



California Simulation Alliance (CSA) Simulation Scenario Template

The California Simulation Alliance (CSA) is comprised of simulation users from all disciplines from throughout the state. Several regional collaboratives have formed totaling 7 as of March, 2011: The Rural North Area Simulation Collaborative (RNASC), the Capital Area Simulation Collaborative (CASC), the Bay Area Simulation Collaborative (BASC), the Central Valley Simulation Collaborative (CVBSC), the Southern California Simulation Collaborative (SCSC), the Inland Empire Simulation Collaborative (IESC), and the San Diego Simulation Collaborative (SDSC). The CINHC, a non-profit organization focused on workforce development in healthcare provides leadership for the CSA.

The purpose of the California Simulation Alliance (CSA) is to become a cohesive voice for simulation in healthcare education in the state, to provide for inter-organizational research on simulation, to disseminate information to stakeholders, to create a common language for simulation, and to provide simulation educational courses. The goals of the alliance will include providing a home within the CINHC for best practice identification, information sharing, faculty development, equipment/vendor pricing agreements, scenario development, sharing and partnership models. More information can be found on the CSA website at www.cinhc.org/programs.

All scenarios have been validate by subject matter experts, pilot tested and approved by the CSA before they were published online. All scenarios are the property of the CINHC/CSA. The writers have agreed to release authorship and waive any and all of their individual intellectual property (I.P.) rights surrounding all scenarios. I.P release forms can be found at www.bayareanrc.org/rsc and click documents. (Please send signed I.P. release forms to KT at kt@cinhc.org)

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SECTION I: SCENARIO OVERVIEW

Scenario Title	Code Blue in Post-op Colectomy		
Original Scenario Developer(s):	Anne Boulter Lucero, RN, MSN anlucero@cabrillo.edu		
Date - original scenario	7-08-07		
Validation date:	8-01-07		
Validated by:	B. Crouch, RN, CCRN & M. Miller, MA, RN, CHSE		
Revision Dates:	11-15-07, 6-26-09, 2-15-10, 7-8-11 Revision for staff nurses: -11-Marjorie Miller, RN, MA, CHSE, Anne Lucero, MSN, Sue Uchiyama, RN, Sarah Kennedy, RN		
Pilot testing date:	10-07		
QSEN Revision	Marjorie A. Miller, MA, RN. CHSE		
Estimated Scenario Time: (i.e. 15 minutes) Debriefing time: (i.e. 30 minutes)			
Target group: Advanced nursing students in pre-licensure nursing programs; staff nurses in medical surgical acute care departments.			
Core case: 1 st day post-op colectomy. Chest Pain following ambulation progresses to Code			
QSEN Competencies: Safety, Patient Centered Care, Teamwork and Collaboration			
Brief Summary of Case: 68 year old retired male first day post-op uncomplicated colectomy. Nursing assistant reports that patient doesn't feel or look well following ambulation. Learners are expected to assess the patient, recognize and analyze c/o pain, differentiate between post-operative pain and new onset of chest pain; assess patient, administer O ² and call for 12 lead EKG and chart to check orders. Learners further expected to call prescriber for orders to report change of status and cover for ACS.			
Learners receive orders and administer ASA, O ² and get 12 lead EKG and administer NTG x1. EKG rhythm demonstrates tachycardia, a run of V Tach progressing to V Fib and the patient codes. Learners expected to call the code, place back board, position the patient and begin CPR, defibrillate the patient, change IV solution to Normal Saline wide open and stop the epidural.			
Patient's rhythm returns to sinus tachycardia and patient responds as Code Team arrive. Primary nurse gives SBAR to end the scenario.			

EVIDENCE BASE / REFERENCES

(List all references include complete citation, following APA guidelines)

American Heart Association, (2010) Handbook of Emergency Cardiovascular Care for Healthcare Providers
Black, J.M. & Hawks, J.H., (2009) Medical Surgical Nursing, Clinical Management for Positive Outcomes, Vol 2, 8th edition. St Louis: Elsevier Saunders.
Deglin, J.H. & Vallerand, A.H., (2011) Davis Drug Guide for Nurses. Philadelphia

