SECTION I: SCENARIO OVERVIEW

Scenario Title:	Gastro-intestinal bleed-hypovolemia in post-op GYN patient
Original Scenario Developer(s):	Marjorie A. Miller, MA, RN, CHSE
Date - original scenario	11/12/07
Validation:	12/09 Dorothy Nunn, MSN
Revision Dates:	2/09, 8/10, 4/11
Pilot testing:	2/09
QSEN revision:	Marjorie A. Miller, MA, RN, CHSE, Colleen O'Leary-Kelley PhD, RN, CNE
Adapted for Med-Surg Nurses	7/11- Marjorie Miller, MA, RN, CHSE Anne Lucero, MSN, Sue Uchiyama, RN, Sarah Kennedy, RN

Estimated Scenario Time: 15-20 min. Debriefing time: 30 – 40 min.

Target group: Fundamentals or early med-surg nursing students for recognizing change in status, implementing immediate actions to protect airway and maintain circulation and notifying higher level of care using SBAR communication. Could also be used for Pre-licensure senior nursing students, new graduates, staff nurses. (Adapted for use with staff nurses on Medical-Surgical unit)

Core case: Unexpected GI bleed in patient being prepared for discharge; unrelated to surgical procedure.

QSEN Competencies:

- Safety
- Patient Centered Care
- Teamwork and Collaboration

Brief Summary of Case: 40 year old woman of Asian descent 3 days post-operative following an abdominal oophorectomy. She is scheduled for discharge this morning. Participants are expected to assess patient, finalize patient teaching and prepare her for discharge. Depending on level of learner, may also plan to administer PO & IV meds.

As participants enter the room, they find patient ½ in and ½ out of the bed, moaning, with coffee ground emesis and black, loose stool all over the bed, gown, linens and floor. Water is spilled on the bedside table and the floor. It looks as if she vomited and was trying to get to the bathroom, but was unable to walk and fell back on the bed. Her skin is pale and cool.

Participants are expected to correctly manage the biohazard while minimizing exposure and falls, recognize significance of situation, place the patient in supine position with head turned to left side, assess airway, level of consciousness, vital signs and perform immediate interventions. They initiate requests for assistance and communicate using SBAR. The team leader should delegate one to call the primary nurse and have the ward secretary to call housekeeping.

More advanced learners can initiate IV's, prepare for NG insertion or transfer to Endoscopy; call health care provider and obtain new orders following principles of communication safety.

EVIDENCE BASE / REFERENCES (APA Format)

Wilson, B., Shannon, M., Shields, K.(2009).*Prentice hall nurse's drug guide 2009*. Upper Saddle River, NJ: Prentice Hall.

CEFAZOLIN (ANCEF ®). *The clinician's ultimate reference*. Retrieved February 21, 2009. http://www.globalrph.com/cefazolin_dilution.htm

Khilnani, N., Hussain, N. (2005). Gastrointestinal bleeding. *Emergency Medicine.* 37(10) p. 27

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide patient care that promotes safety and minimizes risk of error.
2. Apply nursing process in clinical decision making.
3. Integrate understanding of multiple dimensions of patient centered care.
4. Communicate effectively with nursing and members of inter-professional team.
Specific Learning Objectives
1. Apply principles of hand hygiene, infection control and personal protection.
2. Correctly identify patient.
3. Gather relevant patient, environmental and contextual data.
4. Cluster relevant data to identify patient's primary problem.
5. Recognize acute changes in patient's condition/environment needing immediate attention.
6. Position patient for airway safety and optimal circulation.
7. Recognize and initiate request for assistance and further orders appropriate to situation.
8. Use communication strategies to minimize risk associated with change of status reporting
9. Perform timely interventions to address urgent or primary problem(s).
10. Evaluate effectiveness of immediate interventions
Critical Learner Actions
1. Perform hand hygiene, don gloves, contain biohazards to prevent falls/further contamination
2. Position patient safely back in bed. (supine & turned to left side to protect airway & promote circulation.
3. Perform general survey and focused circulatory and airway assessment.
4. Apply oxygen per agency protocol.
5. Initiate request for assistance; delegate team member to contact housekeeping.
6. Delegate tasks using team member name, "call-outs" and closed loop communication.
7. Reassess relevant parameters to evaluate effectiveness of immediate interventions.
8. Review available orders; recognize need for additional health care provider orders.
9. Use standardized communication tool to communicate patient status to inter-professional team.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies	
Knowledge	Skills/ Attitudes
❑ Nursing Process	❑ General survey and focused circulatory & respiratory assessment
❑ CDC Guidelines for prevention of blood/body fluids exposure	❑ Nursing interventions in acute GI bleed including airway protection & management of biohazards
❑ Pathophysiology of GI bleed; hypovolemia	❑ Significance of abnormal assessment findings
❑ Current National Patient Safety Goals	❑ Therapeutic communication skills in acute situations.
❑ Structured Communication Tools (SBAR)	❑ Interprofessional communication utilizing principles of teamwork and collaboration
❑ Legal aspects of taking telephone orders	❑ Protocol for taking telephone orders.

