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SECTION I: SCENARIO OVERVIEW

Scenario Title:	Adult Med-Surg & Interprofessional Nursing/Social Service Alcohol Withdrawal; Schizophrenia
Original Scenario Developer(s):	Colleen Nevins, DNP, RN, CNE; Jaime Hannans, PhD, RN, CNE; Charlene Niemi, PhD, RN, PHN, CNE
Date - original scenario	02/01/2013
Validation:	09/20/2015 – Marjorie Miller, MA, RN, CHSE
Revision Dates:	02/28/2015; 09/23/2015; 01/31/18
Pilot testing:	03/21/2013; 03/20/2014; 03/26/2015

Estimated Scenario Time: 20 – 25 minutes Debriefing time: 30 – 40 minutes
Target group: Pre-licensure nursing students
Core case: Alcohol Withdrawal
QSEN/IOM Competencies:
□ Patient-Centered Care
□ Safety
□ Teamwork & Collaboration

Brief Summary of Case:
Patient is a homeless adult male/female brought in by ambulance after found unresponsive lying in the street, smelling of alcohol. Blood draw results in ED were alcohol level of 0.26 and drug screen positive for THC. He/she has a history of schizophrenia with paranoia, and per last hospital record, the patient was prescribed Olanzapine (Zyprexa) 10 mg daily. Patient is admitted to a medical-surgical unit for IV fluids, monitoring, and stabilization. Patient becomes uncooperative and agitated on morning of hospitalization day 2, requesting to leave against medical advice.
The learner is expected to use therapeutic communication, evaluate using Clinical Institute of Withdrawal Assessment scale, demonstrate professional behaviors to assess the patient, and contact interprofessional health care providers (i.e. social services) to help identify resources to meet patient needs. The learner must maintain safety for the patient and use SBAR when handing off information.
This scenario is appropriate for advanced medical-surgical students or new graduates. Complexity can be enhanced by having the patient become increasingly confused, agitated, hallucinating, or becoming violent and/or having seizure activity.

EVIDENCE BASE / REFERENCES (APA Format)

Donnelly, G., Kent-Wilkinson, A., & Rush, A. (2012). The alcohol-dependent patient in hospital: Challenges for nursing. *MEDSURG* Nursing, *21*(1), 9-36.

Hermanns, M. L. S., & Russell-Broaddus, C. A. (2006). “But I’m not a psych nurse!” *RN, 69*(12), 28 – 32.

Mirijello, A., D'Angelo, C., Ferrulli, A., Vassallo, G., Antonelli, M., Caputo, F., & ... Addolorato, G. (2015). Identification and Management of Alcohol Withdrawal Syndrome. *Drugs*, *75*(4), 353-365. doi:10.1007/s40265-015-0358-1

Sideras, S., McKenzie, G., Noone, J., Diekmann, N., & Allen, T. L. (2015). Impact of simulation on nursing students’ attitudes toward schizophrenia. *Clinical Simulation in Nursing, 11*(2): 134-141. http://dx.doi.org/10.1016/j.ecns.2014.11.005

Sideras, S., McKenzie, G., Noone, J., Markle, D., Frazier, M., & Sullivan, M. (2013). Making simulation come alive; Standardized patients in undergraduate nursing education. *Nursing Education Perspectives*, *34*(6), 421-425. DOI:10.5480/1536-5026-34.6.421

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Analyze assessment data characteristics of a patient with alcoholism and schizophrenia.
2. Utilize the nursing process in prioritizing care for a patient with addictive behaviors and mental illness.
3. Provide patient-centered care utilizing principles of safety and minimize risk of error.
4. Integrate understanding and skill in collaborative care between multiples disciplines.

Specific Learning Objectives

1. Apply principles of hand hygiene and infection control.
2. Correctly identify patient using two identifiers.
3. Utilize assessment technique in gathering relevant patient data.
4. Cluster relevant data to identify and prioritize patient problems.
5. Perform timely nursing dependent and interdependent interventions to address priority problem(s).
6. Evaluate effectiveness of interventions.
7. Communicate effectively with the patient and interprofessional personnel.
8. Administer medications using principles of safety.

