Date: "Today"
File Name: Unwitnessed Fall #1
Discipline: Nursing
Student Level: Beginning Fundamentals
Expected Simulation Run Time: 1 hour
Guided Reflection Time: 30 min
Location: Nursing Skills Lab
Location for Reflection: Lab/Classroom with video viewing ability

Admission Date: 3 days ago **Today's Date:** May 17 **Brief Description of Client:** **Name:** Mrs. Ruth O'Donnell **Gender:** F **Age:** 72 **Race:** Caucasian **Weight:** 63kg (~139 #) **Height:** 165cm (5'5") **Religion:** Prot **Major Support:** daughter (Claudia) **Phone:** 301-555-1236 **Allergies:** NKDA **Immunizations:** Flu/PNA/Td October 2010 **Attending Physician/Team:** Dr.Brown/hospitalist **Past Medical History:** osteoarthritis, HTN **History of Present illness:** Admitted via ER 3 days ago after being found on floor at her home by daughter. Complained of "just not feeling well" x 1 week, also states has had frequency/urgency of urination **Social History:** lives independently in own home, daughter lives in area and checks on her mom every day. Found her mother on the floor when visiting. **Primary Medical Diagnosis:** UTI/fever/dizziness **Surgeries/Procedures & Dates:** n/a **Nursing Diagnoses:** n/a	**Psychomotor Skills Required Prior to Simulation** Observation, ability to move/lift patient and equipment, able to verbalize need to take vital signs and awareness of body mechanics & standard precautions **Cognitive Activities Required prior to Simulation [i.e. independent reading (R), video review (V), computer simulations (CS), lecture (L)]** R, L, V

Simulation Learning Objectives

1. Correctly identify the patient using the arm band.

2. Demonstrate basic assessment for this patient (breathing, pulse, vital signs, pOx, LOC, signs of obvious injury, bleeding and so on)

3. Demonstrate appropriate personal and patient safety measures (standard precautions, body mechanics

4. Use of therapeutic communication techniques with patient.

5. Identify proper procedure and choose correct equipment to get patient back to bed.

6. Identify risk factors for falling.

7. Identify measures to prevent falls

Did they think of the need to use these?
Did they identify the need for personal safety in terms of proper equipment/supplies?
Did they call for help? Who did they call?
What did the students tell the PN when she comes in?
Did they safely (for both students & patient) get patient up off the floor?
What equipment do they use (if any) to move the patient?
How did they report the occurrence and to whom?
Who should be notified of the occurrence?
What kind of documentation is needed?
What are the actions the students can take to prevent falls?
What is wrong with the environment that this has happened?
What are the patient's risk factors for falls?

Fidelity (choose all that apply to this simulation)

Setting/Environment

- ☐ **ER**
- XX **Med-Surg**
- ☐ **Peds**
- ☐ **ICU**
- ☐ **OR / PACU**
- ☐ **Women's Center**
- ☐ **Behavioral Health**
- ☐ **Home Health**
- ☐ **Pre-Hospital**
- ☐ **Other:**

Simulator Manikin/s Needed: n/a

Props: Bedside commode, over-bed table with water pitcher, cups, tissues, emesis basin, other general clutter, "urine" spilled on floor

Equipment attached to manikin:

- ☐ **IV tubing with primary line fluids running at mL/hr**
- ☐ **Secondary IV line running at mL/hr**
- ☐ **IV pump**
- ☐ **Foley catheter mL output**
- ☐ **PCA pump running**
- ☐ **IVPB with running at mL/hr**
- ☐ **02**
- ☐ **Monitor attached**
- XX **ID band**
- ☐ **Other:**

Equipment available in room

- ☐ **Bedpan/Urinal**
- ☐ **Foley kit**
- ☐ **Electronic blood pressure/pulse ox device**
- ☒ **chux**
- ☒ **exam gloves**
- ☒ **sliding board**
- ☐ **IV tubing**
- ☐ **IVPB Tubing**
- ☐ **IV Pump**
- ☐ **Feeding Pump**