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES	
Learning Outcomes	
1. Provide patient care that promotes safety and minimizes risk of error.	
2. Integrate understanding of multiple dimensions of patient care.	
3. Communicate effectively with nursing and members of the inter-professional team.	
4. Apply effective clinical decision making skills in changing situations.	
Specific Learning Objectives	
1. Applies principles of hand hygiene, infection control and personal protection.	
2. Correctly identifies patient.	
3. Gather relevant patient and contextual data to identify patient's current problem.	
4. Recognize acute changes in patient's condition that requires immediate intervention.	
5. Call for additional nursing help.	
6. Recognize need for additional orders and report change of status to provider, using strategies to minimize risk when reporting change of status.	
7. Perform timely interventions to address urgent primary problems as they unfold.	
8. Evaluate effectiveness of interventions.	
Critical Elements (Key points to observe to determine if scenario objectives are met)	
1. Perform hand hygiene; correctly identify patient.	
2. Perform pain assessment; assess vital signs and O ₂ sats; check IV patency	
3. Differentiate causes of pain; recognize new onset of chest pain.	
4. Administer O ₂ per agency protocol	
5. Call for help from other nursing staff	
6. Call for 12 lead EKG	
7. Call physician; report change of status using SBAR. Request orders for ASA, Nitro, MS, fluid bolus	
8. Administer orders received.	
9. Recognize run of V tach <input type="checkbox"/> M. fib . Call Code	
10. Perform basic CPR; stop epidural; defibrillate	

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Knowledge	
Required prior to participating in the scenario	
Knowledge Competencies	Skills/attitudes Competencies
<input type="checkbox"/> Components of CP of cardiac origin	<input type="checkbox"/> Pain assessment (PQRST)
<input type="checkbox"/> Agency procedure for Code Blue	<input type="checkbox"/> Differentiation of incisional pain vs. Chest Pain
<input type="checkbox"/> Pathophysiology of ACS / arrhythmias	<input type="checkbox"/> Significance of abnormal findings
<input type="checkbox"/> Current National Patient Safety Goals	<input type="checkbox"/> Therapeutic communication in acute situations
<input type="checkbox"/> Structured Communication Tools (SBAR)	<input type="checkbox"/> Request for assistance in escalating situations
<input type="checkbox"/> Legal aspects of taking telephone orders	<input type="checkbox"/> Taking and initiating telephone orders
<input type="checkbox"/>	<input type="checkbox"/> ACLS protocol for chest pain/Code Blue

SECTION III: SCENARIO SCRIPT

A. Case summary

68 year old retired male first day post-op uncomplicated colectomy. Nursing assistant reports that patient doesn't feel or look well following ambulation. Learners are expected to assess the patient, recognize and analyze c/o pain, differentiate between post-operative pain and new onset of chest pain; assess patient, administer O2 and call for 12 lead EKG and chart to check orders. Learners further expected to call prescriber for orders to report change of status and cover for ACS.

Learners receive orders and administer ASA, O2 and get 12 lead EKG and administer NTG x1. EKG rhythm demonstrates tachycardia, a run of V Tach progressing to V Fib and the patient codes. Learners expected to call the code, call 911, place back board, position the patient, and begin CPR, change IV solution to Normal Saline wide open and stop the epidural.

Patient's rhythm returns to sinus tachycardia and patient responds as Code Team arrives. Primary nurse gives SBAR to end the scenario.

Significant history: Patient has history of hypertension controlled by a Toprol XL and Diovan.

B. Key contextual details

Day shift fully staffed.

C. Scenario Cast

Patient/ Client	<input type="checkbox"/> High fidelity simulator	
	<input type="checkbox"/> Mid-level simulator	
	<input type="checkbox"/> Task trainer	
	<input type="checkbox"/> Hybrid (Blended simulator)	
	<input type="checkbox"/> Standardized patient	
Role	Brief Description	Confederate (C) or Learner (L)
Primary Nurse	Goes into room to check patient after getting report from CNA	Learner
Second Nurse	Goes into room when primary nurse calls. If PN doesn't call, will be sent in	Learner
CNA	Gives report to Primary Nurse to start scenario	Confederate (Actor)
Charge Nurse	Comes in when alerted by nurse	Confederate (Actor)
Code Team	Receive hand-off report	Confederate (Actor)