SECTION III: SCENARIO SCRIPT

A. Case summary
Patient is a 40 year old woman of Asian descent who is 3 days post-operative following an abdominal oophorectomy. She is scheduled for discharge this morning. Participants are expected to assess patient, administer PRN Oxycodone/Acetaminophen and scheduled morning meds including her last IV antibiotic, remove the IV lock and finalize discharge teaching. As participants enter the room, they find patient ½ in and ½ out of the bed, moaning, with coffee ground emesis all over the bed, gown, linens and floor. Water is spilled on the bedside table and the floor. It looks as if she vomited and was trying to get to the bathroom, but was unable to walk and fell back on the bed. Participants are expected to put on gloves, cover the emesis on the floor to prevent slipping, place the patient in supine position with head turned to left side, assess airway, level of consciousness. The team leader should delegate one to call the primary nurse and have the ward secretary to call housekeeping.

B. Key contextual details
Patient has been complaining of increasing pain and has taken more rather than less Oxycodone/Acetaminophen (Roxicet) and Ibuprofen in the last 36 hours. Nothing else pertinent to the situation except that patient is one of 4 patients that day and is considered the lowest priority. Staffing is appropriate for the day shift on this unit.

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Confederate (C) or Learner (L)
RN 1		Learner
RN 2		Learner
Patient's husband or sister	Arrives to take patient home. Very upset over situation	Confederate (Actor)

D. Patient/Client Profile				
Last name:	Choy		First name:	Hiroko
Gender: Fe	Age: 40	Ht: 5'4"	Wt: 135#	Code Status: Full
Spiritual Practice: None stated		Ethnicity: Asian-American		Primary Language spoken: English
1. History of present illness				
Patient is a gr.0/para 0 female with a 2 year history of lower abdomino-pelvic pain and distention. Her mother was recently diagnosed with ovarian cancer.				
Primary Medical Diagnosis	ovarian cyst			

2. Review of Systems	
CNS	Wnl, slightly anxious
Cardiovascular	Sinus rhythm @ 96; no murmurs, thrills or ectopy . B/P 130/85
Pulmonary	Never smoked. RR-28, O2 sats 98% RA. Lungs clear
Renal/Hepatic	No complaints of urinary difficulties. GFR – wnl. Occasional alcohol (4 drinks/week)
Gastrointestinal	Occasionally uses OTC Zantac and Maalox for GI distress. Bowel habits – once daily
Endocrine	Gr 0/Para 0. Menses-17. Irregular periods w/dysmenorrhea Rx- Advil. Patch for BC
Heme/Coag	No hx of blood dyscrasias, excessive bleeding, clotting deficiencies
Musculoskeletal	Active ROM; moves all extremities equally.
Integument	Clear and intact
Developmental Hx	Married; college graduate; works full time as high tech. executive
Psychiatric Hx	None reported
Social Hx	Married 10 years; stable relationship; family members live in area; husband shares physical custody of 2 teenaged children from a previous marriage
Alternative/ Complementary Medicine Hx	Green tea for health reasons

Medication allergies:	Penicillin – *has taken Cephalosporins in the past without negative effects*	Reaction:	Total body rash
Food/other allergies:		Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Ancef	1 gram/50ml D5W	1V	Every 8 hours
	Docusate sodium (Colace)	100 mg	oral	Once daily
	IV flush	10 ml	IV	Every 8 hours and PRN
	Oxycodone/Acetaminophen	5 mg/325 mg (1 tab)	oral	Every 4-6 hrs PRN pain
	Ibuprofen	600 mg	oral	Every 4 hours PRN mild pain

