Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide

Overview

Target Audience: 2nd year Nursing, Physiotherapy, Speech Pathology & Social Work students

Number of Participants: 4 x nursing students, 2 x physiotherapy, speech pathology & social work students

Estimated pre briefing time: 30 minutes

Estimated simulation time (Part A): 30 minutes

Estimated post- simulation (Part A) and pre-simulation (Part B) time: 30 minutes

Estimate simulation time (part B): 30 minutes

Estimated debriefing time: 60 minutes

Setting: orthopaedic ward in a large metropolitan hospital

Simulation method: simulated patient playing role of Anton

Brief summary of scenario

Hip fractures are a common occurrence in Australia. Every day, more than 40 Australians break their hip (Source: AIHW data), with most being aged over 65 years. Hip fractures almost always necessitate a hospital admission and some kind of surgery to repair the fracture. Significant morbidity and mortality is associated with hip fractures; of the 40 people experiencing hip fractures each day, two will die in the hospital and at least four will need to go into a residential aged care facility, either while they recover or permanently. A year later, less than half will be able to walk as well as they did before the fracture, and another six or seven will have died. Hip fractures most commonly occur as a result of a fall, and osteoporosis is a major risk factor.

This case presents an elderly male who experienced a fall at home, leading to a fractured hip. The scenario starts on the first day after surgery to repair the fracture. In Part A, students from nursing and physiotherapy will work together to minimise his experience of pain and assist in the commencement of early walking, an important factor in enhancing recovery. During the patient encounter, it will be revealed that the patient has developed difficulty swallowing and that he has not been managing at home since the recent death of his wife. Following the encounter, students will be directed to collaborate regarding the patient's potential for discharge home and to identify the need for involvement of other health professionals. The overall aim for the students is to ensure the best possible outcome for the patient.

This project was possible due to funding made available by Health Workforce Australia

Part B of this scenario focusses on the third day after operation, when referrals to a range of health professionals have been made. Students from social work and speech pathology will action these referrals and assist in providing patient-centred care.

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part A
Nursing

Learning objectives

Interprofessional

- ☐ **Interpersonal and Communication Skills**: Communicates sensitively in a responsive and responsible manner demonstrating the interpersonal skills necessary for interprofessional collaboration
- ☐ **Patient-Centred and/or Family-Focused Care**: Through working with others negotiates and provides optimal integrated care by being respectful of and responsive to patient/client and/or family perspectives, needs and values
- ☐ **Collaborative Decision Making**: Establishes and maintains effective and healthy working partnerships with other professionals whether or not a formalised team exists
- ☐ **Roles and Responsibilities:** Consults, seeks advice and confers with other team members based on an understanding of everyone's capabilities, expertise and culture
- ☐ **Team Functioning**: Uses team building skills to negotiate, manage conflict, mediate between different interests and facilitate building of partnerships within a formalised team setting

(Source: The British Columbia Competency Framework for Interprofessional Collaboration, 2008)

Discipline Specific - Nursing

- ☐ Conduct an assessment of a patient's pain status following surgery for hip fracture
- ☐ Administer medications for analgesia according to ANMC standards
- ☐ Liaise with the staff from physiotherapy to facilitate appropriate mobilisation of the patient following surgery for hip fracture

Discipline Specific – Physiotherapy

- ☐ Conduct an assessment of the postoperative patient in preparation for mobilisation
- ☐ Prepare the environment and equipment to facilitate safe transfers and mobilisation of the patient following hip surgery
- ☐ Educate a patient on the correct method of transfer and use of gait aid following surgery for hip fracture
- ☐ Assist the patient to transfer, mobilise and sit out of bed in a safe manner
- ☐ Liaise with staff from nursing to facilitate appropriate mobilisation of the patient following surgery for hip fracture

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part A
Nursing Physiotherapy

