SECTION I: SCENARIO OVERVIEW

Scenario Title:	Skin Assessment in elderly patient
Original Scenario Developer(s):	C. O'Leary-Kelley PhD, RN, CNE; L. Sweeney MS, RN, CNS
Date - original scenario	10/509
Validation:	12/09 K. Bawel-Brinkley, PhD, RN, CNE
Revision Dates:	12/10, 4/18 MMiller, MA, RN, CHSE
Pilot testing:	01/10 M. Miller, MA, RN
QSEN revision:	04/11 C. O'Leary-Kelley PhD, RN, CNE, M. Miller, MA, RN, CHSE

Estimated Scenario Time: 15-20 minutes Debriefing time: 30-40 minutes

Target group: Pre-licensure nursing students; Fundamental
Core case: Fundamentals; Basic Safety-skin assessment

QSEN Competencies: Patient-centered Care, Safety

Brief Summary of Case: Mrs. Foster is an 82-year old woman who was admitted the previous day from an assisted living facility with cellulitis to her RLE (ankle). She was admitted for IV antibiotic therapy and treatment for mild dehydration. Today she has had a low grade fever but otherwise her vital signs are stable. She has a history of Type II diabetes that has been well controlled with medication. Learners are expected to perform a general survey and to assess LOC and vital signs. They are to perform a skin assessment, intervene and communicate assessment data to charge nurse using SBAR communication.
This scenario is appropriate for beginning nursing fundamentals students. It can be made more complex by making the patient increasingly agitated or unstable.

EVIDENCE BASE / REFERENCES (APA Format)

Baronoski, S. & Ayello, E. (2016). Wound Care Essentials: Practice Principles 4th Edition. Wolters Kluwer, NY

Edsberg, L., Black, J., Goldberg, M., McNichol, L., Moore, L. & Sieggreen, M. (2016). Revised National pressure Ulcer Advisory Panel Pressure Injury Staging System, *Journal of Wound, Ostomy & Continence Nursing* (2016) Nov:43(6):585-597.

Center for Disease Control & Prevention Hand hygiene in healthcare settings. Retrieved on 5/18 from https://cdc.gov/hand hygiene/providers/index.html.

Quality and Safety Education for Nurses (QSEN) Institute. (2018). QSEN Competencies. Retrieved May 13, 2018, from http://qsen.org/competencies/pre-licensure-ksas/#safety

The Joint Commission. (2018). 2018 Hospital National Patient Safety Goals. Retrieved from https://www.jointcommission.org/hap_2017_npsgs/

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide patient care that promotes safety and minimizes risk of error.
2. Apply nursing process in clinical decision making.
3. Integrate understanding of multiple dimensions of patient centered care.
Specific Learning Objectives
1. Apply principles of hand hygiene and infection control.
2. Correctly identify patient.
3. Gather relevant patient, environmental and contextual data.
4. Cluster relevant data to identify patient's primary problem(s).
5. Recognize acute changes in patient condition or environment that require immediate attention.
6. Perform timely nursing interventions to address urgent or primary problem(s).
7. Evaluate effectiveness of interventions.
8. Communicate patient needs, values and preferences to other members of the health care team.
Critical Learner Actions
1. Perform hand hygiene, introduce self and role, identify patient using two patient identifiers.
2. Perform a general survey and assessment, to include a focused skin assessment.
3. Recognize the presence of pressure areas on the patient's skin.
4. Position patient for optimal skin integrity.
5. Reassess relevant parameters.
6. Report pertinent data to health care team using standardized communication tool. (SBAR)
7. Provide patient information and education in a manner clearly understood by the patient/family.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
❑ Nursing Process	❑ General survey and physical assessment
❑ Skin integrity pathophysiology	❑ Nursing interventions for pressure injury prevention
❑ Pressure injury staging & prevention guidelines	❑ Engage patients to promote health, safety, well- being and self-care management
❑ National Patient Safety Goals	❑ Communication using SBAR
❑ Structured communication tools (i.e., SBAR)	❑ Value active patient participation in plan of
❑ Dimensions of patient centered care	❑ Pressure Injury Assessment & Staging Tool

SECTION III: SCENARIO SCRIPT

A. Case summary
Mrs. Foster is a 82-year-old woman admitted the previous day for treatment of RLE cellulitis and dehydration. She has a history of type II diabetes that has been well controlled with oral medication. She was admitted for IV antibiotic therapy and IV fluids. Learners are expected to perform the following specific learner actions: assess physical status and vital signs, recognize patient discomfort, and perform focused skin assessment. They are to provide basic intervention(s) to maintain skin integrity and communicate assessment data to charge nurse using SBAR communication. Learners will demonstrate incorporation of QSEN competencies throughout scenario by including the patient/family members in the plan of care; evaluating patient response to nursing interventions; and communicating observations related to hazards of safety.

B. Key contextual details
After receiving report, the nurses enter the room to find the patient lying flat in bed. The patient is stable but begins to complain of discomfort in her lower back after a few minutes. The point is for the learners to investigate the patient's complaint, reposition the patient and note the early signs of a developing pressure ulcer.

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)
RN 1		Learner
RN 2		Learner

D. Patient/Client Profile				
Last name:	Foster		First name: Maria	
Gender: F	Age: 82	Ht: 5'5"	Wt: 80 Kg	Code Status: Full
Spiritual Practice: Catholic		Ethnicity: Hispanic		Primary Language spoken: English
1. History of present illness				
82-year old female admitted from an assisted living facility for cellulitis to her R ankle. History is remarkable for 20 year history of type II diabetes, well controlled with oral agents. Plan: IV antibiotic therapy; treat mild dehydration with IV fluids.				
Primary Medical Diagnosis	Cellulitis Right Ankle			

2. Review of Systems	
CNS	Anxious, alerted and oriented to person, place, time and situation
Cardiovascular	NSR @ 80, BP 130/70; no bruits or murmurs heard
Pulmonary	Lungs CTA in all fields
Renal/Hepatic	GFR – 90 mL/min; Liver non-tender; normal size
Gastrointestinal	Abdomen soft, non-tender, non-distended. Active bowel sounds all quad.
Endocrine	Type II diabetes x 20 years; treated with oral agents
Heme/Coag	No bruising or history of bleeding problems
Musculoskeletal	Active ROM all extremities 5/5
Integument	Skin thin and friable; intact, no lesions
Developmental Hx	Normal female age 82
Psychiatric Hx	No psych history
Social Hx	Denies ETOH; no history of tobacco use. Lives in assisted living facility
Alternative/ Complementary Medicine Hx	none

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

3. Current medications	Drug	Dose	Route	Frequency
	Glipizide	2.5 mg	PO	QD
	Ibuprofen	200 mg	PO	QD

ALL DATA IN THIS SCENARIO IS FICTITIOUS

4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.5	Cl: 102	HCO3: 24	BUN: 26	Cr: 1.0
Ca++: 9.4	Mg:	Phos: 3.5	Glucose:	HgA1C:	
Hgb: 16 g/dL	Hct: 47%	Plt: 265	WBC: 12.2	ABO Blood Type:	
PT:	PTT:	INR:	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR:		ECG:			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: female		Attire: patient gown			
Alterations in appearance (moulage): Elderly female; R ankle wrapped in Kerlix dressing; Stage I pressure injury to coccyx area					
X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:						
No monitor display		Monitor on, but no data displayed	x	Monitor on, standard display		

BP: 128/75	HR: 80	RR: 18	T: 99.0 F	SpO2: 98%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left: clear		Right: clear	
Heart:	Sounds:			
	ECG rhythm:	Sinus rhythm		
	Other:			

ALL DATA IN THIS SCENARIO IS FICTITIOUS

Bowel sounds:	normal	Other:

ALL DATA IN THIS SCENARIO IS FICTITIOUS

3. Initial Intravenous line set up							
	Saline lock #1	Site:	RA				IV patent (Y/N)
X	**IV #1**	Site:	RFA	Fluid type: D5.45NS	Initial rate: 75/ml hour		IV patent (Y/N)
	Main						
	Piggyback						
	IV #2	Site:		Fluid type:	Initial rate:		IV patent (Y/N)
	Main						
	Piggyback						

4. Initial Non-invasive monitors set up					
x	NIBP		ECG First lead: II		ECG Second lead:
x	Pulse oximeter		Temp monitor/type		Other:

5. Initial Hemodynamic monitors set up					
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:

6. Other monitors/devices					
	Foley catheter	Amount:		Appearance of urine:	
	Epidural catheter		Infusion pump:	Pump settings:	
	Fetal Heart rate monitor/tocometer			Internal	External

Environment, Equipment, Essential props

Recommend standardized set ups for each commonly simulated environment

1. Scenario setting: (example: patient room, home, ED, lobby)
Medical-surgical/ telemetry unit

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)							
x	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit		Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag		Wall suction
	Nasogastric tube		ETT suction catheters		Oral suction catheters		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit		Dressing Δ equipment

	IV fluid Type: D5.45NS liter		Tubes/drains Type:		Other: 2 pillows for repositioning pt.

ALL DATA IN THIS SCENARIO IS FICTITIOUS

3. Respiratory therapy equipment/devices							
	Nasal cannula		Face tent		Simple Face Mask		Non re-breather mask
	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
x	Progress Notes	x	Graphic record		Anesthesia/PACU record		ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	Nurses' Notes		Dx test reports		Code Record		Prenatal record
x	Actual medical record binder, constructed per institutional guidelines				Other Describe: Braden Scale		

