



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)

TABLE OF CONTENTS

SECTION I SCENARIO OVERVIEW

- A. Title
- B. Summary
- C. Evidence Base

SECTION II CURRICULUM INTEGRATION

- A. Learning Objectives
 - 1. Primary
 - 2. Secondary
 - 3. Critical Elements
- B. Pre-scenario learner activities

SECTION III SCENARIO SCRIPT

- A. Case Summary
- B. Key Contextual Details
- C. Scenario Cast
- D. Patient/Client Profile
- E. Baseline patient/client simulator state
- F. Environment / equipment / essential props
- G. Case flow /triggers / scenario development

SECTION IV APPENDICES

- A. Health Care Provider Orders
- B. Digital Images of Manikin / Milieu
- C. Debriefing Guide

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Fluid Volume Overload in post-op mastectomy
Original Scenario Developer(s):	Marjorie Miller, MA,RN, CHSE
Date - original scenario	07/2010
Validation:	08/2010 Anne Lucero, MSN
Revision Dates:	03/2011
Revised for Sutter:	Sara Kennedy, RN, Sue Uyematsu, RN (Med Surg clinicians at Sutter)
Pilot testing:	09/2010
QSEN revision:	08/2011 Marjorie Miller, MA, RN, CHSE
Estimated Scenario Time: 15 – 20 minutes Debriefing time: 30-40 minutes	
Target group: pre-licensure nursing students, new graduates, staff nurses	
Core case: Post-operative patient developing fluid overload	
QSEN Competencies:	
<ul style="list-style-type: none"> • Safety • Patient Centered Care • Teamwork and Collaboration 	
Brief Summary of Case: 64 year old female on first morning post-op following a left prophylactic mastectomy with immediate reconstruction with tissue expander. Morning assessment reveals new finding of crackles mid-way up bilaterally and O2 sats of 91%. Learners are expected to recognize IV rate @ 150 mL/hour, position patient for optimal ventilation, assist with incentive spirometer, administer O2 at 4L per nasal cannula, check chart for diuretic orders, formulate SBAR, contact physician, SBAR and receive new orders. Administer IV Lasix accurately and reassess based on drug action.	

EVIDENCE BASE / REFERENCES (APA Format)
ACC/AHA Practice Guidelines for Diagnosis and Management of Chronic Heart Failure in the Adult. <i>Circulation</i> . (2010)
Deglin, J.H. & Vallerand, A.H. (2011) Davis Drug for Nurses. Philadelphia.
Lewis, S. & Dirksen, S. (2011) Medical Surgical Nursing, Assessment and Management of Clinical Problems, 8 th Edition. St. Louis: Elsevier Mosby.
Gahart, B & Nazareno, A. (2011) Intravenous Medications. 27 th edition. St. Louis: Elsevier Mosby.

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes

1. Apply clinical decision making in interpreting and analyzing complex data in changing situations.
2. Prioritize interventions based on accurate interpretation of assessment data.
3. Provide care to patient promoting safety and minimizing risk of error.
4. Communicate effectively with members of the inter-professional team

Specific Learning Objectives

1. Applies principles of hand hygiene, infection control and personal protection.
2. Correctly identifies patient using 2 patient identifiers according to agency protocol.
3. Gathers relevant patient and contextual data to identify patient's priority problem.
4. Recognizes changes in patient's condition that require immediate intervention.
5. Recognizes need for additional orders and reports change of status to provider using SBAR.
6. Correctly obtains, reads back and activates telephone physician's order.
7. Performs interventions accurately using appropriate medication resources
8. Re-evaluate effectiveness of interventions and modify plan of care accordingly.
9. Incorporates patient teaching in all aspects of nursing care provided.

Critical Learner Actions

1. Performs hand hygiene; accurately identifies patient; introduces self and role
2. Performs general survey and focused assessment
3. Recognizes cluster of assessment findings indicating fluid overload
4. Positions patient for optimal ventilation; administers O2 per agency protocol
5. Assists patient with incentive spirometer exercises
6. Notifies provider of change in status using SBAR
7. Correctly obtains, reads back and activates telephone orders
8. Administers IV Lasix
9. Reassesses patient at appropriate time intervals.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies

Required prior to participating in the scenario

Knowledge	Skills/ Attitudes
1. Principles of Cardiopulmonary Assessment	1. Cardiopulmonary Assessment and Vital Signs
2. Significance of abnormal findings	2. Oxygen therapy and protocols
3. Pathophysiology of Fluid Overload	3. Administration of IV medications
4. Clinical Manifestations of Fluid Overload	4. SBAR communication
5. Nursing management of patient's with F.O.	5. Taking & initiating telephone orders
6. Pharmacology of IV diuretic therapy	6. Therapeutic communication in acute situations

