HEART FAILURE

Estimated Time: 30 minutes • Debriefing Time: 30 minutes

Scan to Begin

Patient Name: Hector Fernandez

SCENARIO OVERVIEW

Hector Fernandez is a 62-year-old male patient with a history of heart failure, brought into the Emergency Department via EMS. Students receive a handoff report from paramedics, and begin their focused assessments. The scenario progresses to State 2 when the QR Code: Facilitator code is scanned. (Note: The facilitator may also choose to go directly to State 2 and skip the initial assessments.) In State 2, the students receive report that the patient "coded," and was intubated and placed on mechanical ventilation and the wife is "on her way." When they enter the room, the wife has Hector's advanced directives and states, "he wouldn't want this," and asks that he is removed from the ventilator. State 3 begins with a video of the respiratory therapist removing the patient from the ventilator. This scenario focuses on advanced directives and therapeutic communication with family members during a crisis and end of life care.

LEARNING OBJECTIVES

1. Incorporate evidence-based practice while caring for a patient with heart failure
2. Communicate therapeutically with a patient and family members during an acute health care event
3. Participate in multidisciplinary communication while providing effective health care

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving professional identity as a nurse committed to evidence-based practice, caring, advocacy and quality care

Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts

Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making

Provide patient centered care by utilizing the nursing process across diverse populations and health care settings

Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness

Lead the multidisciplinary health care team to provide effective patient care throughout the lifespan

Use information and technology to communicate, manage data, mitigate error, and support decision-making

NURSING FUNDAMENTALS

Maintain a safe, effective care environment for adults of all ages

Use appropriate communication techniques

Adapt nursing practice to meet the needs of diverse patients in a variety of settings

Provide nursing care for patients and families experiencing grief and loss

COMPLEX HEALTH ALTERATIONS II

Evaluate nursing care for patients with critical/life threatening situations

SIMULATION LEARNING ENVIRONMENT & SET-UP

PATIENT PROFILE

Name: Hector Fernandez

DOB: 09/06/19XX

Age: 62

MR#: 41219

Gender: Male

Height: 175 cm (5 ft 10 in)

Weight: 86.4 kg (190 lbs)

Allergies: Penicillin (Hives)

Admitting Diagnosis: Dehydration (E86.0)

Chronic Medical Conditions: Congestive heart failure (I50.9); Hypertension (I10); Hyperlipidemia (E78.5)

Code Status: Full code

Ethnicity: Hispanic

Spiritual Practice: Catholic

Primary Language: English

EQUIPMENT/SUPPLIES/SETTINGS

Environment

Emergency department room with phone available

Patient

Wearing a gown with NRB mask in place at start of scenario

Cardiac monitoring in place

QR codes placed in various anatomical locations on chest, heart and leg

Monitor/Simulator Settings

Vitals: blood pressure 188/88, respiratory rate 34, heart rate 115, temp 38.5, pain 0

Lung sounds: fine crackles in posterior upper and lower lobes and anterior lower lobes

Heart sounds: S3, regular rhythm

Supplies

Equipment to obtain vitals including oxygen saturation

Ventilator; if not available use QR codes provided

Medications

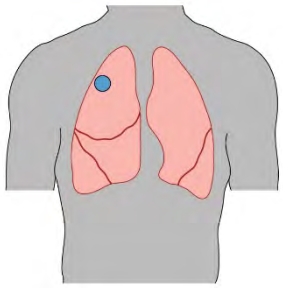
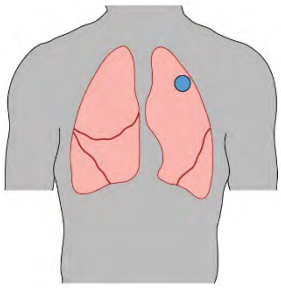
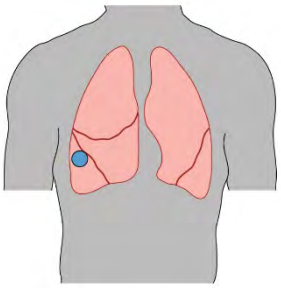
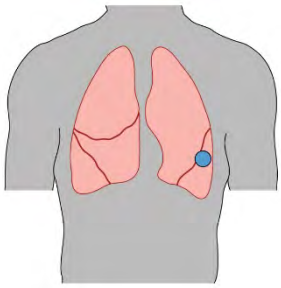
See QR codes below for available medications

