

**Enhancing Registered Nurse Job Readiness and Patient Safety Outcomes
through Clinical Simulation**

Adaptation of California Simulation Alliance (CSA)

Simulation Scenario Template

Elderly Urosepsis

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Final Draft

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SECTION I: SCENARIO OVERVIEW

Scenario Title:	Adult Med Surg/Critical Care: Elderly Urosepsis
Original Scenario Developer(s):	Queen's University School of Nursing Marian Luctkar-Flude, RN, MScN, PhD(c) Clinical/Academic Advisors Cheryl Pulling, RN, MSN & Hilary Machan, RN, MSN
Date - original scenario	February 2014
Validation:	April 2014
Revision Dates:	May 2014
Pilot testing:	
<p>Estimated Scenario Time: Part A & B: 15 min each Debriefing time: Part A 10 min + Part B 20 min Target group: Fourth year BNSc nursing students Core case: Elderly person with sepsis secondary to UTI, manifested as confusion</p> <p>CNO/ CPSI/CIHC Competencies: CNO: Professional responsibility and accountability; Knowledge-based practice: competent application of knowledge CPSI: Domain 1 #1, Domain 2, Domain 3 #1 & #2, Domain 4 #3, Domain 5 #2 CIHC: patient-centered care, interprofessional communication</p> <p>Best Practice Guidelines: Canadian Coalition for Seniors' Mental health: National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Delirium http://www.ccsmh.ca/en/guidelinesUsers.cfm</p> <p>European Association of Urology Guidelines on Urological Infections: Sepsis Syndrome in Urology (Urosepsis) http://www.guideline.gov/popups/printView.aspx?id=34099</p> <p>Registered Nurses' Association of Ontario Clinical Best Practice Guidelines: Promoting Safety: Alternative Approaches to the Use of Restraints http://rnao.ca/sites/rnao-ca/files/Promoting_Safety_-_Alternative_Approaches_to_the_Use_of_Restraints_0.pdf</p> <p>Toward Optimized Practice Program: Alberta Health Services (Edmonton) Seniors Health Guideline for the Diagnosis and Management of Urinary Tract Infections in Long Term Care http://www.topalbertadoctors.org/cpgs/?sid=15&cpg_cats=66</p> <p>Brief Summary of Case:</p>	

82 year old male encountered in the ER department upon transfer from a long-term care (LTC) facility, with foley catheter in situ, and wrist restraints tied to bed/stretchers rails. PSW accompanying patient describes a 2 day onset of increasing confusion & agitation. Family member arrives as patient's condition is deteriorating with worsening vital signs and decreased level of consciousness until patient unresponsive. Patient requires treatment for septic shock and transfer to ICU

EVIDENCE BASE / REFERENCES (APA Format)

Canadian Coalition for Seniors' Mental health (2006). *National Guidelines for Seniors' Mental Health:*

The Assessment and Treatment of Delirium. Retrieved

from: <http://www.ccsmh.ca/en/guidelinesUsers.cfm>

Carlson, B., & Fitzsimmons, L. (2014). Shock syndrome. In L.D. Urden, K.M. Stacy, & M.E. Lough (Eds.), *Critical care nursing: Diagnosis and management (7th Ed.)* (pp. 887-911). St. Louis: Elsevier.

College of Nurses of Ontario (2009). *Practice standard: Restraints.* Retrieved

from: http://www.cno.org/Global/docs/prac/41043_Restraints.pdf

Dunsford, J. (2009). Structured communication: Improving patient safety with SBAR

Enlow, M., Shanks, L., Guhde, J., & Perkins, M. (2010). Incorporating interprofessional communication skills (ISBARR) into an undergraduate nursing curriculum. *Nurse Educator, 35*(4), 176-180.

European Association of Urology (2011). *Guidelines on Urological Infections: Sepsis Syndrome in Urology (Urosepsis).* Retrieved from: <http://www.guideline.gov/popups/printView.aspx?id=34099>

Johnson, V.Y., & Jansen, L. (2014). Urinary tract infection. In S.L. Lewis, S.R. Dirksen, M.M. Heitkemper, L. Bucher, I.M. Camera, M.A. Barry,...D. Goodridge (Eds.), *Medical-surgical nursing in Canada: Assessment and management of clinical problems (3rd Canadian Ed.)* (pp. 1288-1297). Toronto: Elsevier Canada.