ALL DATA IN THIS SCENARIO IS FICTITIOUS

SECTION III: SCENARIO SCRIPT

A. Case summary

64 year old female first post-operative morning following prophylactic mastectomy with immediate reconstruction with tissue expander. Learners are expected to assess the patient, recognize ↓ O² sats, crackles ½ way up, and IV running @ 150 mL/hr. Perform immediate interventions of positioning patient, incentive spirometer, recheck O² sats, check for orders and notify provider of change in status using SBAR communication tool. Learners are to take and initiate new orders accurately and reassess patient at appropriate time.

Report indicates that patient is doing well with pain controlled (2/10) with Morphine PCA. She complained of nausea which was relieved by Zofran @0400. On assessment patient offers no complaints, but is slightly restless and short of breath in the low Fowler's position. Wound is clean and dry with JP draining effectively.

History reveals previous breast cancer in the right breast treated with surgery, immediate reconstruction and chemotherapy. Currently in remission x 1 year.

B. Key contextual details

Morning assessment is different than that received in report. 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 Descriptor (Optional)	Confederate (C) or Learner (L)
RN 1		Learner
RN 2	Comes in room when called to validate assessment.	Learner
Physician	(in control room giving telephone orders)	Confederate (actor)

D. Patient/Client Profile				
Last name:	Cho		First name:	Paula
Gender: Fe	Age: 64	Ht: 5'5"	Wt: 150#	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Asian American		Primary Language spoken: English
1. History of present illness				
Patient admitted for prophylactic mastectomy with immediate reconstruction. Previous history of breast cancer in remission x 1 year following surgery with immediate reconstruction (tissue expander) and chemotherapy. No history of cardiopulmonary risk factors.				
Primary Medical Diagnosis	Left mastectomy			

2. Review of Systems	
CNS	Awake & oriented to person, place, time & situation. No gross deficits
Cardiovascular	Regular rate & rhythm; no murmurs. BP 112/82, HR 86
Pulmonary	Lungs clear to A&P; non-smoker RR 20, O2 sats 98%
Renal/Hepatic	Within normal limits.
Gastrointestinal	Soft, non-tender. No history of bleeding reported.
Endocrine	Post-menopausal woman; post-breast cancer right breast in remission
Heme/Coag	Within normal limits; distal pulses intact
Musculoskeletal	Moves all extremities with full range of motion
Integument	Clear and intact. No lesions noted.
Developmental Hx	College graduate. Retired graphic designer
Psychiatric Hx	None reported
Social Hx	Divorced. No children.
Alternative/ Complementary Medicine Hx	unknown

Medication allergies:	None reported	Reaction:	
Food/other allergies:	NKDA	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Calcium Carbonate + D	2 tabs	PO	Morning and evening
	Alprazolam (Xanax)	0.25 mg	PO	nightly
	Mevacor	40 mg	PO	Every other day

4. Laboratory, Diagnostic Study Results					
Na: 139	K: 4.7	Cl: 99	HCO ₃ : 24	BUN: 15	Cr: 0.75
Ca: 9.6	Mg: 1.2	Phos:	Glucose: 70	HgA1C:	
Hgb: 13.7	Hct: 43.7	Plt: 367	WBC: 6.70	ABO Blood Type: O+	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin: 4.8	Lactate:	
ABG-pH:	paO ₂ :	paCO ₂ :	HCO ₃ /BE:	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR: clear		ECG: 12 lead - NSR			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State
(This may vary from the baseline data provided to learners)

1. Initial physical appearance

Gender: Fe		Attire: hospital gown			
Alterations in appearance (moulage):					
<ul style="list-style-type: none"> • dressings over left breast, w/JP drain • TED stockings/ sequentials on 					
x	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information	x	Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:

x	No monitor display		Monitor on, but no data displayed		Monitor on, standard display	
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BP: 150/90	HR: 96	RR: 26	T: 100	SpO ₂ : 91%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC ₂ :	FHR:		
Lungs: Sounds/mechanics	Left: mod. loud crackles ½ way up		Right: mod. loud crackles ½ way up	
Heart:	Sounds:	S ₁ S ₂		
	ECG rhythm:	Sinus tachycardia		
	Other:			
Bowel sounds:	hypocactive bowel sounds x 4		Other:	

3. Initial Intravenous line set up						
	Saline lock #1	Site:				IV patent (Y/N)
	IV #1	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
x	Main	RA		D5/0.45 NS w/20mEq KCl	150 mL/hr.	
	Piggyback					
	IV #2	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main			Cefazolin (Ancef)	30 minutes	
x	Piggyback					
4. Initial Non-invasive monitors set up						
x	NIBP	x	ECG First lead:		ECG Second lead:	
x	Pulse oximeter	x	Temp monitor/type		Other:	
5. Initial Hemodynamic monitors set up						
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:	
6. Other monitors/devices						
	Foley catheter	Amount:	Appearance of urine:			
	Epidural catheter	x	Infusion pump:	Pump settings: Primary Piggyback (2 nd channel)	150 mL/hr 100 mL/hr	
	Fetal Heart rate monitor/tocometer		Internal	External		
Environment, Equipment, Essential props						
Recommend standardized set ups for each commonly simulated environment						
1. Scenario setting: (example: patient room, home, ED, lobby)						
medical-surgical unit						

2. Equipment, supplies, monitors						
(In simulation action room or available in adjacent core storage rooms)						
x	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit	x Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag	x Wall suction
	Nasogastric tube		ETT suction catheters	x	Oral suction catheters	Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	x Dressing Δ equipment
x	IV fluid Type:	D5/0.45 NS w/ 20 KCl	IV fluid additives:		IV medication in 50 NS Ceftriaxone 1G	Blood product ABO Type: # of units:

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

ALL DATA IN THIS SCENARIO IS FICTITIOUS

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
	Progress Notes		Graphic record		Anesthesia/PACU record		ED Record
x	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
x	Nurses' Notes		Dx test reports		Code Record		Prenatal record
x	Actual medical record binder, constructed per institutional guidelines				Other Describe:		

5. Medications (to be available in sim action room)								
#	Medication	Dosage	Route		#	Medication	Dosage	Route
3	Acetaminophen	325 mg	PO		2	Zolpidem	5 mg	PO
1	Cefazolin	1 gm/50 mL NS	IV		4	Saline flushes		
2	Ondansetron (Zofran)	4 mg	IV		1	Morphine (PCA)	1 mg/mL	IV
					1	Furosemide (Lasix)	40 mg/mL	IV

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario : Off going nurse gives report to primary nurse and rest of team in Debriefing Room
 Ms. Pauline Chappel is a 64 year old female on first morning post-op following a left prophylactic mastectomy with immediate reconstruction with tissue expander. She's had a relatively comfortable first post-op night with pain controlled with PCA Morphine at 2-3/10.
 Vital signs: BP 118/80, HR 86, RR 20, O2 sats 98% RA. She has an IV of D51/2NS with 20 KCl running at 150 mL/hr. She's had 1200 IV and just a couple of teaspoons of ice chips PO. She voided once at 250 ml around 0400. Her breath sounds are clear; abdomen clear with hypoactive bowel sounds. Distal pulses are strong. She used the IS 3 x during the night, the last at 0400.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Patient lying in low fowler's position slumped down in bed with slight shortness of breath. Responds slowly with interrupted speech. c/o restlessness.</p> <p>Attempts to cooperate with position change and incentive spirometer, but complains of shortness of breath.</p>	<p>Operator</p> <p>O₂ sat – 91% - RR – 26 HR –96 BP 150/90</p> <p>Leave idle until Learner assesses patient, then show VS and sats on the screen.</p> <p>When breath sounds checked, display moderately loud crackles ½ way up bilaterally.</p> <p>Triggers: To perform expected actions within 3-5 minutes</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Hand hygiene, identify patient 2. Introduce self and roles 3. Give brief explanation of plan for the morning 4. Perform general post-operative survey. 5. Perform focused assessment – <ol style="list-style-type: none"> a. VS, O² sats, Breath sounds b. Dressings & drainage c. IV site & solution, rate 6. Recognize crackles ½ way up 7. Calls for assistance to position patient in high fowler's position 8. Assist with incentive spirometer 9. Administer O² @ 2-4 L/ 10. Reassess 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Strategies for involving patient in plan of care. 2. Essential components of the post-operative assessment 3. Possible causes for abnormal assessment findings

