

Adult Medical/Surgical Simulation – CAP & ACS: Student Packet

This packet contains the information you need to be successful in the simulation session we have designed for you.

The packet consists of:

1. This document
2. Information on how to prepare for the day in simulation.
3. The case summary for your patient with Community Acquired Pneumonia (CAP)
4. The case summary for your patient with Acute Coronary Syndrome (ACS)

Read through this information and the referenced documentation carefully. As some of the information is provided to you in video form, you are expected to watch the videos to become familiar with the equipment and/or the simulation education processes we employ.

Check the simulation calendar linked from the N420 theory course iLearn page for the date and time of your group's simulation session. Also note the room where you are to meet your instructor. We have a packed day of activities for you so arrive on time, ready for a clinical day.

Preparing for Simulation

First things first, please remember that simulation is designed to be a safe environment for making mistakes. We do not expect perfection from any of you at this point in your education. What we DO expect is that you will approach today with an open mind and an honest desire to learn from the experiences we have designed for you. Accept mistakes as easily as you accept successes and you will get more out of your day in simulation than you think.

As part of the safe environment, once we leave the simulation lab we do not discuss the actions of our peers outside of simulation. **What happens in simulation, stays in simulation.** If we can't trust that our foibles in simulation will not become public knowledge, we can't safely attempt to succeed and gain from the small failures we may encounter.

Respect the effort we have expended to create these experiences. Please do not discuss the simulation activities with your classmates. Let them experience what you will be experiencing so they have the opportunity to learn as much as you will learn.

This simulation is set up to allow you to deal with two patients, one, a homeless woman with Community Acquired Pneumonia (CAP) and the other, a woman experiencing signs of an acute cardiac event. The umbrella term for this is Acute Coronary Syndrome (ACS). We designate these experiences as CAP 1 & 2 and ACS 1 & 2. We will do CAP 1 & 2 first, followed by ACS 1 & 2.

At this time, we are not using DocuCare in simulation so we have a hardcopy chart for you to use. This chart will be made available to you just before you enter the room to interact with the patient.

You will be divided into two groups, Group A & Group B. Each group will be in a simulation experience twice. Group A will be involved with CAP 1 and ACS 2. Group B will be involved with CAP 2 and ACS 1.

Each group will consist of two RNs, and a recorder. If there are four of you in a group, the fourth person will be our runner. Those of you not in an RN role in your first experience will be RNs in the second. How do we choose who will be in which roles at the outset? We let your instructor do that or we let it be by random chance using a deck of playing cards.

Let's spend a few moments to discuss the roles. The two RNs may seem obvious but we expect one of you to be in a primary nurse role. The two of you decide on how you wish to divide up the responsibilities in the room. That division of labor is part of the reason we do this; we want to see how effective the two of you are at getting things done in a medical/surgical situation.

The recorder's job is to be in the room and writing down everything s/he feels is important. Please record the times when these important events or actions took place using the clock on the wall in the room as your timepiece. What's important? That's what we want to know! Based upon your knowledge of the objectives of the exercise, what do **you** think was important? Write it down and we will discuss your list during the debriefing.

The runner is also going to be in the room, just inside the door. Anything that needs to be brought into the room will be given to you at the door with instructions on how to deliver it. Do not leave the room looking for things; we will bring the items to you when requested by the nurses.

The runner's other job is to watch for cases of communication – positive and negative – that occur between the two nurses and between the nurses and outside parties. What was said? What

was the response to what was said? We know you be hearing only half the conversation when a nurse is calling someone on the telephone; just give your thoughts on what was said and what you think the other person might have said. And, yes, you may want to have a pen and paper handy. Your observations of the communication aspects will also be discussed during the debriefing.

While one group is in the room with the patient, the other group will be in the ODR (Observation and Debriefing Room) observing the events. Observation in simulation is **active observation**. Each of you will have an assignment, to look for specific actions that represent one or more of the following competencies:

- Safety
- Effective Communication
- Delegating
- Critical Thinking
- Technical Skills
- Prioritizing
- Patient Centered Care
- Patient/Family Teaching

Your instructor will make these assignments.

Prior to entering the simulation room, the objectives of the scenario will be read and a shift change report performed so everyone – participants and observers alike -- knows the situation at the start of the exercise.

Upon completion of the experience, you will return to the ODR where you will have what's known as a debriefing with your instructor. Debriefing is a post-experience analysis of the events and actions as they pertain to the objectives of the exercise. All of you – participants and observers alike -- will be expected to take an active role in the debriefing.

So how will you know when the experience is completed? We have a PA (Public Address) system in the room so we can speak to you from outside the room. When it is time to enter, you will hear **"Dr. Green"** paged to the room. At the completion of the experience, we will page **"Dr. Black"** to the room. Dr. Black does not mean pivot on your heels and dash out of the room. Close out your patient's room. Check for safety issues, say good-bye to your patient and exit the room. Don't worry about putting equipment back the way you found it; we have staff who will reset the room for the next experience.

One question that always comes up is this: How long are the experiences in the room? The answer is, it depends. We allocate 20 minutes for each experience but rarely do they go that long because the endpoint is determined by achieving milestones associated to the objectives of the exercise. For example, if one of the objectives was to have you convey information about your patient using SBAR communications, as soon as you completed a phone call to the doctor or another external healthcare person, the exercise may be ended. You have achieved the objective(s). On average, experiences last between 12 and 15 minutes.

On the day of your simulation activities you will be given an orientation to the room and to the human patient simulator. As part of that orientation, we have prepared a group of videos on the various equipment you will find in the room. Please go through the documents and videos described below and become familiar with their contents.

Orientation to SimMan 3G Human Patient Simulator Note: This video comes from McMasters University and is designed for preparing medical students and/or trained medical staff for running mock codes. Thus, a lot of attention is paid to the features of airway and cardiac emergency interventions.	http://youtu.be/2wWI6yDJUXg
The Magic Phone (Video)	http://youtu.be/NtT3RBf15g0
The Magic Phone (PDF)	http://bit.ly/1AV8PwK
The Laerdal Monitor (Video) Note: This video was shot in the Pediatrics room but the monitor's controls are the same in the Med/Surg room.	http://youtu.be/oDb7BL0fqI0
How to Operate the Hill-Rom Bed (Video)	http://youtu.be/LXP-7VLPAEo
Orientation to the Oxygen Flow Meter (Video)	http://youtu.be/JQobKbH7e8A
Orientation to the Suction Regulator (Video)	http://youtu.be/tyhjf1ksjKo
Sometimes it really IS That Simple (PDF)	http://bit.ly/1x6H6p8
Optional: Adjusting the Height of the Charting Station (Video)	http://youtu.be/11U_g7qPKQo

See you on your simulation day!

Community Acquired Pneumonia Case History

48 year-old homeless female brought in by homeless shelter worker due to increasing productive cough, fever and dyspnea. She reports being sick for one week, getting worse over past two days. Unable to sleep because of coughing. She is a 30 pack year smoker and an alcoholic. CXR and sputum culture obtained in the ED. Being admitted to the medical surgical floor with a diagnosis of rule out Community Acquired Pneumonia (CAP).

Objectives

1. Demonstrate accurate assessment with focus on the respiratory system.
2. Be aware of patient change in status and prioritize interventions.
3. Assess environment for any safety issues.
4. Effectively communicate any changes to health care team using SBAR.
5. Institute infection control measures.
6. Recognize signs of increased anxiety.
7. Administer medications safely.
8. Support the patient as needed.

Acute Coronary Syndrome Case History

58 year-old female admitted from ED to telemetry unit with new onset chest pain and diagnosis of Acute Coronary Syndrome (ACS). NTG, ASA and O2 given in ED with relief of chest pain. Lab, CXR and EKG demonstrated no cardiac marker elevations or significant EKG changes. Risk factors: overweight and smokes one pack per day.

Objectives

1. Recognizes acute changes in patient condition and acts accordingly.
2. Communicates effectively with patient.
3. Makes appropriate decisions regarding medication choices.
4. Performs timely interventions to address urgent problems.
5. Communicates status to charge nurse using SBAR.
6. Prioritizes interventions based on interpretation of data.
7. Able to put together all of the info to identify patient's current problem.
8. Recognizes laboratory abnormalities, abnormal rhythms and need for MD orders.
9. Initiates call to MD with SBAR.
10. Administers medications safely.