Multi-patient Simulation Template

Concepts:	**Student roles:**
Management of 3 patients on a med/surg unit 3 scenarios	Registered Nurse-current shift Registered Nurse-outgoing shift Observers

Learning Objectives:

1. Utilize principles of prioritization and delegation in caring for multiple patients within the complex hospital environment.
2. Demonstrate therapeutic communication to express respect, patience, and sensitivity to patients which is inclusive of plan of care.
3. Collaborate with interprofessional health care team to provide safe and effective patient centered care.
4. Use relevant assessment data to develop evidenced informed (based) plans of care for the patients(s).
5. Use clinical reasoning processes in modifying patient care decisions.
6.

Psychomotor Skills:	**Cognitive Skills:**
Focused assessment Medication administration	Identify critical assessment findings Communication Prioritization Delegation Organization
 Simulation Time: 30 minutes	 Debriefing Time: 60 minutes

Patient Set Up			
(Manikin/SP)	**Fidelity**	**Fidelity**	**Fidelity**
Simulation setting All patients have ID bracelets; orders, plan of care and the following standard equipment:1 automatic BP cuff with thermometer, O2 sat, transport monitor, glucometer, for "unit", headwall, cannulas.	Med/surg unit	Med/surg unit	Med/surg unit
Preparation of manikin	Write in as per scenario	Write in as per scenario	Write in as per scenario
Medications			
IVs			
Bedside equipment and enhancements			
O2			
Report			
Wounds/skin/other			
Chart forms			
Pre-brief			
Other roles available			

PATIENT CARE SIMULATION PROGRESSION

Time	***Manikin Settings and Changes***	***Student Action***	***Cue / prompt***
0-10 min 	**Patient #1**	**Patient #1**	**Patient #1**
	Patient #2	**Patient #2**	**Patient #2**
	Patient #3b	**Patient #3**	**Patient #3**
10-20min 	**Patient #1**	**Patient #1**	**Patient #1**
	Patient #2	**Patient #2**	**Patient #2**
	Patient #3	**Patient #3**	**Patient #3**
20-30 min 	**Patient #1**	**Patient #1**	**Patient #1**
	Patient #2	**Patient #2**	**Patient #2**
	Patient #3	**Patient #3**	**Patient #3**

Student Version

Student Pre-Simulation Work:

1. Discuss delegation of tasks
2. Differentiate between assertive versus aggressive communication
3. Discuss closed loop communication
4. Identify appropriate prioritization

Student Briefing: Discuss the safe container and review of the objectives.

Simulation Hospital Report

Patient #1

Patient #2

Patient #3

Simulation Hospital(x3)
Patient Information Sheet

<table>
<tr><td colspan="2">Patient name:</td><td colspan="2">Admit Date:
Today's date</td><td colspan="2">Admitting provider name:</td></tr>
<tr><td>DOB:</td><td>Age:</td><td>Gender:</td><td>Ht:</td><td>Wt:</td><td>Religion:</td></tr>
<tr><td colspan="4">Dx:</td><td colspan="2" rowspan="5">Medications:</td></tr>
<tr><td colspan="4">History of Present Illness:</td></tr>
<tr><td colspan="4">Medical History:</td></tr>
<tr><td colspan="4">Surgical History (Procedures & Dates):</td></tr>
<tr><td colspan="4">Social History:</td></tr>
<tr><td colspan="6">Support/Contact person(s):</td></tr>
<tr><td colspan="3">Tubes/Drains:</td><td colspan="3">Nutrition:</td></tr>
<tr><td colspan="3">Wounds/Skin: pressure ulcer on R heel</td><td colspan="3">Activity:</td></tr>
</table>

Simulation Hospital (x3)

PROVIDER ORDERS

	Diagnosis:

☐ **Allergies & Sensitivities:**

Date	Time	PROVIDER ORDER AND SIGNATURE

PROVIDER SIGNATURE:

SIMULATION HOSPITAL (x3)
MEDICATION ADMINISTRATION RECORD

Patient Date of birth MRN

☐**Allergies & Sensitivities:**

Scheduled Medications			
Date Ordered	**Medication**	**0700-1859**	**1900-0659**
PRN Medications			
IV Infusions			

Signature	Initials	Signature	Initials

SIMULATION HOSPITAL (x3)
Plan of Care Worksheet

Client Name: Client Gender: Age Admit date: today's date **DNR:**
Allergies:
Co-Morbidities:
Admitting Diagnosis:
Current Surgery: Surgery Date: ___

Type of Bath	Mobility	IV Therapy	Therapeutic Devices
Complete_____ Assist _____ Self_____ Shower_____ Other: _____ **Skin Management** Braden/Risk Scale _____ Skin Care Products Used: Wound Care Protocol:____ _____	Bedrest _____ Turn _____ C, & DB _____ BSC _____ Chair _____ BRP with assistance Ambulation Restraints _____ Fall/Risk Score _____ **Nutrition** Diet __ TPN _____ Tube Feed_____ FSBS_____	Peripheral Site: _____ Central line/PICC Site _____ Primary IV Solution/Rate 0.9%NS IV Additive: IV pump _____ Gravity: _____ PCA Pump Setting:	Elastic stockings_____ SCDs _____ CPM _____ Pulse oximetry _____ Telemetry _____ Ice bags _____ Cooling Device_____ PCA pump_____ Urinary Catheter _____ NG Tube _____ Ostomy _____ Other: _____ Drain type & site: Other:

Respiratory Care/Oxygen/ Breathing Tx	Physical Therapy	Occupational Therapy/Speech Therapy

Enter Ranges Recorded For:	Date:Today's date-	Date:	Date:	Date:	Date:
Temperature					
Pulse					
Respirations					
Blood pressure					
Pain scale					
FSBS					
Pulse Oximetry					
24 hour intake					
24 hour output					
Weight					
Diet percentage	B L D	B L D	B L D	B L D	B L D

*Laboratory Values (x3)				
Test	**Normal Range**	**Date/Time Today's Date**	**Date/Time**	**Date/Time**
White blood cells-WBCs	5,000-10,000 mm3			
Red blood cells-RBCs	M 4.7-6.1 million/mm3 F 4.2-5.4 million/mm3			
Hemoglobin- Hgb	M 14-18 g/dl F 12-16 g/dl			
Hematocrit- Hct	M 42-52% F 37-47%			
Platelets	150-400			
Prothrombin time-PT	11.0-12.5 sec			
INR	2-3.5x normal			
PTT	60-70			
Sodium-Na	135-145mEq/L			
Potassium-K	3.5-5.0 mEq/L			
Chloride-Cl	98-106mEq/L			
Carbon Dioxide CO2	23-30 mEq/L			
Glucose	70-110 mg/dl			
BUN	10-20 mg/dl			
Creatinine	M 0.5-1.2 mg/dl F 0.5-1.1mg/dl			
Lactic Acid	0.6-2.2 mmol/L			
Albumin	3.5-5.0			
Calcium-Ca	9.0-10.5 mg/dl			
Phosphate	1.6-2.6 mEq/L			
Magnesium	1.5-2.5 mEq/L			

*Customize to your institutional values.

Multi-Patient Simulation Template (Exemplar)

Disclaimer: The exemplars were solely developed by the authors of the toolkit as an illustration for completing the template.

Concepts:	**Student roles:**
Management of 3 patients on a med/surg unit 3 scenarios	Night Nurse Charge Nurse Bedside Nurse Student Nurse

Learning Objectives:

1. Utilize principles of prioritization and delegation in caring for multiple patients within a complex environment.
2. Demonstrate therapeutic communication to express respect, patience, and sensitivity to patients, inclusive of plan of care.
3. Collaborate with interprofessional health care team to provide safe and effective patient centered care.
4. Utilize relevant assessment data to develop evidenced informed (based) plans of care for the patients(s).
5. Use clinical reasoning processes in modifying patient care decisions.
6. Provide and receive constructive feedback to/from health care team members to improve performance (patient outcomes).