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>Patient cooperates with position change and attempts incentive spirometer exercises.</p> <p>When asked, continues to complain of shortness of breath and feeling anxious.</p>	<p>Operator:</p> <p>O₂ sat - 90% Moderately loud crackles ½ way up. RR - 28 HR -96 BP - 150/90</p> <p>Triggers: To perform expected action within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Primary Nurse reassures using clear, calm statements of action 2. PN asks 2nd nurse to validate the breath sounds. 3. Checks provider orders 4. Notes IV rate 5. Recognizes factors that indicate fluid overload 6. Notifies provider of change of status using standard communication tool (SBAR) 7. Takes new orders accurately 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Strategies for communicating findings without undue concern concerning patient 2. Intraoperative and post-operative factors that combine to create a fluid overload situation. 3. Rationale for immediate interventions 4. Significance of VS, O₂ and breath sounds changes. 5. Legalities in taking telephone orders 6. Strategies for dealing with impatient providers.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3.</p> <p>No change in patient's condition; continues to respond with interrupted speech and shortness of breath</p>	<p>Operator:</p> <p>O₂ sat – 90%, RR = 28 HR = 98 BP = 150/90</p> <p>Triggers: Performs action within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Communicates plan to patient 2. Decreases rate of IV (if not done previously) 3. Prepares IV Lasix according to agency policy 4. Uses appropriate resources to assure drug administration knowledge. 5. Administers medication after using 2 patient identifiers 6. Assess patient response while administering drug 7. Safely disposes of equipment. 8. Informs patient of the action of the medication 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Pharmacology of Lasix 2. Rate of administration-40 mg over 1-2 minutes IV Push 3. Onset of action-immediate 4. Peak action – 5 minutes to 2 hours 5. Nursing actions based on 3 & 4 6. Patient teaching – request assistance to get out of bed

ALL DATA IN THIS SCENARIO IS FICTITIOUS

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>Patient distress decreases. Resting calmly in high Fowler's position with O2 on.</p>	<p>Operator:</p> <p>O₂ sats 92% BP 144/84 HR 90 RR 24</p> <p>Triggers: Completes actions within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Reassesses O2 sats and respiratory distress 2. Informs patient that she will probably feel the urge to void in approximately 5-10 minutes 3. Places bedpan and call bell within reach 4. Informs patient to call nurse if needed. Do not attempt to get out of bed alone. 5. Informs patient that she will return within 15 minutes to check breath sounds 6. Documents medication and assessment correctly. 	<p>Debriefing Points</p> <ol style="list-style-type: none"> 1. When to expect changes in assessment indicating improvement. 2. Measures to assure patient safety ... is this patient a Fall Risk at this time? 3. Reassessment findings – which would indicate improvement? Which findings would indicate a need for further treatment?
<p>Scenario End Point: Learners called to another room for an emergency. Leaves bedpan and call bell within reach with instructions to patient to call.</p>			
<p>Suggestions to <u>decrease</u> complexity: Patient symptoms milder ... needs only order for PO Lasix</p> <p>Suggestions to <u>increase</u> complexity:</p> <ul style="list-style-type: none"> • No improvement after treatment; order ABG demonstrating respiratory failure, NPPV BiPap/CPAP or intubation required. • Not able to reach provider. No orders or inadequate orders received. 			

Patient Name: Pauline Chappel		Diagnosis: Left prophylactic mastectomy with immediate reconstruction with tissue expander
DOB: 12/14/1946		
Age: 64		
MR#: 345678		
† No Known Allergies		
† Allergies & Sensitivities		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
08/16	1400	Admit to inpatient services
		Diagnosis: prophylactic left mastectomy
		Standard care for post-op surgical patient
		NPO until nausea subsides, then clear liquids. Progress to regular as tolerated
		Ambulate tonight, progress as tolerated
		TED stockings, remove q shift for 15 minutes
		SCD's until ambulating
		Incentive spirometer q1h while awake
		O2 protocol. Titrate O2 to keep saturations ≥ 92%
		IV D5W ½ NS with 20 mEq KCl @ 150 mL/hr.
		IVL when PO intake adequate. Hang 500 mL bag NS for piggybacks
		PCA Morphine (conc. 1mg/mL) intermittent- 1 mg per 10 min. (see PCA form)
		Ondasetron (Zofran) 4 mg IV q8h PRN nausea
		Cefazolin (Ancef) IV 1 gram q8h
		Reinforce dressings PRN
		Maintain compression on JP bulb. Empty and record q4h
		May catheterize if uncomfortable and unable to void after 12 hours. If > 500 mL, leave Foley in place.
		<i>Dr. M. Patson</i>

<p>Patient Name: Pauline Chappel</p> <p>DOB: 12/14/1946</p> <p>Age: 64</p> <p>MR#: 345678</p>	<p>Diagnosis: Left prophylactic mastectomy with immediate reconstruction with tissue expander</p>
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† No Known Allergies
† Allergies & Sensitivities

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		<i>Telephone orders given during scenario on nurses call to report change in status.</i>
08/17	0800	Decrease rate of IV to 30 mL per hour
		Draw blood for Na, K, Cl, BUN, creatinine, BNP stat
		Administer Furosemide (Lasix) 40 mg IV Push stat

Source of Information: patient

History of Present Illness (HPI) Noted palpable lump in left breast determined to be non-cancerous. Admitted for elective prophylactic mastectomy of left breast with immediate reconstruction.