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route

ALL DATA IN THIS SCENARIO IS FICTITIOUS

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: Learners receive handoff report from the previous shift on Mrs. Foster. She was admitted yesterday morning from a assisted living facility for diagnosis of cellulitis to her RLE. Today she has had a low grade fever but otherwise her vital signs are stable. She has a history of type II diabetes that has been well controlled with oral medication. She was admitted for IV antibiotic therapy and treatment for mild dehydration. The learners are to assess the patient and document her vital signs.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient lying in supine position with 2 side rails up; call light in reach. Alert and oriented to person, place, time and situation. Responds appropriately to learner's questions. IV fluids are infusing via pump. Denies pain when asked.	**Operator** BP – 128/75 HR – 80/sinus rhythm RR - 18 T – 99.0° F. O2 sats – 98% Room Air Vital signs not displayed on monitor until assessed or monitor turned on by learner. **Triggers:** Learner Actions completed or 5 minutes has elapsed	**Learner Actions** 1. Wash hands 2. Introduce self and role 3. Identify patient using 2 patient identifiers 4. Perform general survey 5. Assess vital signs 6. Assess IV site, solution and infusion rate 7. Communicate actions and rationale to patient while seeking patient feedback related to comfort and satisfaction with care.	**Debriefing Points:** National Patient Safety Goals to minimize risk of error and infection. Universal protocol Safety of patient environment to prevent falls Strategies for assessing patient physical and emotional comfort and satisfaction with care. Components of general survey and LOC assessment

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Pt. continues to answer questions appropriately. She remains stable, alert and oriented. States: "My back hurts…" "I can't move myself very easily since my foot has been hurting."	**Operator:** VS are unchanged. HR may be increased to 90 gradually as patient experiences discomfort **Triggers:** Learners check coccyx area or 2 minutes have elapsed in state	**Learner Actions:** 1. Document VS on flow sheet at 2. bedside 3. Assess patient complaints of discomfort 4. Elevate level of bed to assure care givers body mechanics 5. Turn patient and notice reddened area to coccyx 6. Recognize patients attempts for self- care	**Debriefing Points:** Documentation of care Importance of completing a thorough/focused assessment Risk factors for development of pressure ulcers Strategies for valuing patient's expertise with own health and symptoms (A)
STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
3. Pt. remains stable, alert and oriented. She is concerned about what the learners find when they turn her and inspect her back area. States: "What is it?..." "Will I be okay?…I don't need any more trouble with infections."	**Operator:** No change in vital signs **Triggers:** Learner actions complete in 5 minutes	**Learner Actions:** 1. Communicate general skin assessment to pt. 2. Position pt. laterally and support with pillows. 3. Assess area by measuring according to PI Assessment Tool or Braden Scale & document at bedside 4. Patient teaching: explain strategies relieve pressure	**Debriefing Points:** Strategies for assessing levels of physical and emotional comfort. Assessment using Braden Scale Strategies to relieve pressure to prevent skin breakdown

STATE / PATIENT STATUS	**DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
4. Patient calms with communication from learners. Tells learners that she really wants to get better in time to attend a big party at her assisted living facility in 2 weeks	**Operator:** No change in vital signs **Triggers:**	**Learner Actions:** 1. Reassure patient 2. Provide SBAR communication	**Debriefing Points** Elements of SBAR to address patient preferences and values. Elements of SBAR to include in Pressure Injury Assessment or Braden scale staging and interventions.
Scenario End Point: Charge nurse enters room to give learners a break. Receives SBAR			
Suggestions to <u>decrease</u> complexity: No evidence of pressure areas; sheets wrinkled Suggestions to <u>increase</u> complexity: Open wound; patient agitated; daughter accuses staff of poor care leading to "bed sore"			

ALL DATA IN THIS SCENARIO IS FICTITIOUS

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Foster, Maria **DOB: 06/08/XX** **Age: 82** **MR#: 48119**	**Diagnosis: Cellulitis R ankle**

No Known Allergies ☐
Allergies & Sensitivities:

Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
		Dx: Cellulitis of Right Foot; Hx Diabetes type II
		Code Status: Full
		VS: Q 4 hours
		Pulse oximetry Q 4 hours; oxygen 2 – 4 L/min to maintain 02 sat >94%
		Diet: 1800 Cal ADA
		Activity: OOB with assist PRN
		IVF: D5.45%NS @ 75 ml/hr
		Monitor I/O
		Fingerstick blood glucose AC and HS ; call MD if blood glucose > 160 or < 70
		Meds:
		Glipizide 2.5 mg PO QD
		Levaquin 750 mg IVPB QD
		Acetaminophen 650 mg PO Q 4-6 hrs PRN for foot pain
		Labs: CBC, differential, Platelets, CRP, Chem 7 panel in A.M.
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

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 the experience of caring for this patient feel for you and the team?
2. Did you have the knowledge and skills to meet the learning objectives of the scenario?
3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. How would you handle the scenario differently if you could?
6. In what ways did you check feel the need to check ACCURACY of the data you were given?
7. In what ways did you perform well?
8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?
9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?
10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?
11. Discuss actual experiences with diverse patient populations.
12. Discuss roles and responsibilities during a crisis.
13. Discuss how current nursing practice continues to evolve in light of new evidence.
14. Consider potential safety risks and how to avoid them.
15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.

Notes for future sessions: