Alex Lewis
DOB 1/2/1937
6 Stealth St, Huntly
UR: 61295
Dr Nimbin

Scenario outline:

Alex Lewis is a 75 year old woman who was admitted following a collapse at a shopping centre. She has a history of heart failure and was dehydrated. During rehydration she experiences fluid overload and goes into mild pulmonary oedema.
Students are expected to assess the patient and carry our basic nursing interventions and report deterioration to RN supervisors and medical officers.

Learning objectives

- Using a variety of assessment techniques, identify and prioritise issues for a client who has a medical illness
- Communication and Identification of client's physical and psychological needs during an acute exacerbation of the disease.
- Interpret the significance of abnormal assessment findings
- Develop and implement a person-centred care plan for a patient experiencing a medical illness and evaluate.

Roles required in scenario

- Student nurses, playing the role of SN's
- Supervisory (Confederate) RN on the ward
- Manikin voice:
- Technician:
- Brief and debriefing

Scenario Description (*Scenario in prose.)*

At beginning of scenario patient has just been admitted to the ward from the emergency department.

The students begin the baseline assessment. Their vital signs are within reportable limits but BP a little low due to dehydration.

The patient IV fluid has been set at the incorrect rate running at 250 mL per hour instead of 84 mL per hour. The flask has been running for 3 hours = total of 750 mL infused.

- Patient complains of feeling more unwell and becomes short of breath.
- She asks to be sat up as she cannot get her breath.
- She becomes increasingly tachypnoeic, dyspnoeic, pale and clammy.
- Respiratory assessment reveals widespread fine crackles
- O2 saturation drop slowly from 97% to 93%, pulse rate rises from 100 to 120 **(Using remote SpO2 machines)**
- Respiratory depth decreases and rate increases from 20 to 36
- BP rises slightly due to small fluid increase in circulation from 90/60 to 110/80
- Students expected to position patient upright, administer O2
- Report patient condition to supervisor
- **Telephone order for IV Lasix 40 mg, Morphine 1-2.5 mg IV & GTN patch 5mg**
- Patient will slowly improve and resume normal ventilatory effort and asks for pan
- If no interventions implemented RN in charge will enter room and enquire about patient condition and prompt students to begin appropriate care measures.

Handover/Brief

- Consents to be signed
- Explain manikin capabilities
- Explain roles of people
- Students will swap over part way through
- We will debrief at the close of the scenario
- We understand this is synthetic reality but you must practice in a suh a way as you would if the manikin is a real person

Alex is a 75 year old woman who collapsed at a shopping centre this morning. An ambulance was called and transported her to the emergency department. Alex was seen by the Dr and has been diagnosed with dehydration. Alex has now been transferred to the ward and you need to complete an admission of the patient to the ward including a baseline set of vital signs and respiratory assessment.

Patient History

Medical: CCF, Medications: Frusemide 40 mg BD, Digoxin 125mcg daily, Slow K 2 x tablets BD. Allergies: Nil

Patient has had some further issues with swelling of her ankles lately. She dislikes the tablets for her waterworks as it makes her go to the toilet a lot so she has cut down on her oral fluids. She did not take her medication this morning as she was going out shopping and did not want to have to go to the toilet when out.

Review of Systems:

CNS; Patient awake and alert, CARDIOVASCULAR:BP a low on admission
RESPIRATORY: RR 24 SpO2 99%, Chest clear. RENAL: Patient has used a pan
Time of simulation is 1330, Date is 14/8/12

Time frames

Frame/Time	**Frame 1.** Admit to ward Students to complete in 7 minutes
Simulation actions	SpO2 - 99% on air HR – 90 RR – 24 NIBP – 118/80 BP Temp- 37.2 Pain score - 0/10 Lung sounds: (fine crackles volume 9)
Expected interventions	Students conduct admission, assessment including assessment of • O2 sats (use remote spo2) • Vital signs (Temp stated by patient voice when initiated) • IV site & rate check • Assess fluid balance • Begin Documentation

Cues /Manikin Responses	Areas to consider
	• ensure that students introduce themselves,
	• ensure that they inform the patient of what they are doing and why
	• If this does not happen the patient can respond with
	   • "Who are you?"
	   • "What are you doing?"
	   • "Why are you doing that?
	Other comments to engage the learners could be
	• What is my blood pressure? Is it still OK?

