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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
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| **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
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| **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 maskReassesses – no changeConsults and validates findings with 2nd nurseChecks ordersPrimary nurse calls for help (RRT)Gives SBAR to RRT | 🡪🡪 | **Third Frame**RRT responds with NarcanChecks orderIdentifies and assesses patientAdministers per order, titrating doseReassesses | 🡪🡪 |
| **Scenario End Point**Patient responds to Narcan Nurses communicate with patient/family throughout simulation. | 🡪🡪 | ***Debrief******(30 – 40 minutes)*** |