***COMMON STRUCTURE FOR HIGH FIDELITY SIMULATION SCENARIO***

SCENARIO TITLE

Therapeutic education of a patient with lung transplant – Release form – Non-observance

SCENARIO OVERVIEW

DUMMY TYPE:

HEALTHCARE SERVICE: cardiopulmonary transplantation unit

TARGET GROUP[[1]](#footnote-1):

* graduated nurses
* BLOC ¾ learners depending on learning outcomes

ESTIMATED SCENARIO DURATION: 10 minutes

SCENARIO SUMMARY[[2]](#footnote-2):

Man, 31 – lung transplant/cystic fibrosis post-op Day 15 –managing self-care: medicinal treatment – problem non-observance

EDUCATIONAL OBJECTIVES

GENERAL OBJECTIVES:

A patient with lung transplant adopting a therapeutic education approach.

SCENARIO-SPECIFIC OBJECTIVES:

PARTICIPANTS’ ROLE

|  |  |  |  |
| --- | --- | --- | --- |
| STUDENT | Frontline |  |  |
| PROFESSIONAL | Observers |  |  |
| TRAINERS[[3]](#footnote-3) | Trainer 1: facilitator  Trainer 2: Participant |  |  |

EQUIPMENT LIST[[4]](#footnote-4)

Medical supplies:

- Circulation[[5]](#footnote-5): Central venous catheter

- Ventilation[[6]](#footnote-6):

- O2 ln pending

- aerosol mask

- Miscellaneous[[7]](#footnote-7):

- thermometers

- hand sanitiser

- glove box

Medicines and solutes:

- PO

- Prograft

- Methylprednisolone

- + 8h treatment

- DIV

- Drip

- Abelcet aerosol

Documents[[8]](#footnote-8):

- Nursery file

- List of personal medicinal treatment

- Drug table (lnd and side effects)

Accessories[[9]](#footnote-9):

- Reading

- Water bottle

Environment[[10]](#footnote-10):

- Standard room

- Patient armchair

SCENARIO PREPARATION

SIMULATION TYPE:

DUMMY TYPE:

SIMULATOR PREPARATION: standard male patient

- Setting: initial state: patient reading a book

- Positioning[[11]](#footnote-11): patient half-sat in bed

- Accessories[[12]](#footnote-12): specific personal treatment sheet on his lap.

ENVIRONMENT PREPARATION[[13]](#footnote-13): patient half-sat

PREPARATION OF ADDITIONAL EXAMINATIONS[[14]](#footnote-14):

PREPARATION OF STUDENTS/LEARNERS[[15]](#footnote-15): professional outfit and prior reading of nursery file or patient sheet.

BRIEFING

TIME:

SITUATION[[16]](#footnote-16):

DOCUMENTS[[17]](#footnote-17):

PATIENT DATA[[18]](#footnote-18)

Surname: Age:

Name: Weight:

Date of birth: Height:

Allergies: Gender:

History:

Medical history:

Surgeries:

Ob/gyn:

Personal treatment:

FRAMES OF REFERENCE / EXPERTS RECOMMENDATIONS[[19]](#footnote-19)

DEBRIEFING IDEAS

SCENARIO PROGRESS

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **Monitor setting** | **Patient dummy** | **Students’ interventions**  **(what we would like to see…)** | **Messages** | |
| **Beginning time of scenario:** | | | | |
| **Initial state:**  AP: 12/7 cmHG  HR: 87 pls/min  RR: 14/min  SpO2: 99%  Clinical signs:  - eyes[[20]](#footnote-20): opened  - pupils[[21]](#footnote-21): normal  - pulmonary auscultation: some wheezes | The patient is sitting in the armchair, reading his magazine.  Pill box and treatment sheet away from him.  The patient recognises that he reduced the doses on purpose because he feared side effects. The patient is wrong about the side effects. | Asks to see the pill box with the patient.  …………………………………………....  ………………………………………......  (NIC)  …………………………………………....  ………………………………………….... |  | |
| **End time of scenario:** | | | | |

SCENARIO EVALUATION

POSITIVE ASPECTS:

TO IMPROVE:

REALISM:

USED PROTOCOLS:

PROTOCOLS TO IMPLEMENT:

1. Skill level and number of participants [↑](#footnote-ref-1)
2. Scenario key words [↑](#footnote-ref-2)
3. Control of dummy setting / Debriefing/ Dummy voice/ Facilitator/ Disruptive element/ external stakeholder (phone speaker) [↑](#footnote-ref-3)
4. Prefer Check-list for quick check-up [↑](#footnote-ref-4)
5. Catheters, infusion lines, needles (IV, intraosseous, subcutaneous), blood collection tubes, tourniquet… [↑](#footnote-ref-5)
6. Nasal cannulas, non-rebreather masks, intubation supplies… [↑](#footnote-ref-6)
7. Capillary glycaemia, urinary catheter, thermometer, stethoscope, gloves, hand sanitizer…. [↑](#footnote-ref-7)
8. Patient medical file, transmission sheet, ECG, recommendation summary sheet [↑](#footnote-ref-8)
9. Pen, phone, diagnostic penlight for pupils, work outfits (white coats…) [↑](#footnote-ref-9)
10. Wig, basin, tissues with blood, patient’s suitcase… [↑](#footnote-ref-10)
11. Half sit-up, lying down [↑](#footnote-ref-11)
12. Presence of oxygen, of a drip tube, already scoped… [↑](#footnote-ref-12)
13. Raised bed rails, presence of patients belongings, tissues, needed information received

    (Displayed thermometer, glycaemia…) [↑](#footnote-ref-13)
14. If foreseen in the scenario, prepare additional examinations to display (chest radiograph, blood test…) [↑](#footnote-ref-14)
15. Preliminary analysis of documents if needed [↑](#footnote-ref-15)
16. Location where the scenario takes place, information before entering the simulation room [↑](#footnote-ref-16)
17. Document handed during the briefing/ care record, biological results, written transmissions … [↑](#footnote-ref-17)
18. Care record layout or if not necessary to the scenario, voice memo for the trainer [↑](#footnote-ref-18)
19. Quoted sources, bibliography [↑](#footnote-ref-19)
20. Open, half-closed, closed [↑](#footnote-ref-20)
21. Miosis, mydriasis, anisocoria, normal-reactive [↑](#footnote-ref-21)