California Simulation Alliance (CSA)
Simulation Scenario Template

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 *Health**Impact**/CSA*. The writers have agreed to release authorship and waive any and all of their individual intellectual property (I.P.) rights surrounding all scenarios.

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ALL DATA IN THIS SCENARIO IS FICTICIOUS

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post-Partum Home Visit
Original Scenario Developer(s):	Christie Smart, DNP, RN, CNE Janna Le Page, MSN, RN CCM PHN (Written, did not participate in testing and revision)
Date - original scenario	5/22/2019
Validation:	Debra Brady, DNP, RN, CNS 4/23/2020
Revision Dates:	9/19/2019, 10/1/2020, 1/2022, 2/2022
Pilot testing:	With experts (5/2019) Students (1 group of 10) (3/15/22) Students (2 groups of 5) (3/29/22)
QSEN revision:	

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

Target group: Community health nursing students.

Core case: Home visit with a 21 year-old mother experiencing post-partum depression

QSEN/IOM Competencies: Patient Centered Care; Evidenced Based Practice

Brief Summary of Case: 21 year/old mother with a newborn (only child) at home. Nurse Family Partnership client. This is the 3rd visit with this client, but 1st post-partum visit. Infant is between 2-3 weeks old.

EVIDENCE BASE / REFERENCES (APA Format)

Bina, R., Glasser, S., Honovich, M., Levinson, D., & Ferber, Y. (2019). Nurses perceived preparedness to screen, intervene, and refer women with suspected postpartum depression. *Midwifery 76*, 132-141. Doi:10.1016/j.midw.2019.05.009

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Wheeler, C. A., & McNelis, A. M. (2014). Nursing Student Perceptions of a Community-Based Home Visit Experienced by a Role-Play Simulation. *Nursing Education Perspectives (National League for Nursing)*, *35*(4), 259–261. https://doi-org.proxy.lib.csus.edu/10.5480/12-932.1

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Communicates with the client in a compassionate manner using therapeutic communication (Patient Centered Care)
2. Recognizes the signs and symptoms of post-partum depression and utilizes a screening tool (Evidence Based Practice)
3. Refers the client to post-partum support services (PHN Intervention Wheel)
Specific Learning Objectives
1. Implements client centered communication using open ended questions.
2. Recognizes signs/symptoms of potential post-partum depression in the client.
3. Screens the clients for post-partum depression using an evidence-based tool.
4. Provides client education and addresses questions on post-partum depression.
5. Develops plan of care with appropriate referrals to post-partum depression support services.
Critical Learner Actions
1. Introduce self
2. Explain the purpose of the home visit
3. Begins assessment of patient and environment
4. Initiates therapeutic communications
5. Recognizes possible post-partum depression and conducts screening
6. Appropriately implements and scores the postpartum depression tool
7. Communicates screening results and addresses client questions.
8. Provides appropriate interventions/referrals to community agencies and healthcare provider
9. Provides coaching to mom on interacting/bonding.
10. Ensures infant safety and resources for infant's care
11. Provides follow up dates/timelines for appointments

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	**Skills/ Attitudes**
❑ Signs/Symptoms of post-partum depression	❑ Administer the Edinburgh Postnatal Depression Scale
❑ Screening tool for post-partum depression	❑ Assess the home environment
❑ Therapeutic communication	❑ Incorporates information about postnatal adjustment, post-partum depression
❑ Home visits	❑ Facilitates linking to appropriate community resources
❑ Nurse Family Partnership	❑
❑ PHN Intervention Wheel	❑

SECTION III: SCENARIO SCRIPT

A. Case summary
21 year/old Mother with a newborn (only child) at home. Nurse Family Partnership client. This is the 3rd visit with this client, but 1st post-partum visit. Infant is between 2-3 weeks old.

B. Key contextual details
Nurse with Nurse Family Partnership on home visit. Nurse, client, and infant are only ones in the apartment.