Equipment checklist

- ☐ 1x gown
- ☐ 1x arm band
- ☐ 1x patient notes
- ☐ 1x pain scale chart, 1x Neurovascular chart, 1x Neurological chart, 1x sedation score chart
- ☐ 1x hospital bed with monkey bars attached
- ☐ 1x food tray with glass of water
- ☐ 1x packet of tictacs
- ☐ 1x PCA
- ☐ 1x IV pole
- ☐ T.E.D stockings
- ☐ 1x drug trolley (full with consumables: ampoules, syringes, needles, drawing up needles, N/S, sterile water)
- ☐ 1x sharps container
- ☐ 1x pen torch
- ☐ 1x IVT line
- ☐ 1x injection site
- ☐ 1x AUSTRALIAN INJECTABLE HANDBOOK
- ☐ 1x MIMS
- ☐ 1x 2 wheeled frame, adjustable height
- ☐ 1x pair of Elbow crutches
- ☐ 1x high backed chair
- ☐ Slip on shoes or slippers
- ☐ Vital signs monitor
- ☐ Kidney dish
- ☐ Extra sheet for chair
- ☐ Pillow
- ☐ Towel

This project was possible due to funding made available by Health Workforce Australia

Preparation of simulation and environment

- ☐ Mr Moore is dressed in a hospital gown and is resting in bed
- ☐ He has an arm band with his patient identification sticker on it around his wrist
- ☐ An intravenous bung is in situ on his right wrist
- ☐ Beside the bed is a high backed chair, and a foot rest.
- ☐ Near the entrance to the room is a collection of walking aids, including a 2 wheeled frame and a pair of elbow crutches
- ☐ A copy of the patient notes is available at the nurses station, near the bedside.

Note for facilitators

- ☐ Start the scenario by presenting all students with the patient story, found on the following pages. Students are also to read the patient medical history, outlined in the student guide.
- ☐ After reading these materials, encourage students consider and discuss what their roles may entail. Students should also be encouraged to work together to plan and provide intervention to the patient.
- ☐ The scenario will start with nursing students who will enter the ward first. They will be prompted that physiotherapy will be arriving to commence mobilisation with the patient in 10 minutes.
- ☐ Physiotherapy students will also be aware of this information and may watch the nursing encounter remotely until they enter the room 10 minutes later.
- ☐ The patient encounter for nursing and physiotherapy will be 30 minutes. Inform the students that the patient will need to be taken to radiology at this time.

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part A
Nursing Physiotherapy

Patient story

Anton Moore is a 76 year old male who lives at home alone, following the recent death of his wife Lindsay. Yesterday morning when getting out of bed to go to the toilet, Anton suffered a fall. He found himself in a considerable amount of pain and was unable to reach the telephone. Anton's neighbor Serena heard his calls for help and called the paramedics. Anton had recently informed Serena of the location of a hidden spare key to his home, should an emergency arise. Serena was able to let herself into his home and attend to Anton until the paramedics arrived.

The paramedics took Anton to the Emergency Department of the nearest hospital. Upon admission he was found to be alert and oriented. He did not recall losing consciousness, but was vague about the events leading to the fall. Anton complained of severe pain in his left hip (10 out of 10 when asked) and a slight rotation of his left leg was noticed. He was sent to radiology, where a fracture of his left hip was diagnosed upon x-ray. Anton was reviewed by an orthopaedic surgeon, Mr Jones, who explained that surgery would be required to repair the hip. That afternoon, Anton was taken to theatre to have a dynamic hip screw inserted via spinal anaesthesia. Following a short period in recovery, Anton was transferred to the orthopaedic ward.

Today is the first day after Anton's surgery. Mr Jones completed his ward round this morning and was pleased with Anton's postoperative recovery. He has requested that Anton commence mobilization with the assistance of the physiotherapists this morning. The acute pain service also completed their ward round and taken down his PCA (patient controlled analgesia). They have recommended that Anton commence on oral analgesia, and added Endone and Paracetamol to his medications chart.

Anton is a retired builder who lives in his own home in Carlton. He was born in Scotland and immigrated to Australia over 40 years ago after meeting his wife Lindsay. Six months ago, Lindsay passed away from breast cancer. Anton does not have any children or family in Australia. He lives a rather solitary life with his aged dog Archie. The only person that Anton appears to have regular contact with is his neighbor Serena.

