graphic record		Anesthesia/PACU record		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**
2	Norco	5/325	PO					
1	Morphine Sulfate	2 mg	IV					
3	Acetaminophen	325 mg	po					

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: This case presents a 65-year-old female retired college professor, who is admitted on the previous shift to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy for post-menopausal dysfunctional uterine bleeding. The surgeon was not able to do a vaginal approach. The RN and orientee on the medical-surgical unit receives report from the off-going nurse who reports that the patient is stable, has not requested pain medication and denied pain when last assessed one hour ago. The off-going nurses states the abdominal dressing is clean, dry and intact, patient has a patent IV and foley catheter in place, and there is an order for the patient to ambulate.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient is lying in bed. Her surgery was approx. 8 – 9 hours ago. Sleeping with HOB elevated 30 degrees. A & O x 5, responds to voice. Admits to pain when asked. States: "I don't want to get up. I am hurting…." Family member at bedside reading - optional. Assessment (con't) GI: soft, slightly distended abdomen; hypoactive bowel sounds; abdominal dressing clean and dry GU: foley: 150 ml of clear amber urine M/S: able to move all 4 extremities; SCDs on Integumentary: warm, dry; IV intact	**Operator** BP – 120/80 HR – 80 NSR RR – 14, clear bilaterally PP – strong bilaterally T – 37 C (98.6 F) O2 sat – 96% on RA Pain: rate of 5 in abdomen, since surgery, slightly sharp and tight feeling, doesn't radiate, better when not moving **Triggers:** Complete learner actions within 5 minutes; if Failure to obtain full pain assessment – go to state 4	**Learner Actions** Wash hands / ID patient Introduce RNs to patient and family Inform patient of plan to complete an assessment and ambulate – explain rationale Begin focused post-operative assessment/ or direct other RN - Obtain vital signs - Assess pain (OLDCART or PQRST) - Assess respiratory and cardiac status Assess IV, foley and incision site	**Debriefing Points:** National Patient Safety Goals to prevent infection and use of patient identification Potential co-morbidities in the 60+ age group surgical patient Role of ambulation in preventing post-operative complications

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Assessment Patient refuses to get out of bed. Responds with vague answers when RN assesses pain. Expresses concern about taking the pain medication – "I'm afraid I might get nauseated." "I might choke." "I may get addicted."	**Operator:** BP – 128/80 HR – 87 NSR RR – 18 T – 98.6 F. O2 sat – 96% on RA Pain description unchanged **Triggers:** Complete pain assessment- go to state 3; Failure to obtain full pain assessment- go to state 4	**Learner Actions:** Completes assessment (state 1) Further assess pain using OLDCART or PQRST or other assessment framework Express verbal concern for patient comfort, recommending pain medication and rationale	**Debriefing Points:** Rationale for obtaining a thorough baseline pain assessment in managing pain Consideration for patient and family values, preferences
STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
3. Intervention Patient agrees to take the pain medication from the nurse to relieve pain.	**Operator:** Vital signs unchanged **Triggers:** Patient takes pain medication	**Learner Actions:** Check medication record for appropriate medication Administer pain medication using 6 rights and 3 checks Inform patient that he/she will return in 30 minutes to re-evaluate	**Debriefing Points:** Responsibility to honor 6 rights and 3 checks of medication administration to prevent medication errors Reassessment of medication effectiveness

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
4. **Incomplete Assessment** Patient refuses to take the pain pills and becomes distressed during discussion or when attempt to get up. Becomes anxious and develops added concern about taking the pills – "I might vomit." I don't want those pills; can't I have something IV?" "I'm really hurting now!" (Family member, if present, expresses concern about patient's pain) *If Charge Nurse or MD contacted: request a full description of the pain and discussion	**Operator:** BP – 138/90 HR – 98 RR – 20 T – 98.6 F. O2 sat – 96% on RA Pain description unchanged **Triggers**: Pain medication not given or pain medication given without full pain assessment	**Learner Actions:** Assess patient reasons for med refusal; use therapeutic communication in addressing patient/family concerns Utilize SBAR to communicate to Charge Nurse or MD to discuss patient status and pain medication* Administer pain medication using 3 checks but not all 6 rights; inform patient that he/she will return in 30 minutes to re-evaluate	**Debriefing Points** Rationale for obtaining a complete baseline pain assessment Effective communication techniques: therapeutic communication with patient/family and professional closed loop communication Responsibility to honor all 6 rights of medication administration to prevent medication errors; Reassessment of medication effectiveness
Scenario End Point: - Pain medication given with all criteria met. If not, scenario ends in 15-20 minutes.			
Suggestions to decrease complexity: Omit the family member from the scenario Suggestions to increase complexity: Increase pain level necessitating IV Morphine with respiratory depression after administration; Charge nurse or physician becomes frustrated that pain was not fully assessed before calling; the patient or family become increasingly agitated			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Phillips, Anastasia **DOB: 1/15/xx** **Age: 65 years old** **MR#: PCS654321**	**Diagnosis: s/p total abdominal hysterectomy**

†No Known Allergies
†Allergies & Sensitivities Code Status: FULL CODE

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Admit to Medical/Surgical Telemetry Unit
		Diet: sips of water, advance to clear liquids as tolerated
		Activity: Out of bed tonight; up as tolerated
		Post-op vital signs every 2 hours x2, then every 4 hours; Call MD if BP > 160/90, Temp ≥ 38.3 C (101 F)
		IV: LR at 100ml/hour
		Sequential Compression Device (SCDs)
		Indwelling foley catheter to gravity drainage; Call MD if urine output less than 30 ml/hour
		I & O per routine
		Titrate O_2 2-6 liters/min per NC to maintain SpO_2 ≥ 92%
		Incentive Spirometer 10x every hour while awake
		Medications:
		Morphine Sulfate 2 mg IV push every 4 hrs prn severe pain (7 – 10)
		Hydrocodone/Acetaminophen (Norco) 5/325 2 tabs every 4 hrs prn moderate pain (4 – 6)
		Acetaminophen (Tylenol) 325 mg 2 tabs every 4 hours prn for mild pain (1 – 3) or fever > 38.2 C (100.8 F)
		Ancef 1 gm IVPB every 8 hrs x 3 doses
		CBC, Chem Panel in am
Signature		*Georgina Johnson 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 Points	☐ 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 missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. The main objective of the simulation was to complete a thorough pain assessment and appropriately prioritize interventions in a post-op patient.
    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. What issues influenced your ability to provide complete care for the patient in regard to post-operative nursing care and the physician orders? Discuss considerations and potential issues with advanced aged surgical patients.
7. In what ways did you feel the need to check ACCURACY of the data you were given?
8. What communication strategies did you use to validate ACCURACY of your information or decisions with the patient and your team members?
9. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?
10. Discuss actual experiences with diverse patient populations.
11. Discuss roles and responsibilities when addressing acute care needs of patients, especially during a disagreement in the plan of care.
12. Discuss how current nursing practice continues to evolve in light of new evidence.
13. Discuss how each of the QSEN competencies for evidence-based practice, patient-centered care and safety impacted your care of the patient.
14. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?

Notes for future sessions: