2013

Betty

CARING FOR THE CONFUSED

SIMULATED LEARNING SCENARIO

Scenario Title:	Betty
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Acknowledgments	We are extremely grateful for the generous expertise provided by Associate Professor Chris Holmes, Professor Peter Disler, Dr. Dennis O'Connor, Ms Cathy Ward, Ms Adele Callaghan, and Ms Therese Worme who each provided valuable insight to make this scenario authentic. Thanks also to Michelle Lennan who is our actor and is integral to the success of the scenario.
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Pilot testing	31/01/2013, 1/02/2013, 6/02/2013
Pre-reading on DETECT 'Warm Hands Warm Feet' & 'The Confused Patient'	

Estimated actual Scenario time: 20 minutes **Prebriefing time:** 30 minutes

Debriefing time: 30-60 minutes **Set up and pack up time:** 40 minutes

Target group: Medical, nursing, and allied health professionals

Core Case: confusion and shock

Competencies:

- **Primary and Secondary Survey**
- **Abbreviated Mental test Score (AMTS)**
- **Glasgow Coma Scale (GCS) and Cognitive Assessment Method (CAM)**
- **Cardiovascular assessment**
- **Haemoydnamic monitoring and hydration assessment**

Brief Summary of Case:

Betty is a 168 cm, 72 kg 79 year old female. She has experienced a fall overnight in the hostel where she lives while trying to ambulate to the toilet. She has been assessed by the physiotherapist as having poor balance and a four wheeled walker with hand brakes has been recommended for use at all times. Betty dislikes this and often ambulates without it unless prompted by the staff. She became a resident 6 months ago and has developed functional decline with weight loss of 10 kg, subtle memory loss, withdrawal from activities, and poor appetite. Prior to moving into the hostel, Betty was living in her own home independently with her cat 'Tom'. Her husband John died 8 months ago.

Clinical signs at the scenario initially:

- Betty is lying on her right side in the bed with the side rails up
- She is anxious and asking for Tom (her cat that she used to have before moving into the hostel)…this cat was put down 6 months ago
- Looks frail, and appears to be in pain
- Asking to get out of bed to use the toilet (she has an indwelling catheter insitu)
- Vocalizing that she doesn't want her blood pressure taken, and pushing staff away

Evidence Base/ References	Clinical Practice Guidelines for the Management of Delirium in Older People – book, Quick Guide & Patient Information brochure http://www.health.vic.gov.au/acute-agedcare/delirium-cpg.pdf Inouye, S., Confusion Assessment Method: Training Manual and Coding Guide, 2003, MPH Lonergan E, Britton AM, Luxenberg J. Antipsychotics for delirium. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005594. DOI: 10.1002/14651858.CD005594.pub2. New South Wales Department of Education and Training. (2009) DETECT: Between the Flags. Keeping patients safe. Available from: (2009) http://nswhealth.moodle.com.au/DOH/DETECT/content/index.htm Siddiqi N, Holt R, Britton AM, Holmes J. Interventions for preventing delirium in hospitalised patients. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005563. DOI: 10.1002/14651858.CD005563.pub2. Richter T, Meyer G, Möhler R, Köpke S. Psychosocial interventions for reducing antipsychotic medication in care home residents. Cochrane Database of Systematic Reviews 2012, Issue 12. Art. No.: CD008634. DOI: 10.1002/14651858.CD008634.pub2. Tiziani, A., Harvard's Nursing Guide to Drugs, 7th Edition. (2006). Elsevier Australia Wong CX, Carson KV, Smith BJ. Home care by outreach nursing for chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD000994. DOI: 10.1002/14651858.CD000994.pub3.

A.SCENARIO LEARNING OBJECTIVES

Specific Learning Objectives

1. Describe the common causes of confusion, delirium, and altered consciousness
2. Practice assessing an older person with confusion and signs of shock
3. Demonstrate a systematic approach to assessing a person with altered consciousness incorporating Person-Centered Care principles
4. Demonstrate appropriate primary and secondary surveys, and appropriate tests to

rule out biological causes of confusion/altered conscious state
5. Identify and establish the common causes of shock in a patient with altered consciousness
6. Perform Abbreviated Mental Test Score(AMTS), Confusion Assessment Method(CAM), and GCS assessments
7. Provide appropriate interventions and management of a patient with an altered conscious state and shock
8. Demonstrate correct communication using ISBAR framework
9. Develop team work skills

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies
Required prior to participating in the scenario

Knowledge	Skills/Attitudes
☐ normal Aged care parameters	☐ Person-centered care
☐ Functional decline signs & symptoms	☐ Team-work
☐ Dementia versus delirium	☐ Communication
☐ Early & late warning signs of shock	☐ Documentation & reporting
☐ Treatment and management of above	☐ Delegation & referral

A. CASE SUMMARY

- **Betty has just been admitted to your ward and you are assigned to care for her**
- **It has been an hour since her last set of observations as below**
- **She is currently reporting hip and groin pain**
- **She has had nothing to eat and drink since last evening at tea**
- **Her son Neil has been called and is on his way in to see her**
- **CSMW to her left foot has been assessed an four hours ago**
- **Betty has two pillows between her legs to avoid adduction**

Scenario Design Case History

Patient details	**Betty Sanders DOB 2/12/1933** **5 Regent Place, Vic Dr. Morris**
Sex : female	**allergy status**: Haloperidol
Age: 79	**Ethnicity:** Australian
Spiritual Practice: Presbyterian	**Ht:** 168 cm **Wt:** 72 Kg **BMI** 25.51
Past History	CCF, HT, Rheumatoid arthritis, osteoporosis, spondylolisthesis, COPD, deafness
Current Medications	See chart below
Social History	Retired farmer. Moved into a hostel home 6 months ago. Widow, 4 children. Her oldest son lives locally on the farm, and the others

	moved to the city. Does not seem to enjoy her new environment and has 'wandered' off to the shops without letting staff know. She occasionally is found smoking down the street although she quit several years ago. Betty has several close friends who have died over the past few years, and does not socialize with the other residents. Her children visit once every six months. She has refused to attend day activities in the hostel. For the past few months Betty has demonstrated some functional decline, and short term memory loss, but is easily re-oriented and appropriate. She has lost 10 kg since moving into the nursing home. She says she dislikes the food served
Mobility assessment	Prior to the fall, Betty was assessed by the physiotherapist as having poor balance and a four wheeled frame with brakes was recommended, but Betty is non-compliant and often does not to use it.
History of present illness	She was found on the floor in the hallway at 0330 hours this morning, and was unable to get up independently. She was vague on admission to the acute ward, and is anxious and disoriented at times.
Presenting symptoms	Betty reported left hip and groin pain initially, and an x-ray has shown a fracture of the pelvis and left greater trochanter. Due to her frail state, her GP/surgeon feel that surgery would not be tolerated well, and therefore, she is for conservative management with bed-rest and pain relief and regular circulation observations
Initial observations	Temperature: 36.1, Blood Pressure 108/62 mmHg, pulse 104/min and regular, Respirations 26/min., oxygen saturations 92% on room air Circulation observations to left foot: Color: pale to bluish color Warmth: cool (same on right foot) Sensation: dull with no numbness or tingling Movement: slightly restricted due to pain

B. KEY CONTEXTUAL DETAILS

The patient will be a trained simulation actor

This scenario is best suited in an actual ward bed that is available. Alternatively, the minimum requirements are:

- A large room
- a patient bed or trolley with side rails
- bedside table
- documentation and usual notes of relevant health service
- AMTS, GCS, CAM forms and/or admission observation form with GCS
- Observation monitoring including stethoscope, sphygmomanometer, thermometer, oxygen saturation monitor
- Bedpan and specimen container with urinalysis sticks available
- Oxygen therapy equipment (mask, nasal prongs)
- IDC bag with Lemon cordial for 'urine'
- A large clock

Equipment props:

- Wig and eyebrows
- Make up including 'ageing' foundation and baby powder
- Dressing gown and night gown
- Slippers
- A picture of Betty's old cat 'Tom'

- Purse & glasses
- Lip stick
- Stockings/tights
- ID band with accurate information
- Allergy band

* IV cannula arm and equipment
* Normal saline one litre with tubing etc.
*IV pole
* dressing gown and nighty
* wooly socks and jewellery

Initial vital signs monitor display in simulation :
No monitor display
Observations should be initiated and they will be provided by educational facilitator

Primary Medical Diagnosis	fracture of the left pelvis & greater trochanter

Medications Pre-admission	**Drug**	**Dose**	**Route**	**Frequency**
	Panadol Osteo	2 tabs	oral	TDS
	Caltrate Plus	1 tab	oral	BD
	Prednisolone	5 mg	oral	OD
	Seretide 250/50 Accuhaler	1 puff	Inh	BD
	Coloxyl with Senna	1 tab	oral	Nocte
	Spiriva	18 Mcg	Inh	Daily
	Lasix	40 mg	Oral	Daily
	Metoprolol	12.5 mg	Oral	BD
	Aspirin	100 mg	Oral	Daily
	Candesartan	10 mg	Oral	Daily

Observations Pre-admission	**Observations**
Pulse	88/min
Blood Pressure	155/90 mmHg
Respirations	16/min
Oxygen Saturations	92% on room air
Temperature	36.2 Celcius

Hospital Admission Drug Chart

Medication Chart			
Drug	**Dose**	**Route**	**Frequency**
Clexane	40 mg	SC	Daily
Metoprolol	12.5 mg	Oral	BD
Paracetamol	1 g	Oral	QID
Aspirin	100 mg	Oral	Daily
Candesartan	10 mg	Oral	Daily
Lasix	40 mg	Oral	Daily
Ostelin	1000 units	Oral	Daily
Caltrate	600 mg	Oral	Daily
PRN Medications			
Metoclorpramide	10 mg	Oral	Q8Hprn
Endone	5 mg	Oral	Q3H prn
Morphine	2.5-5 mg	SC/IV	Prn
Ventolin	5 ml	Nebs	QID prn

Pathology results on admission

Hae-Haematology General (Full Blood Count)		
Date		**Normal parameters**
Haemoglobin	**72**	(115-165) g/L
RBC	**2.71**	(3.80-5.50) x 10 12/L
PCV	**0.24**	(0.35-0.47)
MCV	87	(80-99) fL
MCH	**26.6**	(27.0-32.0) pg
RDW	**15.1**	(11.0-15.0) %
WCC	**17.1**	(4.0-11.0) x10 9/L
Neutrophils	**13.0**	(2.0-8.0) x10 9/L
Lymphocytes	2.9	(1.0-4.0) x10 9/L
Monocytes	**1.2**	(<1.1) x10 9/L
Eosinophils		
Basophils		
Platelets	376	(150-450) x10 9/L

Biochemistry		
Date		**Normal parameters**
Sodium	**130**	(135-145) mmol/L
Potassium	4.6	(3.7-5.3) mmol/L
Chloride	**111**	(95-110) mmol/L
Bicarbonate	**17**	(20-32) mmol/L
Urea	**21.2**	(3.5-13.0) mmol/L
Creatinine	**107**	(40-85) umol/L
eGFR	**39**	mL/min/1.73m2

CRP-C-Reactive Protein		
Date		**Normal Parameters**
C Reactive Protein (CRP)	**41.8**	(<3.0) mg/L

	UMC-URINE MICRO/CULTURE		
Chemistry	Ph 6.0 Protein: Nil Glucose: Nil Blood: trace		**Normal Parameters**
Microscopy	Leucocytes	**220** x 10 6/L	(<10 x 10 6/L)
	Erythrocytes	**1000** x 10 6/L	(<10 x 10 6/L)
	Epithelelial Cells	**+++**	
	Casts	Moderate numbers of hyaline casts	
Culture	e-coli ++		

Betty-, Cathy Driver, Monash University, All data in this scenario is fictitious, January 2013

CSA REV template

CASE FLOW/TRIGGERS/SCENARIO DEVELOPMENT STATES	
Initiation of Scenario: Using simulation actor Betty was brought in by ambulance to your department via the emergency/acute care area following a fall. She was found collapsed on the floor of the hostel in the night after trying to get to the toilet without her frame. She is oriented to person only, and reports left hip pain. She has previously received analgesia with good effect. Betty has just been transferred to the acute ward for conservative ongoing management and you are now taking over her care. You have received a care plan from the hostel including her care plan and Webster pack with medication sheet. She has been asking for her deceased husband John. This is a new occurrence.	
STATE/PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**
Patient Actions for stage 1: • Betty seems to be in moderate to severe pain , and trying to sit up in bed • She is squirming around and becoming more restless and agitated • Betty's voice is raised • Betty's eyes are open, she squeezes hands when asked, but she is confused to place and time. Betty is slightly deaf, so staff need to speak loud & clear • She says she needs to go to the toilet, yet has and IDC insitu	Recommended words, behaviors, and statements: **Expected questions from staff and possible responses:** 1. Hi Betty, how are you?.....(Betty) Who are you? Where's Tom? 2. Betty, we're just trying to help you…….(B)why are you all in my bedroom? 3. Betty, we are the nurses taking care of you……(B)where's John? Where's John? Johnnnnnnn!!! 4. You are in the hospital, you had a fall……(B)Why are you in my bedroom? Get out! 5. What is your name, what's the date, and where are you?.....(B)I have to use the toilet, let me up! 6. Have you got any pain? Tell me how severe it is…….(B)My hip, my hip, my hip!!! 7. We just need to take your blood pressure and check you out to see how you are doing…(B)off me!! 8. You need to keep this pillow between your legs to protect your hip……(B)What are you doing? And Betty throws the pillow off the bed **If staff try to touch Betty, she responds as follows:** • If they try to take blood pressure, Betty moves away and says 'Get that off me'(Betty pulls off BP cuff) • If they try to listen to her heart and lungs, she shouts 'Just what do you think you're doing'?...'well, I never in all my life'! • If they try to put the pillow between her legs to prevent adduction, Betty shouts 'Keep your hands off'!!! and throw the pillow off the bed onto the floor • If they ask Betty to squeeze their hands, she does this eventually after a few requests • If they take her bed socks off or expose her legs to check them, Betty shouts out ooooohhhh, that's too cold, what are you doing? • If they ask you where you live or where you're from, …….that's none of your business!

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- She doesn't want the blood pressure cuff to be put on and resists this intervention
- She is anxious, agitated, and wants to know where John is (her deceased husband) & Tom is (her deceased cat)

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***If the staff are gentle, explain who they are, and what they're doing, then let them take your blood pressure and observations, but make it harder than usual.**

Staff must initiate requesting a family member or friend to come in to establish usual cognitive function: recency of onset, precipitating factors, management strategies that have worked in the past, and usual state

***Betty is not very cooperative, but she is not hostile or violent.**

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STAGE 1 (8-10 min)

1. **Baseline (~ 5-8 min)**
   Pulse 116/min., BP 100/56 mmHg, respirations 26/min., O2 sats 92% on room air, Temp 36.0
- GCS 14, AMTS
- CSMS to left foot decreased
- Oriented to person only
- ECG normal apart from sinus tachycardia
- FBC electrolytes attached
- CRP high
- UTI on urine microscopy
- Betty has skin tears on her left elbow and shin

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Triggers:

- **Primary and secondary survey completed**
- **Pre-admission observations checked**
- **Medication for pain relief administered**
- **500 ml fluid bolus commenced**
- **X11 leaad ECG checked**
- **AVPU assessment**
- **A = alert**
- **V=responds to voice**
- **P=Responds to pain**
- **U=Unresponsive**
- **AMTS completed**

***Assess and prioritise management using ABCDEFG algorithm**

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Leaner actions

- Perform primary survey
- Talk to Betty, introduce yourself, establish her orientation status using AMTS
- Do a set of baseline observations including oxygen saturations to rule out hypoxia and hypotension etc.
- Compare against previous observations
- Establish location, type, and severity of pain
- Check peripheral circulation (CSMW). Bilaterally cold feet may indicate decreased cardiac output
- Consider liaising with

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Debriefing Points:

***Maintain Betty's dignity, don't dismiss behavior as normal until proven otherwise**

***Key: rule out pathological causes for confusion**

***what are the early warning signs associated with altered conscious state?**

***understand the causes and consequences of an altered conscious state**

***initiate the initial management for confusion, and altered conscious state**

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		nursing home and/or relatives to establish baseline mental status, and oxygen saturation levels • Take or check blood pathology to rule out pathological causes of confusion • Consider ABG's • Take or check urine for microscopy to rule out UTI • Perform X11 lead ECG to rule out cardiac arrhythmias and/or ischemia/infarct • Explain she has a tube going into her bladder so she won't need to void. Explain that she is on bed-rest due to her fractured hip • Check when she last had analgesia and if she is due for more and proceed as ordered • Perform secondary survey… • Check her head and neck area to see if there	***Is Betty's problem chronic, acute, or a combination of both?** **Urinary tract infection and systemic infection on bloods and urine microscopy will exacerbate confusion and altered conscious state** **Sinus Tachycardia is likely due to her pain, agitation, and hypotention** **Betty is due for more analgesia. Pain can contribute to altered conscious state** **Betty has skin tears, but no other injuries apparent**

	☐ **The trigger to go to stage 2 is when Betty's son Neil arrives at the bedside** ☐ **Or, after 10 minutes, proceed to stage 2**	is any evidence she injured this area in the fall, and complete full examination to ensure she is not bleeding from anywhere else. • Check radiography has been completed and checked by medical team	
STATE/PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
Patient Actions for stage 2: Betty is deteriorating and starting to go into shock especially if the staff have not provided pain relief and IV fluids She is becoming less attached to reality and trying to climb out of the bed over the side rails It is becoming hard for staff to reorient her, and she is not cooperating with requests, and keeps repeating the same things over and over again like where's Tom, Where's John,. Let me out, let me out etc. Help, help, help!	**Recommended words and statements:** **Expected questions from staff and possible responses:** • Betty, we are just trying to help you, can you just stay still for a moment while we check your vital signs?.....push them off feebly and say no no no no no • Betty, you are in hospital and you've had a fall……I've done nothing of the sort • Your husband died Betty……..NNNNNOOOOOOOOOOOOOO • We're going to call you doctor to come and see you…no response • Your son Neil is on his way Betty…….'Who's Neil? Where's John, where's Tom? • Where are you Betty?.....Get out, get out! • Why are their spiders everywhere? Asks Betty….'I'm dizzy' **When Betty's son Neil arrives and says hello, Betty says 'Why are you here, where's John'?** **Actions for Betty to perform:** • Pull out the indwelling catheter and hold it up with a puzzled look on your face and say....'what's this'? • Try to climb over the side rails • Staff may try to administer medication. Betty will not take anything orally when staff try to give anything. (The only way they can is by via intravenous route)…If they do, Betty screeches…you are all trying to poison me! ***Betty allows staff to check her observations, but only after several attempts**		

STAGE 2 (2-4 min)	**Triggers:**	**Learner actions:**	**Debriefing points:**
• Pulse 124/min, BP 100/50 mmHg, Respirations 28/min., O2 sats 90% on room air • JVPNE • BGL 7.9 mmmol/L • You observe the IDC bag has 50 mls of dark, concentrated urine. Her urinalysis shows that she is dehydrated • Betty starts picking at her bed sheets and taking off the monitor and pulls out the IDC and says 'what's this'? • Betty's capillary refill is <5 seconds (delayed) • Her skin turgor is poor, and her tongue is furrowed with a thick yellow coating • Betty reports feeling a little dizzy • X11 lead ECG sinus tachycardia with no ischemia or infarct changes	**Betty's son Neil arrives and confirms that Betty's confusion is a new condition** • **Hypovolemia and shock identified** • **Administer following as per medication sheet:** • **Morphine 2.5 mg IV stat** **Phone orders received for:** • **IV Normal saline 500 mls over 30 minutes** • **Oxygen 6-8 lpm via Hudson mask** *****If they don't give fluid, pain relief, oxygen, or identify that she is showing signs of acute delirium, then stage 3** *****If they do give fluid, recognize deterioration, and shock secondary to pain and hypotention, then go to stage 4**	• Commence Betty on a fluid balance chart • Check IV patency to provide access for potential drug and fluid requirements • IV antibiotics for UTI • Perform a urinalysis • Check Betty's BGL • Perform another set of observations • Apply oxygen 6-8 lpm simple face mask • Organise 2 units of packed cells to address anemia & hypotension • Assess hydration status • Betty is showing signs of shock • Ask Betty again if she has any chest pain and how she is feeling(she has no chest pain) • Use ISBAR algorithm to report findings to doctor, AND • suggest fluids, and appropriate antipsychotic drugs; i.e. Respiradone, or	***Key: continue to identify physical causes for confusion and hypotension, report assessment findings to medical officer, and initiate appropriate care** ***what are the early signs of shock?** -poor peripheral circulation with poor cap refill -decreased urine output -Spo2 90% -SBP 100 mmHg ***Call for help as this is a medical emergency**

		Olanzapine 10 mg IM ***following*** fluids and pain relief if no improvement in symptoms • If participants report UTI, then Ampicillin 500 mg IV Q6h	
STATE/PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
Patient Actions for stage 3: Betty is now completely delusional and delirious She is no longer responding to you appropriately even when asked questions about who you are(Betty Sanders) Betty's eyes are closed now, but open to speech and randomly Betty seems to be completely separated from reality	**Recommended words and statements:** **Expected questions from staff and possible responses:** • Betty, squeeze my hand……..no response • Betty, can you hear me……moan • Best response is if they pretend to illicit pain to get a response and you push them away • Betty starts making incomprehensible sounds; • 'Jjjjjjjoooo • 'MMMMMUUUUU • 'HHHHHHIIIIIIIIIllmmm		

STAGE 3 (3-8 min) • Betty becomes less responsive… • Betty 's GCS is now 11 • Her eyes are closed now, and she only responds to speech, she does not obey commands to squeeze hands, and she is making incomprehensible sounds • Observations: Pulse 130/min., BP 90/50 mmHg, respirations 26/min., oxygen saturations 90% on oxygen	**Triggers: If they don't check bloods or rule out pathological causes of confusion, then deterioration until they identify she is in shock, and needs immediate emergency response**	**Learner actions:** • **DRABCD** • **Maintain supportive measures and ensure IV access x 2** • **Administer packed cells** • **Repeat assessments and observations** • **GCS completed and recorded**	**Debriefing points:** ***follow up correct interventions, think about person-centred care, and urgent medical review and/or referrals that may be required** **She will need transfer to larger regional centre for pinning of her hip and femur and rehabilitation**
STATE/PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
Patient Actions for stage 4: • Betty is becoming more responsive and her eyes open to speech, obeys commands to squeeze hands or wiggle toes • She is oriented to	**Recommended words and statements:** **Expected questions from staff and possible responses:** • Hi Betty, can you tell me your name?.....Betty Sanders • Can you tell us where you are and the date?.....I'm at home aren't I**?**		

person only • She is cooperative and allows staff to take her observations and is less agitated • Betty looks at her picture of her cat and says "Tom"			
STAGE 4 (3-8 min) • Betty's GCS 13 and she is showing signs of improvement Her eyes are closed, but opens to speech, she obeys commands to squeeze hands, but she is still confused and only oriented to person She is less agitated and more easily guided/responsive • AMTS is improved to 4 • Observations: Pulse 102/min., BP 110/60 mmHg, respirations 22/min., oxygen saturations 94% on Oxygen	**Triggers:** • **Observations re-checked** • **GCS re-checked** • **Re-oriented gently and reassured**	**Learner actions:** • **DRABCD** • **Consider ABG's** • **Consider CT scan of the brain** • **Manage pain control** • **Consider moving Betty into a room closer to the nursing station** • **Consider having Neil stay with her** • **Consider psychiatric review** • **Put familiar items near Betty to make her feel more oriented and secure** • **Ensure her glasses and hearing aides are put on and in**	**Debriefing points:** ***Consider moving Betty back to her usual bed in the hostel if stable enough** ***Consider transfer to Anne Caudle Centre for rehabilitation** ***Geriatric Evaluation and Management need to be involved if symptoms remain unresolved in 24-48 hours** ***Review the evidence-based pathways for management of delirium in acute settings for both medical & nursing team** ***May need one-to-one nursing care & allow family to stay overnight**
STATE/PATIENT STATUS	**SCENARIO COMPLETED**		