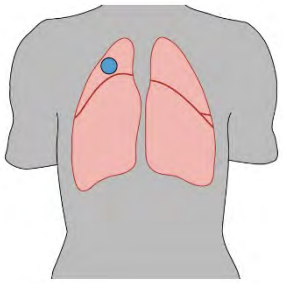
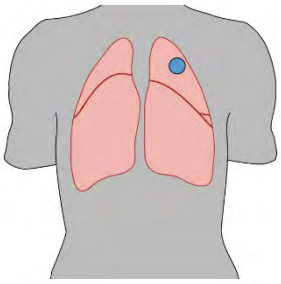
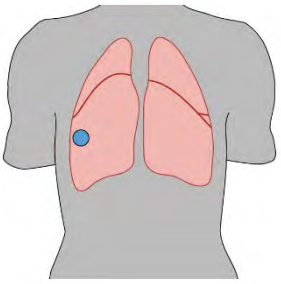
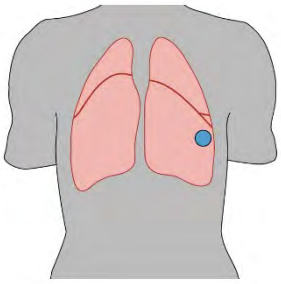
QR CODES

REPORT	PATIENT	LEG	FACILITATOR
FAMILY MEMBER	PATIENT ID	VENTILATOR	HEART
ADVANCED DIRECTIVES	FUROSEMIDE IV	ENOXAPARIN	FAMOTIDINE IV
MORPHINE SUBL			

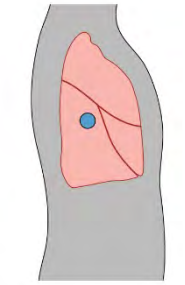
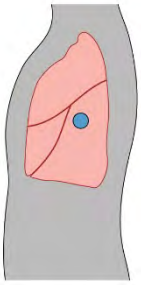
CHEST QR CODES

Cut along the dotted lines to create a folded QR code for each anatomical location. Fold each section along the solid line to create a bi-fold of the diagram and QR code, then apply to the simulator in the appropriate anatomical location.

			
ANTERIOR 2	ANTERIOR 3	ANTERIOR 6	ANTERIOR 7

			
POSTERIOR 0	POSTERIOR 1	POSTERIOR 4	POSTERIOR 5

NURSING | LEVEL: 4B

	
RIGHT AXILLARY 1	LEFT AXILLARY 1

TEACHING PLAN

PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the **QR Code: "Scan to Begin"** while students are in Prebrief.
- "Meet Your Patient" (on iPad) and explain how the iPad works in the simulated learning environment including:
    - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
    - Describe how a QR Code sound will work in the scenario. For the most authentic sound experience, student should use ear buds or the ARISE "stethoscope" for all QR Codes with the following symbol: □. Example: **QR Code: Chest Anterior 1** □
    - Medication Hyperlinks – Medications are underlined and hyperlinked to DailyMed, which is a medication reference housed by the National Library of Medicine. Students can click on these links during the simulation for up-to-date medication content, labels, and package insert information.

Discuss the simulation "Learning Objective(s)" (on iPad) as well as any other Prebrief materials

Get "Report" (on iPad)

- Possible Facilitator Question
    - What are your clinical concerns after listening to the handoff report from the paramedics?

Play the "Patient" video

- Possible Facilitator Question
    - What are your priority concerns after meeting the patient?

- Review initial tabbed content:

HISTORY AND PHYSICAL

No reports available

ORDERS

No reports available

MAR

No reports available

DAILY RECORD

No reports available

VITAL SIGNS

Screen is open for entry;

Simulator values set to: blood pressure 188/88, respiratory rate 34, heart rate 115, temp 38.5

PROGRESS NOTES

No reports available

LABS-DIAGNOSTICS

No reports available

ADVANCED DIRECTIVES

No reports available

LEVEL

The State level is displayed

SCANNER

Students tap this tab to scan various QR codes within the scenario.

EXIT

The iPad reads, “Are you sure you want to exit? All data will be lost.”

If “No” is selected, the iPad will return to the tabbed content.

If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

STATE 1

PATIENT ASSESSMENT

Patient Overview

- Patient was just brought to the ED via EMS. Students have received handoff report from the paramedics and should begin their focused assessments.

Expected Student Behaviors

- Introduce themselves to the patient
- Verify patient identity with name and date of birth and scan **QR Code: Patient ID**
- Communicate therapeutically with patient
- Obtain vital signs
- Perform a focused respiratory physical assessment by scanning **QR codes: Chest** □ at various anatomical locations on anterior, medial and posterior chest
    - Students will hear crackles in all lung fields except the anterior upper lobes
- Perform a focused cardiac assessment by scanning **QR code: Heart** □
    - Students will hear an S3 heart sound
- Perform a focused lower extremity assessment for edema by scanning **QR Code: Leg**
- Position patient appropriately
- Administer oxygen appropriately
- Notify provider of abnormal findings using SBAR format

Technician Prompts

- Patient has severe shortness of breath, even with the Nonrebreather mask, and is becoming increasingly confused. He is speaking in 2-3 word phrases.
- Initial patient responses can include:
    - "I can't... breathe."

- "Where ...am I?"
- "Where ...is my wife?"