C. Scenario Cast		
Patient/ Client/Baby	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer (Infant can be static with "cry" program or Mid-fidelity with cry)	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Confederate/Actor (C/A) or Learner (L)
Public Health Nurse	Nurse working for the Nurse Family Partnership	Learner
Patient/Client	DRESS: PATIENT IS DRESSED IN CLOTHES THAT ARE WRINKLED, APPEAR DIRTY AND DO NOT FIT WELL. POSTURE: WHEN MOVING IS SLIGHTLY BENT OVER LOOKING DOWN, WHEN SITTING IS SLOUCHING IN CHAIR AND LEANING ON ARM. HAIR: BACK IN MESSY PONYTAIL OR MESSY MAKEUP: NO MAKE-UP TONE OF VOICE/SPEECH: SAD ON VERGE OF CRYING, SLOW IN RESPONSES EYE ENGAGEMENT: DOES NOT MAKE EYE CONTACT AFFECT: FLAT, YAWNS FREQUENTLY	C/A

D. Patient/Client Profile				
Last name:	Rivera		First name:	Melissa
Gender: Female	Age: 21	Ht: 5'3"	Wt: 130	Code Status: NA
Spiritual Practice: None		Ethnicity: Hispanic		Primary Language spoken: English

1. Past history	
History of visits during pregnancy. Client has little family support living near.	
Primary Medical Diagnosis	Post-partum

2. Review of Systems	
CNS	N/A
Cardiovascular	N/A
Pulmonary	N/A
Renal/Hepatic	N/A
Gastrointestinal	N/A
Endocrine	N/A
Heme/Coag	N/A
Musculoskeletal	N/A
Integument	N/A
Developmental Hx	WNL
Psychiatric Hx	Nothing diagnosed, some concerns related to lack of family/social support nearby.
Social Hx	Single mother. Father of child is current boyfriend. Living with boyfriend in apartment. Provides some financial support.
Alternative/ Complementary Medicine Hx	N/A

Medication allergies:	N/A	Reaction:	
Food/other allergies:	N/A	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	N/A			

4. Laboratory, Diagnostic Study Results (N/A)					
Na:	K:	Cl:	HCO3:	BUN:	Cr:
Ca:	Mg:	Phos:	Glucose:	HgA1C:	
Hgb:	Hct:	Plt:	WBC:	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:	Cxr:	EKG

E. Baseline Simulator/Standardized Patient State
(This may vary from the baseline data provided to learners)

1. Initial physical appearance

Gender: Female	Attire: Casual clothing such as a t-shirt/sweatshirt and leggings or pajama pants.
Alterations in appearance (moulage): Eyes may be red from crying, hair disheveled, and slumped in chair.	

N/A	ID band present, accurate	N/A	ID band present, inaccurate	N/A	ID band absent or not applicable
N/A	Allergy band present, accurate	N/A	Allergy band inaccurate	N/A	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room: (N/A)

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

BP:	HR:	RR:	T:	SpO²:
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETCO²:	FHR:		
Lungs: Sounds/mechanics	Left:	Right:		
Heart:	Sounds:			
	ECG rhythm:			
	Other:			
Bowel sounds:		Other:		

3. Initial Intravenous line set up (N/A)

	Saline lock #1	Site:					IV patent (Y/N)
	IV #1	Site:	CVC	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						
	A-line Site:		Catheter/tubing Patency (Y/N)		CVC 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)

Client apartment with small table and two chairs, crib, and television with stand. Small kitchenette with dirty dishes in sink; unkempt apartment with clothes and dishware laid about. Standardized Patient: dirty T-shirt, hair uncombed, jeans, no makeup, appears tired.

2. Equipment, supplies, monitors (N/A)

(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 kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural pump		Central line Kit		Dressing Δ equip
	IV fluid Type:		IV fluid additives:		Blood products:_____ ABO Type: ___ # of units:__		

	Nasal cannula		Face tent		Simple Face Mask		Non-rebreather mask
	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
	Provider orders		Med Admin Record		Hx & Physical		Lab Results
X	Progress Notes		Graphic record		Anes/PACU record		ED Record
	Med Reconciliatn		Transfer orders		Standing orders		ICU flow sheet
X	Nurses' Notes		Dx test reports		Code Record		Prenatal record
	Actual medical record binder				Electronic Medical Record		