This project was possible due to funding made available by Health Workforce Australia

Additional information (on request)

Anton visits Serena's house most mornings for tea and toast. Serena was close to Anton's wife Lindsay and has noticed a significant change in Anton and the state of his house since her passing. She called the ward this morning to check on Anton's progress. When speaking to the nurse in charge she mentioned that Anton's house has become quite messy and smelly and that did not appear to be any food in the house. Serena was concerned that Anton was not taking good care of himself and that he has become very isolated.

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part A
Nursing Physiotherapy

Proposed correct action

The checklists below provide a guide of the anticipated actions of students when participating in this scenario. Use this list to tick off each action as it is performed and write any comments that may be of value during debriefing in the comments box below.

Nursing

- ☐ Assess patients pain status using a pain score chart
- ☐ check medication chart for prescribed analgesia
- ☐ 2 x RN drug check
- ☐ 2 x RN drug administration using the rights of medication administration
- ☐ Documentation of care provided

Physiotherapy

- ☐ Liaise with nurse regarding patient's current status
- ☐ Conduct a brief assessment of pain status
- ☐ Establish pre-morbid mobility status
- ☐ Review current level of strength
- ☐ Review vital signs
- ☐ Provide education on correct method of transfer
- ☐ Provide education on correct use of gait aid
- ☐ Prepare the environment – prepare chair, gait aid and use bed mechanics
- ☐ Add footwear or roll up TEDs
- ☐ Facilitate / assist patient to SOOB using gait aid
- ☐ Following mobilisation, makes recommendation to nursing staff re future mobilisation and assistance required
- ☐ Recognise cues regarding swallowing difficulty
- ☐ Recognise cues regarding difficulty managing at home since wife's death
- ☐ Make appropriate referrals to social work and speech pathology

Additional Comments:

This project was possible due to funding made available by Health Workforce Australia

Post simulation activity / Preparation for Part B

- Following completion of Part A, participating students may wish to debrief. Rather than conducting a debriefing session, allow these students up to 10 minutes for a period of "bubbling" i.e. "how do you feel", "what thoughts are running through your head", "what would you like to discuss with the group"? This could involve writing down their thoughts on paper (to refer to in the debriefing) or a brief group discussion (the facilitator can take notes to refer to in the debriefing session).
- Then ask the participants to summarise their main findings for Anton Moore.
- Discuss the prospect of Mr Moore's discharge, which is likely to occur in approximately one week's time. What issues may need to be explored prior to discharge? Do any referrals to other health professionals need to be instigated? What would be the purpose of these referrals? The aim is for the students to instigate referrals to speech pathology regarding swallowing issues and social work regarding managing at home.

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part B
Social Work Speech Path

Learning objectives

Interprofessional

- ☐ **Interpersonal and Communication Skills**: Communicates sensitively in a responsive and responsible manner demonstrating the interpersonal skills necessary for interprofessional collaboration
- ☐ **Patient-Centred and/or Family-Focused Care**: Through working with others negotiates and provides optimal integrated care by being respectful of and responsive to patient/client and/or family perspectives, needs and values
- ☐ **Collaborative Decision Making**: Establishes and maintains effective and healthy working partnerships with other professionals whether or not a formalised team exists
- ☐ **Roles and Responsibilities:** Consults, seeks advice and confers with other team members based on an understanding of everyone's capabilities, expertise and culture
- ☐ **Team Functioning**: Uses team building skills to negotiate, manage conflict, mediate between different interests and facilitate building of partnerships within a formalised team setting

(Source: The British Columbia Competency Framework for Interprofessional Collaboration, 2008)

Discipline Specific – Social Work

Conduct a psychosocial risk

Practice Professional communication when assessing a patient in an acute setting

Assessment of next of kin and person responsible for patient

Discipline Specific – Speech Pathology

Conduct an oral peripheral examination

Undertake clinical bedside examination of swallow

This project was possible due to funding made available by Health Workforce Australia