Lewis, S.L., & McCleary, L. (2014). Delirium. In S.L. Lewis, S.R. Dirksen, M.M. Heitkemper, L. Bucher, I.M. Camera, M.A. Barry,...D. Goodridge (Eds.), *Medical-surgical nursing in Canada: Assessment and management of clinical problems (3rd Canadian Ed.)* (pp. 1737-1740). Toronto: Elsevier Canada.

Registered Nurses' Association of Ontario (2012). *Clinical Best Practice Guidelines: Promoting Safety: Alternative Approaches to the Use of Restraints.* Toronto: Registered Nurses' Association of Ontario.

Seckel, M.A., & Piper, J.A. (2014). Shock. In S.L. Lewis, S.R. Dirksen, M.M. Heitkemper, L. Bucher, I.M. Camera, M.A. Barry,...D. Goodridge (Eds.), *Medical-surgical nursing in Canada: Assessment and management of clinical problems (3rd Canadian Ed.)* (pp. 1960-1982). Toronto: Elsevier Canada.

Thomas, C.M., Bertram, E., & Johnson, D. (2009). The SBAR communication technique: Teaching nursing students professional communication skills. *Nurse Educator, 34*(4), 176-180.

Toward Optimized Practice Program (2010). *Alberta Health Services (Edmonton) Seniors Health Guideline for the Diagnosis and Management of Urinary Tract Infections in Long Term Care.*

Retrieved from: http://www.topalbertadoctors.org/cpgs/?sid=15&cpg_cats=66

Waszynski, C.M. (2001). Confusion Assessment Method (CAM). *Try this: Best practices in nursing care to older adults*, 13. Hartford Institute for Geriatric Nursing. Retrieved

from: [http://consultgerim.org/uploads/File/Confusion%20Assessment%20Method%20\(CAM\).pdf](http://consultgerim.org/uploads/File/Confusion%20Assessment%20Method%20(CAM).pdf)

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES		
Do What	With What	For What
Deliver	Essential data to physician or NP in an urgent situation	To convey the need for timely assistance to effectively diagnose and treat the patient's deteriorating condition.
Perform	Appropriate emergency measures in an urgent situation	To prevent further deterioration of the patient's condition until help arrives.
Recognize	Unsafe practices and conditions within the client's environment	To prevent near misses or errors that could cause further complications in an already compromised patient.
Communicate	Therapeutically with the patient and their family	To decrease anxiety and promote cooperation with care.

B. Learning Outcome Assessment / Rubric			
Competency (based on "What For")	Demonstrated attributes align with required competency	Demonstrated attributes need some improvement to align with required competency	Demonstrated attributes need major improvement to align with required competency
Deliver essential data to physician or NP in an urgent situation to convey the need for timely assistance to effectively diagnose and treat the patient's deteriorating condition.	<ul style="list-style-type: none"> • Immediately recognizes assessment findings indicate a need to get help • SBAR is used in a manner that effectively allows the physician/NP to make timely decisions regarding care • Data used accurately reflects the patient's current condition • Reports evidence in a way that promotes the urgency of the situation 	<ul style="list-style-type: none"> • Has difficulty recognizing assessment findings indicate a need to get help • SBAR is used in a manner that somewhat allows the physician/NP to make timely decisions regarding care • Data used somewhat accurately reflects the patient's current condition • Reports evidence in a way that somewhat promotes the urgency of the situation 	<ul style="list-style-type: none"> • Does not recognize assessment findings indicate a need to get help • SBAR is not used or used in a manner that does not allow the physician/NP to make timely decisions regarding care • Data used does not accurately reflect the patient's current condition • Does not report evidence in a way that promotes the urgency of the situation
Comments			
Perform appropriate emergency measures in an urgent situation to prevent further deterioration of the patient's condition until help arrives.	<ul style="list-style-type: none"> • Resources accessed demonstrate a thorough understanding of urosepsis • Implemented Interventions are likely to be effective in helping to 	<ul style="list-style-type: none"> • Resources accessed demonstrate some understanding of urosepsis • Implemented Interventions may be effective in helping to treat urosepsis • Interventions are carried out in a way that somewhat reflect the 	<ul style="list-style-type: none"> • Resources accessed do not demonstrate an understanding of urosepsis • Implemented Interventions are not likely to be effective in helping to treat urosepsis • Interventions are carried out