D. Patient/Client Profile				
Last name:	Franklin	First name:	Herbert	
Gender: Male	Age: 68	Ht: 5'10"	Wt: 180 #	BMI:
Ethnicity: Caucasian		Religion: Protestant		
1. History of present illness				
3-4 month history of intermittent diarrhea and constipation without pain. CT scan demonstrated questionable mass in the sigmoid colon. Previous colonoscopy 3 years ago revealed diverticulosis and no evidence of malignancy. Diagnostic colonoscopy confirmed mass. Patient scheduled for left hemicolectomy.				
Primary Medical Diagnosis		Colorectal cancer of the upper sigmoid colon		

2. Review of Systems	
CNS	Within normal limits
Cardiovascular	Regular rhythm without murmur. Hx of hypertension controlled BP 102/64
Pulmonary	Chest clear, non-smoker
Renal/Hepatic	Within normal limits
Endocrine	Normal for 8 year old male
Heme/Coag	DC'd ASA 1 week ago, Platelets 135,000, otherwise within normal limits
Musculoskeletal	MAE equally without difficulty
Integument	Clear and intact
Developmental Hx	Normal for male, retired 3 years
Psych History	None
Social History	Married; lives with wife of 30 years. Occasional alcohol; no recreational drugs
Alternative/ Complementary History	Drinks green tea for health reasons.

Medication allergies:	None known	Reaction:	
Food/other allergies:	None known	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Toprol XL	25 mg	PO	daily
	Zetia	10 mg	PO	daily
	Diovan	80 mg	PO	daily

4. Laboratory, Diagnostic Study Results				
Na: 136	K:4.4	Cl:99	HCO3:	BUN:15
Cr:1.2	BS:120	HgA1C:	GFR: >60	
Hgb:12.1	Hct:34.9	Plt:117	WBC:9	
PT	PTT	INR		
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:94
Ca:	Mg:	ABO Blood Type:		
LFTs:	Albumin:	SGOT:	SGPT:	AlkPhos:
VDRL:	GBS:	Herpes:	HIV:	
CXR:	ECG:			
CT:	MRI:			

E. Baseline Patient/Client Simulator State				
This may vary from the baseline data provided to learners				
1. Manikin physical appearance - Mark X next to item and/or describe				
Gender:	Male			
Attire:	Patient gown			
x	ID band present, accurate information		ID band present, inaccurate information	
	Allergy band present, accurate information		Allergy band present, inaccurate information	x
				ID band absent or not applicable
				Allergy band absent or not applicable
Alterations in appearance (moulage):				
Grey mustache, glasses				
Midline incision with gauze and tegaderm 6" long by 2" wide Thigh				
high TED hose				
Sequentials draped over bottom of bed (not replaced after ambulation)				

2. Initial Vital Signs Monitor display in simulation action room:				
(Should be appropriate for the scenario setting)				
	No monitor display	x	Monitor on, but no data displayed	
				Monitor on, standard display

BP:89/60	HR:116	RR:20	T:99.2 F.	SpO2:94%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:				
FHR:				
Lungs: Sounds/mechanics	Left:clear		Right:clear	
Heart:	Sounds: S1, S2 – slightly irregular			
	ECG rhythm: Sinus tachy w/occasional PVC			
	Other: short burst of V. Tachy followed by v. fib			
Bowel sounds:	absent		Other:	

CSA REV template (12/15/08; 5/09; 12/09; 3/11)

ALL DATA IN THIS SCENARIO IS FICTICIOUS

3. Intravenous lines - INITIAL manikin set up						
	Saline lock #1	Site:				IV patent (Y/N)
	IV #1	Site:	(rt) forearm	Fluid type: D5/½NS w/20meq KCl	Initial rate: 150 ml/hr	IV patent (Y/N)
x	Main					
	Piggyback					
	IV #2	Site:		Fluid type: Ancef Gm. 1	Initial rate: 30 minutes	IV patent (Y/N)
	Main					
x	Piggybac					
4. Non-invasive monitors – INITIAL manikin set up						
x	NIBP		ECG First lead:		ECG Second lead:	
x	Pulse oximeter	x	Temp monitor/type			
5. Hemodynamic monitors- INITIAL manikin set up						
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:		PAC Site:
6. Other monitors/devices						
x	Foley catheter	Amount in drainage bag:	200 mL	Appearance of urine:		Light yellow
x	Epidural catheter		Infusion pump (to be brought by Sutter) Pump settings:			
	Fetal Heart rate monitor/tocometer		Internal			External
7. Digital images of initial manikin appearance						
<p>Insert digital photo of initial manikin appearance here</p>				<p>Insert digital photo of initial manikin appearance here</p>		

F. Environment, Equipment, Essential props

Standardized set ups for equipment/supplies for each commonly simulated environment is recommended

1. Scenario setting: (example: patient room, home, ED, lobby)

Medical Surgical patient room (unmonitored unit)

Staff Assist button

Code Blue card on telephone

2. Confederate/ Actor placement - INITIAL scenario set up

Role	<ul style="list-style-type: none"> ▪ General instructions (Initial placement and disposition) ▪ Key actions to implement triggers for learner
CNA	Starts scenario in debriefing room by reporting that patient doesn't look or feel well after ambulation.
Charge nurse and other responding nurses	Wait in Control Room until Director sends in to help

3. Equipment, supplies, monitors

(In simulation action room or available in adjacent core storage rooms)

x	Bedpan/ Urinal		Foley catheter insertion kit		Straight catheter kit	x	Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag	x	Wall suction apparatus
	Nasogastric tube		ETT suction catheters		Oral suction catheters		Chest tube insertion kit
x	Defibrillator	x	Code Cart	x	12-lead ECG machine		Chest tube drainage equip
	PCA infusion pump	x	Epidural infusion pump		Central line Insertion Kit	x	Dressing change equipment
x	IV fluid Type: D5/1/2 NS w/ 20 mEq KCl	x	IV fluid Type: NS 1000 mL		Tubes/drains Type:		Blood product ABO Type: # of units:

4. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent	x	Simple Face Mask	x	Non rebreather mask
x	BVM/Ambu bag		Nebulizer treatment kit		Flowmeters (extra supply)		

5. Essential props/special effects	
Sequential stockings with pump	
Crash Cart/Defibrillator	

6. Documentation and Order Forms							
x	H & P		Consult reports	x	Nurses notes		
x	Admit Orders	x	Vital Sign record		Triage forms		
X	Physician orders		ICU flowsheet	x	Code Record		
x	Blanks available						
x	Progress notes	x	Medication Administration Record	x		CU	
x	Laboratory results	x	Graphic record	x	Standing (protocol) order		
	Medication reconciliation		Activity forms				
	Transfer orders	x	Shift assessment		Prenatal record		
x	Actual medical record binder, constructed per institutional guidelines			x	Other: One complete chart in room		

7. Medications (to be available in sim action room)							
x	ASA 325 mg	x	Ancef	x	Fentanyl Epidural		
x	Nitroglycerin						

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
<p>Initiation of Scenario: In Debriefing Room, CNA reports to staff (primary) nurse. “ I just ambulated Mr. Franklin and got him back to bed. He didn’t go very far before he started complaining of not feeling good. He didn’t look so good either, so I just put him back to bed and came to get you. Can you check him please?”</p> <p>Prior report given to large group: Herbert Franklin is a 68 year old man who is first day post-op hemicolectomy for colorectal cancer. His surgery was uncomplicated. He has a history of hypertension controlled with Diovan and Toprol. (Add report)</p>			
STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Patient lying in bed w/ HOB □□20□. Pale, slightly anxious with hand on chest. States “I don’t feel good ...”</p> <p>If pain assessment is done, patient reports</p> <ul style="list-style-type: none"> • mid sternal chest pain, • onset during ambulation, • rated at 6/10, • not relieved by rest. <p>If pain assessment not done, patient complaints are non-specific.</p>	<p>Operator</p> <p>BP – 89/60 HR – 116 R – 20 T – 99.2 F. O2 sats – 94% on room air</p> <p>Triggers: Complete actions within 5 minutes.</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Performs hand hygiene 2. Identifies patient 3. Identifies self and role 4. Performs pain assessment and vital signs 5. Administers O2 per NC @ 4L 6. Calls for help, 12 lead EKG 7. Checks patency of IV 8. Stops epidural 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Strategies for complying with NPSG’s in acute situations 2. Differentiation of pain 3. Factors involved in decision making 4. Potential co-morbidities in the 60 + age group surgical patient 5. Basis for stopping epidural when patient is in pain 6. Possible reasons for hypotension and tachycardia