Suggested Facilitator Questions

- What are your immediate focused assessments based on the report you received from the paramedics?
- What concerns will you immediately communicate to the provider?

- Tabbed iPad Prompts & Content Changes
  - Students will level up to State 2 after they have scanned the **QR code: Facilitator,** indicating they have performed the Expected Behaviors.
    - Facilitator note: **QR code: Facilitator** can be immediately scanned to skip performing focused assessments and move right into State 2 where patient is intubated and on a mechanical ventilator

STATE 2

PATIENT INTUBATED AND ON VENTILATOR

Patient Overview

- State 2 begins with a timer image with a message that 30 minutes have passed, followed by nurse report explaining that the patient coded with ventricular fibrillation and was resuscitated for 30 minutes. A video follows that shows the patient intubated and on a mechanical ventilator. A video of the wife immediately follows with her explaining "he wouldn't want this," and handing the advanced directives to the student.

Expected Student Behaviors

- If a ventilator is not available, **QR code: Ventilator** may be scanned for students to assess ventilator settings
- Interpret recently arrived lab tests
- Communicate therapeutically with the patient's wife about advanced directives and her wishes for his care. Students may be directed to scan **QR code: Advanced Directives**, as if the wife is handing the document to them, or the facilitator may elect to print them out. They are located in Appendix A
- Communicate wife's concerns by calling the provider
- Call the chaplain for spiritual care

Technician Prompts

- Patient is not conscious or responsive to pain.
- If technician is role playing the wife, initial patient responses can include:
  - "What happened?"
  - "He wouldn't want this. He never wanted to be kept alive by machines."
  - "Please take him off the machine."
  - "His advance directive said he did not want to be kept alive by a machine."

Facilitator Questions

- What focused assessments and interventions are required when a patient is on a ventilator?
- What is the RN's role when advance directives are not part of the official EMR, but are brought to the hospital by a family member?
- What is anoxic brain injury?
- What is the process used to determine when a patient can be removed from a ventilator if anoxic brain injury is suspected?
- What information is important to consider when evaluating the patient's vital signs in this situation?
- How can a nurse promote spiritual care for a family member at this difficult time?

Tabbed iPad Prompts & Content Changes

- Students will progress to State 3 when the **QR code: Facilitator** is scanned

ORDERS

Provider Orders

Date	Time	Order
Today	30 minutes ago	Rapid Sequence Intubation by Respiratory Therapist
		Vent settings: Volume Control, rate of 12, tidal volume of 500, FiO2 100 % and PEEP of 7.
		CT scan of head STAT for potential anoxic brain injury
		Cardiopulmonary monitoring
		Portable CXR STAT PA and Lateral post intubation
		Cardiology Consult STAT
		Implement Ventilator Order Set
		Furosemide 80mg IVP STAT
		Foley catheter for strict I/O
		CBC, Chem 7, BNP, Liver Enzymes, TSH, Troponin STAT
		Transfer to ICU when bed available
		Obtain Advanced Directives if available
		----- James Emerson, M.D.
		VENTILATOR ORDER SET *Nursing and Respiratory Care* • Elevate head of bed at 30 degrees or greater • Evaluate need for kinetic bed therapy

		• Cuff pressure 20-25 cm H_2O
		• Circuit changes: only when visibly soiled or mechanically malfunctioning
		• Humidifiers or moisture exchangers: change only when visibly soiled or mechanically malfunctioning
		• Oral care:
		  o Assess oral cavity and lips every 6-8 hours and prn for hydration, lesions, thrush, pressure ulcers, infection
		  o Oral care and brush teeth for 1-2 minutes every 6-8 hours with 2% chlorhexidine
		  o Apply water-soluble lip balm every 6 -8 hours after oral care to maintain moisture
		• Use a dedicated suction line for endotracheal suctioning of respiratory secretions
		• Rotate position of oral endotracheal tube at least every 24 hours or use ETT holder that takes pressure off mouth
		• Assess patient daily for sedation reduction and readiness to extubate per agency guidelines
		Medications
		• Famotodine 20 mg IV every 12 hours for stress ulcer prophylaxis
		• Enoxaparin 40 mg subq every 24 hours for prophylaxis
		  o Notify provider if bleeding occurs
		  o Discontinue if platelet levels drop by 50% from baseline

MAR

Medication Administration Record

Scheduled		
Furosemide 80 mg IVP STAT	**Due Now**	**Last Given**
	Now	
Enoxaparin 40 mg subq	**Due Daily**	**Last Given**
	Now	
	Due Daily	**Last Given**

Famotidine 20 mg IV	Now	

VITAL SIGNS

Screen is open for entry;

Simulator values set to: blood pressure 106/60, respiratory rate 18, heart rate 55, O2 sat 100%