	<p>treat urosepsis</p> <ul style="list-style-type: none"> • Interventions are carried out in a way that reflect the urgency of the situation • Interventions are implemented with a regard for patient safety 	<p>urgency of the situation</p> <ul style="list-style-type: none"> • Interventions are implemented with some regard for patient safety 	<p>in a way that do not reflect the urgency of the situation</p> <ul style="list-style-type: none"> • Interventions are implemented with no regard for patient safety
Comments			
Recognize unsafe practices and conditions within the client's environment to prevent near misses or errors that could cause further complications in an already compromised patient.	<ul style="list-style-type: none"> • Consistently demonstrates a regard for routine and universal infection control practices • Care consistently demonstrates the need to minimize and remove human error 	<ul style="list-style-type: none"> • Demonstrates a regard for routine and universal infection control practices some of the time • Care sometimes demonstrates the need to minimize and remove human error 	<ul style="list-style-type: none"> • Does not demonstrate a regard for routine and universal infection control practices • Care does not demonstrate the need to minimize and remove human error
Comments			
Communicate therapeutically with the patient and their family to decrease anxiety and promote cooperation with care.	<ul style="list-style-type: none"> • Uses language that effectively allows the patient and their family to understand the situation • Collaborates with the patient and their family to allow them to operate 	<ul style="list-style-type: none"> • Uses language that somewhat allows the patient and their family to understand the situation • Allows the patient and their family to sometimes operate within their values and beliefs 	<ul style="list-style-type: none"> • Does not use language that effectively allows the patient and their family to understand the situation • Does not collaborate with the patient and their family to allow them to operate within

	<p>within their values and beliefs structure</p> <ul style="list-style-type: none"> Respects the patient's/family's right to informed decision-making 	<p>structure</p> <ul style="list-style-type: none"> Shows some respect for the patient's/family's right to informed decision-making 	<p>their values and beliefs structure</p> <ul style="list-style-type: none"> Does not respects the patient's/family's right to informed decision-making
Comments			

C. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> Care of patient with UTI/Urosepsis/septic shock	<input type="checkbox"/> SBAR communication
<input type="checkbox"/> Pharmacology of antibiotics	<input type="checkbox"/> Administration of antibiotics
<input type="checkbox"/> Intravenous therapy	<input type="checkbox"/> Safe intravenous administration
<input type="checkbox"/> Care of patient with delirium	<input type="checkbox"/> Communication with acutely ill, agitated patients
<input type="checkbox"/> Pathophysiology, risk factors & treatment of UTI/Urosepsis/septic shock	

SECTION III: SCENARIO SCRIPT

A. Case summary

Part 1: 82 year old male encountered in the ER department upon transfer from a long-term care (LTC) facility, with Foley catheter in situ, and wrist restraints tied to bed/stretchers rails. Patient is agitated and fighting restraints.

Part 2: Patient's condition is deteriorating with worsening vital signs. Patient has gradually become listless and eventually unresponsive as septic shock sets in. Patient requires treatment for septic shock and transfer to ICU

B. Key contextual details

Part 1: Takes place in the ER department, patient has just arrived from a LTC facility accompanied by a PSW who has a chart with her. ER doctors busy with a multiple trauma.

Part 2: Takes place in the ER department, family member (son or daughter) has arrived and the PSW has left

C. Scenario Cast

Patient/ Client	<input checked="" type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Descriptor (Optional)	Confederate/Actor (C/A) or Learner (L)
Part 1 Nurse		Learner #1
Part 1 Nurse		Learner #2
Part 1 Nurse		Learner #3
Part 1 PSW from LTC	To stay with patient until family member arrives in the ER	Learner #4
Part 2 Nurse		Learner #5
Part 2 Nurse		Learner #6
Part 2 Nurse		Learner #7
Part 2 Family member	Son or daughter	Learner #8
Physician		Confederate

