

COMMON STRUCTURE FOR HIGH FIDELITY SIMULATION SCENARIO

SCENARIO TITLE

Communicating bad news to the patient

SCENARIO OVERVIEW

DUMMY TYPE:

HEALTHCARE SERVICE: surgery service

TARGET GROUP¹: 1st cycle fourth year students

ESTIMATED SCENARIO DURATION: 10 minutes

SCENARIO SUMMARY²:

A 22-year-old patient goes to emergency with intense abdominal pains in upper quadrants, more noticeable in the right hypochondrium, accompanied with vomiting and abdominal distension, for the past four days. She has been admitted in the surgery service for examination. Conscious, anxious, she complains a lot about pain in the abdomen.

EDUCATIONAL OBJECTIVES

GENERAL OBJECTIVES:

To announce bad news.

SCENARIO-SPECIFIC OBJECTIVES:

To identify oneself to the patient; to choose the appropriate location;
to announce the news of neoplasm

¹ Skill level and number of participants

² Scenario key words

PARTICIPANTS' ROLE

STUDENT	Introduces themselves to the patient	Chooses the appropriate location and moment	Gives the bad news
PROFESSIONAL		The doctor (trainer) is there	Present, but does not speak
TRAINERS ³	Facilitator – Pass information	Guide the debrief	

EQUIPMENT LIST⁴

Medical supplies:

- Circulation⁵: peripheral venous catheter No. 18 in the upper right limb
- Ventilation⁶: O2 through oxygen tube 2 l/min
- Miscellaneous⁷:

Medicines and solutes: saline solution 0.9%, 1500 cc/day; metoclopramide 1 vial 12/12 h poss. and in case of pain; paracetamol 1000 mg. poss. 8/8 h

Documents⁸: clinical file; ECG; analyses; abdominal and thoracic X-ray; abdominal-pelvic TAC

Accessories⁹:

Environment¹⁰: patient lying in a private space

SCENARIO PREPARATION

SIMULATION TYPE:

DUMMY TYPE:

SIMULATOR PREPARATION:

- Setting: Patient cast (paleness, perspiration and abdominal ascites)
- Positioning¹¹: Patient lying with a nasal cannula 2 l/m and 0.9% saline solution in the upper right limb
- Accessories¹²: Clinical file

³ Control of dummy setting / Debriefing/ Dummy voice/ Facilitator/ Disruptive element/ external stakeholder (phone speaker)

⁴ Prefer Check-list for quick check-up

⁵ Catheters, infusion lines, needles (IV, intraosseous, subcutaneous), blood collection tubes, tourniquet...

⁶ Nasal cannulas, non-rebreather masks, intubation supplies...

⁷ Capillary glycaemia, urinary catheter, thermometer, stethoscope, gloves, hand sanitizer....

⁸ Patient medical file, transmission sheet, ECG, recommendation summary sheet

⁹ Pen, phone, diagnostic penlight for pupils, work outfits (white coats...)

¹⁰ Wig, basin, tissues with blood, **patient's suitcase**...

¹¹ Half sit-up, lying down

¹² Presence of oxygen, of a drip tube, already scoped...

ENVIRONMENT PREPARATION¹³:

The patient is lying on the bed and complaining about intense pains. She needs a quiet, private environment, such as a room where she can stay alone with the team to receive the information.

PREPARATION OF ADDITIONAL EXAMINATIONS¹⁴:

ECD with sinus tachycardia (120 p/min). Blood cell count with alterations of platelets (low), haemoglobin (low); neutrophilia and biochemistry with alterations of hepatic enzymes (phosphatase, very high transaminases). Scan: two hypodense, moderately contrasted, nodular images, with well-defined limits in the left lobe of the liver.

PREPARATION OF STUDENTS/LEARNERS¹⁵: not applicable

BRIEFING

TIME: 11h

SITUATION¹⁶:

DOCUMENTS¹⁷:

Clinical file with medical observation and record of nursing care without clinical relevance.

PATIENT DATA¹⁸

Surname: Mendes

Age: 24

Name: Patricia Isabel

Weight: 50 kg

Date of birth: 13/05/1995

Height: 1.58 m

Allergies: None

Gender: Female

History: No relevant history

Medical history: does not take

Surgeries: none so far

Ob/gyn:

Personal treatment: not applicable

FRAMES OF REFERENCE / EXPERTS RECOMMENDATIONS¹⁹

DEBRIEFING IDEAS

¹³ Raised bed rails, presence of patients belongings, tissues, needed information received (Displayed thermometer, glycaemia...)

¹⁴ If foreseen in the scenario, prepare additional examinations to display (chest radiograph, blood test...)

¹⁵ Preliminary analysis of documents if needed

¹⁶ Location where the scenario takes place, information before entering the simulation room

¹⁷ Document handed during the briefing/ care record, biological results, written transmissions ...

¹⁸ Care record layout or if not necessary to the scenario, voice memo for the trainer

¹⁹ Quoted sources, bibliography

SCENARIO PROGRESS

Monitor setting	Patient dummy	Students' interventions (what we would like to see...)	Messages
Beginning time of scenario:			
<p>Initial state:</p> <p>AP: 90/60mm/Hg HR: 123p/min RR:22cc/min SpO₂: 96% with O₂</p> <p>ECG curve ²⁰: sinus tachycardia</p> <p>Clinical signs:</p> <ul style="list-style-type: none"> - eyes²¹ open - pupils²² isochoric and reactive - pulmonary auscultation (with respiratory sounds – ascites) 	<p>Patient complaining a lot, pain 7 with abdominal ascites and breathing difficulties</p>	<ul style="list-style-type: none"> - Confirm the patient's name - Introduce themselves to the patient - Set the patient in an appropriate location - Give the bad news (diagnosis of advanced neoplasia). 	<p>The nurse (teacher) passes the baton saying: "Isabel had an abdominal-pelvic scan showing neoplasia. She must be given the news in cooperation with the team."</p>
	<p>No change of vital signs</p>	<ul style="list-style-type: none"> - The student goes with the team and the doctor, sits down so as to face the patient in order to give her the news in a clear way. 	<ul style="list-style-type: none"> - The doctor (teacher) goes with the patient and the nurse in an appropriate room to announce the bad news.
End time of scenario: 11h10			

SCENARIO EVALUATION

POSITIVE ASPECTS:

TO IMPROVE:

REALISM:

USED PROTOCOLS:

PROTOCOLS TO IMPLEMENT:

²⁰ Sinus, Fibrillation...

²¹ Open, half-closed, closed

²² Miosis, mydriasis, anisocoria, normal-reactive