PROGRESS NOTES

Progress Notes

Date/Time	Note
Today/ 10 minutes ago Respiratory Therapy	Brought to ER via EMS for acute exacerbation of chronic heart failure. Patient demonstrated decreased level of consciousness and STAT ABGs came back with pH 7.34, PaO2 78 and PaCO2 50. As preparing for immediate Rapid Sequence Intubation, patient became unresponsive with no pulse. 30 minutes of CPR was provided for Vfib arrest, with four shocks administered and IV Epi and Amiodarone given. He is currently tachycardic in the 120s with occasional PVCs. Rapid Sequence Intubation was performed using Etomidate and Succinylcholine. Has a #8 ETT secured on the right with a Hollister, 22 at the teeth. Vent settings are Volume Control, rate of 18, tidal volume of 500, FiO2 100 % and PEEP of 10. He has not received any sedation, and has no observable respiratory effort. Wife is on her way to the hospital. Discussed CT scan for potential anoxic brain injury with physician. --- Roxanne Jones, RRT

LABS-DIAGNOSTICS

Laboratory Results

Arterial Blood Gas (ABG)					
	30 mins ago			Units	Reference Range
pH	7.34				7.35-7.45
$PaCO_2$	50			mmHg	35-45
PaO_2	58			mmHg	80-100
HCO_3	25			mmol/L	22-26
Base Excess	1			mmol/L	0+/-3
SaO_2	80% on RA			%	

CBC with Differential					
	30 mins ago			Units	Reference Range
WBC	8.0			$x10^3uL$	F: 4.7-10.3/M: 4.5-10.5
RBC	5.1			$x10^6uL$	F: 4.0-4.9/M: 4.0-4.9
Hgb	10.3			g/dL	F:10.9-13.3/M:11.0-13.3
HCT	49.3			%	F: 33.0-39.6/M: 32.7-39.3
MCV	72.2			fL	F: 78.5-90.4/M: 76.5-90.6
MCH	27.8			Pg	25-33
MCHC	33			g/dL	31-37
RDW	12.5			%	F: 11.6-13.4/M: 12.0-14.0
Platelet	224			$x10^9uL$	F: 183-368/M: 194-364
MPV	9.8				7.4-10.4
Neutro	48				38-68
Lymph	30				25-54
Mono	0.5				0-0.8
Eos	4				1-5
Baso	1				0-2

Chem 7					
	30 mins ago			Units	Reference Range
Glucose	100			mg/dL	Fasting 70-150
BUN	40			mg/dL	10-25
Creatinine	2.6			mg/dL	F: 0.4-1.4/M: 0.5-1.5
Sodium	156			mEq/L	135-145
Potassium	3.5			mEq/L	3.5-5.3
Chloride	100			mEq/L	98-108
Carbon Dioxide	25			mEq/L	23-27

BNP					
	30 mins ago			Units	Reference Range
BNP	320			Pg/mL	Below 100 pg/mL: no heart failure. 100-300 pg/mL: suggest heart failure is present. Greater than 300 pg/mL: mild heart failure. Greater than 600 pg/mL: moderate heart failure. Greater than 900 pg/mL: severe heart failure

Liver Enzymes					
	30 mins ago			Units	Reference Range
ALT (SGPT)	45			u/L	4-36
AST (SGOT)	65			u/L	0-35

TSH					
	30 mins ago			Units	Reference Range
TSH	8			uU/L	2-10

Troponin					
	30 mins ago			Units	Reference Range
Troponin	0.5			*ng*/ml	<0.2

ADVANCED DIRECTIVES

Not available - wife has paper copies in hand that can be viewed by scanning **QR Code: Advanced Directive**, or printing paper copy available in Appendix A.

STATE 3

PATIENT IS REMOVED FROM THE VENTILATOR

Patient Overview

- The physician has reviewed the advances directive document, performed the anoxic brain death procedure, and agreed to remove the patient from the ventilator. The scenario begins with a message that "6 hours has elapsed," followed by a video of the respiratory therapist removing the patient from the ventilator with the wife at the bedside. Students should communicate therapeutically with the wife during this moment of crisis and loss.

Expected Student Behaviors

- Communicate therapeutically with the wife at patient's end of life
- Perform post-mortem cares and initiate Death Protocol
- Call the chaplain for spiritual care if have not done so already

Technician Prompts

- Patient is no longer breathing
- While roleplaying the wife, statements may include:
  - "I can't believe this is happening. He was fine this morning, he just thought he had a bad cold."
  - "I don't know what I'll do without him."
  - "I need to call my sons and tell them their father is dead."
  - "This is what he would have wanted. He wanted to die naturally and not be on machines."
  - "Maybe we should have waited longer before removing him from the breathing machine?"
  - "Did I do the right thing?"
  - "I keep thinking he will open his eyes and start breathing again."
  - "I love you, Hector" (Crying and holding onto patient)

Facilitator Questions

- Review the physician's progress note. What procedures were done to document anoxic brain death?
- How can the nurse best therapeutically communicate with the wife at this time of crisis/end of life?
- Should the wife be in the room at the time the ventilator is disconnected? Why or why not?
- Review the Death Protocol; what are the RN responsibilities at a patient's end of life?
- What other therapeutic interventions may be helpful to provide the wife to enhance coping with her loss (i.e., provide a lock of hair, obtain a handprint, etc.)?