Speech Pathology, to receive and discuss the patient referral from RN, and Physiotherapist.
Speech Pathology, to review the relevant patient notes.
Speech Pathology, to collect case history information from the patient regarding swallowing history and current presentation.
Speech Pathology, to conduct a bedside oral peripheral examination.
Speech Pathology, to conduct a bedside swallowing assessment and provide feedback to the patient.
Speech Pathology to document the findings of the OPE and swallowing assessment in the patient notes.
Speech Pathology, to handover relevant information to RN, regarding dietary modifications and swallowing recommendations.
Speech Pathology to handover relevant information to SW regarding meal preparation and swallowing safety in the home.
Speech Pathology to establish and maintain effective working partnerships with the patient, significant others, and other professionals.
Speech Pathology to use interpersonal communication skills to facilitate the effective practice of
Speech Pathology to use oral and written communication skills to communicate effectively with work teams.
Speech Pathology to conduct self in a professional manner and demonstrate ethical behavior

This project was possible due to funding made available by Health Workforce Australia

Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide
Part B
Social Work Speech Path

Equipment checklist

- ☐ 1x gown
- ☐ 1x arm band
- ☐ 1x patient notes
- ☐ 1x hospital bed with monkey bars attached
- ☐ 1x food tray with glass of water
- ☐ T.E.D stockings
- ☐ 1x pen torch
- ☐ 1 x caddy with assorted food items: pureed fruit, dry biscuits, juice box, pre-packaged thick fluids
- ☐ Cups, spoons, straws
- ☐ 2 x tongue depressors
- ☐ Gloves
- ☐ Tissues
- ☐ Stopwatch
- ☐ 1x 2 wheeled frame, adjustable height
- ☐ 1x high backed chair
- ☐ Slip on shoes or slippers
- ☐ Extra sheet for chair
- ☐ Pillow

Preparation of simulation and environment

- ☐ Mr Moore is dressed in a hospital gown / pyjamas and is sitting on a chair with a table in front of hime.
- ☐ He has an arm band with his patient identification sticker on it around his wrist
- ☐ An intravenous bung is in situ on his right wrist
- ☐ A copy of the patient notes is available at the nurses station, near the bedside.
- ☐ A trolley/ caddy containing equipment for a speech pathology assessment is on the ward.

This project was possible due to funding made available by Health Workforce Australia

Note for facilitators

- ☐ Start the scenario by presenting all students with the patient story, found on the following pages. Students are also to read the patient medical history, outlined in the student guide.
- ☐ After reading these materials, encourage students consider and discuss what their roles may entail. Students should also be encouraged to work together to plan and provide intervention to the patient.
- ☐ Social work and speech pathology students will be given up to 30 minutes in total to review / assess the patient.

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Patient Name: Anton Moore

Diagnosis: hip fracture, musculoskeletal condition

Facilitators Guide

Patient story

Anton Moore is a 76 year old male who was admitted to hospital following a fall three days ago. The fall left him with a broken hip, which was surgically repaired in a procedure completed by the orthopaedic team. Anton has recovered well from the operation. He began walking with the physiotherapist on the first day after surgery and is now able to walk from his chair to the bathroom using a walking frame. His pain has been well managed and he no longer requires continuous pain medication.

Since his admission, Anton has described difficulty with swallowing liquids. One the first day after operation he was noted to cough and splutter when attempting to take his pain medications with water. His medications have now been either crushed and given to him by spoon or delivered intravenously. It has been noted that he is eating very little of his meals. Anton denies having difficulty swallowing in the past. It has been queried whether this change is related to the cause of his fall, however to date, no investigations have been performed.

Anton's neighbor Serena has rung the ward daily to check on his progress. When speaking to nursing staff she has voiced her concerns about Anton not looking after himself well since the death of his wife Lindsay six months ago. Serena reports Anton's house to be messy and unkept. She has noticed very little food in the house and that Anton has lost a significant amount of weight recently. She provides him with toast and tea most mornings when he visits her house, but has not raised her concerns with him as she does not want to interfere. Serena is looking after Anton's dog Archie while he is in hospital.

Proposed correct action

The checklists below provide a guide of the anticipated actions of students when participating in this scenario. Use this list to tick off each action as it is performed and write any comments that may be of value during debriefing in the comments box below.

Speech Pathology

Collect a case history

SP student to undertake an oral peripheral examination

SP student to undertake a clinical bedside examination of swallow (trails with water and thickened fluid and solids e.g. biscuit

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Social Work

- ☐ Demonstrate a heightened awareness of patient rights and particularly the right to confidentiality and participation in decision-making around treatment and discharge
- ☐ Establishes rapport and starts building a positive working relationship with the patient
- ☐ Discusses the role of the social worker in the hospital context
- ☐ Explores the patient's story starting with the patient's immediate concerns
- ☐ Assesses patient's current psychosocial situation using a multidimensional assessment framework
- ☐ Demonstrates a strengths-based practice approach in conducting the assessment
- ☐ Discusses available community resources and options for support in line with the patient's stated needs and wants
- ☐ Establishes at least one intervention goal with the patient
- ☐ Advocates on the patient's behalf in handover to RN and other appropriate people within the interprofessional team

Additional Comments:

Debriefing overview

Self-reflection (10 minutes)

Upon return to the observation room, ask students to take 10 minutes to reflect on their performance during the scenario. During this time, encourage students to write down what they feel they did well, and what they would like to improve on. Following completion of the group debriefing session, students will be given an opportunity to receive brief feedback from a staff member from their discipline. They may wish to bring up some of the technical/ discipline specific aspects to their reflection during this time.

Group Debriefing (30 minutes)

The primary aim of this activity is for students to gain an interprofessional learning experience, focussing on the following themes:

- Interpersonal and Communication Skills
- Patient-Centred and/or Family-Focused Care
- Collaborative Decision Making
- Understanding Roles and Responsibilities of health professionals
- Functioning as a Health care team

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Where possible it is encouraged that group debriefing and feedback be steered towards these topics. An advocacy – inquiry model is the recommended format for group debriefing. Under this model, debriefing is conducted in three stages:

1. Reactions
2. Understanding
3. Summary

1. Reactions

This stage allows the students an opportunity to release some emotions so that they can focus on constructive discussion.

Ask each student who participated in the scenario "How did that feel?" This will guide you on what issues may need to be covered further in the debrief. Listen, but do not make many comments at this stage. This section will highlight any topics they may like to cover in the understandings stage.

Then, review the clinical facts "Can you explain what happened during this scenario?" or "Can you explain what happened to the patient?" It is recommended that they report on the patient's problems, the assessment findings, any interventions provided, outcome measures used (if any) and how effective the intervention appeared. Let the students answer, then fill in the details if necessary.

2. Understanding

This stage allows exploration of the rationale for a student's behaviour or decision making. The observed action should be important to the individual and the group. It is recommended that an advocacy inquiry approach is used. "Student…. I **observed** X". "I was **concerned** that X occurred because….". "I am wondering **why** X happened" or "**Help me understand** why X happened?" Once an issue is exposed, generalise the discussion to the group. "Has this happened to/for anyone else?" "How did that feel?" Allow the group to discover solutions "How have you dealt with this problem in the past?" "Can anyone think of a strategy to overcome this problem in the future?"

It is also suggested that you focus on the positives from the scenario by asking the group "What went well?" Encourage the students to explore how they worked as a team and what they may have learnt about eachother's roles.

To help you with phrasing your questions, below are some examples:

Observation	Reasoning	Question
I noticed… I see/ saw that …. I hear / heard you say…..	I liked that…. I thought that was interesting I was thinking…. I was worried / concerned… I had the impression that … It seemed to me that ….	How do you see it? I was wondering, what are your thoughts? What were you thinking at the time? Help me understand how you decided that?

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3. Summary

In brief, review what was learnt throughout the session "Today we learned about…" You may wish to summarise the learning objectives. Ask each participant for their take home message from this scenario.

Discipline Specific Feedback (up to 20 minutes)

Using the remaining time, students may gather in their discipline specific groups led by a facilitator from their own discipline. Students may lead the discussion and identify any gaps or areas of concern regarding their performance.

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