D. Patient/Client Profile				
Last name:	Thompson		First name:	Bruce
Gender: M	Age: 82	Ht: 182 cm	Wt: 74.8 kg	Code Status: Not determined
Spiritual Practice: Unknown		Ethnicity: Caucasian		Primary Language spoken: English
1. Past history				
<p>Previously stable elderly gentleman who has lived in a LTC facility for 8 months following a stroke that left him with right-sided weakness and inability to walk or perform ADL without assistance. Patient has had incontinence since his stroke and had Foley catheter inserted in the LTC facility. Patient has no residual speech or memory deficits.</p>				
Primary Medical Diagnosis		Confusion NYD		

2. Review of Systems	
CNS	Alert but disoriented, active, spontaneous movement of all 4 extremities (weaker on R side), does not follow simple instructions, communicates inappropriately, behaviour agitated
Cardiovascular	Heart rate & rhythm regular, absence of peripheral edema, skin warm & dry, dorsalis pedis & posterior tibial pulses present, V/S: 37.8, 88, 18, 144/84
Pulmonary	Respirations regular & unlaboured, air entry equal to bases with no adventitious sounds, no evidence of dyspnea or orthopnea, O2 sat: 94% on room air
Renal/Hepatic	Foley catheter in situ, draining scant amount of dark amber, cloudy urine
Gastrointestinal	Has not been eating or drinking much since onset of confusion and agitation, last bowel movement two days ago, abdomen soft and non-tender, mouth and tongue dry
Endocrine	N/A
Heme/Coag	N/A
Musculoskeletal	R-sided weakness, requires assistance to walk or perform ADL
Integument	Skin warm and dry
Developmental Hx	Normal
Psychiatric Hx	None reported, 2 day onset of increasing confusion and agitation
Social Hx	Widowed; Two grown children (1 son, 1 daughter) each live about an hour away.
Alternative/ Complementary Medicine Hx	None

Medication allergies:	Penicillin	Reaction:	Hives & itching
Food/other allergies:		Reaction:	

3. Cur	Drug	Dose	Route	Frequency
	Aspirin	81 mg	P.O.	Daily

	Telmisartan	40 mg	P.O.	Daily

4. Laboratory, Diagnostic Study Results					
Na: 151 mmol/L	K: 3.5 mmol/L	Cl: 115 mmol/L	HCO ₃ :	BUN: 18 mmol/L	Cr: 140 umol/L
Ca:	Mg:	Phos:	Glucose: 8.4	Hga1C:	
Hgb: 180 g/L	Hct: 58%	Plt: 250 x 10 ⁹ /L	WBC: 25 x 10 ⁹ /L	ABO Blood Type: O+	
PT	PTT	INR	Troponin:	BNP:	
ABG-pH:	paO ₂ :	paCO ₂ :	HCO ₃ /BE:	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:	Cxr:	EKG

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: Male		Attire: Hospital gown			
<u>Alterations in appearance (moulage):</u> foley catheter in situ, draining dark amber, cloudy urine; wrist restraints tying patient's wrists to the stretcher rails					
	ID band present, accurate		ID band present, inaccurate	X	ID band absent or not applicable
	Allergy band present, accurate		Allergy band inaccurate	X	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:					
X	No monitor display		Monitor on, but no data displayed		Monitor on, standard display
				X	Display vital signs when learner takes them
BP: 110/64		HR: 114	RR: 22	T: 38.0°C	SpO ₂ : 93%
CVP:		PAS:	PAD:	PCWP:	CO:
AIRWAY:		ETCO ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: Clear, good A/E	Right: Clear, good A/E			
Heart:	Sounds:				
	ECG rhythm:		Sinus tachycardia		
	Other:				
Bowel sounds:					Other:

3. Initial Intravenous line set up						
	Saline lock #1	Site:				IV patent (Y/N)
	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					
	Piggyback					
4. Initial Non-invasive monitors set up						
	NIBP			ECG First lead:		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						
X	Foley catheter		Amount: scant		Appearance of urine: dark amber, cloudy	
	Epidural catheter		Infusion pump:		Pump settings:	
Environment, Equipment, Essential props						
Recommend standardized set ups for each commonly simulated environment						
1. Scenario setting: (example: patient room, home, ED, lobby)						
Patient cubicle in ER: stretcher, bedside table, overbed table, chair for visitor/family member						