Medications and Fluids

- ☐ **IV Fluids**

Oral Meds

- ☐ **IVPB**
- ☐ **IV Push**

IM or SC

Diagnostics Available

XX **Labs** Urinalysis on admission shows WBCs TNTC (too numerous to count)

- ☐ **X-rays (Images)**
- ☐ **12-Lead EKG**
- ☐ **Other:**

Documentation Forms

- ☐ **Physician Orders**
- ☐ **Admit Orders**
- ☐ **Flow sheet**
- ☐ **Medication Administration Record**
- ☐ **Kardex**
- ☐ **Graphic Record**
- ☐ **Shift Assessment**
- ☐ **Triage Forms**
- ☐ **Code Record**
- ☐ **Anesthesia / PACU Record**
- ☐ **Standing (Protocol) Orders**
- ☐ **Transfer Orders**
- XX **Other:** Occurrence report, nurse's notes

Recommended Mode for Simulation (i.e. manual, programmed, etc.)

Manual, low fidelity, use real person as patient.

☐ **Pressure Bag** ☐ **02 delivery device (type)** ☐ **Crash cart with airway devices and emergency medications** ☐ **Defibrillator/Pacer** ☐ **Suction** XX **Other:** wheelchair, cane, lift device (students to choose best equipment to use) yellow slippers, extra patient gown	
Roles/Guidelines for Roles XX **Primary Nurse** ☐ **Secondary Nurse** ☐ **Clinical Instructor** ☐ **Family Member #1** ☐ **Family Member #2** XX Observers x 3-4* ☐ **Recorder** ☐ **Physician/Advanced Practice Nurse** ☐ **Respiratory Therapy** ☐ **Anesthesia** ☐ **Pharmacy** ☐ **Lab** ☐ **Imaging** ☐ **Social Services** ☐ **Clergy** ☐ **Unlicensed Assistive Personnel** ☐ **Code Team** XX **Other: ***Nursing students x4 (one half of clinical group) to observe, other half to "find" the patient and perform scenario. **Important Information Related to Roles:** Student nurses will find patient on the floor, an apparent unwitnessed fall, when they check on her after receiving report from the Primary RN. **Significant Lab Values:** Urinalysis on admission showed: WBCs TNTC **Physician Orders:** "Up with assistance, force fluids"	**Student Information Needed Prior to Scenario:** XX **Has been oriented to simulator** XX **Understands guidelines /expectations for scenario** XX **Has accomplished all pre-simulation requirements** XX **All participants understand their assigned roles** XX **Has been given time frame expectations** ☐ **Other:** **Report Students Will Receive <u>During</u> Simulation** **Time:** 1500 Mrs. O'Donnell is a 72 year old female admitted via ER 3 days ago for <u>UTI, fever, weakness</u>. Was found on the floor of her home by her daughter. C/O "not feeling well" for 1 week prior to admission. A&O x3 and "doesn't know what all the fuss is about, I had to go to the bathroom all the time and just got a little dizzy." Does not recall how she got on the floor at home. Falls have not been a problem previously, per the daughter. Now needs assist x1 to BSC, reminders to use call light. Pt still c/o urgency/frequency and will be incontinent if assistance is not prompt. Vital signs an hour ago were: T = 98.9F (oral), P = 88, R = 22, BP 138/76, pulse ox = 98% on Room Air, no c/o pain. Does not like the "force fluids" order because "it makes me have to use the bathroom too much."

References, Evidence-Based Practice Guidelines, Protocols, or Algorithms Used For This Scenario (site source, author, year, and page):

Potter P.A. & Perry, A.G. (2009). *Fundamentals of nursing, 7th ed.* St. Louis, MO: Mosby, Chapters 38 (beginning page 811) and 47 (beginning page 1219).

Tinetti, M.E. & Kumar, C. The patient who falls. *Journal of the American Medical Association* 2010; (303)3: 258-266.

Scenario Progression Outline

Timing (approximate)	**Patient Actions**	**Expected Interventions**	**May Use the Following Cues**
First 10 minutes	Patient is lying on the floor of her room amidst a puddle of fluid beside the bed, moaning.	Students find the patient on the floor. They should: --enter the room immediately --check pt id band -- identify issues of personal safety in the environment before approaching patient --call for help --verbalize that vital signs need to be taken, get equipment & document --verbalize need to put something down on floor to soak up fluid before stepping in it	**Role member providing cue:** another RN or student say/ask any/all of the following: --"what should we do?" --"who is this?" --"do you need help?" --"what is that on the floor?" -- "get the Dynamap (or equivalent)" --"don't slip-something is spilled—I'll get towels." --"who is writing this down?"
	Patient gown is wet with unknown substance.	--put on gloves while looking over the situation	**Role member providing cue:** student or other RN **Cue:** "what is that on her gown--urine?"
	Moaning, crying out when touched on upward turned hip. Has visible contusion on forehead. Unable to answer questions as to why she's on the floor.	--assess the patient for LOC, pain, obvious injury, etc without moving the patient --provide comfort/ reassurance	**Role member providing cue:** student or other RN **Cue:** "let's look at … first" if students attempt to move pt first
Primary Nurse arrives (next 10 minutes), asking "what happened?" Gives brief report as previously stated, including that pt is known fall risk.	Now asking "what happened?"	Students respond --with info from above assessment --reassure and comfort the patient. --continue assessment --recognize that pt is on fall precautions	**Role member providing cue:** PN **Cue:** --"Did you assess/take vital signs/see obvious signs of injury/pain?" --"I don't see the fall precaution items in this room."

PN supervising: getting patient up and back in bed (last 10 minutes)	Stating "I just needed to go to the bathroom. My head hurts…" and repeats. Cries out when upward hip is touched. Pt knows name and place, not time.	Student to: --query for pt weight (how many need to help?) --obtain a slider board or lifting sheet/device. --(all) assist in lifting pt as one unit back to bed.	**Role member providing cue:** PN **Cue:** Asks --"do you know where the slider board is?" --"we need everyone to help lift."
PN: After patient returned to bed, asks students next steps.	Pt resting in bed, occasionally c/o hip pain.	Students to verbalize: --apply fall risk items (yellow bracelet, socks, blanket) --need to contact physician & family --documentation in pt's medical record --documentation on appropriate incident/ occurrence form	**Role member providing cue:** PN **Cue:** --"this pt needs those yellow socks and…" --"now what do we need to do?" --"Who should we call?" --"What do we write down?"

Debriefing/Guided Reflection Questions for This Simulation

(Remember to identify important concepts or curricular threads that are specific to your program)

1. How did you feel throughout the simulation experience?
2. Describe the objectives you were able to achieve?
3. Which ones were you unable to achieve (if any)?
4. Did you have the knowledge and skills to meet objectives?
5. Were you satisfied with your ability to work through the simulation?
6. To Observer: Could the nurses have handled any aspects of the simulation differently?
7. If you were able to do this again, how could you have handled the situation differently?
8. What did the group do well?
9. What did the team feel was the primary nursing diagnosis?
10. What were the key assessments and interventions?
11. Is there anything else you would like to discuss?

Complexity – Simple to Complex

Suggestions for Changing the Complexity of This Scenario to Adapt to Different Levels of Learners

Beginning nursing students: keep it simple.

Late 1st semester/early 2nd semester: include lines, tubes and drains to be assessed and managed.

Later 2nd semester: as above, plus increase complexity of co-morbidities, physical limitations

NCLEX-RN TEST PLAN CATEGORIES & SUBCATEGORIES:

Safe & Effective Care Environment

Management of Care: Establishing priorities
Safety & Infection Control: Injury Prevention, Reporting of Incident /Event, Standard Precautions, Safe Use of Equipment

Health Promotion & Maintenance:

Aging Process
Techniques of Physical Assessment

Psychosocial Integrity

Therapeutic Communications
Therapeutic Environment

Physiologic Integrity

Basic Care and Comfort: Assistive devices, Nutrition & oral hydration, elimination, personal hygiene
Pharmacological & Parenteral Therapies: none
Reduction of Risk Potential: lab values, vital signs, alterations, potential for complications
Physiologic Adaptation: alterations in body systems, infectious diseases, illness mgt