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 individuals 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

Centers for Disease Control and Prevention. (n.d.). *Naloxone training*. https://www.cdc.gov/opioids/naloxone/training/index.html

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 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 x 7years, 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 **X** Nurse 2 ☐ Nurse 3 ☐ Provider (physician/advanced practice nurse) ☐ Other healthcare professionals: (pharmacist, respiratory therapist, etc.)	☐ Observer(s) ☐ Recorder(s) ☐ Family member #1 ☐ Family member #2 ☐ 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*	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*

	what I deserve, I am a drug 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

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