2. Equipment, supplies, monitors						
(In simulation action room or available in adjacent core storage rooms)						
	Bedpan/ Urinal	X	Foley catheter kit	X	Selection of catheters	Incentive spirometer
X	IV Infusion pump		Feeding pump		Pressure bag	X Wall suction
	Nasogastric tube		ETT suction catheters		Oral suction catheters	Chest tube kit
X	Defibrillator	X	Code Cart		12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	Dressing Δ equipment
X	IV fluid Type:	1000 mL N/S 500 mL N/S 100 mL N/S 1000 mL R/L	IV fluid additives:	X X	ID bands Allergy bands	X IV start tray with IV catheters, tegaderm, tape, alcohol swabs, blood tubes, cultures

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

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

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
2	Ampicillin	1 g	IV		2	Gentamycin	80 mg	IV
	(premixed in IV mini-bag & labelled)					(premixed in IV mini-bag & labelled)		
2	Ceftriaxone	1g	IV					
	(premixed in IV mini-bag & labelled)							

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario :

Patient is lying on hospital stretcher. Team #1 nurses receive report from the PSW who has accompanied the patient and read the brief chart that the PSW gives to them from the LTC facility. ER physicians are busy with a multiple trauma situation and nurses approach patient to begin baseline assessment.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Patient is supine in low Fowler's position with wrist restraints attached to the stretcher rails.</p> <p>Patient is agitated and requesting that wrist restraints be removed. PSW explains that restraints were applied to prevent patient from pulling out the foley catheter. If nurse does not suggest removing restraints, PSW can ask if it is OK to take off 1 restraint.</p> <p>HR-114; RR-22</p> <p>BP-110/64; T-38°C</p> <p>O2 sat-93% on room air</p>	<p>Operator</p> <p>Display V/S on monitor after learners take pulse and respiratory rate from the mannequin.</p> <p>Triggers:</p> <p>Once call to physician has been completed and orders have been obtained</p> <p>Physician: I'm busy with this trauma, what's the matter with this guy? He's confused? So are most 80 year olds. I'll get to him when I get to him.</p> <p>When nurse insists, physician responds: "well what do you want me to</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Performs head to toe assessment including neuro status, CAM assessment, & V/S 2. Delegates/divides tasks amongst team members 3. 1 nurse remains with patient, if wrist restraints removed, patient calms somewhat 4. 1 nurse calls physician/NP/RACE (Rapid Assessment of Critical Event) team to report change in patient's condition and request that patient be seen/orders obtained 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Recognizing abnormal assessment findings: V/S, agitation, confusion 2. Collecting/communicating relevant data that will assist with diagnosis and identify potential delirium secondary to a UTI: V/S, new onset of confusion, agitation, CAM assessment (see appendix E) 3. Potential causes of delirium in an elderly patient 4. Teamwork and collaboration: conflict resolution 5. Communicating with agitated patients

	do?” and physician will give some verbal orders. If not, physician will drop by for a “minute” with some orders.		
STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>Patient less agitated, more drowsy but rouses easily.</p> <p>HR-110; RR-24</p> <p>BP-100/60; T-37.2°C</p> <p>O2 sat-92% on room air</p>	<p>Operator:</p> <p>Change vital signs as indicated.</p> <p>Triggers:</p> <p>Once orders have been implemented or total of 15 minutes have passed.</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Delegates/divides tasks amongst team members 2. Applies patient ID band and allergy band prior to taking any bloodwork or administration of IV antibiotics 3. Takes bloodwork 4. Removes and reinserts new Foley catheter and collects urine sample 5. Initiates IV with assistance of another nurse or the PSW to hold patient’s arm and initiates IV fluid infusion 6. Identifies risk of allergic reaction to ampicillin due to 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Monitoring unstable patients 2. Specimen collection procedures & standard precautions 3. Recognizing & reporting medical errors or unsafe conditions

		penicillin allergy and reports/questions orders	
		7. Reassesses/monitors ABCs, V/S, O2 sat	
STATE / PATIENT STATUS		DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE	
<p>3.</p> <p>Patient's son/daughter arrives and PSW leaves to return to LTC.</p> <p>Patient difficult to rouse, no longer agitated. Skin cool to touch.</p> <p>No additional urine output since initiation of IV.</p> <p>HR-124; RR-28</p> <p>BP-94/58; T-36.2°C</p> <p>O2 sat-85% on 2L per NP</p>	<p>Operator:</p> <p>Change vital signs as indicated.</p> <p>Triggers:</p> <p>Once orders have been implemented or 7 minutes have passed</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Performs change of shift assessment after receiving report from Team #1 2. Calls ER physician to report change in patient's condition and request that patient be seen/orders obtained 3. Applies O2 at 2L/min per nasal prongs as per oxygen therapy protocol (OTP) orders on chart, increases to 4L/min when O2 sats do not improve 4. Raises HOB to 45° 5. Administers fluid bolus and monitors lung sounds and urine output 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Collecting/communicating relevant data that will assist with identification of diagnosis and appropriate treatment 2. Communicating with patients and families 3. Titrating oxygen

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Patient now unresponsive</p> <p>HR-128; RR-32</p> <p>BP-80/50; T-36.2°C</p> <p>O2 sat-80% on 4L per NP</p> <p>Family member upset.</p>	<p>Operator:</p> <p>Change vital signs as indicated.</p> <p>When called, physician gives verbal order for another 2L fluid bolus and O2 by non-rebreather, and transfer to ICU</p> <p>Triggers:</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Reassesses/monitors ABCs, V/S, O2 sat 2. Switches O2 to non-rebreather mas as O2 sats continue to fall 3. 1 nurse remains with patient and family member 4. 1 nurse calls ER physician to report critical change in patient's condition and request that patient be seen immediately 5. 1 nurse brings crash cart to bedside 6. Initiates additional fluid bolus when ordered 7. Prepares for ICU transfer and calls report to ICU 8. 	<p>Debriefing Points</p> <ol style="list-style-type: none"> 1. Monitoring unstable patients 2. Recognizing critical abnormal findings 1. Communicating urgency of patient status 2. Communicating with patients and family members during an emergency situation 3. Anticipating and preparing for patient deterioration
<p>Scenario End Point: Once report has been called to ICU</p>			
<p>Suggestions to decrease complexity: Have learners complete Part 1 of the scenario only; focus on appropriate assessment & recognition of UTI</p>			

as source of delirium; focus on safety issues with elderly & communication with patient and other health care providers

Suggestions to increase complexity: Have patient more agitated and experiencing hallucinations; Have family member upset about use of restraints, foley catheter etc. Focus on deteriorating patient status and management

APPENDIX B: Digital images of manikin and/or scenario milieu

<p>Insert digital photo here</p>	<p>Insert digital photo here</p>
<p>Insert digital photo here</p>	<p>Insert digital photo here</p>

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	X Group	<input type="checkbox"/> With Video	X Without Video
Debriefing Materials			
X Debriefing Guide	X Objectives	X Debriefing Points See Appendix D: student requirements	X Assessment Rubric
CPSI Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Culture	X Teamwork/Collaboration	X Identify safety risk	
X Communication	<input type="checkbox"/> Issues in environment	X Respond to safety risk	
Sample Questions for Debriefing			
1. How did you feel about the communication and collaboration amongst your team members? 2. What safety risks did you encounter during the scenario? How did your team manage these safety risks?			
Interprofessional Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Role Clarification		<input type="checkbox"/> Interprofessional Teamwork Functioning	
X Patient/Family /Client/Community-centred care		<input type="checkbox"/> Collaborative Leadership	
X Interprofessional Communication			
Sample Questions for Debriefing			
1. How did you feel about your team's interprofessional communication and collaboration? 2. How did you feel about your team's communication with the patient and family member?			