Past Medical History: Status post right mastectomy for breast cancer followed by adjuvant chemotherapy, radiotherapy and hormone therapy.

Current Medications, dosage and frequency:

Calcium Carbonate + D	2 tabs	PO	Morning and evening
Alprazolam (Xanax)	0.25 mg	PO	nightly
Mevacor	40 mg	PO	Every other day

Personal & Social History: 64 year old female; self-employed graphic designer

Review of Systems:

Height: 5'5"	Weight: 150 #	BMI:	LMP:
BP 130/85	T 98.6	P 68	R 18

General: 64 year old female, alert and cooperative

CNS	Awake & oriented to person, place, time & situation. No gross deficits		
Cardiovascular	Regular rate & rhythm; no murmurs. BP 112/82, HR 86		
Pulmonary	Lungs clear to A&P; non-smoker RR 20, O2 sats 98%		
Renal/Hepatic	Within normal limits.		
Gastrointestinal	Soft, non-tender. No history of bleeding reported.		
Endocrine	Post-menopausal woman; post-breast cancer right breast in remission		
Heme/Coag	Within normal limits; distal pulses intact		
Musculoskeletal	Moves all extremities with full range of motion		
Integument	Clear and intact. No lesions noted.		
Developmental Hx	College graduate. Retired graphic designer		
Psychiatric Hx	None reported		
Social Hx	Divorced. No children.		
Alternative/ Complementary Medicine Hx	unknown		

HISTORY AND PHYSICAL	
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WBC	<u>6.7</u>	(4.8 – 10.8)	_____
RBC	<u>4.91</u>	(4.2 – 6.0)	_____
HGB	<u>13.7</u>	(12.0 – 16.0)	_____
HCT	<u>43.7</u>	(34.0 – 43.0)	_____
MCV	<u>89.7</u>	(81.0 – 99.0)	_____
MCH	<u>27.9</u>	(27.0 – 31.0)	_____
MCHC	<u>31.3</u>	(32.0 – 36.0)	_____
RDW	<u>12.0</u>	(11.5 – 14.5)	_____
PLAT COUNT	<u>367</u>	(150 –400)	_____

CHEMISTRY

NA	<u>136</u>	(135-153)	_____
K+	<u>4.7</u>	(3.6-5.4)	_____
CL-	<u>99</u>	(98-108)	_____
CO2	<u>28</u>	(23-33)	_____
ANION GAP	<u>12</u>	(7-19)	_____
OSM CA++	_____	(275-300)	_____
CA++ BLD	_____	(8.7-10.4)	_____
ALBUMIN	<u>4.8</u>	(3.2 – 5.5)	_____
Total PROTEINS	<u>7.5</u>	(6.0-8.3)	_____
GLU	<u>70</u>	(70-110)	_____
BUN	<u>15</u>	(7-29)	_____
CREAT	<u>0.75</u>	(0.5-1.4)	_____
BUN/CREAT	_____	(10.0-20.0)	_____
GFR	<u>>60</u>		_____
AST(SGOT)	<u>26</u>	(15-41)	_____
ALT(SGPT)	<u>31</u>	(11-55)	_____
ALK PHOS	<u>73</u>	(42-121)	_____
TOTAL BILI	_____	(0-1.0)	_____
BNP	_____	(0-99)	_____
CPK	_____		_____
Troponin	_____		_____

<p>LABORATORY REPORT 08/12/11</p>	<p>Pauline Chappel M. Patson M.D. D.O.B. 12/14/1946 MR #345678</p>
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APPENDIX B: Digital images of manikin and/or scenario milieu

Insert digital photo here

Insert digital photo here

Insert digital photo here

Insert digital photo here

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
<input type="checkbox"/> Individual	<input type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
Debriefing Materials			
<input type="checkbox"/> Debriefing Guide	<input type="checkbox"/> Objectives	<input type="checkbox"/> Debriefing Points	<input type="checkbox"/> QSEN
QSEN Competencies to consider for debriefing scenarios			
<input type="checkbox"/> Patient Centered Care	<input type="checkbox"/> Teamwork/Collaboration	<input 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 continues 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. 			
<p>Notes for future sessions:</p>			