Tabbed iPad Prompts & Content Changes:

- Students may exit at any time during this state.

ORDERS

Provider Orders

Date	Time	Order
Today	6 hours ago	Rapid Sequence Intubation by Respiratory Therapist
		Vent settings: Volume Control, rate of 12, tidal volume of 500, FiO2 100 % and PEEP of 7.
		CT scan of head STAT for potential anoxic brain injury
		Cardiopulmonary monitoring
		Portable CXR STAT PA and Lateral post intubation
		Cardiology Consult STAT
		Implement Ventilator Order Set
		Furosemide 80mg IVP STAT
		Foley catheter for strict I/O
		Transfer to ICU when bed available
		Obtain Advanced Directives if available
		----- James Emerson, M.D.
		VENTILATOR ORDER SET

		Nursing and Respiratory Care • Elevate head of bed at 30 degrees or greater • Evaluate need for kinetic bed therapy • Cuff pressure 20-25 cm H_2O • Circuit changes: only when visibly soiled or mechanically malfunctioning • Humidifiers or moisture exchangers: change only when visibly soiled or mechanically malfunctioning • Oral care: o Assess oral cavity and lips every 6-8 hours and prn for hydration, lesions, thrush, pressure ulcers, infection o Oral care and brush teeth for 1-2 minutes every 6-8 hours with 2% chlorhexidine o Apply water-soluble lip balm every 6 -8 hours after oral care to maintain moisture • Use a dedicated suction line for endotracheal suctioning of respiratory secretions • Rotate position of oral endotracheal tube at least every 24 hours or use ETT holder that takes pressure off mouth • Assess patient daily for sedation reduction and readiness to extubate per agency guidelines *Medications* • Famotodine 20 mg IV every 12 hours for stress ulcer prophylaxis • Enoxaparin 40 mg subq every 24 hours for prophylaxis o Notify provider if bleeding occurs o Discontinue if platelet levels drop by 50% from baseline
Today	15 minutes ago	Code Status: DNR with comfort cares; advance directives in place
		Initiate anoxic brain death procedure with STAT ABG after 10 minutes off ventilator
		Discontinue enoxaparin, furosemide, famotidine
		----- James Emerson, M.D.
	5 minutes ago	Respiratory therapist to disconnect ventilator.
		Morphine 10 mg IV PRN for pain
		----- James Emerson, M.D.

MAR

Medication Administration Record

Scheduled		
PRN		
Morphine 10 mg IV q 1 hour PRN		**Last Given**
Discontinued		
	Discontinued	Last Given
Furosemide 80 mg IVP STAT		1 hours ago
Enoxaparin 40 mg subq		
Famotidine IV 20 mg IV		

VITAL SIGNS

Screen is open for entry;

PROGRESS NOTES

Progress Notes

Date/Time	Note
Today/ 7 hours ago Respiratory Therapy	Brought to ER via EMS for acute exacerbation of chronic heart failure. Patient demonstrated decreased level of consciousness and STAT ABGs came back with pH 7.34, PaO2 78 and PaCO2 50. As preparing for immediate Rapid Sequence Intubation, patient became unresponsive with no pulse. 30 minutes of CPR was provided for Vfib arrest, with four shocks administered and IV Epi and Amiodarone given. He is currently tachycardic in the 120s with occasional PVCs. Rapid Sequence Intubation was performed using Etomidate and Succinylcholine. Has a #8 ETT secured on the right with a Hollister, 22 at the teeth. Vent settings are Volume Control, rate of 18, tidal volume of 500, FiO2 100 % and PEEP of

	10. He has not received any sedation, and has no observable respiratory effort. Wife is on her way to the hospital. Discussed CT scan for potential anoxic brain injury with physician. --- Roxanne Jones, RRT
Today 5 minutes ago	Maria, patient's wife, arrived with copy of advanced directives soon after patient was intubated and placed on a ventilator, and was activated as patient's Power of Attorney per his Advanced Directive. Maria desires patient to be DNR and to be removed from the ventilator per his Advance Directive. Described the apnea test to wife and she agreed to the procedure. I found positive neurological assessments for brain death: pupil response is absent; no response present to sharp pain stimulus on face; corneal reflexes are absent; cough is absent with tracheal suctioning. Apnea test was positive with no respiratory response after 10 minutes of ventilator disconnection, with ABG prior to disconnection demonstrating PaCO2>60 and pH 7.27. Apnea test was completed with patient core temperature of 37.2 degrees C and systolic BP 104 before disconnection of ventilator. Notified wife of patient's brain death status and respiratory therapist notified to permanently remove ventilator. ----- James Emerson, M.D.