5. Medications (to be available in sim action room) (N/A)

#	Medication	Dosage	Route		#	Medication	Dosage	Route

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: **-**Nurse receives Nurse Family Partnership chart for review along with a folder with multiple resource handouts. -Patient is waiting inside of apartment -Baby is in crib sleeping -Apartment is cluttered, sink with dishes, laundry basket overflowing, bottle on floor -Student nurse knocks on door ****Structured debriefing using the Promoting Excellence And Reflective Learning in Simulation (PEARLS) approach, with the four phases of 1) reactions, 2) description, 3) analysis, and 4) summary.**			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient is slouching in chair, with head in hands. Disheveled appearance, does not make eye contact and has flat affect. Yawns frequently. Responds to questions with a lack of interest.	**Operator** **Triggers:** Baby Crying	**Learner Actions** -Introduces self -Explains the purpose of the home visit -Begins assessment -Initiates therapeutic communication	**Debriefing Points:** How did this experience feel to you? Is there anything you thought went really well? Is there anything you would change? What are your thoughts on the nurse attempts to build rapport with the client? What objective behavior did the client display to have you initiate therapeutic communication? What clues helped you assess the health status and literacy of the client? What was the first thing you noticed when you entered the apartment? Why did you feel those things were important?

			What does this mean? Discuss anything that could have been done differently.
STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
2. Patient is ignoring baby crying.	**Operator:** **Triggers:** Nurse starts screening for PPD or patient makes "I Can't do this" statement still crying.	**Learner Actions:** -Continues therapeutic communication -Nurse intervention: Inquires with client if nurse can pick-up and console baby	**Debriefing Points:** How did you feel when the patient ignored the baby crying? Discuss nurse concerns for baby's safety when mom initially did not respond to the infant crying. Discuss importance of trust-building within the nurse-client relationship. Recognize client values vs. nurses' values.

STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
3. Baby stops crying, patient is still distressed but no longer crying, is able to respond to questions. Patient continues to hold baby. (Standardized patient will respond to questions asked in conversation with short answers, will convey that she has been feeling sad, anxious, overwhelmed, and not sleeping. If asked, she does not have any help with the baby. If asked about suicidal ideation, she has not had any thoughts. Responds to the EPDS as noted in appendix.)	**Operator:** **Triggers:** Nurse completed PPD screening	**Learner Actions:** -Continues therapeutic communication -Recognizes possible post-partum depression and initiates pp screening	**Debriefing Points:** I am curious about what assessment patterns you recognized that helped you identify PPD in this new mom? Discuss strategies chosen to address client's distress. Discuss health status and literacy of client. Discuss and recognize how to utilize risk-reduction strategies for mother and baby. Discuss SDH impacting client's well-being. Discuss nurse's awareness of SDH when designing client-centered care plan.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
4. Patient continues to hold baby. Scores 10 or above with #10 being "never" resulting in "possible depression" result.	**Operator:** **Triggers:** Begins to discuss follow up contact.	**Learner Actions:** -Communicates results to the patient -Provides appropriate interventions/referrals	**Debriefing Points** What did you find challenging in communicating the screenings findings to the patient? How did you feel after making referrals? What in the client's response indicated that she was accepting of screening outcome? Can you please elaborate on the value of nurse interventions and referrals. What are your thoughts on the likelihood of client compliance with referrals? Summarize the conclusion of the home visit and plans for future follow-up. How would you approach this scenario differently in the future?

Scenario End Point: Nurse discusses referrals with patient, connecting patient to post-partum resource, and sets up follow up contact. Leaves home.
Suggestions to decrease complexity: Suggestions to increase complexity:

APPENDIX A: PRE-BRIEF CASE PROGRESS NOTES

Nurse Family Partnership

CONTACT INFORMATION

Melissa Rivera
123 Folsom Blvd. Apt. #46
Sacramento

916-883-5501

PROGRESS NOTES

Visit 1: Home visit with 21 y/o female, 7 months pregnant. No other children in home. FOB lives in home with her. Connected to prenatal care. No pregnancy complications to date. Denies ETOH and tobacco use in home. Home appears clean and tidy. No safety concerns.

Visit 2: Home visit with patient, one week from due date. FOB not present at visit is working, but still living in home. Patient continues to keep prenatal visits, has identified hospital and pediatrician. Home environment remains clean and tidy. Patient is smiling and excited for upcoming birth. Support network includes patient's mother and sister who live 30 minutes away.

Patient cancelled visit one-week port partum.

APPENDIX B: EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

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APPENDIX C: EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS) ANSWER KEY AND SCORING

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
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   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
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   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
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   - ☐ Yes, most of the time I haven't been able to cope at all
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   - ☐ Yes, most of the time
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   - ☐ No, never

*10 The thought of harming myself has occurred to me
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   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

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Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
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4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

APPENDIX D: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☒ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☒ Debriefing Guide(PEARLS)	☒ 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. 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: