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| **Identified Problem/Scenario topic**  Post-operative respiratory depression | | **Desired Change/Overall Goal**   1. Recognize respiratory depression 2. Correctly identify cause 3. Intervene appropriately 4. Effective ventilation returns | | |
| **Case Summary:**  68 year old female patient just transferred from PACU to medical-surgical unit in stable condition following a right total knee replacement (THR).  She begins to have ↓ level of consciousness, falling respiratory rate and depth, ↓ O2 saturation | | **Critical performance elements**   1. Receives bedside report 2. Begins post-operative assessment 3. Connects equipment 4. Notices ↓ O2 sats, ↓ RR & depth, ↓ LOC 5. Changes nasal cannula to mask 6. ↑ O2 liter flow & reassesses 7. Calls for help (Rapid Response Team) 8. SBAR communication 9. Administers Narcan & reassesses 10. Communicates effectively to family throughout | | |
| **Case Flow (15 - 20 minute simulation time)** | | | | |
| **Initiation of Scenario**  Patient in bed – “hand-off” report at bedside.  Patient in stable condition with reported pain level “2/10” after general anesthesia and 3 doses of IV Morphine. | 🡪🡪 | | **First Frame**  Nurse introduces self and co-workers and begins assessment. Patient is responsive at first. *(Gives learners a chance to settle in to the environment and simulation)*  Vital signs begin to change with ↓ O2 sats, ↓ RR & depth, ↓ LOC | 🡪🡪 |
| **Second Frame**  Change O2 from NC to mask  Reassesses – no change  Consults and validates findings with 2nd nurse  Checks orders  Primary nurse calls for help (RRT)  Gives SBAR to RRT | 🡪🡪 | | **Third Frame**  RRT responds with Narcan  Checks order  Identifies and assesses patient  Administers per order, titrating dose  Reassesses | 🡪🡪 |
| **Scenario End Point**  Patient responds to Narcan  Nurses communicate with patient/family throughout simulation. | 🡪🡪 | | ***Debrief***  ***(30 – 40 minutes)*** | |