Critical Learner Actions

1. Demonstrate washing hands, introducing self, and identifying the patient using two identifiers.
2. Perform assessment, recognizing signs of increased anxiety/agitation and safety risks.
3. Identify signs and symptoms of delirium tremens.
4. Utilize Clinical Institute Withdrawal Assessment (CIWA) scale for alcohol intoxication monitoring.
5. Employ interdependent nursing intervention by facilitating collaborative care planning in order to intervene appropriately to promote physiological and psychological safety.
6. Use therapeutic communication with the patient to assure needs, values, and preferences are understood and relayed to the health care team.
7. Collaborate with social services to develop and validate interventions.
8. Administer medications using three checks and six rights to assure safety.
9. Hand off communication to health care team members using a standardized tool, e.g., SBAR.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies

Knowledge	Skills/ Attitudes
❑ Nursing process	❑ General survey and head-to-toe assessment
❑ Etiology of alcohol withdrawal	❑ Therapeutic and professional communication
❑ Pathophysiology of alcoholism and schizophrenia	❑ Nursing interventions for alcohol withdrawal and mental health issues, including use of CIWA scale
❑ National Patient Safety Goals	❑ Value active participation in plan of care
❑ Dimensions of patient-centered care	❑ Value the perspectives and expertise of all health team members
❑ Six rights of medication administration	❑ Effective use of technology and standardized practices that support safety and quality
❑ Structured communication tool, i.e., SBAR	❑

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SECTION III: SCENARIO SCRIPT

A. Case summary
A 33-yr-old male (or female) with a history of alcoholism and schizophrenia, is admitted to the medical-surgical floor from the ED the night before last, after being found unresponsive in the street. He/she presented to the ED obtunded, and only responsive to painful stimuli, with positive drug and alcohol screening, along with low magnesium level. CT of head was WNL. IV fluids were administered, and patient monitoring continued since admission. He/she has been a poor historian about past medical history and drug/alcohol use. The patient is now alert, oriented to name and place, becoming increasingly agitated with notable tremors, pacing, talking to self and uncooperative with care. The patient asks every person who enters the room to sign his/her notebook. He/she continually asks about the location of his/her belongings and his/her dog. Patient becomes restless and frustrated, expressing a desire to leave the hospital.

B. Key contextual details

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ √ Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
Team Leader	Oversees and guides care; communicates with healthcare team	L
Primary Nurse	Assessment and evaluation of patient	L
Secondary Nurse	Interventions including medication review and administration	L
Social Worker	Assists with de-escalating patient through negotiation; assists patient with available resources;	L or SP
Friend	(optional; may omit this role)	SP

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D. Patient/Client Profile				
Last name:	Jones		First name:	R. Kelly
Gender: Male/Female	Age: 33	Ht: 178 cm (5'10")	Wt: 77.27 kg (170 lbs)	Code Status: Full
Spiritual Practice: Unknown		Ethnicity: Caucasian		Primary Language spoken: English

1. Past history

R. Kelly Jones is a 33-year-old homeless male/female after found unconscious in the street 2 days ago and was brought to ED via ambulance. Blood draw results in ED showed an alcohol level of 0.26 and drug screen positive for THC. Ct of the head was WNL. He/she has a history of schizophrenia with paranoia, and per last hospital record, the patient was prescribed Olanzapine (Zyprexa) 10 mg daily. Patient was admitted to a medical-surgical unit for IV fluids, monitoring, and stabilization. The patient has received 2 banana bags. He/she is awake and alert but appears more agitated this morning, asking about his/her belongings and dog. Vital signs are stable.

Past medical history: Alcohol abuse; Schizophrenia with paranoia; probable drug use.

Primary Medical Diagnosis	Alcohol Withdrawal; Schizophrenia

2. Review of Systems

CNS	Alert, oriented x 2 (person, place)
Cardiovascular	Regular sinus rhythm, no gallops, rubs or murmurs; apical clear S1 and S2; radial and pedal pulses +3
Pulmonary	Lung fields clear bilaterally
Renal/Hepatic	WNL
Gastrointestinal	WNL
Endocrine	WNL
Heme/Coag	No abnormal bleeding or bruising noted
Musculoskeletal	WNL
Integument	Intact; tanned face, hands and feet; dirt under nails
Developmental Hx	Normal adult
Psychiatric Hx	Diagnosed with schizophrenia at age 20
Social Hx	Homeless with known alcohol abuse; Denies drug use or smoking
Alternative/ Complementary Medicine Hx	Unknown