	• Can I have a drink please?

Frame/Time	2. Frame 2 Students to complete in 7 minutes
Simulation actions	SpO2 - 96% on air HR – 100 RR – 28 NIBP – 110/60 BP Temp- 37.2 Pain score - 2/10 Lung sounds: (fine crackles volume 9)
Expected interventions	Students conduct ongoing assessment of patient Students may • sit patient up • Administer oxygen via nasal cannula • Auscultation if performed may reveal fine crackles
Cues /Manikin Responses	Patient verbalizes "I am not feeling well, I think I need to sit up I Feel a little light headed and can't get my breath"

Additional information;

The RN enters the room informs the students that their educator wants to meet with them and another group will take over the care for the patient. The RN hands over to the second group. (This is if you have a bigger group, choose three students who are observing to take over)

Frame/Time	Frame 3. Second group of students enter 10 minutes
Simulation actions	SpO2 - 94% HR – 120 RR – 34 NIBP – 120/90 Temp- 37.2 Pain score - 0/10 Lung sounds: (fine crackles volume 9)
Expected interventions	Students to reassess the resp' status including • O2 sats • Vital signs • Auscultation reveals course crackles • Documentation • BGL • Call for help alert the RN they call the Dr orders are: Perform ECG (Sinus tachycardia) Administer oxygen via Hudson mask at 8 LPM as ordered by medical officer Lasix 40mg IV, Morphine 1-2.5mg IV
Cues /Manikin Responses	I don't feel right. My chest is beginning to feel a little tight The patient then complains that they are having trouble breathing The patient exacerbates quickly into only speaking short phrases
Frame/Time	Frame 4. Second group of students 5 minutes
Simulation actions	SpO2 - 98% HR – 110 RR – 28 NIBP – 130/90 BP Temp- 37.9 Pain score - 3/10 Lung sounds: (fine crackles volume 9)

Expected interventions	Students administer medication as ordered Lasix 40mg IV stat and decide how much morphine to give Continue oxygen 8 litres via Hudson Students evaluate effect of medication on patient. Document all care
Cues /Manikin Responses	I feel a little better now I am not so short of breath.

Reflection / Debriefing (30 mins)

All participants are to sit in a circle.

Debriefing is extremely important in clarifying and consolidating the learning gained from the simulation experience yet is still challenging. Students should not feel as if they have failed this is practice! Students are to be reminded not to discuss each other's performance out of class; they are here to support and respect each other.

Begin by asking each and every student how they felt about the simulation experience, how did it feel? Ask for a short answer.

Ask the student group what happened in the simulation and then guide them if they are on the wrong track. We are to focus on nursing care, assessments and procedures not on the pathophysiology of the patient's condition.

Consider the Clinical reasoning process
- Collecting cues – What signs and symptoms did the patient exhibit?
- - Were you able to competently assess the patient?
- Analysing the cues – What do these S & S mean?
- - Were you able to call for help at the appropriate time?
- - Why would the patient be experiencing APO
- Making a decision - What actions did you take and why?
- -What is the action of Frusemide?
- Evaluating care - What happened to the patient after administration of the medication?

Also think about
- Medication skills
- Assessment skills
- Communication skills with the patient and the team
- Technical skills
- 3. What areas would you do differently next time?
- 4. What is one take home message from this session?

Ask the students to each identify one area that went well and one they feel they could improve upon. (Identifying own learning objectives)

Finish by highlighting area's students need to practice or improve upon then finish on a positive note