4. Laboratory, Diagnostic Study Results					
Na: 138	K: 3.8	Cl: 100	HCO3: 24	BUN: 12	Cr: 0.8
Ca: 9.0	Mg:	Phos: 3.5	Glucose: 98	HgA1C:	
Hgb: 11.2	Hct: 32	Plt: 145	WBC: 7.9	ABO Blood Type: O +	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR:		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: Female	Attire: hospital gown

Alterations in appearance (moulage):

- Medium length straight black hair
- Patient half in and half out of bed with legs dangling. She is moaning.
- Coffee ground appearing substance is on the bed linens, patient's gown and on the floor surrounding the bed. It looks as if patient has vomited and was trying to get to the bathroom, but was unable to walk and slumped back into the bed.
- Skin: pale, cold, clammy (ice bags over arms, chest, head for 20 minutes prior to start of simulation. Be sure to remove ice prior to learners entrance) use either glycerin and water to spray face, arms, chest … or cover areas with Vaseline and spray with cold water prior to learners entrance into room.

X	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
X	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

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

x	No monitor display	x	Monitor on, but no data displayed		Monitor on, standard display		

BP: 86/40	HR: 120	RR: 24	T: 97.0 °F.	SpO2: 94%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left: clear		Right: clear	
Heart:	Sounds:	S1, S2		
	ECG rhythm:	Sinus tachycardia		
	Other:	Pulses weak and thready		
Bowel sounds:	Active x 4		Other:	

3. Initial Intravenous line set up							
x	**Saline lock #1**	Site:	Rt. forearm				IV patent (Y/N)
	IV #1	Site:		Fluid type:	Initial rate:		IV patent (Y/N)
	Main						
	Piggyback						
	IV #2	Site:		Fluid type:	Initial rate:		IV patent (Y/N)
	Main						
	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		Infusion pump:	Pump settings:	
	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 patient room

2. Equipment, supplies, monitors

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

x	Bedpan/ Urinal	x	Foley catheter kit		Straight cath. kit	x	Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag	x	Wall suction
x	Nasogastric tube		ETT suction catheters	x	Oral suction cath.		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Kit	x	Dressing Δ equipment
x	IV fluid Type: Normal Saline (available) IV tubing types: standard for Alaris pump Piggyback tubing.				Tubes/drains Type:		Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices

x	Nasal cannula		Face tent	x	Simple Face Mask	x	Non re-breather mask
x	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
	Progress Notes	x	Graphic record	x	Anesthesia/PACU record		ED Record
x	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
x	Nurses' Notes	x	Dx test reports		Code Record		Prenatal record
x	2 medical record binders, constructed per institutional guidelines (Sutter)			x	Other Describe: Bedside chart with meds/documentation		

5. Medications (to be available in sim action room)								
#	**Medication**	**Dosage**	**Route**		**#**	**Medication**	**Dosage**	**Route**
1	Ancef	I gram	IVPB		1	Colace	100 mg	PO
6	Pre-filled NS flush	3 mL	IV		4	Ibuprofen	600 mg	PO
4	Hydrocodone/Acetaminophen	5/325	PO		1	Normal Saline	1000mL	IV
2	Ondansetron (Zofran)	4 mg	IV		1	Normal Saline	500 mL	IV

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario : (Report from previous shift) Hiroko Choy is a 40 year old Asian-American who is 3 days post op abdominal oophorectomy who is ready for discharge after her last dose of Ancef this morning. She has done well, but still has pain. She just called out a minute ago requesting something for pain and nausea. She has Roxicet and Zofran ordered. Vital signs are stable at 120-130/70-90, HR 72-80, R 16-20. She is afebrile. Dressings are dry, minimal abdominal distention, appetite poor due to indigestion, which she reports she has when she gets stressed. She's drinking and voiding well. Scenario begins with nurses entering room.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient slumped with one leg out of bed as if she couldn't quite make it back to bed. She is moaning. Linens, gown, floor stained with coffee ground emesis. Patient moaning and saying "sorry". HOB is ↑ to 45°.	**Operator** ▪ O_2 sats 95% ▪ EKG – sinus tachy @ 120 ▪ BP – 86/40 to 90/44 w/position change **Triggers:** • Learner actions completed within 4 minutes • If not completed in time allotted, ↓ BP, ↑ HR,	**Learner Actions** ▪ Lower head of bed to flat ▪ Turn patient to (L) side, check airway ▪ Universal precautions ▪ Manage biohazard to minimize exposure and slipping ▪ Check BP, O_2 sats, Check quality of pulse ▪ Administer O2 per agency protocol ▪ Reassure patient w/ clear, calm statements	**Debriefing Points:** ▪ National Patient Safety Goals to minimize risk of error and exposure to biohazards. ▪ Rationale for positioning ▪ Signs of increasing/decreasing perfusion ▪ Skin signs of perfusion ▪ Significance of changes in patient status ▪ Strategies for communicating with patient to decrease own and patient anxiety

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Patient's anxiety ↑, restless, apologizing for making such a mess. Gradually demonstrates ↓ LOC during scene.	**Operator:** ▪ O_2 sats 95% ▪ EKG – sinus tachy @ 126 ▪ BP 80/50 ▪ R 26/shallow. Breath sounds clear When (if) HOB is ↓, raise BP to 84/50. EKG – sinus tachycardia 120 **Triggers:** ▪ Learner Actions complete within 4 minutes ▪ If incomplete, gradually ↓ BP, ↑ HR, ↓ LOC	**Learner Actions:** ▪ Reassess following immediate interventions ▪ Assess breath sounds ▪ Recognize deteriorating vital signs and LOC ▪ Check health care providers orders ▪ Initiate call for assistance o Charge nurse o Housekeeping ▪ Communicate change of status to charge nurse. ▪ Initiate call to physician for new orders. ▪ Take telephone orders accurately per agency protocol. ▪ Continue to reassure patient	**Debriefing Points:** ▪ Rationale for lack of response to immediate interventions ▪ Communication strategies to minimize risks of error during reporting change of status ▪ Factors indicating requirement for collaboration with higher level of care ▪ Anticipate health care provider orders ▪ Rationale for checking breath sounds -vomiting – possible aspiration

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
3. Continues to demonstrate ↓ LOC. Physician orders received by charge nurse, IV initiated with bolus of 500 mL within compressed time of 4 minutes. Calls made to lab for stat hematology, coagulation panel, Type and Cross Match Patient's husband or sister arrives to take patient home. Visibly upset over change in condition. Patient to be transferred to Endoscopy momentarily	**Operator:** HR 120→110 RR 24 →20 RR deepens O_2 Sat 95% BP gradually ↑ to 90/68 **Triggers:** ▪ Learner Actions completed within 8 minutes	**Learner Actions:** ▪ Respond appropriately to patient's continued ↓ LOC ▪ Delegate tasks to assisting staff utilizing names, "call-out's" & closed loop communication. ▪ Continue to stimulate, orient the patient and protect airway. ▪ Assess IV lock for size and patency. Restart if necessary. ▪ Initiate IV Normal Saline ▪ Assist charge nurse in carrying out orders as directed. ▪ Assist with preparation of patient for Endoscopy procedure ▪ Communicate with family to allay anxiety.	**Debriefing Points:** ▪ Anticipate health care providers orders in situation ▪ Standards of practice for patients with GI bleed ▪ Rationale and patient preparation for endoscopy ▪ Strategies to protect patient during transport ▪ Scope of practice for staff nurse on med-surg unit ▪ Importance of continued reassessment of unstable patient ▪ Importance of communication with family. ▪ Strategies to deal with anxious and disruptive family members. ▪ Team *STEPPS* teamwork and collaboration protocols

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
4. Patients LOC ↑. Responds to husband or sister. Continues to apologize for the mess and inconvenience. Family member calms – communicating with patient and nurses. Not disruptive.	**Operator** HR 110→100 RR 20 O_2 Sat 95% BP 104/68	**Learner Actions** ▪ Reassess patient's VS & airway ▪ Reassess IV status ▪ Completes Pre-procedure check list.	**Debriefing Points** ▪ Elements of safe "hand-off" report to Endo team ▪ Elements of important communication with family
Scenario End Point: Endoscopy arrives to collect patient. Learner communicates "hand-off" report.			
Suggestions to <u>decrease</u> complexity: Discontinue scenario when charge nurse arrives to help. Suggestions to <u>increase</u> complexity: Higher level of learners – initiate IV, NG tube. Husband arrives to take patient home, visibly upset and demands to see physician immediately. Disruptive.			