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>After Nitro given and nurse reassesses pain:</p> <p>Patient responds to nurses questions about pain. Reports that pain is still at a "5/10".</p> <p>Patient becomes unresponsive in presence of V tach & V fib.</p>	<p>Operator:</p> <p>After Nitro given: BP 84/56 EKG shows Sinus Tach with occasional couplet PVC's</p> <p>If rhythm is not noticed by nurses, repeat:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Occasional couplet PVC <input type="checkbox"/> Move to run of V Tach <input type="checkbox"/> Move to v. fib with full arrest <p>Triggers:</p> <p>Learner Actions completed within 5 minutes</p> <p>V fib with full arrest</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Directs other team members 2. 12 lead EKG 3. Recognizes occasional PVC 4. Initiates call to MD 5. Communicates using SBAR requesting orders for ASA, Nitroglycerin 6. Repeats orders back 7. 2nd nurse administers meds after rechecking VS 8. Reassesses CP/VS/rhythm 9. Notices V tach <input checked="" type="checkbox"/> V fib <input type="checkbox"/> 10. Calls Code 11. Initiates CPR 12. Defibrillates 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Components of teamwork & communication in acutely changing situations. 2. Strategies for assuring that all important assessments / interventions are completed and not duplicated 3. Significance of PVC's with this constellation of s/s 4. SBAR communication with MD 5. Essential elements of taking telephone orders 6. Strategies for assuring rapid intervention – meds 7. Code Blue/ACLS in Physician's Absence Protocol (Sutter) 8. Transfer of rest of patient assignment to other nurses during acute situation.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3.</p> <p>No response to verbal or painful stimulus</p>	<p>Operator:</p> <p>Monitor shows v fib with CPR waveform.</p> <p>Triggers:</p> <p>Learner Actions completed in 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Direct team members 2. Identify time keeper/recorder 3. AED - Defibrillate 4. Effective CPR for 2 minutes 5. Administer Epinephrine 6. Change IV to Normal Saline 7. Stop epidural if not previously done in # 1 or 2 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Rationale for changing IV to NS 2. Rationale for stopping epidural 3. Division of tasks and feedback from team
STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Patient responds, awakens</p> <p>c/o aching mid-sternum different from previous CP.</p> <p>Asks “what happened? Why is everyone in here?”</p>	<p>Operator:</p> <p>Monitor demonstrates NSR @ 90 bpm with occasional PVC</p> <p>BP 110/84</p> <p>RR 18 unlabored</p> <p>O² sats – 98%</p> <p>Triggers:</p> <p>PM arrive – “handoff”</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Reassesses patient 2. Communicates effectively with patient regarding status and plan 3. Prepares patient for transfer 4. Delivers effective hand-off report to Code team 5. Call to family members 	<p>Debriefing Points</p> <ol style="list-style-type: none"> 1. Components of essential communication with patient 2. Role of nurse in change of status communication with patient and family. 3. Essential components of “hand-off” communication with paramedic team 4. Strategies for debriefing critical incident and returning to patient care
<p>Scenario End Point: ICU team arrive to transfer patient to higher level of care</p>			
<p>Suggestions to increase or decrease scenario complexity: Wife arrives in the middle of Code and is disruptive. Unhelpful physician responds to Code. Patient does not respond to initial defibrillation and Epinephrine.</p>			

Patient Name: Herbert Franklin	Diagnosis: Colorectal CA sigmoid colon
DOB: 12/20/1942	Left hemicolectomy
Age: 68	
MR#: 654321	

No Known Allergies
†

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
08/16	1400	Admit to inpatient services
		Diagnosis: (Left) hemicolectomy
		Standard care for post op surgical patient.
		NPO
		Ambulate tonight, progress as tolerated
		TED stockings, remove q shift for 15 minutes
		SCD's until ambulating
		Incentive spirometer q 1 hr. while awake
		O2 protocol Titrate O2 to keep saturation \geq 92%
		IV D5W 1/2 NS 20 KCL 125 ml/hr; hang 500 mL NS flush bag for piggy backs
		Fentanyl Epidural
		Ondansetron (Zofran) 4 mg IV q8h PRN nausea
		Cefazolin (Ancef) IV 1 gm q. 6 hours.
		Reinforce dressings PRN
		M Zoccoli MD

Patient Name: Herbert Franklin DOB: 12/20/1942 Age: 68 MR#: 654321	Diagnosis: Colorectal CA sigmoid colon Left hemicolectomy
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† No Known Allergies

†

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
08/17	0900	<i>Telephone orders received during scenario on nurses call to report change of status.</i>
		Follow ACS protocol
		ASA 325 mg
		O ² @ 4L/min
		12 lead EKG
		Nitroglycerin 0.4 mg sublingually every 5 minutes x 3
		Prepare for transfer to DSCH
		M Zoccoli MD

Source of Information: patient

History of Present Illness (HPI) 3-4 month history of intermittent diarrhea and constipation

Past Medical History: Patient has been in good health. Has a history of hypertension and hypercholesterolemia controlled with Toprol XL, Diovan and Zetia

Current Medications, dosage and frequency: Toprol, Zetia, Diovan. Discontinued ASA 1 week ago

Personal & Social History: 68 year old retired male living with wife of 30 years

Review of Systems:

Height: 5'10"	Weight: 180 #	BMI:	LMP:
BP 130/85	T 98.6	P 68	R 18

General: 68 year old retired male, alert and cooperative

Head/CNS: No problems with balance, walking; speech clear, articulates clearly, answers questions in detail.

Skin: clear and intact

EENT: within normal limits

Lungs: Chest clear, non-smoker, Respirations equal bilaterally without distress

Cardiac: Regular rhythm, without ectopy or murmurs. History of hypertension controlled with diet, exercise and medications

Gastrointestinal: Abdomen soft, rounded & non-tender, bowel sounds heard all quadrants. See chief complaint for additional information. Colonoscopy 3 years ago was normal except for diverticulosis.

Musculoskeletal: within normal limits

HISTORY AND PHYSICAL	Herbert Franklin	Mark Zoccoli M.D.
	D.O.B. 12/20/1942	MR# 654321

WBC	<u>9.0</u>	(4.8 – 10.8)	_____
RBC	_____	(4.2 – 6.0)	_____
HGB	<u>12.1</u>	(12.0 – 16.0)	_____
HCT	<u>34.9</u>	(34.0 – 43.0)	_____
MCV	_____	(81.0 – 99.0)	_____
MCH	_____	(27.0 – 31.0)	_____
MCHC	_____	(32.0 – 36.0)	_____
RDW	_____	(11.5 – 14.5)	_____
PLAT COUNT	<u>117</u>	(150 –400)	_____
M PLAT CT	_____	(7.4 – 10.4)	_____

CHEMISTRY

NA	<u>136</u>	(135-153)	_____
K+	<u>4.4</u>	(3.6-5.4)	_____
CL-	<u>99</u>	(98-108)	_____
CO2	<u>24</u>	(23-33)	_____
ANION GAP	_____	(7-19)	_____
OSM CA++	_____	(275-300)	_____
CA++ BLD	_____	(8.7-10.4)	_____
ALBUMIN	_____		_____
SERUM PROTEINS	_____		_____
GLU	<u>120</u>	(70-110)	_____
BUN	<u>15</u>	(7-29)	_____
CREAT	<u>1.12</u>	(0.5-1.4)	_____
BUN/CREAT	_____	(10.0-20.0)	_____
GFR	<u>>60</u>		_____
AST(SGOT)	_____	(8.42)	_____
ALT(SGPT)	_____	(0-55)	_____
ALK PHOS	_____	(50-136)	_____
TOTAL BILI	_____	(0-1.0)	_____
BNP	_____	(0-99)	_____
CPK	_____		_____
Troponin	_____		_____

LABORATORY REPORT
08/15/11

Herbert Franklin Mark Zoccoli M.D.

D.O.B. 12/20/1942 MR #654321

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input checked="" type="checkbox"/> Objectives	<input checked="" type="checkbox"/> Debriefing Points	<input checked="" type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input checked="" type="checkbox"/> Teamwork/Collaboration	<input checked="" type="checkbox"/> Evidence-based Practice	
<input type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
Sample Questions for Debriefing			
<ol style="list-style-type: none"> 1. How did the experience of caring for this patient feel for you and the team? 2. Did you have the knowledge and skills to meet the learning objectives of the scenario? 3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience? 4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP? 5. How would you handle the scenario differently if you could? 6. In what ways did you check feel the need to check ACCURACY of the data you were given? 7. In what ways did you perform well? 8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members? 9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting? 10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome? 11. Discuss actual experiences with diverse patient populations. 12. Discuss roles and responsibilities during a crisis. 13. Discuss how current nursing practice continue to evolve in light of new evidence. 14. Consider potential safety risks and how to avoid them. 15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care. 			
Notes for future sessions:			