Appendix D:
Student Requirements: Queen's Elderly Urosepsis

Learning Outcomes	Student Requirements
To obtain assistance to diagnose and treat patient condition	<ul style="list-style-type: none"> -communicates relevant data <ul style="list-style-type: none"> -V/S, confusion & agitation, has not been eating or drinking, low urine output -lab values -medications -uses SBAR effectively <ul style="list-style-type: none"> -situation: concerned regarding change in patient status/symptoms -background: elderly male, transfer from LTC facility, no previous confusion, history of stroke with right-sided weakness, Foley cath in situ -assessment: change in patient status/potential delirium/potential UTI -recommendation: patient to be seen now or orders for urinalysis/C&S/initiate IV -communicates urgency of situation <ul style="list-style-type: none"> -to uncooperative physician -communicates in a timely manner
To prevent further deterioration of patient until help arrives	<ul style="list-style-type: none"> -recognizes urgency of critical abnormal findings <ul style="list-style-type: none"> -recognizes increased RR & decreased O2 sat -recognizes increased anxiety & restlessness/unresponsiveness in patient -verbalizes/anticipates transfer to ICU -implements appropriate emergency measures <ul style="list-style-type: none"> -monitors ABCs, V/S, pain, O2 sat, lung sounds, urine output, lab values -applies/adjusts oxygen -requests/administers IV fluid bolus -requests/administers IV antibiotics -requests/brings crash cart to bedside -accesses appropriate resources <ul style="list-style-type: none"> -calls physician/NP/RACE (Rapid Assessment of Critical Event) team -performs actions in a timely manner
To prevent adverse events	<ul style="list-style-type: none"> -employs universal/routine infection control practices <ul style="list-style-type: none"> -hand hygiene -recognizes medical errors/near misses/unsafe practices/conditions <ul style="list-style-type: none"> -practices least restraint policy, assesses need for wrist restraints -recognizes risk of catheter-associated UTI -applies patient ID band and allergy band -reports medical errors/near misses/unsafe practices/conditions <ul style="list-style-type: none"> -questions long-term use of Foley catheter for incontinence -identifies risk of allergic reaction to ampicillin due to penicillin allergy
To decrease anxiety in the patient and family members	<ul style="list-style-type: none"> -stays with patient in emergency situation -uses calm approach with patient and family members -uses short sentences/lay terms with patient and family members -uses eye contact/touch to reassure patient

Appendix E:

Confusion Assessment Method (CAM)		
Acute Onset and Fluctuating Course (Circle appropriate)	Box 1	
Is there evidence of an acute change in mental status from the patient's baseline?	No	Yes
Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?	No	Yes
Inattention	Box 2	
Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?	No	Yes
Disorganized Thinking	Box 3	
Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear illogical flow of ideas, or unpredictable switching from subject to subject?	No	Yes
Altered Level of Consciousness		
Overall how would you rate the patient's level of consciousness?	No: Alert normal	Yes: Vigilant (hyper-alert), lethargic (drowsy, easily aroused), stupor (difficult to arouse, coma (un-arousable)
If either/both items in Box 1 are circled YES <u>and</u> Box 2 is circled YES <u>and</u> either item in Box 3 is circled YES a diagnosis of delirium is suggested.	Physician Notified:	
	Date/Time:	Initials:

Appendix F: Scripts for Confederates (Print and mount on cue cards)

Instructions to PSW

Give a verbal report to the nurse: You are accompanying a previously stable elderly gentleman, Bruce Thompson, who has lived in a LTC facility for 8 months following a stroke that left him with right-sided weakness and inability to walk or perform ADL without assistance. He had a Foley catheter inserted for incontinence. Patient has no residual speech or memory deficits. He is on medications for hypertension. He's been confused and agitated over the last couple of days and restraints were put on overnight so he wouldn't pull the catheter out.

Then hand the transfer note/chart to the nurse
(copy of the Patient Profile on page 6)

Comfort the patient: Patient is agitated and requesting that wrist restraints be removed. Explain that restraints were applied to prevent patient from pulling out the foley catheter. If nurse does not suggest removing restraints, ask if it is OK to take off 1 restraint. If restraint removed stay with the patient. OK to ask nurses what they are doing and what they think is going on. Ask if 2nd restraint can be removed.

Instructions to the Physician (usually a faculty member)

You are busy in the ER and reluctant to assess the patient at this time

e.g. Physician: I'm busy with this trauma, what's the matter with this guy? He's confused? So are most 80 year olds. I'll get to him when I get to him.

When the nurse insists and/or gives a satisfactory report you can give some verbal orders. If not drop by "for a minute" with some written orders. (see order sheet). Prompt the nurses to give you the pertinent assessment information.

Repeat for Part 2

Instructions to the Family Member (Son or Daughter)

You are concerned about your father and his confusion. You ask lots of questions about what is going on and what the nurses are doing. If the restraints have not been removed you should question this. If the nurses do not notice that your father is becoming less responsive you can point this out.