NO STIGMA
Simulation Manual

NOSTIGMA

Building pathways to equitable care

Funded by the Foundation for Opioid Response Efforts (FORE)
https://forefdn.org/

Developed by nursing faculty from the University of Massachusetts Dartmouth

Table of Contents

I. Introduction iii

II. Pre-Work Documents 1
1. Baccalaureate and Master's Students 2
2. DNP Students 8

III. Simulation 1: Access to Timely Care 22
1. Simulation Learning Objectives 23
2. Required Psychomotor Skills and Cognitive Activities 23
3. Simulation Design Template 24
4. Additional Simulation Details 26
5. Pre-Briefing/Briefing 28
6. SBAR Report 29
7. Simulation Progression Outline 30
8. Debriefing/Guided Reflection 33
9. Supplemental Documents 34
    a. ED Physician Orders 34
    b. Medication Administration Record 35
    c. Vital Signs Flowsheet 36
    d. Labs 37
10. Faculty References 39

IV. Simulation 2: Pain Management 40
1. Simulation Learning Objectives 41
2. Required Psychomotor Skills and Cognitive Activities 41
3. Simulation Design Template 42
4. Additional Simulation Details 44
5. Pre-Briefing/Briefing 46
6. SBAR Report 47
7. Simulation Progression Outline 49
8. Debriefing/Guided Reflection 51
9. Supplemental Documents 52
    a. Physician Orders 52
    b. Orders Received After Communicating with Provider 53
    c. Medication Administration Record 54
    d. Vital Signs Flowsheet 55
    e. Clinical Opiate Withdrawal Scale (COWS) Protocol 56
    f. Labs 57
10. Faculty References 58

V. Simulation 3: Family Centered Neonatal Abstinence Syndrome 59
1. Simulation Learning Objectives 60

2. Required Psychomotor Skills and Cognitive Activities 60
3. Simulation Design Template 62
4. Additional Simulation Details 64
5. Pre-Briefing/Briefing 66
6. SBAR Report 67
7. Simulation Progression Outline 68
8. Debriefing/Guided Reflection 70
9. Faculty References 71

VI. Simulation 4: Harm Reduction 73
1. Simulation Learning Objectives 74
2. Required Psychomotor Skills and Cognitive Activities 74
3. Simulation Design Template 76
4. Additional Simulation Details 78
5. Pre-Briefing/Briefing 80
6. SBAR Report 81
7. Simulation Progression Outline 82
8. Debriefing/Guided Reflection 85
9. Faculty References 86

VII. Simulation 5: Telehealth/Remote Care 87
1. Simulation Learning Objectives 88
2. Required Psychomotor Skills and Cognitive Activities 88
3. Simulation Design Template 90
4. Additional Simulation Details 92
5. Pre-Briefing/Briefing 94
6. SBAR Report 95
7. Simulation Progression Outline 96
8. Debriefing/Guided Reflection 98
9. Faculty References 99

VIII. Simulation 6: Older Adult/Stigmatizing Labels 100
1. Simulation Learning Objectives 101
2. Required Psychomotor Skills and Cognitive Activities 101
3. Simulation Design Template 103
4. Additional Simulation Details 105
5. Pre-Briefing/Briefing 107
6. SBAR Report 108
7. Simulation Progression Outline 109
8. Debriefing/Guided Reflection 112
9. Faculty References 113

Introduction

About NO STIGMA Nursing

Building Pathways to Equitable Care

The NO STIGMA Nursing team is a dedicated team of nurse scientists committed to transforming nursing education by addressing and reducing the stigma associated with caring for individuals from marginalized communities and patients with chronic illnesses. Led by Dr. Mary McCurry, the NO STIGMA Nursing Team includes Associate Professors Jennifer Viveiros and Monika Schuler, and Assistant Professors Mirinda Tyo and Shannon Avery-Desmarais. Team members have expertise in nursing education, including simulation development and instruction, and as nurse practitioners in the care of patients with substance use disorder, caregiver burden and end-of-life care. Together, we aim to develop and implement educational simulations that equip nursing students and other health care professionals with the knowledge and skills needed to provide non-judgmental, evidence-based care. Our vision is to foster a culture of understanding and compassion where every patient is treated with dignity and respect. Through our collaborative efforts, we aim to cultivate a healthcare community that upholds the principles of empathy and inclusivity in the treatment of all patients.

Addressing Stigma Associated with Opioid Use Disorder

In 2022, the NO STIGMA Nursing Team was awarded a $595,485 grant from the Foundation for Opioid Response Efforts (FORE) to develop an evidence-based toolkit of high-fidelity simulations for undergraduate, masters, and doctoral nursing students to address stigma towards populations with opioid use disorder. The educational interventions were designed to increase awareness among future nurses and nurse practitioners about opioid use disorders as a chronic illness. By fostering empathy, these interventions seek to eliminate barriers to treatment and improve outcomes for patients with opioid use disorders.

The NO STIGMA team has developed six evidence-based, high-fidelity simulations to address stigma when caring for patients with opioid use disorders. The simulations were shown to result in statistically significant improvement in reducing stigma in baccalaureate, masters, and Doctor of Nursing Students. The NO STIMGA Nursing team has also developed a Simulation Tool Kit that houses the simulation content, including a detailed narrative of each simulation in a standardized format, detailed scripts including appropriate prompts for both the educator and student, debriefing guides, and training videos.

The NO STIGMA Nursing team continues to foster dissemination of the results of the NO STIGMA Simulation Project. We are honored to have presented our work regionally, nationally, and internationally with the hope of contributing to the advancement of evidence-based education to improve the quality of care for individuals with opioid use disorder and their families. Our initial work has been published in the *Journal of Nursing Scholarship,* while

additional papers are under review. Publications from members of our team can be found in several high impact, peer-reviewed journals including *Journal of Nursing Scholarship, Substance Use and Misuse, American Journal of Nursing,* and *Journal of Addiction Nursing.*

The NO STIGMA Nursing team would like to acknowledge the funding received from FORE. FORE is a national, private, grantmaking foundation focused solely on inspiring and accelerating action to end the nation's opioid epidemic. We share their vision and are thankful for their support.

NO STIGMA Simulation
Pre-Work Documents

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Building pathways to equitable care

Pre-Work (Baccalaureate and Master's Students)

Opioid Use Disorder (OUD) Simulation Pre-Work

NOSTIGMA
Building pathways to equitable care

Effective Strategies for Communication with Patients

Establish Trust	Trust helps a person to feel safe. Over time, the person may feel more comfortable talking about information that is critical to their health
Person-First Language	Use person first language, i.e. a person with opioid use disorder, a person in recovery, or a person being treated for substance use disorder
Be Authentic and Present	Give the person your full attention, respond to their questions and concerns
Listen and Validate Concerns	• Listen intently to the person's concerns • Validate what you have heard, by confirming with the person • Ask open ended questions • Ask clarifying questions if needed
Be Empathetic	• Try to understand how chronic OUD and pain maybe impacting the person's quality of life • Validate concerns and emotions • Consider sharing a positive experience • Use empathetic statements "I understand this must be difficult for you"
Be Professional and Nonjudgmental	• Help to normalize the situation by keeping a professional manner • Explain to the person why you need to ask specific questions • Explain you are asking out of concern for their health, so you understand the how to help decrease their risks • Screen all persons for OUD, so it becomes a routine part of your practice. "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"
Emphasize Safety	Show concern for the person's safety and work collaboratively to find safe approaches to improve their overall health
Be Supportive	Use effective communication to help set effective and achievable goals. Be aware of your nonverbal communication cues, such as facial expressions and tone of voice.
Use Direct Communication	• When helping patients manage their pain, you might encounter discordance between a patient's desired treatment options and the clinically recommended treatment regimen. Address these challenges directly with your patients and focus on improving quality of life. • Explain recommendations and compare risks and benefits to the patient's expectations • Discuss alternative plans to reach goals of improved function and lessened pain
Positive Attitude	Positive attitudes and knowledge about OUD lead to better treatment outcomes for patients

Some Facts About OUD

SUD is a complex brain disorder and mental illness that presents as a pattern of behavior involving compulsive use of a substance despite harmful physical, social, and/or psychological consequences.

Signs of acute opioid withdrawal include tachycardia, sweating, restlessness, dilated pupils, bone or joint discomfort, runny nose or tearing, gastrointestinal upset, tremor, yawning, anxiety, irritability, and piloerection of skin (gooseflesh skin).

Patients with mental health conditions, such as depression and anxiety, are more likely to experience OUD and overdose than other patients, especially if they are also taking a benzodiazepine.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur during childhood, including child abuse, neglect, and other violence. Having a history of an ACE is a risk factor for several psychiatric disorders, including substance use disorder.

Many patients who have OUD report a history of childhood trauma. ACEs have been associated with younger age of opioid initiation, injection drug use, and lifetime overdose in adults treated for OUD.

Individuals with ACEs are more likely to report chronic pain symptoms that interfere with daily activities and are also more likely to be prescribed multiple prescription medications.

Patients with chronic pain and depression are at elevated risk for suicide.

Some Facts About Treatment for OUD

Medication-assisted treatment (MAT) is the best evidence-based treatment option for OUD, but stigmatizing attitudes affect retention and adherence to the treatment regimen.

MAT includes the use of buprenorphine, naltrexone, or methadone, in combination with cognitive behavioral therapy. MAT is safe to use for months, years, or even a lifetime.

Buprenorphine (Suboxone, Subutex, Sublocade) is considered the first-line MAT. It is thought to be safer than methadone for overdose risk since it is a partial opioid agonist and has a lower potential for respiratory depression. It suppresses and reduces cravings for opioids. Buprenorphine can be prescribed by healthcare providers without a waiver.

Methadone is a long-acting full opioid agonist and requires outpatient visits for supervised administration. Some patients may be allowed to take methadone at home. The length of treatment is a minimum of 12 months. Methadone helps to reduce craving and withdrawal and blocks the effects of opioids.

Naltrexone is an alternative treatment for highly motivated patients, patients with mild OUD, and patients whose occupation (pilots, healthcare workers, public safety) do not permit the use of methadone or buprenorphine. Naltrexone blocks the euphoric and sedative effects of opioids and prevents feelings of euphoria.

Particularly Vulnerable Populations with OUD

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals are two times more likely to have OUD than their non-LGBTQ+ peers.

Opioid overdose deaths are rising two times faster in Black, Indigenous and People of Color (BIPOC) than in White individuals.

Youth who identify as a sexual or gender minority (LGBTQ+) are twice as likely to experience homelessness than their non-LGBTQ+ peers. LGBTQ+ youth who are also BIPOC are at an ever higher risk of homelessness.

Human Trafficking Concerns

An estimated 24.9 million people in the world are victims of human trafficking in which victims are forced into labor. One such type of human trafficking is sex trafficking in which victims are coerced or forced into sexual acts.

OUD is common among victims of sex-trafficking. Traffickers often exploit individuals with OUD by coercing them into trafficking in exchange for opioids.

Sex trafficking inflicts trauma on these victims which can lead to increased opioid use as a coping mechanism.

LGBTQ+ homeless youth are 2 times more likely to be sex trafficked than non-LGBTQ homeless youth.

The National Human Trafficking Hotline provides resources to victims of sex and labor trafficking to allow them to get help and stay safe. Phone, text, and online chat is available 24/7, 365 days per year. Help is available in over 200 languages.


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CONTACT THE NATIONAL HUMAN TRAFFICKING HOTLINE
Do you want to get out of the life?
Are you being forced to work against your will?
Or threatened or tricked by your boss?
Do you know someone who may be?
CALL
1-888-373-7888
TEXT
"BeFree" (233733)
LIVE CHAT
HumanTraffickingHotline.org
✓ Get help.
✓ Report a tip.
✓ Find services.
✓ Learn about your options.
24/7 • Toll free • Confidential • 200+ languages
Polaris received $1.75 million through competitive funding through the U.S. Department of Health and Human Services, Administration for Children and Families, Grant #90ZV0134-01-00. The project will be financed with 43.75% of federal funds and 56.25% ($2.25 million) by non-governmental sources. The contents of this flyer are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services, Administration for Children and Families.
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Harm Reduction

Harm reduction approaches have been proven to prevent death, injury, disease, overdose, and substance misuse. Talk to your patients about the serious risks of respiratory depression associated with concurrent use of opioids and benzodiazepines.

Naloxone distribution is associated with decreased opioid overdose deaths at the community level. Naloxone should be offered to patients and their family members when the following factors that increase risk for opioid overdose are present:

- History of nonfatal overdose
- History of substance use disorder
- Higher opioid dosages (> 50 MME/day)
- Concurrent benzodiazepine use
- High risk of returning to a dose to which tolerance is no longer expected

Fentanyl is 50 times more potent than heroin and overdose deaths related to fentanyl have quadrupled in the past decade. Fentanyl is added to other substances because it is cheap to manufacture, so individuals sometimes do not know what they are consuming. Fentanyl strips are distributed by many states and can be used by individuals prior to using a substance. If positive, individuals can choose to take additional precautions to reduce harm such as use less, go slow, snort or smoke instead of inject, and stagger use with a trusted friend.

Harm associated with injecting drug use includes HIV, viral hepatitis, and bacterial and fungal infections. Needle exchange programs can help to reduce infectious disease transmission among people who use drugs, including those who inject drugs by equipping them with new supplies, accurate information, and facilitating referral to resources.

Many people with OUD need help connecting to community recovery services. Recovery support services, including recovery coaches and peer navigators, reduce ED utilization in patients with OUD by connecting patients with community resources. A warm handoff can facilitate healing and help remove some of the burden from the person. At minimum, providing the person with a list of recovery support services in their community should be part of their discharge instructions.

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Pre-Work (DNP Students)

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Or threatened or tricked by your boss?
Do you know someone who may be?
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✓ Report a tip.
✓ Find services.
✓ Learn about your options.
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SAMHSA
Substance Abuse and Mental Health Services Administration

BUPRENORPHINE
QUICK START GUIDE

Important Points to Review With the Patient

Specifically discuss safety concerns:

- **Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.**
- **Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.**
- **Understand the importance of informing providers if they become pregnant.**
- **Tell providers if they are having a procedure that may require pain medication.**

Facts About Buprenorphine

- FDA approved for Opioid Use Disorder treatment in an office-based setting.
- For those with tolerance to opioids as a result of OUD, buprenorphine is often a safe choice.
- Buprenorphine acts as a partial mixed opioid agonist at the μ-receptor and as an antagonist at the κ-receptor. It has a higher affinity for the μ-receptor than other opioids, and it can precipitate withdrawal symptoms in those actively using other opioids.
- It is dosed daily, has a long half-life, and prevents withdrawal in opioid dependent patients.
- Can be in tablet, sublingual film, or injectable formulations.
- Many formulations contain naloxone to prevent injection diversion. This formulation is the preferred treatment medication. The buprenorphine only version is often used with pregnant women to decrease potential fetal exposure to naloxone.
- There is a "ceiling effect" in which further increases above 24mg in dosage does not increase the effects on respiratory or cardiovascular function.
- Buprenorphine should be part of a comprehensive management program that includes psychosocial support. Treatment should not be withheld in the absence of psychosocial support.
- Overdose with buprenorphine in adults is less common, and most likely occurs in individuals without tolerance, or who are using co-occurring substances like alcohol or benzodiazepines.

Checklist for Prescribing Medication for the Treatment of Opioid Use Disorder

1

Assess the need for treatment

For persons diagnosed with an opioid use disorder,* first determine the severity of patient's substance use disorder. Then identify any underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

Your assessment should include:

- A patient history
- Ensure that the assessment includes a medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient's prescription drug use history through the state's Prescription Drug Monitoring Program (PDMP), where available,

to detect unreported use of other medications, such as sedative-hypnotics or alcohol, that may interact adversely with the treatment medications.
- A physical examination that focuses on physical findings related to addiction and its complications.
- Laboratory testing to assess recent opioid use and to screen for use of other drugs. Useful tests include a urine drug screen or other toxicology screen, urine test for alcohol (ethyl glucuronide), liver enzymes, serum bilirubin, serum creatinine, as well as tests for hepatitis B and C and HIV. Providers should not delay treatment initiation while awaiting lab results.

2

Educate the patient about how the medication works and the associated risks and benefits; obtain informed consent; and educate on overdose prevention.

There is potential for relapse & overdose on discontinuation of the medication. Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.

3

Evaluate the need for medically managed withdrawal from opioids

Those starting buprenorphine must be in a state of withdrawal.

4

Address co-occurring disorders

Have an integrated treatment approach to meet the substance use, medical and mental health, and social needs of a patient.

5

Integrate pharmacologic and nonpharmacologic therapies

All medications for the treatment of the opioid use disorder may be prescribed as part of a comprehensive individualized treatment plan that includes counseling and other psychosocial therapies, as well as social support through participation in mutual-help programs.

6

Refer patients for higher levels of care, if necessary

Refer the patient for more intensive or specialized services if office-based treatment with buprenorphine or naltrexone is not effective, or the clinician does not have the resources to meet a particular patient's needs. Providers can find programs in their areas or throughout the United States by using SAMHSA's Behavioral Health Treatment Services Locator at www.findtreatment.samhsa.gov.

*See The Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association, page 541.

Induction Considerations

The dose of buprenorphine depends on the severity of withdrawal symptoms, and the history of last opioid use (see flowchart in appendix for dosing advice).

- **Long acting opioids, such as methadone, require at least 48-72 hours since last use before initiating buprenorphine.**
- **Short acting opioids (for example, heroin) require approximately 12 hours since last use for sufficient withdrawal to occur in order to safely initiate treatment. Some opioid such as fentanyl may require greater than 12 hours.**
- **Clinical presentation should guide this decision as individual presentations will vary.**

Determine Withdrawal

Objective withdrawal signs help establish physical dependence

The risk with initiating buprenorphine too soon is that buprenorphine has a very high affinity for the mu receptor and will displace any other opioid on the receptor, thereby causing precipitated opioid withdrawal.

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

COWS Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face	Tremor: *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness: *Observation during assessment* 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning: *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability: 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerection of skin can be felt or hairs standing up on arms 5 Prominent piloerection
Runny nose or tearing: *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment: _____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

Information on Precipitated Withdrawal

- Precipitated withdrawal can occur due to replacement of full opioid receptor agonist (heroin, fentanyl, or morphine) with a partial agonist that binds with a higher affinity (Buprenorphine).
- Symptoms are similar to opiate withdrawal.
- Avoid by ensuring adequate withdrawal before induction (COWS > 12; Fentanyl may require higher COWS score and lower initial dosing), starting Buprenorphine at a lower dose (2.0mg/0.5 mg), and reassessing more frequently.
- Should precipitated withdrawal occur, treatment includes:
  - Providing support and information to the patient
  - Management of acute symptoms
  - Avoid the use of benzodiazepines
  - Encourage the patient to try induction again soon

Buprenorphine Side Effects

- **Buprenorphine's side effects may be less intense than those of full agonists. Otherwise, they resemble those of other mu-opioid agonists.**
- **Possible side effects include: Oral numbness, constipation, tongue pain, oral mucosal erythema, vomiting, intoxication, disturbance in attention, palpitations, insomnia, opioid withdrawal syndrome, sweating, and blurred vision**
- **Buprenorphine FDA labels list all potential side effects**

Co-prescribing of overdose reversal agents such as Naloxone is also recommended

Maintenance Therapy

Goal = once-daily dosing, no withdrawal between doses. Ideally, average dosing does not exceed 16 mg/4 mg (See flowchart in appendix)

- **Check PDMP regularly to ensure prescriptions are filled, and to check other prescriptions.**
- **Order urine drug testing (UDT) and consider confirmatory testing for unexpected results. UDT can facilitate open communication to change behavior.**
- **Assess for readiness for extended take-home dosing**

Psychosocial Therapies

- **Although people often focus on the role of medications in MAT, counseling and behavioral therapies that address psychological and social needs may also be included in treatment. To find treatment, please consult www.findtreatment.gov.**

Diversion

Diversion is defined as the unauthorized rerouting or misappropriation of prescription medication to someone other than for whom it was intended (including sharing or selling a prescribed medication); misuse includes taking medication in a manner, by route or by dose, other than prescribed.

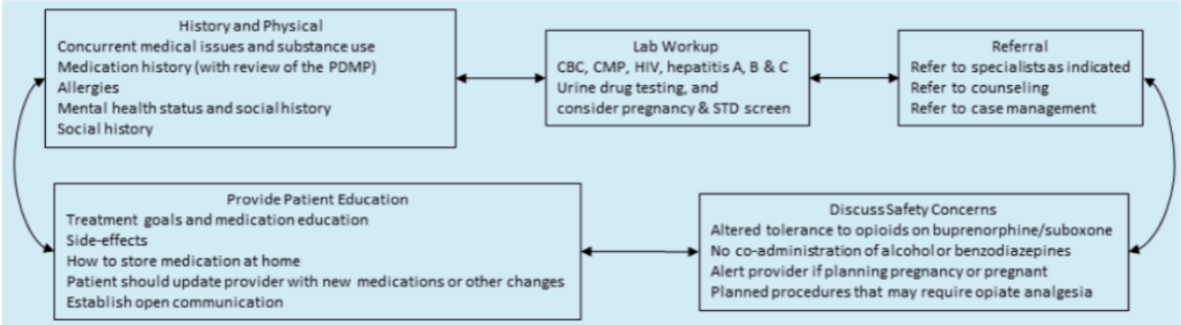
How can providers minimize diversion risk?

1. Early in treatment patients should be seen often, and less frequently only when the provider determines they are doing well.
2. Providers should inquire about safe and locked storage of medications to avoid theft or inadvertent use, especially by children. Patients must agree to safe storage of their medication. Counsel patients about acquiring locked devices and avoiding storage in parts of the home frequented by visitors.
3. Limit medication supply. Prescribe an appropriate amount of medications until the next visit. Do not routinely provide an additional supply "just in case."
4. Use buprenorphine/naloxone combination products when medically indicated. Reserve daily buprenorphine monoproducts for pregnant patients and/or patients who could not afford treatment if the combination product were required.
5. Counsel patients on taking their medication as instructed and not sharing medication.
6. Ensure that the patient understands the practice's treatment agreement and prescription policies. Providers can utilize the sample treatment agreement in SAMHSA's TIP 63, Page 3-78. A treatment agreement and other documentation are clear about policies regarding number of doses in each prescription, refills, and rules on "lost" prescriptions.
7. Directly observe ingestion randomly when diversion is suspected.
8. Providers should order random urine drug testing to check for other drugs and for metabolites of buprenorphine. Providers should also consider periodic point of care testing.
9. Doctors should schedule unannounced pill/film counts. Periodically ask patients to bring in their medication containers for a pill/film count.
10. Providers should make inquiries with the Prescription Drug Monitoring program in their state to ensure that prescriptions are filled appropriately and to detect prescriptions from other providers.
11. Early in treatment, providers can ask the patient to sign a release of information for a trusted community support individual, such as a family member or spouse, for the purpose of communicating treatment concerns including diversion.

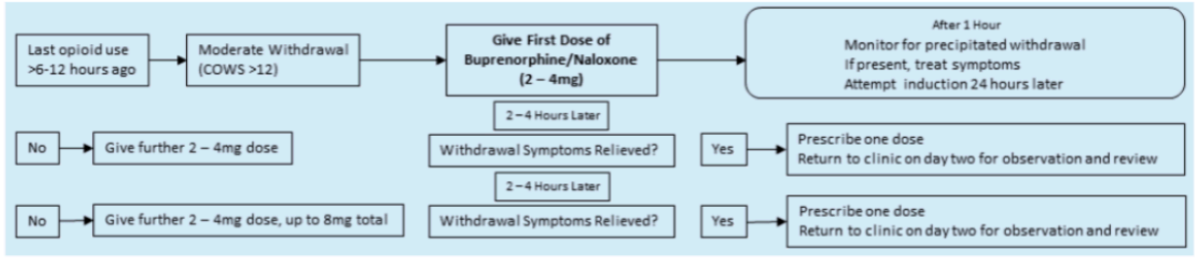
TRANSMUCOSAL BUPRENORPHINE/ NALOXONE QUICK START GUIDE

Algorithm for In-Office Induction (for home induction prescriptions may be given)

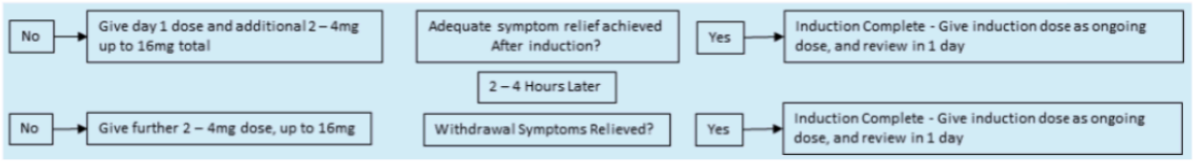
INITIAL ASSESSMENT



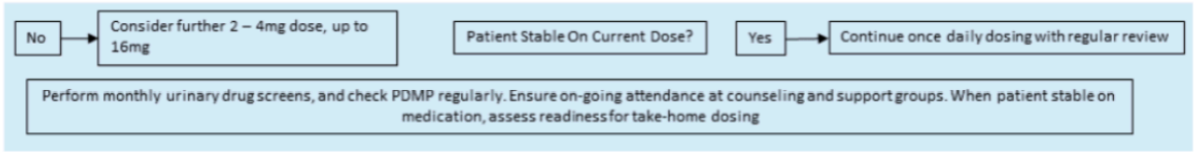
DAY ONE (INDUCTION)



DAY TWO



MAINTENANCE

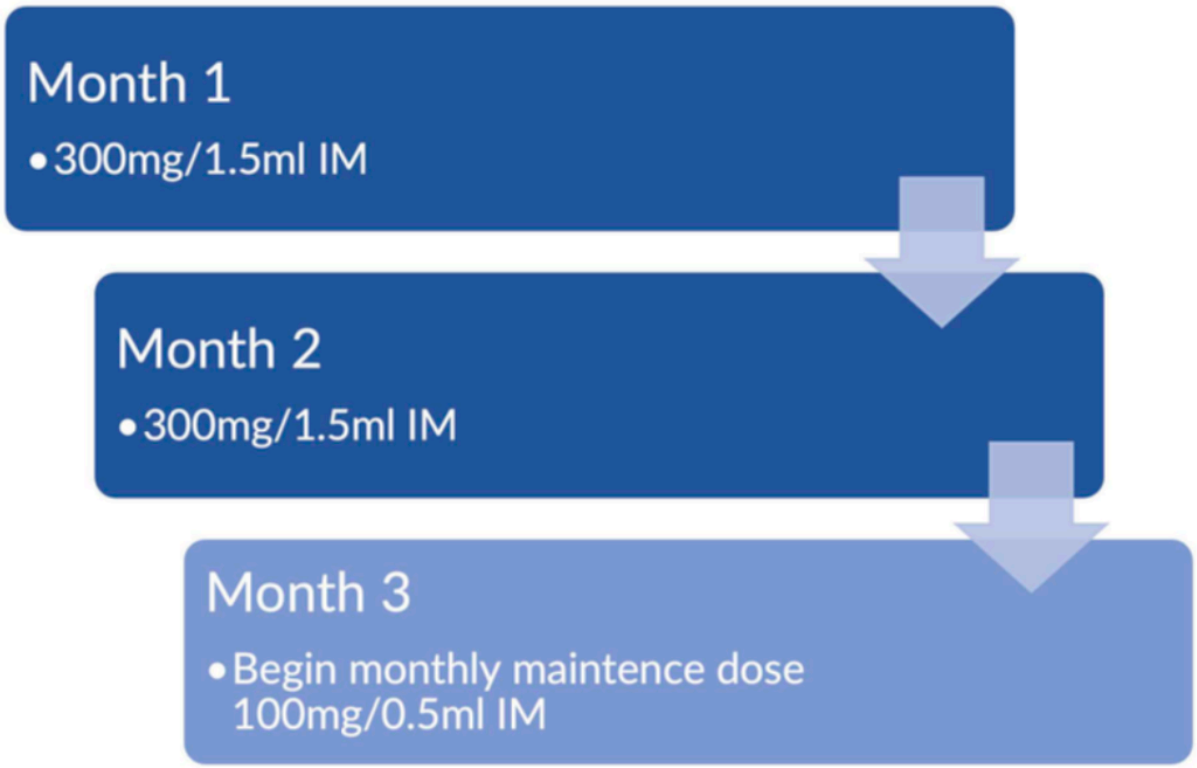


(Adapted from Substance Abuse and Mental Health Services Administration (2022). Buprenorphine quick start guide. https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf)

INJECTABLE BUPRENORPHINE TRANSITION GUIDE

- Patients with moderate to severe OUD who have stabilized on a buprenorphine-containing product (at least 7 days on a stable dose) may switch to extended-release injectable buprenorphine.

- Injectable buprenorphine is available in two doses: 300 mg/1.5 mL and 100 mg/0.5 mL prefilled syringes.



(Adapted from Substance Abuse and Mental Health Services Administration (2021). Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings. https://store.samhsa.gov/sites/default/files/pep21-06-01-002.pdf)

BUPRENORPHINE MONITORING

- Once stable, visits should occur every two to four weeks via in-person or telehealth.
- Patients on injectable buprenorphine should visit the clinic in person every 26-28 days for their monthly injection.
- Maintenance clinic visits include the following elements, as well as telehealth support as needed.
  - ✓ Urine drug testing to identify the level of buprenorphine or presence of other substances
  - ✓ Indicated lab testing (e.g., liver function tests)
  - ✓ Patient assessment
    - Medication status: dosage, adherence, side effects, cravings, withdrawal symptoms, safe storage
    - Medical, psychiatric, and social issues
    - Other elements of recovery (engagement in counseling, peer support meetings, recovery groups, etc.)

Opioid Withdrawal Symptom Management

Anxiety	Clonidine	0.1mg PO Q4H PRN
	Quetiapine	25mg PO QHS PRN
Sleep	Trazodone	50-100mg PO QHS PRN
Pain	Ibuprofen	600mg PO Q6H PRN
Nausea	Dimenhydrinate	50mg PO Q6H PRN
	Ondanestron	4mg PO Q6H PRN
Diarrhea	Loperamide	4mg PO, followed by 2mg after each loose stool (do not exceed 16mg/day)

Funding for the NO STIGMA project by the FORE Foundation.

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Simulation 1:
Access to Timely Care

This image was created with the assistance of DALL·E 2

Estimated Run Time: 15 minutes
Adapted for Student Population: Undergraduate
Setting: Emergency Department
Patient Population: Adult

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Examines awareness of implicit attitudes that contribute to stigma
2. Performs priority nursing actions based on clinical assessment findings
3. Communicates with the patient using an empathetic and nonjudgmental approach
4. Uses SBAR to communicate appropriately with other healthcare team members in a timely, organized manner using a patient-centered approach

Simulation Scenario Objectives:

1. Collects comprehensive data pertinent to the healthcare client's health and/or the situation (AMERSA Standard 1)
2. Delivers care for clients with OUD utilizing evidence-based practice and best practice principles in a manner that preserves an individual's autonomy, dignity, rights, values, and beliefs (AMERSA Standards 4, 7, 9)
3. Utilizes evidence-based knowledge to guide practice in the prevention, identification and treatment of substance use disorders (AMERSA Standards 5, 16)

Psychomotor Skills Required of Participants Prior to Simulation

- Assessment of the adult patient, including symptoms of withdrawal
- Assessment of wound

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, lecture notes, articles, websites, etc.)

Centers for Disease Control and Prevention. (n.d.). *Assessing risk factors for opioid overdose*. https://www.cdc.gov/opioids/naloxone/training/risk-factors-of-opioid-overdose.html

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No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 1: Access to Timely Care

Date:
Discipline: Nursing
Expected Simulation Run Time: 15 minutes
Location: Emergency Department
Today's Date:

File Name: Kevin Dos Santos
Student Level: Undergraduate
Guided Reflection Time: 45 minutes
Location for Reflection:

Brief Description of Patient

Kevin is a 32-year-old male presently in the emergency room waiting for admission to the floor. He is being admitted for cellulitis and has a profound infection in the anterior aspect of his left forearm. He is restless and complains of arm pain, nausea, and overall fatigue.

Kevin has a 5-year history of substance use disorder. He reports using intravenous fentanyl routinely and occasionally uses some of his friend's medications to avoid withdrawal. He estimates 2 bags of fentanyl every day. He was admitted for opioid use disorder treatment in the past, last inpatient admission was 8 months prior. Kevin has no health insurance, and reports he was unable to afford additional outpatient therapy or medication for opioid use disorder.

Name: Kevin Dos Santos **Pronouns:** He/Him

Date of Birth: 06/03/_ _ **Age:** 32

Sex Assigned at Birth: Male **Gender Identity:** Male

Sexual Orientation: Heterosexual **Marital Status:** Single

Weight: 152 lbs (69 kg) **Height:** 5'9"

Racial Group: Multiracial **Language:** English **Religion:** Catholic

Employment Status: Unemployed **Insurance Status:** None **Veteran Status:** None

Support Person: Mother **Support Phone:** (999) 867-5309

Allergies: Sulfa **Immunizations:** Up to date, Covid x2

Attending Provider/Team: Dr. Alicia Mendes

Home Medications: None

Past Medical History: Asthma; Depression; Anxiety; PTSD from sexual assault; Methicillin sensitive staphylococcus aureus; Hepatitis C; Infective endocarditis; Sepsis

History of Present Illness: Patient presented for a left forearm abscess, fever, and chills x6 days. He was seen 3 days ago in this ED where the abscess was incised and drained, and a wick inserted. He was prescribed antibiotics, but unable to get them filled due to the cost. Today he presents for worsening symptoms and was found to have a WBC of 15.7. On exam, there is a 3x4 cm tunneling wound with erythema and purulent foul-smelling discharge noted to his left anterior forearm.

Social History: Resides at men's shelter; Tobacco (2ppd) x10 years; Alcohol socially, mainly weekends; Intravenous fentanyl use x7 years, last 10 hours ago

Primary Medical Diagnosis: Left forearm abscess, Sepsis

Surgeries/Procedures & Dates: Appendectomy; Femur fracture MVC (2011); Biological aortic valve prosthesis (2018)

Setting/Environment

X Emergency Department	☐ ICU
☐ Medical-Surgical Unit	☐ OR/PACU
☐ Pediatric Unit	☐ Rehabilitation Unit
☐ Maternity Unit	☐ Home
☐ Behavioral Health Unit	☐ Outpatient Clinic
	☐ Other:

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed:

- Patient – sim manikin or standardized patient
- Nurse – learner/student
- Charge Nurse – actor

Recommended Mode for Simulator: script/training for SP

- Healthy adult

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
X ID band	☐ Bedpan/urinal
X IV tubing with pump at NS at 999 mL/hr	☐ 02 delivery device (type)
☐ Secondary IV line running at __ mL/hr	☐ Foley kit
X IVPB with cefazolin (Ancef) 2,000mg running at 200 mL/hr	☐ Straight catheter kit
☐ IV pump	☐ Incentive spirometer
☐ PCA pump	☐ Fluids
☐ Foley catheter with __mL output	☐ IV start kit
☐ 02	☐ IV tubing
☐ Monitor attached	☐ IVPB tubing
X Other: Dirty, malodorous old bandage to forearm	☐ IV pump
X Other: 3x4 cm open tunneling wound	☐ Feeding pump
X Other: Odor paste for pseudomonas	☐ Crash cart with airway devices and emergency medications
X Other: Kerlix	☐ Defibrillator/pacer
	☐ Suction
Other Essential Equipment:	**X** Other: Bed/stretcher
Medications and Fluids:	
☐ Oral Meds:	
☐ IV Fluids:	

☐ IVPB: ☐ IV Push: ☐ IM or SC:	

Roles

X Nurse 1	☐ Observer(s)
X Nurse 2	☐ Recorder(s)
☐ Nurse 3	☐ Family member #1
☐ Provider (physician/advanced practice nurse)	☐ Family member #2
☐ Other healthcare professionals: (pharmacist, respiratory therapist, etc.)	☐ Clergy ☐ Unlicensed assistive personnel ☐ Other:

Guidelines/Information Related to Roles

Learners in role of nurse should determine which assessments and interventions each will be responsible for, or facilitator can assign nurse 1 and nurse 2 roles with related responsibilities.

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from scenario progression outline.

Pre-Briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this simulation is to provide learners with an opportunity to engage in meaningful conversation using therapeutic communication to address stigmatizing behaviors (delay in care, dismissiveness) and language (frequent flyer, drug seeker) experienced by individuals with OUD in the acute care setting.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Simulation during which the student will engage with the mannequin/teacher/patient in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the mannequin (if applicable) as if the mannequin is a 'real human' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse
            2. Healthcare provider/Nurse practitioner
        iii. Describe roles within the simulation
            1. Student nurse
            2. Charge nurse/Nurse for hand-off report
            3. Patient
        iv. Describe the setting
            1. ED
            2. Orient the student to the simulation room, medication cabinet, supplies, how to phone the provider, etc.
    b. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        i. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    c. Post-simulation survey (if incorporated)
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report Students Will Receive Before Simulation (Use SBAR format)

Time:	Middle of busy shift, 1pm in ER
Person providing report:	Charge Nurse to Nurse
Situation:	The patient is in room 4, waiting for admission. There is an overwhelming smell of staph and pseudomonas (exacerbated by the fact he and the bed have been stuffed into an extremely small room).
Background:	The patient has been in the ER all day. He came in about four hours ago. You will recognize him, he is here all the time. Three of us tried, but we couldn't get his IV started. We sent the labs. Liz the resource nurse came down and finally got his IV using the ultrasound. She started his IV fluids and antibiotics a few minutes ago.
Assessment:	There are no recent vital signs noted. The patient has mild rigors and there is a filthy bandage that was placed 4 days ago.
Recommendation:	Most of the ER orders have just been completed (last 10 min), including first dose IV antibiotics, wound cultures, and IV access. However, the patient is upset and now wants to leave AMA.

Scenario Progression Outline

Patient Name: Kevin Dos Santos **DOB:** 06/03/_ _

Timing (approx.)	Manikin/SP Actions	Expected Interventions	May Use the Following Cues
0-5 min	Brief report, 30-50 seconds. **Charge RN**: "*You have Room 4. The guy is just an addict who can't stop shooting drugs into his arm. You might recognize him. He came in about 4 hours ago. He's been here multiple times before. We were able to get his labs but couldn't start an IV. The resource nurse came down and started his IV a few minutes ago. She also started the fluids and antibiotics*. *Now he wants to leave!*" **Charge RN** states in an annoyed and critical voice: "*The whole room stinks so bad. Your priority should be to get him upstairs so we can have housekeeping clean the room*. *Honestly, it's fine if he just leaves.*"	Nurse recognizes serious delay in care.	**Patient**: "*I mean, you heard her call me a druggie like. That's not why I am here. I wasn't unconscious. I brought myself in here. I've been waiting for hours.*" "*Nobody does anything for me, you know, like my arm is infected. And I heard what she said that it stinks. You know, I know it does.*" "*My arm hurts. I am in a lot of pain*." "*When is someone going to take care of my arm, it really hurts*." Restless, moving around in bed. "*Can you just leave the door open? This room is making me claustrophobic.*"
5-10 min	**Patient** states in an exhausted and stressed voice: "*I have been in this room for hours and no one has really done anything for me until 10 minutes ago. Nobody is even nice to me. They always treat me like a dirtbag addict*. *It's probably what I deserve, I am a drug*	Introduce self to patient. Establish a therapeutic relationship. Start with apologizing for delay in care. Listen intently to patient's concerns, trying to empathize with his perspective.	**Patient** states in a loud voice (aggressive): "*This place is awful, and the staff don't care*. *You heard that, nurse*." "*I am just sitting here in pain. I mean, I can't sit here anymore. I'm. I'm totally crawling out of my*

	user. *My arm really hurts*." "*I'm wasting my time and I should just leave*."		*skin like. I got. I don't even know what to do. I gotta go*."
10-15 min	Displays subjective signs of pain, states "*oh that really hurts*" while nurse is trying to take blood pressure. VS: HR 92 – BP 92/51 – RR 22 – O2 sat – 98% RA – T 101.3 – Pain 8/10	Establish trust and express empathy regarding the impact of pain. Use empathetic communication to help the patient understand why he needs to stay for treatment. Make eye contact. Use a caring tone.	Patient has active signs of anxiety and irritability. **Patient** states in a frustrated voice: "*Just take this IV out*." **Patient** states in a stressed and exhausted voice: "*I'm just going to leave*. *Can you get me my belongings and take this IV out? I mean it's not like I'm after drugs, I can get those on the street."* **Patient** in an exhausted tone: "*It's been a week already.*"
15-20 min	Patient complains of nausea and shakiness. Arm pain is 8/10. Patient has increased anxiety, irritability, and mild diaphoresis.	Recognize signs of withdrawal. Consider opioid withdrawal as the potential reason the patient is considering leaving. Ask the patient if he has received MOUD and if so, what worked/didn't work for him. Ask the physician or healthcare provider to evaluate the patient for opioid withdrawal. Provide handoff to ED provider using SBAR.	Patient starts to dry heave and has visible tremors. **Patient** in an anxious tone: "*It just got worse and then I got a fever and you know, so I had to come back, and now I've been here for hours and I've just been sitting here and nobody's come in here and nobody's helped me and I'm anxious and my stomach hurts. And I just, you know, like, I'm really overwhelmed by all of this. And I just. I don't want to be in pain. I don't know what I want. I thought I was coming here for help. But you*

			know, everyone just treats me like a druggie. You know? Like they don't want to take care of me. I heard her say I stink, you know, like. I don't know. I don't think that is going to help any of this. Like I'm in pain like I need. I need real help." "*You are going to have to give me something for withdrawal if you expect me to stay here. Otherwise, I'm out. I'm not going through that again!*"
End Scenario		Nurse SBAR handoff to the healthcare provider for concern for opioid withdrawal. Offer referral to peer recovery coach or hospital social services resources if available.	**Patient** in an anxious tone: "*I can't. I can't stay here and not get something to help*." "*I know what this is, and if I stay here any longer, it's gonna get worse.*"

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Delay in care
2. Therapeutic communication
3. Opioid withdrawal
4. Social determinants (no insurance, homeless, limited transportation)

4. Were you satisfied with your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

ED Physician Orders

Dos Santos, Kevin **Preferred Name:** Kevin **DOB:** 06/03/_ _ **Sex:** Male **MRN:** 123000045	**CC:** Wound recheck **Encounter date:** **PCP:** None	**Allergies:** Sulfa
	Labs:	
	CBC with diff, CMP, APTT, PT, blood culture x 2, lactic acid	
	Wound culture	
	Imaging:	
	XR chest 1 view portable	
	Ultrasound Left Forearm	
	Medications:	
	Sodium chloride 0.9% bolus 1,000mL, intravenous, once	
	cefazolin (Ancef) 2,000mg, intravenous, once	
	acetaminophen (Tylenol) 1000mg, po, for mild pain	
	Nursing:	
	Insert and maintain peripheral IV	
	Vital signs Q 4 hours	
	Notify MD if SBP < 90mmHg	
	Cleanse wound, apply bulky dressing	

Medication Administration Record

MEDICATION ORDER	8/2/__ Today	__ / __ / __	__ / __ / __
SCHEDULED			
cefazolin (Ancef) 2,000mg, intravenous, every 8 hours 0600 1400 2200	14:55 LB		
ONE TIME ONLY			
Sodium chloride 0.9% bolus 1,000mL, intravenous, once	14:45 LB		
PRN MEDICATIONS			
acetaminophen (Tylenol) 1000mg, po, every 6 hours as needed for mild pain up to 4 grams daily	09:30 SH		

Vital Sign Flowsheet

TIME	TEMP	PULSE	RESP	BP	SPO2	PAIN	INITIALS
0800							
0900							
1000	101.6	119	24	108/52	99	10/10	SH
1100							
1200							
1300							
1400	101.3	92	22	92/51	98	8/10	LB
1500							
1600							
1700							
1800							
1900							
2000							

Lab			
COMPLETE BLOOD COUNT WITH DIFFERENTIAL			**Reference Range**
	00/00/00 14:46		
White Blood Cell (WBC)	15.7		4.0 - 10.0 k/uL
Red Blood Cell (RBC)	4.42		4.5 - 5.5 M/uL
Hemoglobin (HGB)	12.6		12 - 17 g/dL
Hematocrit (HCT)	36.2		36 - 51%
MCV	89		80 - 100 fl
MCH	31		31 - 37 g/dL
MCHC	34.8		32 - 36 g/dL
RBC Distribution Width	42.4		12.2 - 16.1
Platelet	290,000		150,000 - 350,000 uL or mm^3
Neutrophils (%)	81.6		34.0 - 67.9
Lymphocytes (%)	24.7		21.8 - 53.1
Monocytes (%)	7.7		5.3 - 12.2
Eosinophils (%)	0		0.8 - 7
Basophils (%)	0.8		0.1 - 1.2
BASIC METABOLIC PANEL			**Reference Range**
	00/00/00 14:46		
Sodium	147		135 - 147 mmol/L
Potassium	3.5		3.5 - 5.2 mmol/L
Chloride	100		95 - 107 mmol/L
Co2	23		22 - 30 mmol/L
Urea Nitrogen (BUN)	54		7 - 20 mg/dL
Creatinine	2.1		0.5 - 1.2 mg/dL
Glucose	135		60 - 110 mg/dL
Lactate	3.2		< 2.2 mmol/L

URINALYSIS		**Reference Range**
	00/00/00 9:56	
Color	Amber	Pale to dark yellow, amber
pH	7.3	5 - 8
Specific Gravity	1.020	1.002 - 1.035
Protein	Trace	Negative/trace
Glucose	Negative	Negative
Ketones	Negative	Negative
Nitrites	Negative	Negative
Bilirubin	Negative	Negative
Blood	Negative	Negative
Leukocyte	Negative	Negative
Urobilinogen	0.3	0.2 - 1.0 Ehr U/L
URINE TOXICOLOGY SCREEN		**Reference Range**
	00/00/00 9:56	
Amphetamine Screen, Ur	Negative	Negative
Barbiturate Screen, Ur	Negative	Negative
Benzodiazepine Ur, Qual	Negative	Negative
Opiate Screen, Ur	Positive	Negative
PCP Screen, Ur	Negative	Negative
Ethanol Screen, Ur	Negative	Negative
Cannabinoid, Ur	Positive	Negative
Cocaine Screen, Ur	Negative	Negative

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

Association for Multidisciplinary Education and Research in Substance Use and Addiction. (2019, March). *Specific disciplines addressing substance use: AMERSA in the 21st century – 2018 update.* https://amersa.org/wp-content/uploads/AMERSA-Competencies-Final-31119.pdf

Centers for Disease Control and Prevention. (2022, July 7). *Empathy: Talking to patients about substance use disorde*r. Conversation Starter: Clinicians. https://www.cdc.gov/opioids/addiction-medicine/conversation-starters/pdf/talking-to-patients.pdf

Mateu-Gelabert, P., Sandoval, M., Meylakhs, P., Wendel, T., & Friedman, S. R. (2010). Strategies to avoid opiate withdrawal: Implications for HCV and HIV risks. *International Journal of Drug Policy*, *21*(3), 179–185. https://doi.org/10.1016/j.drugpo.2009.08.007

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Wesson, D. R., & Ling, W. (2003). The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs, 35*(2), 253–259. https://doi.org/10.1080/02791072.2003.10400007

Simulation 2:
Pain Management

This image was created with the assistance of DALL·E 2

Estimated Run Time: 15 minutes
Adapted for Student Population: Undergraduate
Setting: Acute Care
Patient Population: Adult

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Performs priority nursing actions based on clinical assessment findings
2. Communicates with the patient using an empathetic and nonjudgmental approach
3. Utilizes evidence-based practice regarding opioid substitution therapy and acute pain management
4. Uses SBAR to communicate appropriately with other healthcare team members in a timely, organized manner using a patient-centered approach

Simulation Scenario Objectives:

1. Analyzes pertinent data to plan the healthcare for the consumer's health and/or the situation (AMERSA Standard 1)
2. Delivers care for clients with OUD utilizing evidence-based practice and best practice principles in a manner that preserves consumer autonomy, dignity, rights, values, and beliefs (AMERSA Standards 4, 7, 9)
3. Prioritizes and implements the identified care plan to meet the needs of patient and family experiencing substance use disorder (AMERSA Standard 5)
4. Utilizes evidence-based knowledge to guide practice in the prevention, identification, and treatment of substance use disorders (AMERSA Standard 5)

Psychomotor Skills Required of Participants Prior to Simulation

- Effective communication skills
- Assessment of the adult patient, including symptoms of withdrawal
- OUD/SUD withdrawal signs/symptoms and evidence-based care
- COWS assessment tool

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, lecture notes, articles, websites, etc.)

National Institute on Drug Abuse. (n.d.). *Words matter*. National Institutes of Health. https://nida.nih.gov/sites/default/files/words_matter_handout.pdf

The National Alliance of Advocates for Buprenorphine Treatment. (2011). *Clinical opiate withdrawal scale (COWS)*. http://www.naabt.org/documents/cows_induction_flow_sheet.pdf

No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 2: Pain Management

Date:
Discipline: Nursing
Expected Simulation Run Time: 15 minutes
Location: Medical floor
Today's Date:

File Name: Kevin Dos Santos
Student Level: Undergraduate
Guided Reflection Time: 45 minutes
Location for Reflection:

Brief Description of Patient

Kevin is a 32-year-old male admitted to the floor for cellulitis to the anterior aspect of his left forearm. He is restless and complains of arm pain, nausea, and overall fatigue.

Kevin has a 5-year history of substance use disorder. He reports using intravenous heroin routinely and occasionally uses some of his friend's meds to avoid withdrawal. He estimates 2-3 bags of heroin every day. He was admitted for opioid use disorder treatment in the past, last inpatient admission was 8 months prior. Kevin has no health insurance, and reports he was unable to afford additional outpatient therapy or medication for opioid use disorder.

Name: Kevin Dos Santos **Pronouns:** He/Him

Date of Birth: 06/03/_ _ **Age:** 32

Sex Assigned at Birth: Male **Gender Identity:** Male

Sexual Orientation: Heterosexual **Marital Status:** Single

Weight: 152 lbs (69 kg) **Height:** 5'9"

Racial Group: Multiracial **Language:** English **Religion:** Catholic

Employment Status: Unemployed **Insurance Status:** None **Veteran Status:** None

Support Person: Partner **Support Phone:** (999) 867-5309

Allergies: Sulfa **Immunizations:** Up to date, Covid x1

Attending Provider/Team: Dr. Alicia Mendes

Home Medications: Not taking any at this time

Past Medical History: Asthma; Depression; Anxiety; PTSD from sexual assault; Methicillin sensitive staphylococcus aureus; Hepatitis C; Infective endocarditis; Sepsis

History of Present Illness: Patient was admitted to the medical floor for a left forearm abscess, fever, and chills x6 days. He was seen 3 days ago in the ED where the abscess was incised and drained, and a wick inserted. A bulky dressing is currently in place. It is clean, dry, and intact. He is prescribed IV antibiotics. His WBC count is 15.7. He is afebrile. He reports nausea, abdominal pain, and general malaise.

Social History: Resides at men's shelter; Tobacco (2ppd) x10 years; Alcohol socially, mainly weekends; Intravenous heroin use x7 years, last 4-6 hours ago

Primary Medical Diagnosis: Left forearm abscess; Sepsis

Surgeries/Procedures & Dates: Appendectomy; Femur fracture MVC (2011); Biological aortic valve prosthesis (2018)

Setting/Environment

☐ Emergency Department **X** Medical-Surgical Unit ☐ Pediatric Unit ☐ Maternity Unit ☐ Behavioral Health Unit	☐ ICU ☐ OR/PACU ☐ Rehabilitation Unit ☐ Home ☐ Outpatient Clinic ☐ Other:

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed: standardized patient

- Patient – sim manikin or standardized patient
- Nurse – learner/student
- Family member – actor (elective)
- Off-going nurse handoff for coverage – actor or faculty

Recommended Mode for Simulator: script/training for SP

- Healthy adult

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
X ID band **X** IV tubing with primary line fluids running at 100 mL/hr **X** Secondary IV line running at 50 mL/hr **X** IVPB with Cefazolin 2g running at 50 mL/hr **X** IV pump ☐ PCA pump ☐ Foley catheter with __mL output ☐ 02 ☐ Monitor attached **X** Other: bulky kerlex dressing to forearm **X** COWS protocol **X** Patient chart/paper or electronic **Other Essential Equipment:** **Medications and Fluids:** ☐ Oral Meds: ☐ IV Fluids: ☐ IVPB:	☐ Bedpan/urinal ☐ 02 delivery device (type) ☐ Foley kit ☐ Straight catheter kit ☐ Incentive spirometer ☐ Fluids ☐ IV start kit ☐ IV tubing ☐ IVPB tubing ☐ IV pump ☐ Feeding pump ☐ Crash cart with airway devices and emergency medications ☐ Defibrillator/pacer ☐ Suction ☐ Other:

☐ IV Push: ☐ IM or SC:	

Roles

X Nurse 1	☐ Observer(s)
X Nurse 2	☐ Recorder(s)
☐ Nurse 3	**X** Family member #1
X Provider (physician/advanced practice nurse) phone communication	☐ Family member #2
	☐ Clergy
☐ Other healthcare professionals: (pharmacist, respiratory therapist, etc.)	☐ Unlicensed assistive personnel
	☐ Other:

Guidelines/Information Related to Roles

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from scenario progression outline.

Pre-Briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this simulation is to allow learners an opportunity to role model addressing biases and barriers to providing pain management for individuals with OUD and their family.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Pre-simulation survey and consent
    b. Simulation during which the student will engage with the mannequin/teacher/patient in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the mannequin (if applicable) as if the mannequin is a 'real human' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse
        iv. Describe roles within the simulation
            1. Student nurse
            2. Nurse handing off report
            3. Family member
        v. Describe the setting
            1. Inpatient MS
    c. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        ii. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    d. Post-simulation survey if indicated
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report Students Will Receive Before Simulation (Use SBAR format)

Address mother and include in SBAR:

"*Hi Andrea. I'm Shannon, one of the other nurses. Have I met you yet?*
No.
Nice to meet you.
Nice to meet you too.
So, you know, we're taking care of Kevin here. I just wanted to give you a quick little history…"

Time:	9 pm
Person providing report:	Off-going nurse needs coverage as she transports a patient. Student receives an SBAR hand off.
Situation:	*"Kevin is a 32-year-old. He is a new admission from the ED for left forearm cellulitis with elevated WBC count, fever, and SIRS. IV antibiotics are infusing. He has been complaining a ton about pain and nausea and feeling tired. He's been a drug addict for like 5 years and he's been using fentanyl. Sometimes he uses his friends' drugs, he's just… he's such a mess. I feel like we've seen him so many times before*."
Background:	*"I didn't bother asking him about previous treatment. You know, he's here. We're just going to take care of his abscess. He was in the ED 3 days ago, and they did an incision and drainage and cleaned it out. They gave him antibiotics, but he didn't even fill the prescription. Supposedly it was too expensive and so now we've got him, and he's got a dressing we just changed. He's got IV antibiotics, his white count is a little high, he has no fever, but he's a complainer. He keeps complaining about everything. And what else? We gave him Tylenol about half an hour ago, so that should be enough for his pain anyway. So that's his info, OK? And then you've got his labs and his MAR here. OK, so there you go. Good luck to you*." **If asked any other questions during report**: Patient has a 6-day history of cellulitis getting worse with outpatient management because he did not fill his outpatient antibiotic prescription. Patient is an IV drug user and the infection is related to injecting. He presented to the ED earlier today with worsening cellulitis, fever, and general malaise. WBC count was 15.7. Admitted for IV antibiotics, awaiting blood culture results. He received 4 mg of suboxone in the ED at 6pm.

Assessment:	Patient reports pain at infection site 7/10, HA, abd pain, and general malaise. Vital signs are: HR 110, BP 134/88, RR 20, 0_2 Sat 96%, temp 99.7F. Patient appears uncomfortable.
Recommendation:	Revaluate pain and vital signs, patient may need medication for pain.

Scenario Progression Outline

Patient Name: Kevin Dos Santos **DOB:** 06/03/_ _

Timing (approx.)	Manikin/SP Actions	Expected Interventions	May Use the Following Cues
0-5 min	Brief report to oncoming RN. Patient lying in bed, appears uncomfortable. Reports arm pain 7/10. Cramps, headache, nausea, and generalized discomfort. VS: BP: 134/88 P: 110 R: 20 T: 99.7 O2 Sat: 96%	Shift assessment (to include COWS). Review COWS protocol. Recognize need for withdrawal intervention. Communicate with the patient regarding pain management in OUD.	**Patient**: "*She said a lot of things. Yeah, but I'm in pain. My arm is killing me. I really feel bad, my arm hurts. I think I may get sick.*" "*My head hurts, my stomach keeps cramping, and I really can't bear this pain.*" **Family**: "*I hate to see him like this. He is really uncomfortable.*" **If asked about prescriptions** **Patient**: "*You know, I don't have insurance and I was hanging out with friends*."
5-10 min	**Patient** states in an exhausted and stressed voice: "I*s there anything that can help my arm pain? I hate asking, it just is really hurting.*"	Explores evidence-based plans for pain management for individuals with OUD. Communicates with provider for pain medication. Obtains Toradol and Zofran orders. Establishes trust and express empathy regarding the impact of pain. Listens intently to patient and family concerns.	**Patient**: "*I hate to keep asking but it's just really hurting.*" Patient starts to dry heave. **Family**: "*Is it ok for him to take pain medication, that's what started all the problems?*" **If asked about previous inpatient treatment** **Patient**: "*Yeah, no, I've tried man. I put my mom through hell, you know. I was impatient like 8 months ago. They had me in a*

		Medicates patient while addressing the neurobiological factors in OUD as a chronic illness.	*rehab*." **Family**: "*He just can't seem to beat it. He's been through multiple programs*." *"I hate that he is controlled by those drugs. He tries hard to quit but can't beat it.*"
10-15 min	Asks questions and responds to the nurse.	Reevaluates COWS and pain score. Explores patient's readiness to seek OUD treatment. Offers referral/resources for patient and family regarding support and treatment options.	**If student does not discuss referral** **Patient**: "*I don't know what I'm going to do next. I'm all out of chances."* **Family**: "*This is so hard to live with. My heart breaks for him and none of my family or friends understand.*"

Additional cues depending on how scenario progresses:

Patient: "*Well, it's just been an addiction for a long time, and I can't bite the cravings sometimes. You know? I don't want to be like this, and I don't want to go through all these awful feelings and being sick. Who would want this?*"

Family: "*This is just, it's really hard to live with, you know? So my heart just breaks for him. And none of my family and friends really understand*."

"*I have some friends, but you know, they don't really understand. They'll say to me, why do you just keep trying? Why do you let him back?*"

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient to you (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Opioid withdrawal
2. Pain management
3. Therapeutic communication
4. Interprofessional resources

4. How did you feel about your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

Physician Orders

Dos Santos, Kevin **Preferred Name:** Kevin **DOB:** 06/03/_ _ **Sex:** Male **MRN:** 123000045	**CC:** Wound recheck **Encounter date:** **PCP:** None	**Allergies:** Sulfa

Today	Admit to Dr. Mendes service. Admit to telemetry bed.	
	Diagnosis: cellulitis	
	Continuous cardiac monitoring	
	Diet: House	
	Labs:	
	CBC with diff, CMP, APTT, PT, blood culture x2, lactic acid	
	Imaging:	
	XR chest 1 view portable	
	Ultrasound Left Forearm	
	Medications:	
	Sodium chloride 0.9% bolus 1,000mL, intravenous, once	
	cefazolin (Ancef) 2,000mg, intravenous, every 8 hours	
	acetaminophen (Tylenol) 1000mg, po, every 6 hours as needed for mild pain up to 4 grams daily	
	Initiation of Buprenorphine for Opioid Use Disorder	
	buprenorphine/naloxone (Suboxone) 4/1 mg, sublingual, every 2 hours to a maximum of 32mg for day 1, then 8/2mg, sublingual, every 12 hours for 2 weeks.	
	Nursing:	
	Insert and maintain peripheral IV	
	Vital signs Q 4 hours	
	Notify MD if SBP < 90mmHg	
	I&O every 8 hours	
	Change dressing every shift or more frequent if soiled	
	COWS Protocol	

Orders Received After Communicating with Provider

Dos Santos, Kevin **Preferred Name:** Kevin **DOB:** 06/03/_ _ **Sex:** Male **MRN:** 123000045	**CC:** Wound recheck **Encounter date:** **PCP:** None	**Allergies:** Sulfa
Today		
	Medications:	
	ketorolac (Toradol) 10mg, IV, every 6 hours prn for moderate pain 5-7/10	
	ondansetron (Zofran) 4mg, po/IV, every 4 – 6 hours as needed	
	loperamide (Lomotil) 4mg, po, every 4 hours as needed	

Medication Administration Record

MEDICATION ORDER	8/2/__ Today	__ / __ / __	__ / __ / __
SCHEDULED			
cefazolin (Ancef) 2,000mg, intravenous, every 8 hours 0600 1400 2200			
buprenorphine/naloxone (Suboxone) 4/1 mg, sublingual, every 2 hours to a maximum of 32mg for day 1 0600 0800 1000 1200 1400 1800			
buprenorphine/naloxone (Suboxone) 8/2mg, sublingual, every 12 hours for 2 weeks 0900 2100			
ONE TIME ONLY			
Sodium chloride 0.9% bolus 1,000mL, intravenous, once			
PRN MEDICATIONS			
acetaminophen (Tylenol) 1000mg, po, every 6 hours as needed for mild pain up to 4 grams daily	09:30 SH		

Vital Sign Flowsheet

TIME	TEMP	PULSE	RESP	BP	SPO2	GLUCOSE	PAIN	INITIALS
0000								
0400								
0800								
1200								
1600								
2000	99.7	110	20	134/88	96	-	7/10	JDV
2400								

Clinical Opiate Withdrawal Scale (COWS) Protocol

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last* 1/2 *hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past* 1/2 *hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs,* 35(2), 253–9.

Lab			
COMPLETE BLOOD COUNT WITH DIFFERENTIAL			**Reference Range**
	08/02/__ 15:46		
White Blood Cell (WBC)	15.7		4.0 - 10.0 k/uL
Red Blood Cell (RBC)	4.42		4.5 - 5.5 M/uL
Hemoglobin (HGB)	12.6		12 - 17 g/dL
Hematocrit (HCT)	36.2		36 - 51%
MCV	89		80 - 100 fl
MCH	31		31 - 37 g/dL
MCHC	34.8		32 - 36 g/dL
RBC Distribution Width	42.4		12.2 - 16.1
Platelet	290		150,000 - 350,000 uL or mm^3
Neutrophils (%)	81.6		34.0 - 67.9
Lymphocytes (%)	24.7		21.8 - 53.1
Monocytes (%)	7.7		5.3 - 12.2
Eosinophils (%)	0		0.8 - 7
Basophils (%)	0.8		0.1 - 1.2
BASIC METABOLIC PANEL			**Reference Range**
	08/02/__ 15:46		
Sodium	147		135 - 147 mmol/L
Potassium	3.5		3.5 - 5.2 mmol/L
Chloride	100		95 - 107 mmol/L
Co2	23		22 - 30 mmol/L
Urea Nitrogen (BUN)	54		7 - 20 mg/dL
Creatinine	2.1		0.5 - 1.2 mg/dL
Glucose	135		60 - 110 mg/dL
Lactate	5.2		< 2.2 mmol/L
URINALYSIS			**Reference Range**
	08/02/__ 7:56		
Color	Amber		Pale to dark yellow, amber
pH	7.3		5 - 8
Specific Gravity	1.020		1.002 - 1.035
Protein	Trace		Negative/Trace
Glucose	Negative		Negative
Ketones	Negative		Negative
Nitrites	Negative		Negative
Bilirubin	Negative		Negative
Blood	Negative		Negative
Leukocyte	Negative		Negative
Urobilinogen	0.3		0.2 - 1.0 Ehr U/L

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update*. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

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Strayer, R. J., Hawk, K., Hayes, B. D., Herring, A. A., Ketcham, E., LaPietra, A. M., Lynch, J. J., Motov, S., Repanshek, Z., Weiner, S. G., & Nelson, L. S. (2020). Management of opioid use disorder in the emergency department: A white paper prepared for the American Academy of Emergency Medicine. *The Journal of Emergency Medicine, 58*(3), 522-546. https://doi.org/10.1016/j.jemermed.2019.12.034

Wesson, D. R., & Ling, W. (2003). The clinical opiate withdrawal scale (COWS). *Journal of Psychoactive Drugs,* 35(2), 253–259. https://doi.org/10.1080/02791072.2003.10400007

Simulation 3:
Family Centered Neonatal Abstinence Syndrome

This image was created with the assistance of DALL·E 2

Estimated Run Time: 15 minutes
Adapted for Student Population: Graduate
Setting: Level 2 nursery
Patient Population: Infant

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Examines awareness of implicit attitudes that contribute to stigma
2. Constructs clear and empathetic communication of health information and treatment options devoid of stigma
3. Employs strategies to reduce risk of harm to the patient and family

Simulation Scenario Objectives:

1. Develops an understanding of unconscious (implicit) bias influenced by stereotyping and manifested in the language used by nurses when interacting with family members of infants born with NAS (AMERSA Standards 4, 7)
2. Tests strategies to redirect and educate nursing students on appropriate language when interacting with patients and their families with the goal of creating a safe, non-stigmatizing environment so that family members feel welcome and as a part of the team responsible for caring for their infant (AMERSA Standards 4, 13, 16)
3. Formulates harm reduction approaches when considering person/family-centered outcomes (AMERSA Standards 3, 16)

Psychomotor Skills Required of Participants Prior to Simulation

- Ability to recognize the role of the mother in caring for the infant
    - Ability to have a therapeutic conversation with the mother

<u>If integrating assessment and care of infant with NAS:</u>

- Assessment of the infant
    - Assess for s/s withdrawal
    - Complete Finnegan Score
- Interventions to reduce infant stress
    - Swaddling, holding, nonnutritive sucking, pressure, rubbing, swaying, rocking, and reducing external stimulation
    - Medication management

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, notes, articles, websites, etc.)

Committee on Obstetric Practice. (2017, August). *ACOG committee opinion: Opioid use and opioid use disorder in pregnancy* (Report No. 711). The American College of Obstetricians and Gynecologists & American Society of Addiction Medicine.

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

Kondili, E., & Duryea, D. G. (2019). The role of mother-infant bond in neonatal abstinence syndrome (NAS) management. *Archives of Psychiatric Nursing*, *33*(3), 267-274. https://doi.org/10.1016/j.apnu.2019.02.003

Mossabeb, R., & Sowti, K. (2021). Neonatal abstinence syndrome: A call for mother-infant dyad treatment approach. *American Family Physician*, *104*(3), 222-223.

Nguyen, T. T., Toney-Noland, C., Wong, J., Chyi, L., Castro, R., Huang, A., Aron-Johnson, P., Lee, H. C., & Quinn, M. K. (2022). Neonatal abstinence syndrome and mother's own milk at discharge. *Journal of Perinatology*, *42*(8), 1044-1050. https://doi.org/10.1038/s41372-022-01430-5

Schierholz, E., French, R., & Boucher, A.-M. (2020, January 5). Caring for infants and families affected by neonatal abstinence syndrome. *American Nurse*, *15*(1), 6-11. https://www.myamericannurse.com/wp-content/uploads/2020/01/AN-CE-NAS-12-11.pdf

Wu, D., & Carre, C. (2018). The impact of breastfeeding on health outcomes for infants diagnosed with neonatal abstinence syndrome: A review. *Cureus*, *10*(7), e3061. https://doi.org/10.7759/cureus.3061

If running simulation as maternity/pediatric focus:
Modified Finnegan Neonatal Abstinence Score (NAS). https://www.mdcalc.com/modified-finnegan-neonatal-abstinence-score-nas

Schierholz, E., French, R., & Boucher, A.-M. (2020, January 5). Caring for infants and families affected by neonatal abstinence syndrome. *American Nurse*, *15*(1), 6-11. https://www.myamericannurse.com/wp-content/uploads/2020/01/AN-CE-NAS-12-11.pdf

Wachman, E. M., & Werler, M. M. (2019, January 22). Pharmacologic treatment for neonatal abstinence syndrome: Which medication is best? *JAMA Pediatrics*, *173*(3), 221-223. doi:10.1001/jamapediatrics.2018.5029

No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 3: Family Centered Neonatal Abstinence Syndrome

MS instructor OR clinical educator simulation

Date:
Discipline: MS Educator/Clinical Instructor
Expected Simulation Run Time: 15 minutes
Location: Level 2 nursery
Today's Date:

File Name: Jonas Simas/Suzi Morey
Student Level: Graduate
Guided Reflection Time: 45 minutes
Location for Reflection:

Brief Description of Patient

Infant is a 5-day-old male born at 34 weeks gestation to a 21-year-old female with a history of SUD/OUD including cocaine, THC, and fentanyl. Mother has been on a methadone program since finding out she was pregnant at 20 weeks; she is currently on 120 mg methadone daily.

Infant was diagnosed with neonatal abstinence syndrome (NAS) and is currently in a Level 2 nursery. Infant was started on morphine 0.04 mg/kg/dose q4 hours along with a loading dose of phenobarbital at (15 mg/kg/day) and maintenance dose (4 mg/kg/day).

The mother has been visiting sporadically. She reported she is having issues with transportation.

A student nurse has been assigned to care for the infant and mother. The student nurse is in the room with the infant and attempting to console the fussy infant.

You are the nurse educator who comes into the room to check in on the student and guide the student nurse in the care he/she gives to the infant and his mother.

Infant Name: Jonas Simas

Mother Name: Suzi Morey

Date of Birth: 5 days ago
Time of Birth: 11:50 a.m.

Birth Age: 35 weeks and 1 day
Infant is currently 5 days old

Birth Weight: 2359 grams
Current Weight: 2250 grams

Length: 19.9 inches

Sex Assigned at Birth: Male

Gender Identity: Male

Apgar Score at Birth: 7
Apgar Score at 5 minutes: 7

Feeding: High calorie infant formula

Racial Group: Mixed race **Religion:** Not yet determined **Language:** English

Support Person: Mother and aunt **Support Phone:** (980) 909-9000

Allergies: None **Immunizations:** Up to date

Attending Provider/Team: Dr. Sanchez – attending if needed
NP Darjung – if needed
Nurse Marie

Home Medications: None

Past Medical History: Infant – none
Mother – SUD
Father – unknown

History of Present Illness (Infant): Infant is a 5-day-old male born via vaginal birth to a mother with a history of SUD/OUD. Mother reportedly had minimal prenatal care and has been on a methadone treatment program for the last 3 months for her SUD.

Infant was transferred to a Level 2 nursery. On day two of life, infant began exhibiting signs of NAS including hyperactive reflexes, poor feeding, hypertension, tachycardia, and hyperthermia. Infant was started on morphine per protocol. Infant continues to be irritable with multiple bouts of high-pitched crying. Infant had diarrhea 4 times today. Most recent Finnegan Score was 12.

Mother visited with the infant 20 minutes ago and complained that her baby was irritable and difficult to console. Mother will be visiting again in two hours and would like to discuss the following with a nurse:

- She heard “breast milk is best” and would like to breast feed her infant
- She wants to bring her infant home today
- She would like some resources for free diapers

Social History: Mother lives with aunt and significant other (not biological father of infant)

Primary Medical Diagnosis: Neonatal Abstinence Syndrome

Surgeries/Procedures & Dates: None

Setting/Environment

☐ Emergency Department ☐ Medical-Surgical Unit ☐ Pediatric Unit ☐ Maternity Unit ☐ Behavioral Health Unit **X** Level 2 NICU	☐ ICU ☐ OR / PACU ☐ Rehabilitation Unit ☐ Home ☐ Outpatient Clinic ☐ Other:

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed: standardized patient

- Infant (mannequin)
- Nursing student – actor
- MS nurse educator – learner/student

Recommended Mode for Simulator: script/training for SP

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
X ID band ☐ IV tubing with primary line fluids running at __ mL/hr ☐ Secondary IV line running at __ mL/hr ☐ IVPB with __ running at mL/hr ☐ IV pump ☐ PCA pump ☐ Foley catheter with __mL output **X** 02 at bedside PRN ☐ Monitor attached ☐ Other: **X** IV access in R dorsal arch (hand) **Other Essential Equipment:** **Medications and Fluids:** ☐ Oral Meds: ☐ IV Fluids: ☐ IVPB: ☐ IV Push: ☐ IM or SC:	☐ Bedpan/urinal ☐ 02 delivery device (type) ☐ Foley kit ☐ Straight catheter kit ☐ Incentive spirometer ☐ Fluids ☐ IV start kit ☐ IV tubing ☐ IVPB tubing ☐ IV pump ☐ Feeding pump ☐ Crash cart with airway devices and emergency medications ☐ Defibrillator/pacer ☐ Suction ☐ Other:

Roles

X Student nurse	☐ Observer(s)
X Clinical educator	☐ Recorder(s)
☐ Nurse 3	☐ Family member #1
☐ Provider (physician/advanced practice nurse)	☐ Family member #2
☐ Other healthcare professionals: (pharmacist, respiratory therapist, etc.)	☐ Clergy
	☐ Unlicensed assistive personnel
	☐ Other:

Guidelines/Information Related to Roles

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from scenario progression outline.

Roles:

- Infant (mannequin)
- Nursing student (actor)
- Nurse educator (learner)

Pre-Briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this stimulation is to provide learners an opportunity to address biases in the healthcare delivery and education systems, while emphasizing the importance of non-judgmental communication among novice nurses/nursing students when caring for families impacted by neonatal abstinence syndrome.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Pre-simulation survey and consent
    b. Simulation during which the student will engage with the mannequin/teacher/patient in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the mannequin (if applicable) as if the mannequin is a 'real human' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse Educator
        v. Describe roles within the simulation
            1. Student nurse
            2. Patient
        vi. Describe the setting
            1. Level 2 nursery
    c. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        iii. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    d. Post-simulation survey
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report MSN-Educator Student will Receive Before Simulation (Use SBAR format)

Time:	Now
Person providing report:	Student nurse (actor) to nurse educator (student)
Situation:	Mother had a vaginal delivery of a 34 week plus 1-day infant 5 days ago. Infant was diagnosed with NAS on day two of life and was started on morphine per protocol. Mother has just visited her baby in the Level 2 nursery where she found her infant irritable and difficult to console. Mother would like to discuss the following with a nurse: • She heard "breast milk is best" and would like to breast feed her infant • She wants to bring her infant home today • She would like some resources for free diapers <u>If focus is on caring for infant with NAS:</u> Infant has not gained weight since birth despite receiving high calorie infant formula and eating every 2 hours. Finnegan scores 9-12 for the last two days. VS: B/P 99/58, HR 125, RR 26, 98% O^2 sat on 2 liters per minute via Nasal Canula, Temp 100.3 rectal (note the infant is hypertensive, tachycardic, and hyperthermic). Mother has arrived at the Level 2 NICU two hours after her scheduled time. Mother wants to speak with the nurse about breast feeding and taking her child home.
Background:	Mother was on 120 mg methadone daily. Mother reports having only minimal prenatal care and had been using cocaine, fentanyl, and THC prior to learning she was pregnant at 20 weeks gestation.
Assessment:	Infant continues to exhibit symptoms of NAS and has not gained weight despite high calorie infant formula. Mother would like to breast feed infant and is anxious to bring the child home.
Recommendation:	Address the concerns of the mother and discuss the needs of the infant.

