



## Clinical Column

# Adult simulation and demonstration of nurse competency with neurological assessment



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Nurses work in challenging environments and vast amounts of information are shared on a continual basis. Changes in health care and bedside nursing are constant which make maintaining competency in this dynamic environment challenging. In addition, as documentation has transitioned to electronic medical records, new challenges have been created. The purpose of this paper is to describe an educational intervention using a live standardized patient (actor) simulation with staff nurses that care for patients after a stroke or carotid intervention. Staff nurses at a large Midwestern Level 1 trauma center were preparing for stroke recertification from The Joint Commission. During the preparation period, it was recommended to create an educational opportunity for nurses that would allow them to demonstrate competency with both the neurological assessment and bedside swallow screen that they perform. The American Heart Association Stroke guidelines provide recommendations for frequent neurological assessments in the first 24 hours of admission after stroke as well as bedside swallow screening to assess for dysphagia.<sup>1</sup> The neurological assessment and close monitoring for stroke patients is so that any changes in neurological status can be detected and managed in a timely manner. The neurological assessment in the electronic medical record (EMR) was used as a guide for the simulation and included an evaluation of: mental status, Glasgow coma scale, pupil reaction and accommodation, speech, motor function of arms and legs, facial symmetry, pronator drift, and shoulder shrug. In order to establish consistency and assess competency for all staff, educational didactic review sessions for the neurological assessment were conducted, and a checklist for the neurological assessment and the bedside nurse swallow screen using the EMR were created (Table 1.)

The checklists were used during the simulation to assure that all components were being consistently assessed, evaluated, and documented.

### BACKGROUND/LITERATURE REVIEW FOR SIMULATION

Simulation is an educational technique that can be used in the clinical setting that can be developed to teach new concepts as well as assess competency with complex procedures including physical assessment, codes, and sterile technique.<sup>2-4</sup> Simulation is an effective education method which can be used to educate and assess health care provider competency for various skills and provide an opportunity for debriefing and feedback in a one-one setting.<sup>2</sup> Simulation can be done in a formalized setting with high fidelity computerized mannequins, in a setting using live (actor) standardized patients or a combination of both.<sup>5,6</sup> In addition, simulation with adult volunteers provides an opportunity for health care providers to practice technical and nontechnical skills in a safe practice environment.<sup>2,3</sup> A simulation experiential program for nurses working with the acute stroke population was developed and implemented to allow staff nurses the opportunity to practice neurological assessment skills for the acute stroke population and was shown to enhance skills and confidence for staff.<sup>7,8</sup> In another study, mannequins and standardized patients were used to educate and evaluate nurses performing bedside swallow screens and found that nurses were able to transfer knowledge they learned with mannequins to a live patient scenario.<sup>6</sup> Nurses who participated in simulation-based training demonstrated the ability to improve sterile technique and competency in managing central lines in critical care.<sup>9,10</sup> Clinical simulation for health care providers using standardized patients can enhance knowledge, while allowing for practice and evaluation of both clinical skills and technology in a safe environment.

### EDUCATIONAL INTERVENTION

Nurses chose one of several case studies (Table 2) and demonstrated a complete neurological assessment on a live adult standardized (simulated) patient and described how and where they would document the data in the EMR. In addition, nurses

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**TABLE 1**

**NEURO ASSESSMENT CHECK-OFF**

*Associate:* \_\_\_\_\_

<i>Skill Assessed:</i>	<i>Performed:</i>	<i>Not Performed:</i>
1. Level of consciousness		
2. Orientation level		
3. Cognition		
4. Speech		
5. Pupil assessment (size, shape, reaction)		
6. Motor function/sensation assessment (grip, dorsiflexion, plantar flexion, motor response, sensation, strength)		
7. Tongue deviation/lip sensation		
8. Facial symmetry/sensation		
9. Pronator drift assessment		
10. Shoulder shrug		
11. Sedation scale (POSS)		
12. Glasgow coma scale		

Documentation of above reviewed in CareConnect? Yes  
 Date \_\_\_\_\_ Educator signature \_\_\_\_\_  
 Associate signature \_\_\_\_\_

*Associate:* \_\_\_\_\_

<i>Skill Assessed:</i>	<i>Performed:</i>	<i>Not Performed:</i>
Preswallow screen, including:		
1. Observing the patient		
2. Able to sit upright		
3. Able to follow commands		
4. Tolerates nasal cannula, if impaired O2		
5. Facial droop assessed		
6. Vocal quality assessed		
7. Speech assessed		
8. Cough and throat assessed		
9. Drooling assessed		
10. Clearance of foods assessed		
11. Signs of dysphagia assessed		
12. History of dysphagia assessed		
13. Pass/fail indicated		
Swallow screen, including:		
1. Swallow 2–3 ice chips		
2. Swallow 2 Tsp. H <sub>2</sub> O		
3. Drink 1/3 cup H <sub>2</sub> O		

(Continued)

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