

Integrating gerontology and community concepts through simulation

By: [Jacqueline K. DeBrew](#) and Susan Hensley-Hannah

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Abstract:

This article describes an innovative simulation experience for nursing students. Faculty from a community health nursing course and a course in gerontology worked together to provide a comprehensive simulation experience that combined low-fidelity and high-fidelity experiences that provided an integrated learning experience and gave faculty with an opportunity to collaborate to improve outcomes. Student and faculty feedback was overwhelmingly positive. Future plans include incorporating a third didactic course, Leadership and Management, and working with other disciplines to demonstrate interprofessional collaboration.

Keywords: Community Health Nursing | Gerontology | Home Visits | Sensory Changes of Aging | Simulation

Article:

Simulation in nursing education promotes critical thinking (Shepherd, Kelly, Skene, & White, 2007) and enhances students' knowledge and skills (Linden, 2008). Simulation also offers an abundance of opportunities for students to implement the didactic content of a course. However, there is little published literature on simulations that integrate the learning outcomes of two courses.

Community health nursing and gerontology faculty worked together to provide the comprehensive simulation experience described in this article. This was a natural partnership as the community health course includes an emphasis on older adults as a vulnerable population, and the gerontology course has a community emphasis, with most older adults living independently in their homes. Gerontology and community health, along with

leadership/management, are the courses our nursing students take, along with one integrated clinical practicum, in the first semester of the senior year.

Simulations were offered to students in two ways that took place simultaneously: 1) through stations designed to simulate the hearing, visual changes of aging, and common eye disorders in older adults and 2) through a home visit. Students rotated in groups through the stations while waiting for their scheduled home visit appointment. Both experiences took place during the combined class periods of the two courses, which were offered back-to-back. Students received their schedule, patient assignment, and simulation outcomes several days in advance. They also provided consent for videotaping.

For both courses, students viewed a narrated PowerPoint and had an assigned reading before participating in the simulation. All 47 students met in a large, centralized room for a prebriefing where they were directed to the activities of the day and told that a debriefing would conclude the class.

SENSORY SIMULATIONS

The sensory simulation stations were set up using multiple tables with needed materials and instructions. They were designed for experiential learning (Eyler, 2009) with the goal of helping students know what it is like to be an older adult experiencing sensory change. The course content covered by the stations included visual disorders, such as cataracts, glaucoma, and macular degeneration, as well as other sensory changes, like hearing loss.

We attempted to recreate issues common to community-dwelling older adults: taking medications, reading pharmacy pamphlets, even threading a needle. At one station, the students had to be a caregiver who had glaucoma and needed to assist the “patient” who had had a stroke. Some stations required students to get up and move around. For example, students had to find their “grandson’s” picture in one of the class composites on the wall.

The stations helped the students begin to think about community-dwelling older adults, their caregivers, and the situations they might encounter. For example, students were asked to put on glasses that simulated the normal changes of aging that affect color discrimination and then take their daily medications. Later, in debriefing, we discussed why teaching patients medication administration by the way their pills look (i.e., shape and color) is not a good practice for older adults.

To demonstrate age-related hearing loss, students were instructed to listen to an audio clip of a physician with a foreign accent giving medication instructions to an older adult in a crowded doctor’s office. The student had to write down what was heard — the result was similar to the game of telephone. (See Supplemental Digital Content, <http://links.lww.com/NEP/A11>, for an outline of the activities, materials needed, and debriefing topics.)

Using a revised Bloom’s taxonomy (Krathwohl, 2002), we also allotted 20 minutes to give students the task of creating a brochure that could be given to older adults to teach them about the sensory changes of aging. In debriefing, we pointed out that the brochure should not only

include important content but should also be appropriate to the sensory changes of older adults, for example, using appropriate font and color. We learned in debriefing that students had never even thought about that aspect of the brochure; their focus was on the content.

HOME VISITS

For the home visit simulations, in which students left the sensory station room and went to one of two simulation rooms, the primary focus was on safety and environmental assessment. Safety is a concern for all older patients, because annually one in three individuals over the age of 65 will experience a fall (Centers for Disease Control and Prevention, 2015). Also, because most patients rarely have only one problem, we wanted our students to see how the patient was functioning in the home, assess the patient's situation, and prioritize the most critical needs. We wanted students to teach the patient using what they themselves had learned about sensory changes.

Students were assigned to one of two home visit scenarios chosen from the National League for Nursing Simulation Innovation Resource Center (SIRC). Both were unfolding cases. Sherman "Red" Yoder (Boese, 2012) was placed in our apartment-style simulation room. Julia Morales (Cato, 2012) was seen in a small office area with a few home furnishings. For the scenarios, each of the 14 groups of three to four students were given a home visit bag with essential supplies and a copy of Lawton's Instrumental Activities of Daily Living Scale.

When the students visited Red Yoder, they immediately noticed that Red was listening to his music loudly; they had to ask him to lower the volume to continue their discussion. The students proceeded to review Red's current health issues and knowledge of diabetes while completing a physical assessment and safety assessment. They concluded the visit by assessing his sleep pattern and ability to monitor his blood sugar. They noted that Red was using alcohol and Benadryl to help him sleep.

The Julia Morales case focused on end-of-life care for a client with lung cancer. Julia and her same-sex partner Lucy Grey had made the decision to end treatment and seek an evaluation for hospice services. Students performed a physical and environmental assessment and assessed Julia's ability to care for herself. They noted the couple's coping abilities and needed resources.

STUDENT OUTCOMES

Both simulation experiences offered rich learning opportunities for the 47 students. Asked to describe the simulation experience, their comments included the following: "Experiencing the challenges older adults face was really eye-opening. I will definitely educate my patients differently now." "I understand why knowing about community resources is so important." "My patient had so many problems, I didn't know where to start. I couldn't fix him in one visit." "If we hadn't assessed him so thoroughly, I would have never known how dependent he was on his family."

CONCLUSION

The students were debriefed collectively following the simulations using the Dreifuerst (2015) Debriefing for Meaningful Learning tool. Feedback was given by faculty as well as by the standardized patients and simulation facilitator. Student and faculty feedback was overwhelmingly positive. Students also reported having more confidence as they entered their community experiences, particularly when doing home visits. As the simulation experience took place early in the semester, faculty were able to identify students with weak clinical skills and those who seemed to lack self-direction. They shared this information with clinical faculty so that interventions could begin early.

This simulation experience provided students with an integrated learning experience and provided faculty with an opportunity to collaborate to improve course outcomes. A future goal is to incorporate the third didactic course, Leadership and Management, into the joint simulation experience. A long-term goal is to involve other disciplines, such as social work. Providing students opportunities to collaborate with other professionals and practice skills such as delegation would be of great value in their journey to becoming professional nurses.

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