Scenario Progression Outline

Patient Name: Jonas Simas - infant **DOB:** 07/01/_ _
Mother: Suzi Morey

Timing (approx.)	SP Actions	Expected Interventions	May Use the Following Cues
0-15 min **Concept:** Stigmatizing language	Student nurse (SN) is holding mannequin (infant) who is fussy. SN states she wants to report on her conversation with the mother. **SN**: "*I just got off the phone with Jonas' drug addicted mother. She's something else. She's making a bunch of ridiculous demands…*"	Nurse educator enters the room to check on the student nurse. Educator: Address the language that is being used by the student. Address the tone of the student.	**SN**: "*Would you like me to report on what I'm doing with baby Jonas and my conversation with his mom?*"
Concept: SUD/OUD is a chronic illness	**SN**: "*It's all her fault that the baby is going through withdrawals and is addicted.*"	Address the concept that SUD/OUD is a chronic illness and not a choice. Note: Infants cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome.	**SN**: "*She's nothing but a junkie pill popper who probably didn't even want the baby.*" "*It was her choice to take drugs. She decided to do this.*"
Concept: Empathy for both mother and infant	**SN**: "*I feel so bad for the baby. I just get so mad that she hurt her baby boy even before he was born. I would never want to deal with her if I had her as a patient.*" "*She doesn't even need to be here – we're*	Educator: Discuss the importance of providing all patients with care no matter their past medical history. Discuss the term "*deal with*" and how it is inappropriate.	**SN**: "*The baby should be given up for adoption – he'll be better off.*"

	feeding the infant with formula anyway."	Educator: Address the feelings the SN has. Discuss the role the mother plays in caring for the infant. Discuss ways to support the mother-infant dyad.	
Concept: Stigma related to breastfeeding & reinforce non-stigmatizing language	**SN**: "*The druggie wants to breast feed her baby. She's on methadone which makes her high all the time. She'll pass it on to her baby and just make him a junkie too.*" "*She thinks she can take the baby home. She has no idea. I told her she couldn't take the baby home unless she has a bunch of clean urines.*"	Educator: Address the issue of breast feeding and OUD/SUD. Educator: Readdress the terms "*druggie*", "*junkie*", "*clean/dirty urine*", and "*high*".	**SN**: "*She could kill the baby with methadone if she breast feeds him – or maybe turn him into an addict later in his life.*" "*I bet her urine will be dirty again today.*"
Concept: Bias in understanding needs of mothers	**SN**: "*The other thing – she wants all this free stuff. She's taking advantage of us. She should work for this like everyone else does. I told her we could only give her one package.*"	Educator: Discuss the bias the student is demonstrating by withholding potentially needed supplies.	

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient to you (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Stigmatizing language
2. Personal/professional bias
3. Role of the Nurse/clinical/faculty educator in shaping perspective
4. Supporting the mother-infant dyad/family centered care

4. How did you feel about your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

Association for Multidisciplinary Education and Research in Substance Use and Addiction. (2019, March). *Specific disciplines addressing substance use: AMERSA in the 21st century – 2018 update.* https://amersa.org/wp-content/uploads/AMERSA-Competencies-Final-31119.pdf

Byerley, E. M., Mohamed, M. W., Grindeland, C. J., & Muzzy Williamson, J. D. (2021). Neonatal abstinence syndrome practices in the United States. *The Journal of Pediatric Pharmacology and Therapeutics*, *26*(6), 577–583. https://doi.org/10.5863/1551-6776-26.6.577

Committee on Obstetric Practice. (2017, August). *ACOG committee opinion: Opioid use and opioid use disorder in pregnancy* (Report No. 711). The American College of Obstetricians and Gynecologists & American Society of Addiction Medicine. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

Devlin, L. A., Breeze, J. L., Terrin, N., Pomar, E. G., Bada, H., Finnegan, L. P., O'Grady, K. E., Jones, H. E., Lester, B., & Davis, J. M. (2020). Association of a simplified Finnegan neonatal abstinence scoring tool with the need for pharmacologic treatment for neonatal abstinence syndrome. *JAMA Network Open*, *3*(4), e202275. https://doi.org/10.1001/jamanetworkopen.2020.2275

Kondili, E., & Duryea, D. G. (2019). The role of mother-infant bond in neonatal abstinence syndrome (NAS) management. *Archives of Psychiatric Nursing*, *33*(3), 267-274. https://doi.org/10.1016/j.apnu.2019.02.003

Modified Finnegan Neonatal Abstinence Score (NAS). https://www.mdcalc.com/modified-finnegan-neonatal-abstinence-score-nas

Mossabeb, R., & Sowti, K. (2021). Neonatal abstinence syndrome: A call for mother-infant dyad treatment approach. *American Family Physician*, *104*(3), 222-223.

Nguyen, T. T., Toney-Noland, C., Wong, J., Chyi, L., Castro, R., Huang, A., Aron-Johnson, P., Lee, H. C., & Quinn, M. K. (2022). Neonatal abstinence syndrome and mother's own milk at discharge. *Journal of Perinatology*, *42*(8), 1044-1050. https://doi.org/10.1038/s41372-022-01430-5

Schierholz, E., French, R., & Boucher, A.-M. (2020, January 5). Caring for infants and families affected by neonatal abstinence syndrome. *American Nurse*, *15*(1), 6-11. https://www.myamericannurse.com/wp-content/uploads/2020/01/AN-CE-NAS-12-11.pdf

Tobin, K. B. (2018). Changing neonatal nurses' perceptions of caring for infants experiencing neonatal abstinence syndrome and their mothers: An evidenced-based practice opportunity. *Advances in Neonatal Care*, *18*(2), 128-135. doi:10.1097/ANC.0000000000000476

Wachman, E. M., & Werler, M. M. (2019, January 22). Pharmacologic treatment for neonatal abstinence syndrome: Which medication is best? *JAMA Pediatrics*, *173*(3), 221-223. doi:10.1001/jamapediatrics.2018.5029

Wu, D., & Carre, C. (2018). The impact of breastfeeding on health outcomes for infants diagnosed with neonatal abstinence syndrome: A review. *Cureus*, *10*(7), e3061. https://doi.org/10.7759/cureus.3061

Simulation 4:
Harm Reduction

This image was created with the assistance of DALL·E 2

Estimated Run Time: 25 minutes
Adapted for Student Population: Undergraduate
Setting: Emergency Department
Patient Population: Adult

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Performs priority nursing actions based on clinical assessment findings
2. Employs strategies to reduce risk of harm to the patient and family
3. Utilizes evidence-based practice in the care of individuals with OUD
4. Communicates with the patient using an empathetic and nonjudgmental approach

Simulation Scenario Objectives:

1. Obtains comprehensive, including bio-psycho-social data through systematic and ongoing healthcare consumer substance use assessments using reliable and valid screening instruments (AMERSA Standard 1) *
2. Assesses health disparities of age- and gender-specific populations, e.g., LGBT, homeless, underserved, marginalized, and other specific groups such as Veterans, immigrants, those with comorbid mental health disorders (AMERSA Standard 1) *
3. Applies harm reduction approaches when considering person-centered outcomes (AMERSA Standards 3, 16) *
4. Creates an individualized plan in partnership with the healthcare consumer and others considering the person's situation, including values, spiritual/ health practices, preference, coping, culture, barriers to treatment and environment (AMERSA Standard 4) *
5. Demonstrates non-judgmental attitudes and behaviors to develop therapeutic relationships (AMERSA Standards 5, 7) *
6. Engages the interprofessional team in strategies to address the nursing and medical diagnoses and healthcare consumer issues (AMERSA APRN Standards 4, 13) **
7. Leads interprofessional teams to communicate, coordinate, and collaborate on the delivery of care services and evaluation of treatment planning (AMERSA APRN Standards 5A, 13) **

* Student nurse and student NP objective

** Student NP objective

Psychomotor Skills Required of Participants Prior to Simulation

- Competence in the assessment and care of a patient with OUD/acute overdose
- Competence to identify and respond to patients who are experiencing trafficking
- Competence in interprofessional collaborative communication

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, notes, articles, websites, etc.)

For student nurses and NPs:
Centers for Disease Control and Prevention. (n.d.). *Module 5: Assessing and addressing opioid use disorder (OUD).* https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Hogan, K. A., & Roe-Sepowitz, D. (2020). LGBTQ+ homeless young adults and sex trafficking vulnerability. *Journal of Human Trafficking, 9*(1), 63-78. https://doi.org/10.1080/23322705.2020.1841985

Implementing Technology and Medication Assisted Treatment Team Training and Resources. (n.d.). DSM-5 criteria for diagnosis of opioid use disorder. https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf

National Human Trafficking Hotline. (2022, November 1). *Trafficking hotline flyer.* https://humantraffickinghotline.org/get-involved/downloadable-resources

No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 4: Harm Reduction

Date:
Discipline: Nursing
Expected Simulation Run Time: 25 minutes
Location: Emergency Department
Today's Date:

File Name: James Alvarez
Student Level: Undergraduate
Guided Reflection Time: 35 minutes
Location for Reflection:

Brief Description of Patient

Patient is an 18-year-old male with no medical history. He is homeless and presented to the ED s/p overdose. You are the RN coming on shift to care for the patient.

Name: James Alvarez
Pronouns: He/Him

Date of Birth: 5/1/_ _
Age: 18

Sex Assigned at Birth: Male
Gender Identity: Male

Sexual Orientation: Gay
Marital Status: Unmarried

Weight: 160 lbs.
Height: 5'10"

Racial Group: Latinx
Language: English
Religion: None

Employment Status: Unemployed
Insurance Status: Uninsured
Veteran Status: No

Support Person: Friend (declines to provide name)
Support Phone: Declines to answer

Allergies: None
Immunizations: Up to date

Attending Provider/Team: Dr. Mohamed – ED Attending MD

Home Medications: None

Past Medical History: None

History of Present Illness: The patient presented to the ED after being found unresponsive, with agonal breathing in a local park. He received 1mg naloxone in each nostril for a total of

2mg by EMTs on route to the ED. EMT arrives with patient and provides student RN with report. On arrival to the ED, patient is alert, and vitals stable.

Social History: Reports he is currently homeless, staying on a friend's couch.

Primary Medical Diagnosis: Overdose

Surgeries/Procedures & Dates: None

Setting/Environment

X Emergency Department	☐ ICU
☐ Medical-Surgical Unit	☐ OR / PACU
☐ Pediatric Unit	☐ Rehabilitation Unit
☐ Maternity Unit	☐ Home
☐ Behavioral Health Unit	☐ Outpatient Clinic
	☐ Other:

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed: standardized patient

- Patient (James Alvarez) – actor or mannequin
- Nurse – learner/student
- Nurse Practitioner – learner/student (if you choose to include)
- LICSW – actor
- EMT – actor

Recommended Mode for Simulator: Healthy patient or script/training for SP

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
X ID band	☐ Bedpan/urinal
☐ IV tubing with primary line fluids running at __mL/hr.	☐ 02 delivery device (type)
☐ Secondary IV line running at ___mL/hr.	☐ Foley kit
☐ IVPB with _____ running at mL/hr.	☐ Straight catheter kit
☐ IV pump	☐ Incentive spirometer
☐ PCA pump	☐ Fluids
☐ Foley catheter with ___mL output	☐ IV start kit
X 02	☐ IV tubing
X Monitor attached: HR, O2sat, BP cuff, end tidal CO2	☐ IVPB tubing
X Other: Empty chair next to bed	☐ IV pump
X Mannequin sitting straight up in bed, fully dressed, holding his backpack	☐ Feeding pump
X DSM-5 Criteria for Diagnosis of Opioid Use Disorder	☐ Crash cart with airway devices and emergency medications
X Human Trafficking Hotline Flyer	☐ Defibrillator/pacer
	☐ Suction
	☐ Other:

Other Essential Equipment: Street clothes (hoodie/ball cap/sweatpants) **Medications and Fluids:** ☐ Oral Meds: ☐ IV Fluids: ☐ IVPB: ☐ IV Push: ☐ IM or SC:	

Roles

X Patient **X** Nurse practitioner student (if including) **X** Nurse student ☐ Provider (physician/advanced practice nurse) **X** Other healthcare professionals: (pharmacist, respiratory therapist, etc.) **X** Social worker **X** EMT for report	☐ Observer(s) ☐ Recorder(s) ☐ Family member #1 ☐ Family member #2 ☐ Clergy ☐ Unlicensed assistive personnel ☐ Other:

Guidelines/Information Related to Roles

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from scenario progression outline.

Roles:

- EMT (actor)
- Patient (actor)
- Nurse (learner/student)
- Nurse practitioner (learner/student – if including)
- Social Worker (actor)

Pre-Briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this simulation is to enable learners to demonstrate their ability to provide client-centered care for a young LGBTQ male with OUD who is a victim of sex trafficking, including assessing for human trafficking and providing harm reduction initiatives for high-risk behaviors.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Pre-simulation survey and consent
    b. Simulation during which the student will engage with the mannequin/teacher/patient in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the mannequin (if applicable) as if the mannequin is a 'real human' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse
            2. Nurse Practitioner (if you are tailoring this for NP students)
        vi. Describe roles within the simulation
            1. Student nurse
            2. Patient
            3. EMT (initial handoff)
            4. Social worker (warm handoff)
        vii. Describe the setting
            1. ED
    c. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        iv. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    d. Post-simulation survey (if incorporated)
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report Students Will Receive Before Simulation (Use SBAR format)

Time:	11 am
Person providing report:	EMT on arrival to ED location of care. Student receives an SBAR handoff.
Situation:	EMT handoff of patient post Naloxone administration in route to the ED. On arrival to the ED, patient is alert, and vitals stable.
Background:	The patient was brought by rescue to the ED after being found unresponsive, with agonal breathing in a local park. He received 1mg naloxone in each nostril for a total of 2mg by EMTs on route to the ED. Patient is homeless with a history of illicit drug use.
Assessment:	Patient appears anxious. Vital signs are: HR 100, BP 134/88, RR 20, 0_2 Sat 97%, temp 98.7F.
Recommendation:	Revaluate respiratory assessment. Determine patient's need for resources and/or harm reduction strategies.

Scenario Progression Outline

Patient Name: James Alvarez **DOB:** 5/1/_ _

Timing (approx.)	Manikin/SP Actions	Expected Interventions	May Use the Following Cues
0-5 min	**EMT** enters the ED with patient, now alert, and gives report to student RN: "*Male found unresponsive in park. We know him - he's a junkie. S/p 1mg naloxone in each nostril for a total 2mg and now he's your problem. Vitals stable. No known allergies. Another quality life saved - I've done my duty. Good luck with this one.*"	Student nurse will address stigmatizing language with EMT briefly and introduce themselves to patient, do an initial assessment.	**Patient**: "*Are you going to talk like that to me, too? I'm sick of being treated like this.*"
0-5 min	**Patient** to student nurse (anxious tone): "*Listen, I'm fine. I've got to get out of here. My friend is going to be wondering where I am. I can't stay here.*"	Student nurse will use therapeutic communication to motivate patient to stay in the ED and will ask questions to screen for OUD.	**Patient***:* "*I appreciate what you're doing, but I'm fine. I've got to get out of here.*"
5-10 min	**Patient** to student nurse (with increasing anxiety and vulnerability): "*I don't want to answer your questions. I use heroin and cocaine, alright? I'm a junkie ok, I know I'm addicted. I can't go long without it - whatever. I have to go before my friend realizes I am gone.*" **Patient** to student nurse (with vulnerability): "*I'm going to be in trouble with my friend. Sure, he sets me up with customers, but I*	Student nurse will screen for sex trafficking using a non-judgmental and person-centered approach. Student nurse uses motivational interviewing without stigmatizing language to provide resources for safety, shelter, and SUD treatment.	**Patient**: "*I think it's heroin anyway. I know it could be laced with fentanyl.*" "*You know what you could do? I don't know if you guys have it, but like one of my friends got them from when he was in the hospital. Those strips that you can test your drugs, you know?*" "*I mean that could have been what happened today because usually I don't have this problem*."

	need him. My customers…that's how I get money. My parents kicked me out 2 years ago when they caught me with a guy. They told me I was going to hell and changed the locks. I was on the streets and my friend gave me a place to stay. He's my hookup for my stuff. I gotta get out of here before he comes looking for me."	Student addresses STI testing.	"*Well, I appreciate that. But you know, I don't really want to answer all your questions*." "*I guess since I'm here, do you think you could check me out for STDs and stuff? I can't really wear condoms. Sometimes I worry about that.*"
10-15 min	**Patient** to student nurse: "*I feel like I'm trapped. I just don't know what else to do. I guess I'd be willing to talk to somebody.*"	Student nurse responds to the patient's sex trafficking experience with interprofessional collaboration. Consults social work, psych NP.	
15-25 min	Social worker and student psych NP arrive at patient's bedside. **Social worker**: Introduces themselves and says: "*We can get you into a safe house tonight. You don't have to go back there.*" **Patient** to all: "*I can't. He's, my hookup. I'll get dopesick.*"	Student NP provides patient with evidence-based OUD treatment options including MOUD. Student NP develops an EBP OUD treatment plan including appropriate screening tests. NP uses motivational interviewing to support patient in choosing to access interprofessional treatment.	**Patient:** "*Like I told you. Like cocaine, OK? Heroin, I use it. I'm a junkie, OK? I'm going to be in a lot of trouble if I don't get out of here so…*" "*Man, like I appreciate that, but, you know… I'm kind of trapped, you know? If I went to a shelter, then I'll have to withdraw and I don't want to get dope sick and, you know... I'm just stuck*." "*I mean, I think that sounds good, but I know it's not for me because I have no insurance. I've got no resources. You have a job to pay for that kind of stuff and right now… I mean, thanks for telling me that it's there and you know,*

			maybe one day, but right now I just gotta go."
	Patient to student NP: "*Nah, I can't. I'm leaving.*" **Social worker**: "*You have the right to leave, but at least let the nurse give you the contact info so you can get help if you change your mind.*" **Patient**: "*I can't take that. He might see it. Let me just put it in my phone. I'll think about it.*"	Student RN and NP provide patient with a flyer for a human-trafficking hotline. Uses non-stigmatizing, therapeutic communication to encourage patient to think about getting help.	
	Patient says to student NP and RN: "*Yeah, I guess I can take that Narcan. Thanks for helping me.*"	Student NP offers naloxone rx to patient as harm reduction strategy.	**Patient**: "*Could I get some Narcan to take with me? Just in case?*"

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient to you (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Populations at higher risk for sex trafficking
2. Screening for sex trafficking
3. Motivational interviewing using a trauma-informed approach without stigmatizing language
4. EBP for OUD treatment
5. Interprofessional collaboration in the care of a patient with OUD
6. Harm reduction for patients who are not yet ready for treatment

4. How did you feel about your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

Association for Multidisciplinary Education and Research in Substance Use and Addiction. (2018, March). *Specific disciplines addressing substance use: AMERSA in the 21st century – 2018 update*. https://amersa.org/wp-content/uploads/AMERSA-Competencies-Final-31119.pdf

Centers for Disease Control and Prevention. (n.d.). *Module 5: Assessing and addressing opioid use disorder (OUD)*. https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Hogan, K. A., & Roe-Sepowitz, D. (2020). LGBTQ+ homeless young adults and sex trafficking vulnerability. *Journal of Human Trafficking, 9*(1), 63-78. https://doi.org/10.1080/23322705.2020.1841985

Simulation 5:
Telehealth/Remote Care

This image was created with the assistance of DALL·E 2

Estimated Run Time: 15 minutes
Adapted for Student Population: NP/DNP
Setting: Virtual/Telehealth
Patient Population: Adult

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Communicates with the patient using an empathetic and nonjudgmental approach
2. Employs strategies to reduce risk of harm to the patient and family
3. Utilizes evidence-based practice in the care of individuals with OUD
4. Communicates appropriately with other health care team members in a timely, organized, patient-centered manner

Simulation Scenario Objectives:

1. Demonstrates proficiency in telehealth care as evidenced by proper etiquette, developing rapport, professionalism, therapeutic communication, assessment, and clinical reasoning in the care of the individual with OUD (AMERSA Standard 11)
2. Formulates strategies to address stigma associated with OUD and medication assisted therapy (AMERSA Standards 5D, 7)
3. Employs use of evidence-based guidelines during telehealth for assessment, diagnose, management, and harm reduction for a patient with OUD and comorbid conditions (AMERSA Standards 4, 9, 16)
4. Designs interprofessional care coordination, planning, and handoff in the care of patient/family (AMERSA APRN Standard 5A)

Psychomotor Skills Required of Participants Prior to Simulation: N/A

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, lecture notes, articles, websites, etc.)

Centers for Medicare & Medicaid Services. (2023, May). *Telehealth for providers: What you need to know.* U.S. Department of Health and Human Services. https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf

Garett, R., & Young, S. D. (2022). The role of misinformation and stigma in opioid treatment uptake. *Substance Use & Misuse*, *57*(8), 1332-1336. doi:10.1080/10826084.2022.2079133

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Massachusetts Screening, Brief Intervention, and Referral to Treatment. (2012). *SBIRT: A step-by-step guide*. Massachusetts Department of Public Health Bureau of Substance Abuse Services.

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Rutledge, C., O'Rourke, J., Mason, A., Chike-Harris, K., Behnke, L., Melhado, L., Downes, L., & Gustin, T. (2021). Telehealth competencies for nursing education and practice: The four p's of telehealth. *Nurse Educator, 46*(5), 300-305. https://doi.org/10.1097/NNE.0000000000000988

Substance Abuse and Mental Health Services Administration. (2022). *Buprenorphine quick start guide.* https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 5: Telehealth/Remote Care

Date:
Discipline: Nursing
Expected Simulation Run Time: 15 minutes
Location: Virtual/Telehealth
Today's Date:

File Name: Bill Garcia
Student Level: NP/DNP
Guided Reflection Time: Twice the amount of time that the simulation runs
Location for Reflection: Virtual or conference room

Brief Description of Patient

Name: Bill Garcia **Pronouns:** He/Him/His

Date of Birth: 9/2/_ _ **Age:** 25

Sex Assigned at Birth: Male **Gender Identity:** Male

Sexual Orientation: Heterosexual **Marital Status:** Single

Weight: 210 lbs **Height:** 5'8"

Racial Group: LatinX **Language:** English/Spanish **Religion:** Catholic

Employment Status: Employed **Insurance Status:** Insured **Veteran Status:** Non-Veteran

Support Person: Mother **Support Phone:** (555) 999-3247

Allergies: PCN **Immunizations:** Up to date

Attending Provider/Team: AGNP/FNP or PMHNP, NP student (optional)

Past Medical History: OUD

History of Present Illness: Mr. Garcia presents for a follow-up telehealth visit for his OUD medications. He was seen in the clinic one month ago. At that time, he reported snorting heroin daily. He had purchased some suboxone on the street and found it helpful so came to the clinic last month asking for a prescription stating, "I want to be legit". He was started on suboxone 8 mg sublingual and returns today with his mother. He would like to discuss long-acting medications, counseling, and his mother has some questions about the medication.

Social History: Fisherman, single, lives with mother, two children with ex-girlfriend

Primary Medical Diagnosis: OUD

Surgeries/Procedures & Dates: Appendectomy 2012

Setting/Environment

☐ Emergency Room ☐ Medical-Surgical Unit ☐ Pediatric Unit ☐ Maternity Unit ☐ Behavioral Health Unit	☐ ICU ☐ OR / PACU ☐ Rehabilitation Unit ☐ Home **X** Outpatient Clinic **X** Other: Telehealth

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed: NP preceptor (optional), standardized patient, family member

Recommended Mode for Simulator: Script/training for SP

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
☐ ID band ☐ IV tubing with primary line fluids running at __mL/hr ☐ Secondary IV line running at ___mL/hr ☐ IVPB with _____ running at mL/hr ☐ IV pump ☐ PCA pump ☐ Foley catheter with ___mL output ☐ 02 ☐ Monitor attached ☐ Other: **Other Essential Equipment:** **Medications and Fluids:** ☐ Oral Meds: ☐ IV Fluids: ☐ IVPB: ☐ IV Push: ☐ IM or SC:	☐ Bedpan/urinal ☐ 02 delivery device (type) ☐ Foley kit ☐ Straight catheter kit ☐ Incentive spirometer ☐ Fluids ☐ IV start kit ☐ IV tubing ☐ IVPB tubing ☐ IV pump ☐ Feeding pump ☐ Crash cart with airway devices and emergency medications ☐ Defibrillator/pacer ☐ Suction ☐ Other:

Roles

☐ Nurse 1 AGNP student	☐ Observer(s)
☐ Nurse 2	☐ Recorder(s)
☐ Nurse 3	**X** Family member #1
X Provider (advanced practice nurse) AGNP/FNP or PMHNP	☐ Family member #2
	☐ Clergy
☐ Other healthcare professionals: (pharmacist, respiratory therapist, etc.)	☐ Unlicensed assistive personnel
	☐ Other:

Guidelines/Information Related to Roles

Learner is a nurse practitioner who has a follow-up appointment with a patient who was seen one month ago and started on suboxone. During that visit the patient disclosed they had been snorting heroin daily for over a year. He had purchased suboxone on the street, found it helpful, and presented at the clinic requesting a prescription to "make it legit". Today he has a telehealth visit for follow-up to review medication, ask about long-acting medications, and talk about counseling. His mother is also present on the Zoom meeting, and she has some questions about OUD treatment.

Providers will meet briefly prior to beginning the scenario to plan how to approach the visit. Learners in role of nurse practitioner and nurse practitioner student (if using) should determine which assessments each will be responsible for, or facilitator can assign roles and related responsibilities.

Alternative Scenarios:

- Standardized Patient - Farmer, patient in a rural setting, student at college
- Family Member/Caregiver - Spouse, sibling, friend, paid caregiver
- Learner - Any health care provider (MD, DO, PA, LSW, CP, CNS), can add student NP to scenario

Pre-briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this simulation is for APRN learners to use simulated telehealth to treat substance use in a primary care setting including taking a HPI, completing limited physical and mental status exams, establishing differential diagnoses, and providing interprofessional collaborative planning and care. This case can be structured as an initial or follow-up telehealth visit by either behavioral health or primary care and then a handoff can be made via telehealth to the appropriate professional for interprofessional collaboration and ongoing care and follow-up.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Pre-simulation survey and consent
    b. Simulation during which the student will engage with the mannequin/teacher/patient/fisherman in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the actor as a 'real patient' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse Practitioner
        vii. Describe roles within the simulation
            1. Student nurse
            2. Patient
            3. Fisherman
        viii. Describe the setting
            1. Telehealth
    c. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        v. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    d. Post-simulation survey
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report Students Will Receive Before Simulation (Use SBAR format)

Time:	1pm
Person providing report:	Case notes
Situation:	Follow-up telehealth visit
Background:	Male Latinx patient, age 25, was seen last month for OUD and suboxone initiation. He was seen in the clinic one month ago. At that time, he reported snorting heroin daily. He had purchased some suboxone on the street and found it helpful so came to clinical last month asking for a prescription stating, “I want to be legit”. He was started on suboxone and returns today for his telehealth visit with his mother. He wants more information about counseling options, long-acting medications, and his mother has some questions about the medication.
Assessment:	You will provide appropriate assessment of the patient which may include HX, ROS, physical assessment, and psychiatric screening tools.
Recommendation:	What do you suggest needs to be done? Patient education. Consider types of support and interprofessional collaboration with behavioral health for medication and ongoing treatment and care.

Scenario Progression Outline

Patient Name: Bill Garcia **DOB:** 9/2/_ _

Timing (approx.)	Manikin/SP Actions	Expected Interventions	May Use the Following Cues
0-5 min	**Patient**: Have license and verbally assure privacy. Establish consent to have mother present for visit.	**Learners should begin by:** • Confirming patient ID and privacy • Review information from last visit • Establish rapport	**Patient:** "*I was here last month and started on suboxone.*"
5-10 min	**Patient**: State concerns about possibility of a new job that would start in a few months. New job is on a fishing boat that will be out to sea for up to 4 weeks at a time. Asking about other long-acting medications. **Family**: Her concerns and stigma, fear of him being on another drug forever	**Learners are expected to**: • Therapeutic communication/SBIRT • Discuss extended release medication • Acknowledge concerns and address misinformation/stigma	**Patient:** "*I might have the chance to work on a scallop boat this fall that goes out for up to 4 weeks at a time. How can I continue with my medication?*" "*One of my buddies told me there is a shot you can use that lasts a month.*" "*I've heard it's hard to get insurance to pay for the medications and they are expensive.*" "*The guys on my boat told me these drugs are a life sentence*." **Family**: "*Will he have to be on drugs forever?"* "*Will his medical records always have him labeled as a drug user?*"
10-15 min	**Patient**: Agree to rediscuss starting Sublocade closer to starting new job	**Learners are expected to**: • Use clinical reasoning to assess, diagnose, and develop treatment plan	**Patient:** "*I've heard the drugs may have changed my brain and I have a disease now.*"

	Family: Ask about side effects, risks	• Review medication usage, side effects, risks	"*What happens if I use heroin while I am on the medication?*" "*Can I drink?*" **Family:** "*Other people don't understand how difficult this is for him.*" "*They just think I was a bad mother.*" "*We don't have any family support.*"
15-20 min	**Patient**: Ask about counseling and other resources **Family**: Ask about follow-up	**Learners are expected to**: • Develop interprofessional collaboration plan • Demonstrate handoff	**Patient:** "*When I was in your office last month you mentioned the possibility of setting up an appointment with someone I could talk to.*" **Family:** "*Are there any other resources? Who will contact us? Will his medical records be shared?*"

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient to you (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Safety issues to consider when conducting telehealth (call back number)
2. EPB for MOUD
3. MOUD options for limited access individuals (remote location, fisherman, farmer)
4. Therapeutic communication via telehealth
5. Interprofessional resources to support care

4. How did you feel about your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

Anvari, M. S., Kleinman, M. B., Massey, E. C., Bradley, V. D., Felton, J. W., Belcher, A. M., & Magidson, J. F. (2022). "In their mind, they always felt less than": The role of peers in shifting stigma as a barrier to opioid use disorder treatment retention. *Journal of Substance Abuse Treatment*, *138*, 108721. https://doi.org/10.1016/j.jsat.2022.108721

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Substance Abuse and Mental Health Services Administration. (2022). *Buprenorphine quick start guide.* https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf

Simulation 6:
Older Adult/Stigmatizing Labels

This image was created with the assistance of DALL·E 2

Estimated Run Time: 25 minutes
Adapted for Student Population: NP/DNP
Setting: Primary Care
Patient Population: Older Adult

NOSTIGMA
Building pathways to equitable care

Learning Objectives

General Objectives:

1. Performs priority nursing actions based on clinical assessment findings
2. Communicates with the patient using an empathetic and nonjudgmental approach
3. Utilizes evidence-based practice in the care of individuals with OUD
4. Communicates appropriately with other health care team members in a timely, organized, patient-centered manner

Simulation Learning Objectives:

1. Obtains comprehensive, including bio-psycho-social, data through systematic and ongoing healthcare consumer substance use assessments using reliable and valid instruments (AMERSA Standard 1) *
2. Utilizes current DSM criteria to formulate an OUD diagnosis (AMERSA APRN Standard 2)
3. Considers the continuum of substance use, the progression of behaviors, and the re-occurring nature of OUD (OUD as chronic illness) (AMERSA Standard 3)
4. Communicates consultation recommendations with emphasis on person-centered care, alleviation of suffering and uses non-stigmatizing language for SUDs (AMERSA APRN Standard 5C)
5. Utilizes evidence-based medication treatment for substance use (AMERSA APRN Standard 5D)
6. Leads interprofessional teams to communicate, coordinate, and collaborate on the delivery of care services and evaluation of treatment planning (AMERSA APRN Standards 5A, 13)

Psychomotor Skills Required of Participants Prior to Simulation

- Competence in the assessment and diagnosis of a gerontological patient with multiple comorbidities
- Competence in interprofessional collaborative communication

Cognitive Activities Required of Participants Prior to Simulation

(textbooks, notes, articles, websites, etc.)