Psychomotor Skills:	**Cognitive Skills:**
Focused assessment Medication administration	Identify critical assessment findings Communication Prioritization Delegation Organization
Simulation Time: 30 minutes	Debriefing Time: 60 minutes

Patient Set Up			
Patient	**Virginia Kramer #1**	**Kevin Stevens #2**	**Annie Wilson #3**
(Manikin/SP)	**High fidelity**	**Low or high fidelity**	**Low or high fidelity**
Simulation setting All patients have ID bracelets; orders, plan of care and the following standard equipment:1 automatic BP cuff with thermometer, O2 sat, transport monitor, glucometer, for "unit", headwall, cannulas.	Med/surg unit Virginia Kramer DOB – 4/3/1956 MR # 313122 Dr. Stone Right knee replacement, spouse at bedside	Med/surg unit Kevin Stevens DOB – 11/3/1954 MR # 777998 Dr. Fenske GI study, spouse at bedside.	Med/surg unit Annie M. Wilson DOB – 6/10/1932 MR # 7654321 Dr. Collins Status post UTI, DC home today.
Preparation of manikin	Adult, female, fresh post –op right knee replacement with dressing and ACE wrap. Pale, diaphoretic. IV access. All pulses present. Lung and heart sounds WNL. Bowel sounds – hypoactive. Alert and oriented X3.	Adult male, general appearance. IV access. Lung and Heart sounds WNL, bowel sounds hyperactive. Alert and oriented X3. Skin warm and dry.	Female, elderly appearance. IV access. Urinary catheter in place. Lung, bowel, and heart sounds WNL. Skin warm and dry. Confused as to person and place.
Medications	morphine sulfate 2mg IVP every 2-4 hours as needed for pain. hydromorphone 0.2 mg to 1 mg IVP every 4 hours as needed for pain. ondansetron 4 mg IVP every 6 hours as needed for nausea and vomiting. losartan 50 mg PO BID toradol 30 mg IVP once per day. bisacodyl 5 mg tablets PO as needed for constipation. zolpidem 5 mg tablet PO as needed for sleep.	Only bowel prep, take as directed.	acetyl salicylic acid 81 mg PO triamterene 50 mg PO regular insulin

IVs	Normal Saline at 100 ml/hour	Capped with normal saline for flush	Capped with normal saline for flush
Bedside equipment and enhancements	Bedpan, basin, table, personal care, walker, c-pap	Bedpan, basin, table, personal care,	Bedpan, basin, table, personal care, walker, family pictures, flowers, glasses, robe.
O2	Titrate as needed, CPAP and or cannula at 02.	Nasal Cannula PRN	Nasal Cannula PRN
Report	Yes	yes	Yes
Wounds/skin/other	Right knee surgery with dressing and ACE wrap in place.6 inch incision closed with cyanocrylate adhesive. Compression stockings. Cold therapy machine.	None	Indwelling urinary catheter, urine color is yellow and clear, 200 ml in Foley bag.
Chart forms	Surgical report, MAR, provider orders, lab values, History.	Provider orders, MAR, history, lab values, consent for colonoscopy.	Provider orders, MAR, nursing documentation, history, discharge orders.
Pre-brief	Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report.	Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report.	Room, supply, and manikin orientation. Enforce safe environment, with confidentiality of actions, and during debriefing. Hand-off report.
Other roles available	UAP, MD, Anesthesiologist, Pharmacist, other RN, PACU nurse	MD, GI Lab RN	UAP, Daughter, MD, other RN

