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Innovations in Simulation

How John Barleycorn Spun Simulation Gold

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standardized patient

Abstract: As it becomes increasingly difficult to secure mental health clinical placement sites for nursing students, creativity can provide a way to fill the gap. This article aims to describe how a simulation experience which was born out of a need for more clinical hours in mental health became the “favorite simulation experience the whole time we were in nursing school.” The author was challenged to create a mental health—simulated experience with limited funds and turned it into an interprofessionally orchestrated simulation experience that will not soon be forgotten by the students who experienced it.

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Nursing educators are finding it increasingly difficult to find relevant clinical placements for prelicensure students, especially in the acute care setting. This has resulted in rethinking what a clinical placement looks like across the curriculum. Nursing programs have begun shifting clinical hours to outpatient settings and in particular to the simulation lab, when appropriate. The shift toward simulation has been aided by the landmark study by the National Council of the State Boards of Nursing and has become the gold standard for replacing clinical hours with simulation experiences (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014). The challenge of clinical placement is especially true in mental health, where sites and access are more limited, particularly in rural regions. Out of this crisis, an idea for a simulated experience to replace an inpatient clinical experience was envisioned and executed with a very modest budget.

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Setting for the Simulated Case

The setting was a small public university with an annual enrollment of 150 nursing students, located in a semirural region with limited mental health site availability. The faculty brainstormed ideas, ultimately created a simulation of a homeless veteran with the comorbidities of post-traumatic stress disorder and alcoholism. The students were taking Community and Mental Health courses concurrently during the first semester of their senior year.

The faculty chose to recreate a simulated street setting that mimicked an inner-city street where homeless people live. Because the University is in a suburban setting, an inner-city was a place that these students were unlikely to encounter in their clinical rotations. An online search was conducted to find an appropriate scene that could be used to create a backdrop for the street. A scene with a busy city street in a rundown neighborhood was chosen. The backdrop had posters of events (such as concerts) and a dog, and some boxes and blankets were strewn about on the street. With the help of the university’s graphic designer,

the photo of the scene was enlarged and printed on lightweight fabric to serve as the backdrop for the simulation case and could be easily installed on a curtain rod. To give the scene a more three-dimensional setting, boxes were added, and a blanket and a pillow with simulated vomit on it was conceived and placed strategically. A shopping cart, such as a homeless person might use, with various empty alcohol bottles, old newspapers, and other props were added for effect (See Figure 1).

Key Points

- With a modest budget, an impactful simulation is possible.
- With a scarcity of mental health clinical placements, simulation can provide a similarly meaningful experience.
- Using phone Apps can help create an immersive simulation environment.

This simulation was run with a standardized patient (SP) named John Barleycorn. The simulation ran over three days, and three SPs were used throughout the simulated experience. The SPs were a combination of helpers, two obtained

from the drama department and one was the spouse of a faculty member. The SP was placed in an old camouflage jacket and hat that gave the appearance of a military connection. The SP was briefed ahead of time and asked to stay in character to the best of one's ability, with a fine motor tremor, some mild agitation, and intermittent confusion.

The BSN students were placed in groups of three to four and prebriefed before entering the room. They were instructed they were serving as a community health nurse for the day, making their rounds to connect with new homeless persons. As part of the outreach, each new

homeless person in the city was to have an intake form filled out. The intake form was shared with students a few days ahead of time via the Learning Management System used by the University. They were also given the Clinical Institute Withdrawal Assessment of Alcohol Scale tool to review and the Clinical Opiate Withdrawal Scale. The intent was that the students would come into the experience prepared and readily recognize the signs of withdrawal. To further replicate an inner-city vibe, an app was downloaded with city street noises and speakers were placed around the room; the city noise track was played throughout the simulation experience.

The Simulated Scenario

As the students entered the room, their initial reactions were mixed. Some students immediately got down on the street with Mr. Barleycorn while others towered over him, seemingly at a loss of what to do. As the students began to attempt to answer the questions on the intake form, Mr. Barleycorn became agitated and his tremors increased. It became clear to the students that the seventeen-page form was not going to be filled out today because Mr. Barleycorn needed help with his withdrawal symptoms. The students commenced to plan how to get him help, but he was resistant to getting help and showed signs of paranoia. The simulated experience lasted approximately 10 minutes, followed by debriefing that lasted another 15 minutes. The debriefing was performed using the Debriefing with Good Judgement theoretical framework (Rudolph, Simon, Rivard, Dufresne, & Raemer, 2007). The debriefing sessions, which included the SPs, provided a fruitful, thought-provoking dialogue.



Figure 1 Photo of the nursing students participating in the simulation with “John Barleycorn”.

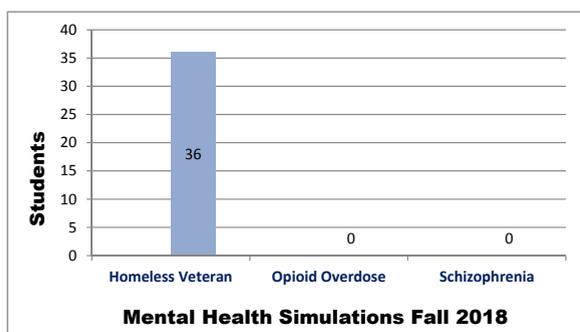


Figure 2 What was your favorite simulation this semester?

A plethora of issues was discussed in the debriefing sessions that drew upon all that they had learned to this point in the curriculum and emphasized the nature of the experience about their current courses. These issues included, but were not limited to, the following:

1. How do you help someone who does not want to be helped?
2. How do you prioritize care on a person with multiple comorbidities?
3. How do you obtain care without a home address?
4. Do you give alcohol to someone with withdrawal symptoms?
5. How long does it take to go into withdrawal?
6. How do you get a veteran integrated into the Veterans Administration system?

As the groups completed the simulation experience and exited the room, they were reminded to honor the confidentiality of the lab, preserving the experience for the next group. Confidentiality was well maintained, and each group was quite surprised by the experience.

Feedback

Feedback from the participants and the SPs was very positive and was the simulation chosen by 100% of the

students as their “favorite” of the semester when data were later collected (See Figure 2). Mr. Barleycorn was still being talked about the week of graduation and was even mentioned by the class speaker at the nurse pinning ceremony.

Faculty were also quite pleased with the simulated experience as well. The mental health faculty had expressed interest in including more simulation into the class for some time but were at a loss as to how to do so. The simulation coordinator relied on their expertise, and they participated in the debriefing process as the content expert. The integration of the use of the theater students and faculty showed students the importance of interprofessionalism.

Discussion

John Barleycorn is a case that could be played out daily in simulation labs across the world. He certainly represents the complex health care needs of homeless veterans and highlights the important role nurses can play in advocating for this vulnerable population. As technology use increases, there is still a case to be made for a simple, low-tech simulation that fosters adaptability and promotes good clinical judgement. This simulation represents a creative interprofessional collaboration of nursing faculty and university partners and illustrates faculty capabilities to develop meaningful teaching/learning strategies even with limited funds. John Barleycorn may have been born out of real need but ultimately became the simulation that students remember for years to come.

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