Centers for Disease Control and Prevention. (n.d.). *Module 5: Assessing and addressing opioid use disorder (OUD)*. https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Implementing Technology and Medication Assisted Treatment Team Training and Resources. (n.d.). DSM-5 criteria for diagnosis of opioid use disorder. https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf

Valdez, A. (2021). Words matter: Labelling, bias and stigma in nursing. *Journal of Advanced Nursing*, *77*(11), e33-e35. https://doi.org/10.1111/jan.14967

No Stigma Simulation Design Template

(Revised 2/25/24)

Simulation 6: Older Adult/Stigmatizing Labels

Date:
Discipline: Nursing
Expected Simulation Run Time: 25 minutes
Location: Primary Care
Today's Date:

File Name: Norma Richardson
Student Level: NP/DNP
Guided Reflection Time: 35 minutes
Location for Reflection:

Brief Description of Patient

Patient is a 77-year-old female with a history of hypertension, hypothyroidism, breast cancer, anxiety, depression, and lumbar spondylosis seen as an outpatient for hospital follow-up. You are the NP who is seeing the patient in the office today.

You have an electronic health record (EHR) on the laptop in front of you. Your office has a LICSW whose office is down the hall. She can be reached by the live chat feature on the EHR.

Name: Norma Richardson **Pronouns:** She/Her

Date of Birth: 4/22/_ _ **Age:** 77

Sex Assigned at Birth: Female **Gender Identity:** Female

Sexual Orientation: Heterosexual **Marital Status:** Married

Weight: 145 lbs (65.77 kg) **Height:** 5'2" (157.5 cm)

Racial Group: White **Language:** English **Religion:** Christian

Employment Status: Retired **Insurance Status:** Medicare **Veteran Status:** None

Support Person: Husband & adult daughter **Support Phone:** (726) 980-1277

Allergies: Sulfa (hives) **Immunizations:** Up to date

Attending Provider/Team: Dr. Abimbola – primary care MD

Home Medications:
- lisinopril 10 mg daily
- hydrochlorothiazide 25mg daily

- levothyroxine 125mcg daily
- tramadol 50mg q6 hours as needed for lower back pain

Past Medical History: Hypertension; Hypothyroidism; Breast Cancer; Anxiety and Depression; Lumbar Spondylosis

History of Present Illness: The patient presented to the ED on 6/2/_ _ with c/o flu-like symptoms: abdominal cramping, headache, and low-grade fever. Cardiac work-up (EKG, troponin, cxray) was normal. CMP, CBC, amylase/lipase, CRP, and UA were unremarkable. Abdominal/pelvic CT was unremarkable. Her BP was elevated at 210/119, so she was admitted for further management. She was seen by cardiology who added lisinopril 10mg to her home regimen of hydrochlorothiazide. BP normalized and she was discharged home without services on 6/3/_ _.

Social History: Lives with husband who has end-stage lung cancer and has recently been admitted to visiting hospice. She is caring for him at home. They have two adult daughters who live out of state.

Primary Medical Diagnosis: Hypertensive urgency (I16.0)

Surgeries/Procedures & Dates: Bilateral mastectomy (6/2004); Decompression laminectomy L4-L5 (9/2019)

Setting/Environment

☐ Emergency Room ☐ Medical-Surgical Unit ☐ Pediatric Unit ☐ Maternity Unit ☐ Behavioral Health Unit	☐ ICU ☐ OR / PACU ☐ Rehabilitation Unit ☐ Home **X** Outpatient Clinic ☐ Other

Equipment/Supplies (choose all that apply to this simulation)

Simulated Patient/Manikins Needed: standardized patient

- Patient (Norma Richardson) – actor
- Nurse Practitioner – learner/student
- LICSW – actor

Recommended Mode for Simulator: script/training for SP

Other Props & Moulage

Equipment Attached to Manikin/Simulated Patient:	**Equipment Available in Room:**
☐ ID band ☐ IV tubing with primary line fluids running at __mL/hr ☐ Secondary IV line running at ___mL/hr ☐ IVPB with _____ running at mL/hr ☐ IV pump ☐ PCA pump ☐ Foley catheter with ___mL output ☐ 02 ☐ Monitor attached **X** Other: 1 laptop with EHR instant messaging **Other Essential Equipment:** **Medications and Fluids:** ☐ Oral Meds: ☐ IV Fluids: ☐ IVPB: ☐ IV Push: ☐ IM or SC:	☐ Bedpan/urinal ☐ 02 delivery device (type) ☐ Foley kit ☐ Straight catheter kit ☐ Incentive spirometer ☐ Fluids ☐ IV start kit ☐ IV tubing ☐ IVPB tubing ☐ IV pump ☐ Feeding pump ☐ Crash cart with airway devices and emergency medications ☐ Defibrillator/pacer ☐ Suction ☐ Other:

Roles

X Patient	☐ Observer(s)
X Nurse practitioner student	☐ Recorder(s)
☐ Nurse 3	☐ Family member #1
☐ Provider (physician/advanced practice nurse)	☐ Family member #2
X Other healthcare professionals: (pharmacist, respiratory therapist, etc.) social worker	☐ Clergy
	☐ Unlicensed assistive personnel
	☐ Other:

Guidelines/Information Related to Roles

Information on behaviors, emotional tone, and what cues are permitted should be clearly communicated for each role. A script may be created from scenario progression outline.

Roles:

- Patient (actor)
- Nurse practitioner (learner/student)
- Social worker (actor)

Pre-Briefing/Briefing

Prior to report, participants will need pre-briefing/briefing. During this time, faculty/facilitators should establish a safe container for learning, discuss the fiction contract and confidentiality, and orient participants to the environment, roles, time allotment, and objectives.

The purpose of this simulation is to allow APRN learners to screen, diagnosis OUD, and provide a brief intervention and referral to interprofessional treatment for OUD in a patient with dual diagnosis.

Simulation Pre-Briefing*:

1. Welcome participant
2. Let participant know the objective of today
3. Let participant know what's going to happen today
    a. Pre-simulation survey and consent
    b. Simulation during which the student will engage with the mannequin/teacher/patient in such a way that will address the issue of stigma in some capacity
        i. Let participant know you are looking for engagement with the mannequin (if applicable) as if the mannequin is a 'real human' (Note: this is known as the fiction contract)
            1. The educator will do all she/he is able to create a scenario that is as real as possible within the limitations of the simulated environment
        ii. Describe role the participant will play
            1. Nurse Practitioner
        viii. Describe roles within the simulation
            1. Student nurse practitioner
            2. Elderly woman in practitioner's office
            3. Social worker (LICSW)
        ix. Describe the setting
            1. Provider office
    c. Debriefing with educator during which you'll review the simulation and discuss learning opportunities
        vi. Reinforce the concept of simulation as a learning environment
            1. Missteps/errors/oversights etc. are puzzles to be solved, not punishable
    d. Post-simulation survey (if indicated)
4. Reinforce the concept that the simulation is a safe environment
    a. Participant will be observed and recorded but no personal identifiers will be used

*Note: Pre-Brief is based on NLN Pre-Briefing Checklist

Report Students Will Receive Before Simulation (Use SBAR format)

Time:	Morning time clinic follow-up appointment
Person providing report:	Medical Assistant who has placed the patient in the exam room.
Situation:	Patient is a 77-year-old female scheduled for an outpatient hospital follow-up.
Background:	History of hypertension, hypothyroidism, breast cancer, anxiety, depression, and lumbar spondylosis seen as an outpatient for hospital follow-up. Patient is a primary caregiver for husband on hospice.
Assessment:	You will provide appropriate assessment of the patient which may include HX, ROS, physical assessment, psychiatric screening tools.
Recommendation:	What do you suggest needs to be done? Consider types of support and interprofessional collaboration with behavioral health for medication and ongoing treatment and care.

Scenario Progression Outline

Patient Name: Norma Richardson **DOB:** 4/22/_ _

Timing (approx.)	Manikin/SP Actions	Expected Interventions	May Use the Following Cues
0-5 min	**Patient**: "*I am so overwhelmed with caring for my husband. He's on hospice at home and he has some nurses that come in, but it's just not enough. I can't sleep because I worry he'll need me. My back has been killing me after trying to help him move around in the hospital bed. It's just too much - no wonder why my blood pressure was so high. Is there any way we can go up on my tramadol?*"	Student NP addresses pain - asks about current symptoms, past evaluation.	**Patient**: "*No one can tell me why my back hurts. It's an awful feeling.*"
5-10 min	**Patient** (frustrated): "*I've already seen a bunch of different specialists - the spine doctor, the pain doctor. They don't do anything for me except give me the meds (begins to cry). I've been taking some of my husband's morphine tablets because I keep running out of my tramadol. They help take the edge off. The day before I went to the hospital, I had cut back on the pills because it wasn't time to refill his morphine either. I'm just so stressed and anxious.*" "*I've tried to cut down, but*	Student NP validates patient's feelings without use of stigmatizing language. Student NP assesses for OUD using DSM-5 Criteria for OUD. Student NP explains	

	I just can't. I know it's not good for me to take something that's not prescribed to me, but I get so sweaty and shaky if I don't have it." "*One time after I took the medicine, I fell asleep so soundly I didn't hear my husband calling for me. My husband had to call my daughter because he needed me.*" "*What kind of person am I to steal from him when he's suffering? Our kids can't find out I'm a drug abuser. It started with just one tablet a day about 3 months ago. Before the hospital, I was taking about 3 of his 15 mg tablets per day. The cravings got really bad when I was running low and spacing them out more. Are you writing this down? Please don't - if it goes in my record my doctor and my family will never look at me the same.*"	moderate OUD diagnosis to patient with a non-stigmatizing approach. Reiterates the pathophysiology of OUD and provides non-judgmental support.	
10-15 min	**Patient**: "*I don't think I can stop. I don't know where to start.*"	Student NP uses motivational interviewing without stigmatizing language to explain treatment options, offer treatment access, and encourage patient to seek treatment.	
15-25 min	**Patient**: "*I don't want to swap one drug for*	Student NP reiterates that OUD is a chronic illness and	

	another."	MOUD is a critical tool in an OUD treatment plan.	
	"*I guess that makes sense. I can take a pill. But I'm not crazy. I don't want to go to a head doctor.*"	Student NP develops an EBP OUD treatment plan and uses motivational interviewing to support patient in choosing to access interprofessional treatment.	
	"*But what about my pain? Will that medication help enough?*"	Student NP provides options for pain treatment/referral to pain management.	**Patient**: "*Maybe I could go back to the pain doctor.*"
	"*I guess so, but this is so embarrassing. I can't believe this is happening to me. I don't want to have to go in and tell someone else this whole story.*"	Student NP offers to refer the patient to a psychiatrist and social worker. When patient agrees, student NP messages the psychiatrist and LICSW with a brief report via EHR secure chat to see if either provider is available for a warm handoff (SBI**RT**).	
	(**LICSW** knocks on door): "*Hello, I heard you wanted to introduce me to Mrs. Richardson. I'm Hannah, the social worker. It's so nice to meet you.*"	Student NP provides a warm handoff with the LICSW in the office for counseling. She is able to provide the patient with an appointment for both providers before the end of the visit.	

Debriefing/Guided Reflection

Note to Faculty: We recognize that faculty will implement the materials we have provided in many different ways and venues. Some may use them exactly as written and others will adapt and modify. Some may choose to implement materials and initiate relevant discussions around this content in the classroom or clinical setting in addition to providing a simulation experience. We have designed this scenario to provide an enriching experiential learning encounter that will allow learners to accomplish the listed objectives and spark rich discussion during debriefing. Learner actions and responses observed by the debriefer should be specifically addressed using a theory-based debriefing methodology (e.g., Debriefing with Good Judgment, Debriefing for Meaningful Learning, PEARLS). Remember to also identify important concepts or curricular threads that are specific to your program. There are a few main themes that we hope learners will bring up during debriefing, but if they do not, we encourage you to introduce them.

1. How did caring for this patient make you feel (internal stigma)?

2. Who is this patient to you (therapeutic rapport)?

3. What are your main concerns (prioritization)?

Themes to consider for this scenario:

1. Stigmatizing language – drug abuser, crazy
2. OUD as a chronic illness
3. Stigma of being "labeled" in the medical record
4. EBP treatment for OUD
5. Interprofessional collaboration in the care of a patient with OUD

4. How did you feel about your ability to work through the simulation (empowerment)?

5. If you were able to do this again, how could you have handled the situation differently?

6. Do you feel his opioid use disorder impacted the quality of care he received (external stigma)?

7. Are there other resources or team members that would be important in this patient's care (interprofessional collaboration; social determinates)?

8. Is there anything else you would like to discuss?

Faculty References

(references, evidence-based practice guidelines, protocols, or algorithms used for this scenario, etc.)

Association for Multidisciplinary Education and Research in Substance Use and Addiction. (2018, March). *Specific disciplines addressing substance use: AMERSA in the 21st century – 2018 update*. https://amersa.org/wp-content/uploads/AMERSA-Competencies-Final-31119.pdf

Centers for Disease Control and Prevention. (n.d.). *Module 5: Assessing and addressing opioid use disorder (OUD)*. https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Department of Public Health Bureau of Substance Addiction Services. (2023). *Screening, brief intervention and referral to treatment (SBIRT).* Mass.gov. https://www.mass.gov/info-details/screening-brief-intervention-and-referral-to-treatment-sbirt