PATIENT CARE SIMULATION PROGRESSION

Time	*Manikin Settings and Changes*	*Student Action*	*Cue / prompt*
0-10 min 	**Patient #1:** Pale, diaphoretic. Moans when awake, but answers questions. Nauseated from morphine IV. V/S. Pain level.	**Patient #1**: Receive bedside report from PACU nurse. Assess patient's leg, V/S and pain. Discuss with spouse.	**Patient #1**: Patient voices acute discomfort.
	Patient #2 Going for mid-morning GI diagnostic test. Awake and alert. No discomfort.	**Patient #2** Finish patient GI preparation, ensuring consent and patient teaching is finished. V/S taken.	**Patient #2** Patient asking questions as to what the test entails.
	Patient #3: Normal patient, v/s within normal limits.	**Patient #3:** Receive report, does initial contact/ assessment.	**Patient #3:** Patient asleep
10-20min 	**Patient #1:** Remains unchanged. Patient c/o increased pain and nausea.	**Patient #1:** Assess for pain and nausea. Assess respiratory status, mentation and peripheral vascular. Identifies need to administer medications. (Can give ondansetron for nausea, hyrdomorphone IVP for pain after assessment.)	**Patient #1:** C/O severe nausea, and pain increasing to a level 8/10. If not recognized.
	Patient #2 Patient appears anxious. Wife at bedside. Pain free.	**Patient #2** Assess any patient teaching issues. Physical assessment.	**Patient #2** Anxiety, asking several questions regarding procedure.
	Patient #3: Normal patient, v/s within normal limits. Lung, heart and bowel sounds within normal limits. Skin WNL. Can ID self.	**Patient #3:** Responds to patient's calls. Gets blood sugar, calls for tray. Uses therapeutic communication to establish rapport and reduce patient anxiety.	**Patient #3:** Patient calling out, "I am hungry".

20-30 min 	**Patient #1** Patient sleeping at times, arouses easily. C-PAP on. Denies pain, if meds were given. Peripheral pulses intact.	**Patient #1** Continue the assessment, address any changes. Give the pain meds and ondansetron, if not done.	**Patient #1** Moans upon initial arousal. If meds, not given spouse verbalizes C/O's
	Patient #2 Patient appears scared. BP 148/90, HR 90, RR 22, T 98.6	**Patient #2** Therapeutic communication with patient. Gives report to GI lab nurse.	**Patient #2** "What are they going to find? What if it is cancerous?"
	Patient #3: Patient unchanged.	**Patient #3:** Call for help with tray, and contacting daughter.	**Patient #3:** Tray arrived, patient needs help with tray. Patient states, "When can I go home? Where is my daughter, can you call her?"

Student Version

Student Pre-Simulation Work:

1. Discuss delegation of tasks
2. Differentiate between assertive versus aggressive communication
3. Discuss closed loop communication
4. Identify appropriate prioritization

tudent Briefing: Discuss the safe container and review of the objectives.

Simulation Hospital Report

Patient #1 Virginia Kramer
PACU Nurse to Med-Surg: 59 y/o female who was Dr. Stone's 1st knee replacement this morning, Right knee. Pressure dressing and elastic wrap are clean, dry and intact. A&O X3 when awake. Lungs clear, able to cough and deep breathe when cued. Patient is a nurse. IV is NS at 100 ml/hour in left forearm. The anesthesiologist ordered morphine sulfate 2-4 mg every 2 hours for immediate post-op pain once she was awake. I gave the patient 6 mg in 2 hours and there was no pain relief, but she became nauseated and threw up. Order added for ondansetron 4mg IV, which was not given. Spouse in the room.

Patient #2 Kevin Stevens
RN Night to day shift report. Patient finished bowel prep this morning with good results. Scheduled to go to GI lab at 10 AM for colonoscopy for changes in bowel habits. Patient has several questions and repeats them often. He has colon cancer history in family. Wife is here, seems to be calming for him. Take a second look at paperwork, I think everything is all done. I have not had time to talk to him. Awake and alert. No pain. BP 120/70 HR 78 RR 18 SP02 98% room air. Just quit smoking 3 months ago. Up without difficulty. No past medical hx.

Patient #3 – Anne M. Wilson
RN Night to day shift: Mrs. Wilson had a difficult night, she had trouble sleeping, could not get comfortable, and was up in the chair at times. Gets afraid and disoriented at night. Finally fell asleep at 0400. I let her sleep this morning, so did not get a blood sugar. She is to be discharged home today with her daughter Betty. Was admitted with a UTI, on antibiotics, has hx of diabetes (2) which really is not a problem, except poor eater. No pain, last V/S at 0300, T-98.0 BP 110/70, HR 70 RR 16 SP02 98% RA. No open areas or redness on skin. Lungs clear. Urinary catheter is draining clear yellow urine, which needs to be removed. Daughter taking her home today.