LABS-DIAGNOSTICS

Laboratory Results

Arterial Blood Gas (ABG)					
	6 hours ago	10 mins ago		Units	Reference Range
pH	7.34	7.27			7.35-7.45
$PaCO_2$	50	62		mmHg	35-45
PaO_2	58	48		mmHg	80-100
HCO_3	25	26		mmol/L	22-26
Base Excess	1	1		mmol/L	0+/-3
SaO_2	80% on RA	38% on RA		%	

CBC with Differential					
	6 hours ago			Units	Reference Range
WBC	8.0			$x10^3$uL	F: 4.7-10.3/M: 4.5-10.5
RBC	5.1			$x10^6$uL	F: 4.0-4.9/M: 4.0-4.9
Hgb	10.3			g/dL	F:10.9-13.3/M:11.0-13.3
HCT	49.3			%	F: 33.0-39.6/M: 32.7-39.3
MCV	72.2			fL	F: 78.5-90.4/M: 76.5-90.6
MCH	27.8			pg	25-33
MCHC	33			g/dL	31-37
RDW	12.5			%	F: 11.6-13.4/M: 12.0-14.0

ADVANCED DIRECTIVES

See Appendix A

DEATH PROTOCOL

See Appendix B

DEBRIEF

SUGGESTED QUESTIONS

1. Reaction: “How do you feel this scenario went?” (Allow students to vent their emotional reactions before delving into learning objectives.)
2. Review understanding of learning objectives: Incorporate evidence-based practice while caring for a patient with heart failure
    a. Shortly after arrival to the ED with severe shortness of breath, the patient went into Ventricular fibrillation. What are possible causes of ventricular fibrillation?
    b. Hector was intubated and placed on a mechanical ventilator. What focused assessments and interventions are required when a patient is on a ventilator.
    c. The respiratory therapist communicated concerns about “anoxic brain injury” in his progress note. Elaborate on the causes of anoxic brain injury?
    d. How did the physician establish anoxic brain death before agreeing to remove the patient from the ventilator per his advance directives wishes?
3. Review understanding of learning objectives: Communicate therapeutically with a patient and family members during an acute health care event
    a. When the wife arrived with a copy of Hector’s advance directives, what were your concerns?
    b. How did you therapeutically communicate with his wife at that time? Was it effective?
    c. After the order was received to disconnect Hector from the ventilator, how did you therapeutically communicate with his wife at this difficult time? Was it effective?
    d. If you could “do over,” what would you change about your therapeutic communication?
4. Review understanding of learning objectives: Participate in multidisciplinary communication while providing effective health care
    a. How did you prioritize your care after listening to the paramedic handoff report?
    b. How do chaplains help nurses to provide spiritual care during crises and end of life situations with patients and their family members?

5. Tie the scenario to learning objective: Develop a nursing plan of care for a patient on a ventilator.
    a. Identify 3 priority nursing problems
    b. Create a patient centered goal for each nursing problem you identified.
    c. Discuss focused assessments for each nursing problem.
    d. Discuss nursing interventions for each nursing diagnosis.
    e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?
6. Summarize/Take Away Points: "In this scenario you care for a patient who coded, was intubated and placed on a ventilator shortly after being brought into the Emergency Department for acute shortness of breath secondary to heart failure. His wife brought advance directives stating his wishes were to not be on a ventilator. What is one thing you learned from participating in this scenario that you will take into your nursing practice?" (Ask each student to share something unique from what the other students share.)

NOTE: Debriefing technique is based on INASCL Standard for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
    a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
    b. This QR Code will not work in the ARIS app.

SURVEY

2. Copy and paste the following survey link into your browser.
    a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

APPENDIX A: ADVANCED DIRECTIVE

Honoring Choices
WISCONSIN
AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY

Advance Directive
including Power of Attorney for Health Care

Overview

This is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a Power of Attorney for Health Care and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **health care agent**. This document gives your health care agent authority to make your decisions *only when you have been determined incapable by your physicians to make them.* It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your health care agent.** If you do not closely involve your health care agent, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for:

Name Hector Fernandez Date of Birth 9/6/19XX

Telephone (Home)_____ (Work) _____ (Cell) _____

Address 101 Main Street

City Anytown State/ZIP WI 99999

January, 2014 For additional copies visit: www.honoringchoiceswi.org.

Part 1: My Health Care Agent

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable of making health care decisions as provided under Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).

Your health care agent must be at least 18 years old and may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative. You may also designate an alternate and second alternate health care agent.

The person I choose as my health care agent is:

Name Maria Fernandez Relationship wife

Telephone (Home)_____ (Work) _____ (Cell) 555-555-0100

Address 101 Main Street

City Anytown State/ZIP WI 99999

If this health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:** n/a

Second choice (alternate health care agent):

Name _____ Relationship _____

Telephone (Home)_____ (Work) _____ (Cell) _____

Address _____

City _____ State/ZIP _____

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:** n/a

Third choice (2nd alternate health care agent):

Name _____ Relationship _____

Telephone (Home)_____ (Work) _____ (Cell) _____

Address _____

City _____ State/ZIP _____

☐ Check here if you do not have an agent, and wish for your physician to follow the instructions below.

3

Part 2: General Authority of the Health Care Agent

I want my health care agent to be able to do the following:
*Draw a line through (e.g., ~~Arrange for~~) anything listed below that you do **not** want your health care agent to do.*

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment already has been started, my health care agent can keep it going or have it stopped based on my stated instructions or my best interests.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state, as my health care agent thinks is appropriate.
- Determine which health care professionals and organizations provide my medical treatment.
- Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

Limitations on Mental Health Treatment
Pursuant to Wisconsin statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

4

To complete the next 3 sections:
Initial or check the box beside one statement in each section. If you do not mark any box in a section, your choice is "no" according to Wisconsin statute. This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

1. Admission to a Nursing Home or Community-Based Residential Facility
My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

☐ **Yes,** my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This is subject to any limits I set in this document.

☒ **No,** my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

Unless I choose "yes," I can be admitted to a long-term care facility for a long-term stay only with a court order.

2. Withholding or Withdrawal of Feeding Tube

☒ **Yes**, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

☐ **No,** my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

Unless I choose "yes," a feeding tube can be withdrawn or withheld from me only with a court order.

3. Health Care Decisions during Pregnancy

☐ **Yes,** my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

☐ **No,** my health care agent does not have authority to make health care decisions for me if I am pregnant.

Unless I choose "yes," health care decisions during pregnancy can be made for me only with a court order.

☒ **Does not apply**. I am either a male or no longer capable of becoming pregnant.

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Part 3: Statement of Desires, Special Provisions, or Limitations

You are not required to provide any instructions or make any selections in this section.

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

Instructions Regarding Life-Prolonging Treatments

Initial or check the box beside the statement or statements you agree with.

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my health care agent to:

- [X] Stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including intravenous (IV) hydration, respirator/ventilator, and cardiopulmonary resuscitation (CPR). If I suffer this type of condition, in my view, the potential benefits of supportive medical treatments are outweighed by the burdens of those treatments.
- [ ] Continue or start feeding tubes including intravenous (IV) hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator and cardiopulmonary resuscitation (CPR).
- [ ] I want my agent to be able to make decisions for me about life-sustaining treatment.
- [ ] Follow my instructions as provided below.

Pain and Comfort

Initial or check the box beside this statement if you agree.

- [X] If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

The following are important to me for comfort (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible):

_____

_____

_____

6

Cardiopulmonary Resuscitation (CPR)

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. **If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency.**

Initial or check the box beside the statement you agree with.

☐ I want CPR attempted ***unless*** my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

☒ I do not want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

Other instructions or limitations I want my health care agent to follow:

LET ME GO PEACEFULLY

When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:

If I am nearing my death, I want the following:

List the type of care, ceremonies, etc. that would make dying more meaningful for you.

LAST RIGHTS

Person or people I want my health care agent to include when making health care decisions:

I ask that my health care agent make a reasonable effort to include the following person or people in my health care decisions if there is time: _____

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NURSING | LEVEL: 4B

Spirituality and/or Religious Affiliation
I am of the CATHOLIC faith and am a member of the ST. ANDREWS congregation, parish, synagogue, or worship group in (city) ~~ANY~~TOWN.
The telephone number of the congregation, parish, synagogue, or worship group is: ?.
Please attempt to notify someone there if I am unable to give authorization to do so.

☐ I am not religious or spiritually affiliated.

Upon My Death
After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

- **Donation of my Organs or Tissue (Anatomical Gifts)**

Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves. Initial or check the box beside the one statement you agree with.

☐ After I die, I wish to donate any parts of my body that may be helpful to others.
To make your wishes legally effective, register at www.donorregistry.wisconsin.gov

☐ After I die, I wish to donate **only** the following organs and tissue: _____

_____

☒ I do not wish to donate any part of my body.

- **Autopsy**

Initial or check the box beside one choice, or both A and B.

☐ A. I would accept an autopsy if it can help my blood relatives understand the cause of my death or affect their own health care choices.

☐ B. I would accept an autopsy if it can help advance medicine or medical education.

☒ C. I do not want an autopsy performed on me.

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Part 4: Making the Document Legal

This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below.

My Signature

I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.