Medication allergies:	NKDA	Reaction:	
Food/other allergies:	NKA	Reaction:	

3. Current medications	**Drug**	**Dose**	**Route**	**Frequency**
	Olanzapine	10 mg	PO	daily

4. Laboratory, Diagnostic Study Results					
Na: 144	K: 4.0	Cl: 100	HCO3:	BUN: 24	Cr: 1.4
Ca: 9.3	Mg: 1.9 mEq/L	Phos:1.7 mEq/L	Glucose: 118	HgA1C:	
Hgb: 13	Hct: 36.8	Plt: 155,000	WBC: 5,200	ABO Blood Type: O+	
PT	PTT	INR 1.0	Troponin:	BNP:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV: Neg	Cxr:	EKG
ETOH: 0.26	Albumin: 2.9	AST/SGOT: 38	ALT/SGPT: 36	CT of Head: WNL	

E. Baseline Simulator/Standardized Patient State

1. Initial physical appearance					
Gender: Male/female	Attire: Hospital gown, posey vest on and untied				
Alterations in appearance (moulage): Hair disheveled; Nail beds dirty; Bed sheets messy; area cluttered; belongings in bag on bed. Patient sitting at bedside wearing posey vest over gown/pants/slippers. ID band pinned to posey –					
√	ID band present, accurate		ID band present, inaccurate		ID band absent or not applicable
√	Allergy band present, accurate		Allergy band inaccurate		Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:					
√	No monitor display		Monitor on, but no data displayed		Monitor on, standard display
BP: 144/86	HR: 104	RR: 20	T: 99.2° F. oral		SpO^2: 94%
CVP:	PAS:	PAD:	PCWP:		CO:
Lungs:	Left:			Right:	
Heart:	Sounds:				
Bowel sounds:			Other:		

3. Initial Intravenous line set up						
√	**Saline lock #1**	Site: Left Arm *(pulled out; lying on bedside table)*			√	IV patent (Y/N) - Y
	IV #1	Site:	Fluid type:	Initial rate:		IV patent (Y/N)
	Main					
	Piggyback					
	IV #2	Site:	Fluid type:	Initial rate:		IV patent (Y/N)
	Main					

4. Initial Non-invasive monitors set up						
√	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:

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Environment, Equipment, Essential props Recommend standardized set ups for each commonly simulated environment
1. Scenario setting: (example: patient room, home, ED, lobby)
Patient room

2. Equipment, supplies, monitors
(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
	Progress Notes		Graphic record		Anes/PACU record		ED Record
	Med Reconciliatn		Transfer orders		Standing orders		ICU flow sheet
√	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)

#	Medication	Dosage	Route		#	Medication	Dosage	Route
1	Olanzapine	10 mg	Po		5	Geodon	10 mg	IM
2	Chlordiazepoxide	100 mg	Po					
3	Lorazepam	2 mg	Po					
4	Lorazepam	1 mg	IV					

ALL DATA IN THIS SCENARIO IS FICTITIOUS

<table>
<tr><th colspan="4">CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES</th></tr>
<tr><td colspan="4">Initiation of Scenario: Charge Nurse Report at 0700: The patient is a homeless adult male or female brought in by ambulance to the ED 2 days ago after found unresponsive in the street with blood alcohol of 0.26 and testing positive for THC. Admitted to medical-surgical unit for IV fluids, observation, and monitoring. Patient has a history of schizophrenia with paranoia and prescribed Olanzapine (Zyprexa) 10 mg daily. Patient slept most of the day yesterday but was awake most of the night. Patient seems anxious this morning, exhibiting tremors, pacing, and talking to self in room. Vital signs are normal. IV per saline lock. Plan today per orders is Psychology and Social Service consults. As nurses, you are asked to perform an assessment, continue MD orders, and intervene appropriately.</td></tr>
<tr><th>STATE / PATIENT STATUS</th><th colspan="3">DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</th></tr>
<tr><td>Baseline
Patient sitting at side of bed wearing posey vest over gown, wearing pants and slippers. Hair is disheveled and nails dirty. ID band pinned to posey – patient refuses anything around wrists.

Patient agitated, constantly smacking lips; dialing phone. Patient tremulous; frequently pacing. Patient demands all personnel “sign” his/her small notebook before starting any procedures.

Saline lock pulled out and on bedside table along with restraints.</td>
<td>Operator

N/A – use of standardized patient; vital signs verbalized by operator or pre-set electronically, e.g., iPad, monitor
Initial vital signs:
BP: 144/86
HR: 104 regular rhythm
RR: 20
T: 99.2 F orally
SpO2: 94%, room air

Triggers:
Learner performs actions within 10 - 15 minutes</td>
<td>Learner Actions

1. Enter room, wash hands, and introduce self & role.
2. Identify the patient using 2 identifiers (name, DOB).
3. Engages patient in plan of care, calmly explaining need for assessment and morning medications.
4. Assess Vital Signs
5. Performs neuro, cardio, respiratory systems.
6. Assess for tremors, nausea, vomiting
7. Acknowledge patient anxiety
8. Uses the Clinical Institute Withdrawal Assessment (CIWA) scale to calculate score.
9. Accommodates patient by writing name in notebook.
10. Secondary nurse looks up medications.</td>
<td>Debriefing Points:

1. The Joint Commission National Patient Safety Goals: Patient identification
2. Therapeutic communication techniques
3. Assessment of medical-surgical patient
4. CIWA scale for scoring to quantify status in severity of alcohol withdrawal
5. Nursing care of patient with schizophrenia disorders</td></tr>
</table>

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State / Patient Status	Desired Actions & Triggers to Move to Next State		
Frame 2 Patient tries to use phone to call a taxicab, stating "I need to go because my friend has my dog. My friend is going to take my dog Smokey if I don't get out of here. What happened to all my belongings? Who took them?" Patient becomes highly anxious, frequently pacing. Refusing to take Zyprexa as ordered. Refuses to take Lorazepam. Patient expresses he/she is going to leave "as soon as he can find all of his/her belongings." **Optional:** Patient becomes angry and argumentative to friend, demanding his/her dog back.	**Operator:** Vital signs verbalized by operator or pre-set electronically, e.g., iPad, monitor Vital signs: BP: 166/90 HR: 118 regular rhythm, sinus tachycardia RR: 24 T: 99.2 F orally SpO2: 94%, room air **Triggers:** Learner completes actions within 5 minutes.	**Learner Actions:** 1. Primary nurse and/or Team Leader use therapeutic communication attempting to calm patient. 2. 2nd nurse washes hands, identifies self, informs patient of time for medications; identifies using 2 identifiers. (name, DOB) 3. Engages patient in plan of care, calmly explaining reason and action of Olanzapine and Chlordiazepoxide. 4. 2nd nurse demonstrates use of 3 checks; 6 rights of med. admin. 5. 2nd nurse discusses observations of anxiety w/patient, suggesting need for meds including option of Lorazepam Po. 6. 2nd nurse informs TL of ↑agitation, refusal of meds; poss. of AMA. 7. TL calls for Social Service and Psychology to assist with patient. **Optional:** Friend arrives and informs patient that he/she has the dog but does not know how long he/she can take care of it. Friend leaves irritated and angry.	**Debriefing Points:** 1. National Patient Safety Goals: Identifying patients at risk for suicide. 2. QSEN competencies of patient-centered care, safety, teamwork and collaboration. 3. Strategies for meeting patient needs during escalating situation. 4. Recognition of interprofessional resources and roles, i.e., Psychology, Social Service. 5. The 3 checks and 6 rights in medication administration.

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<table>
<tr><th>STATE / PATIENT STATUS</th><th colspan="3">DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</th></tr>
<tr>
<td>Frame 3
Patient anxious, tremulous, pacing. Patient states “No need to come in, I’m leaving.”

Patient responds to negotiation, agreeing to accept shelter accepting her dog.</td>
<td>Operator:
N/A

Triggers:
Actor/leaner interaction completed in 5 minutes</td>
<td>Learner Actions:
1. Social Service approaches patient, introducing self; identifies pt. w/2 identifiers after washing hands.
2. Social Service explains that the physician has ordered a consult; to determine how to help the pt. in their current situation during and after hospitalization.
3. Social Service personnel asks patient if okay to sit down.
4. Social Service:
a. Acknowledge anxiety; discusses pts. perceived needs
b. Negotiates w/pt. to not leave AMA in exchange for finding shelter and her dog
c. Discusses reason for meds
d. Summarizes agreement that SS will find shelter that will allow a dog
e. Informs pt. that it could take 2 hr. to make arrangements
5. SS thanks pt for being cooperative.
6. Primary Nurse stays in room to observe interaction; informs TL & 2nd nurse of new plan.</td>
<td>Debriefing Points:
1. Teamwork and collaboration skills, including QSEN KSA competencies
2. Closed loop communication</td>
</tr>
<tr><td colspan="4">Scenario End Point: Total time 20 – 25 minutes. Social Service depart to call homeless shelters; Charge Nurse returns to relieve/ receive report.</td></tr>
<tr><td colspan="4">Suggestions to <u>decrease</u> complexity: Patient history excludes diagnosis of schizophrenia.
Suggestions to <u>increase</u> complexity: Patient exhibits increasing signs of alcohol withdrawal, e.g., agitation, auditory and visual hallucinations, increase tremors, seizure; patient escalates to violence.</td></tr>
</table>

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APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Jones, R. Kelly **DOB:** **Age: 33** **MR#:**	**Diagnosis:** **Alcohol Withdrawal** **Schizophrenia**

☐No Known Allergies ☐Allergies & Sensitivities		
Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
x/x/xx		1. Admit to Medical-Surgical Unit 2. Institute protocol for Detox Precautions 3. Clinical Institute Withdrawal Assessment (CIWA) each shift 4. Safety restraints per protocol 5. D5 ½ NS 1000 ml with 20 mEq KCL, 1 amp MVI, 100 mg thiamine, 200 mcg Folic Acid, 1 Gram Magnesium at 125 ml/hour; infuse 2 liters then convert to saline lock 6. Olanzapine 10 mg po daily 7. Chlordiazepoxide 100 mg po every 8 hours 8. Lorazepam 2 mg po every 2 – 4 hours prn to maximum of 10 mg per 24 hours for anxiety, tremors 9. Ziprasidone (Geodon) 10 mg IM every 2 hours prn for agitation or anxiety, up to maximum of 40 mg per day 10. Lorazepam 1 mg IV push for seizures and call MD 11. I & O 12. Regular diet 13. May be up and ambulate freely 14. Psychology consult 15. Social Services consult for discharge planning
Signature		

APPENDIX B: Digital images of manikin and/or scenario milieu	
Insert digital photo here	Insert digital photo here
Insert digital photo here	Insert digital photo here

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APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☒ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☒ Debriefing Guide	☐ 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 this experience feel for you and the team?
2. Have you had a similar experience to this before? If so, can you share that experience?
3. Take a few minutes to think about what was most important to you in delivering care to the patient during this experience. I would then like to hear your thoughts.
4. The main objective of the simulation was to learn about recognizing signs of alcohol withdrawal and appropriate intervention including dealing with safety risks.
   a. With that in mind, can you identify aspects of your nursing care where you addressed the objectives?
   b. Are there any aspects of your care that you would handle differently if you could?
5. What communication strategies did you use in care of the patient?
6. What communication strategies did you use with the healthcare team?
7. Questions to Actor (patient):
   a. How did you feel during this episode of care?
   b. Could nursing have done anything different to make you feel comfortable with the care you received?
8. What are the priorities of care for a medical-surgical patient with alcohol withdrawal and schizophrenia?
9. What are the actions of each of the prescribed medications? How do they assist in the management of the patient?
10. How do you respond to a patient who is reluctant to medical care?
11. Discuss the importance of developing an interprofessional plan of care with a patient, who is experiencing alcohol withdrawal and complicated by a history of schizophrenia?
12. How does the Clinical Institute Withdrawal Assessment (CIWA) contribute to assessment and plan of care?
13. Discuss when patients are safe to be released AMA.

Notes for future sessions:

Addendum:

1. Clinical Institute Withdrawal Assessment (CIWA) Scale
2. Sample Script for Patient & Social Service