My signature HECTOR FERNANDEZ Date X/X/20XX

If I cannot sign my name, I ask the following person to sign for me _____

Signature of the person who I asked to sign this document for me _____

Statement of Witnesses

By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

Witness Number One:

Signature Lisa Smith Date X/XX/20XX

Print name Lisa Smith

Address 2000 Main Street

City Anytown State/ZIP WI 99999

Witness Number Two:

Signature Angela Meyer Date X/XX/20XX

Print name Angela Meyer

Address 2000 Main Street

City Anytown State/ZIP WI 99999

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APPENDIX B: DEATH PROTOCOL

DEATH MANAGEMENT PROTOCOL

1. Notify primary MD/Covering MD of patient's death.
    a. Only physicians, coroners, medical examiners or deputy medical examiners may pronounce death. A nurse, physician's assistant, paramedic or emergency medical technician may not pronounce a person dead and may not be listed on the Notice of Removal Form as a pronouncer of death.

    b. A registered nurse or licensed practical nurse may report observations that indicate an apparent death to a physician by telephone.

    c. The nurse should report to the physician immediately upon observation of the apparent death. The physician may then exercise professional judgment in pronouncing the individual dead.

        i. There should be no unnecessary delay in reporting to the physician. The nurse should record the information given to the physician and the physician's response in the person's medical record.

        ii. The date and time of death that is recorded in the medical record must reflect the date and time of the pronouncement of death by the physician, coroner, deputy coroner, medical examiner or deputy medical examiner. This is the same date and time of death that must be placed on the death certificate.

2. If a patient dies while in restraints or seclusion, is on one or more psychotropic meds, or is a suspected suicide, the death must be reported within 24 hours to the Department of Health and Human Services using the Patient Death Determination form.
    a. Scene Preservation
        i. If a coroner or medical examiner determines that a case requires an actual scene investigation it is important that no one inadvertently alters potential evidence at the death scene.
        ii. The coroner or medical examiner will determine if the body may be moved or removed, if the family or others may enter the death

scene, and what, if any, of the items at the death scene should be preserved.

iii. Any medical device attached to or introduced into the body should be left in its original position. The coroner or medical examiner will need to document all of the medical intervention rendered. This information is important for the pathologist who performs the autopsy and is especially important for trauma cases, no matter how long the person has been in the facility.

3. Notify STATLINE of death (1-866-894-2676). The Eye Bank will determine medical suitability for potential tissue/eye donation.
    a. RN/Recovery Coordinator may talk with family regarding potential tissue donation after suitability is determined.
    b. Complete consent for tissue donation with legal next of kin if applicable

4. Notify family – ensure accurate contact number and name before disclosing information

5. Notify spiritual care – call on-call chaplain

6. Determine if patient is a Medical Examiner's case. Call the County Medical Examiner and document in EMR. Discuss with police if evidence needs to be preserved in the following conditions:
(a) All deaths in which there are unexplained, unusual or suspicious circumstances.
(b) All homicides.
(c) All suicides.
(d) All deaths following an abortion.
(e) All deaths due to poisoning, whether homicidal, suicidal or accidental.
(f) All deaths following accidents, whether the injury is or is not the primary cause of death.
(g) When there was no physician, or accredited practitioner of a bona fide religious denomination relying upon prayer or spiritual means for healing, in attendance within 30 days preceding death.
(h) When a physician refuses to sign the death certificate.

7. Notify House Supervisor. Let them know if Medical Examiner, Autopsy and/or tissue/eye recovery involved.

8. Obtain the morgue cart from the morgue.

9. Complete the Notice of Removal of Human Corpse form and take to ED Registration.

10. Take body to morgue
    a. Place body in the cooler on the morgue cart with pillow under patient's head.
    b. If autopsy is requested/ordered, place the "Autopsy pending sheet" over the body.
    c. Body can only be left in the morgue for 24 hours. Inform legal next of kin that the decision on the funeral home must be made within 24 hours of death.

11. Notify the funeral home when the body is in the morgue. (Notify them if patient weighs > 300 lb/136 kg).
    a. If tissue recovery and/or autopsy will occur, let the Funeral Home know they will receive a second call when the body is ready to be picked up.

Guidelines for Tissue/Eye Donation or Autopsy Cases

1. Cooling procedure for Tissue Donor
    a. Nothing is required if body is placed in morgue cooler

2. Cooling procedure for Eye Donor. After the family has left:
    a. Gently irrigate both eyes with sterile saline
    b. Gently close the eyelids with gloved fingers; apply a cool compress of saline soaked gauze over the closed eyelids. Ensure the gauze covers the lid line.
    c. Elevate the head to decrease chances of bleeding/bruising and apply a light ice pack over closed eyelids.
    d. Document the date/time eye care was completed on the ice pack
    e. Cover patient with sheet and transport to the morgue. (Eye bank will coordinate all recovery details.)

3. Autopsy Guidelines if applicable: Place "autopsy pending" sheet on body
    a. "Medical Examiner ordered" requires no family consent. The Medical Examiner makes all arrangements including the release of the body to the funeral home.
    b. Physician requested: Complete the Permission for Postmortem Examination form. Next of kin or POA signature is required. Contact pathology for a post mortem examination.
    c. Family requested: Arrangements and payments are their responsibility.

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