Patient Name: Hiroko Choy **DOB: 12/20/1970** **Age: 40** **MR#: 123456**	**Diagnosis: Ovarian Cyst.** **Left abdominal salpingo- oophorectomy**

† No Known Allergies
† Allergies & Sensitivities Penicillin – has taken cepalosporins without reaction in past

Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
08/14	1000	Admit to medical surgical floor
		Diagnosis: ovarian cyst, (L) salpingo-oophorecomy
		Standard care for post op surgical patient.
		NPO for 4 hours, clear liquid diet until tomorrow morning then, advance diet as tolerated
		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 ≥ 92%
		IV D5W 1/2 NS 20 KCL 125 ml/hr; hang 500 mL NS flush bag for piggy backs
		Morphine PCA, basal rate 2-4 mg/hr. 1-2 mg/hour bolus dose not to exceed 4mg/hr.
		Ondansetron (Zofran) 4 mg IV q8h PRN nausea
		Cefazolin (Ancef) IV 1 gm q. 6 hours.
		Docusate Sodium (Colace) 100 mg qHS
		M Markam MD
08/16	0800	DC PCA Morphine
		Hydrocodone/Acetaminophen (5/325) 2 Tabs P.O. q 4hrs PRN, moderate to severe pain
		Acetaminophen 650 mg PO q6 hours PRN mild pain or temperature > 38° C.
		Ibuprofen 600 mg P.O. q6 hours
		Convert IV to IV lock
		M Markam MD
8/17	0800	Discharge home today
		Discharge medications:
		Hydrocodone/Acetaminophen (5/325) 1-2 Tabs P.O. q 6 hrs PRN, moderate incision pain
		Ibuprofen 1-2 tabs P.O. q4-6 hours PRN, not to exceed 1200 mg/d, mild incision pain
		Discontinue IV
		Appointment to see me in one week
		. M Markam MD

Patient Name: Hiroko Choy **DOB: 12/20/1970** **Age: 40** **MR#: 123456**	**Diagnosis: Ovarian Cyst.** **Left abdominal salpingo- oophorectomy**

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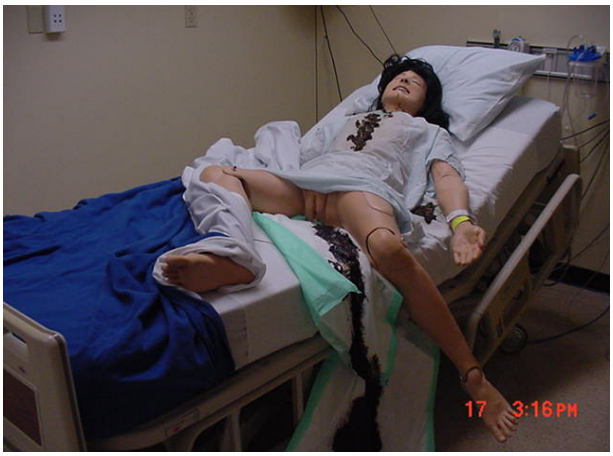
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		Telephone Orders during scenario
8/17	1000	1. Vital Signs and O2 sat. Q 5-15 min. PRN
		2. Give NS 1L now wide open rate
		3. NPO
		4. STAT Lytes and CBC, platelets
		5. Type and Cross 2 units PC
		6. Call endoscopy for potential client, I will call GI consult
		7. O2 per protocol
		8. Discontinue discharge
		M Markam MD

APPENDIX B: Digital images of manikin and/or scenario milieu



HISTORY AND PHYSICAL

Source of Information: patient
Chief Complaint: lower abdominal and pelvic pain

History of Present Illness (HPI) Patient is a gr.0/para 0 female with a 2 year history of lower abdomino-pelvic pain and distention. Her mother was recently diagnosed with ovarian cancer. Patient's preliminary diagnosis is ovarian cyst.

Past Medical History: Patient has been in good health

Current Medications, dosage and frequency: Zantac and Maalox occasionally for GI distress

Personal & Social History: Asian Female, age 40, Married 10 years; stable relationship; family members live in area; husband shares physical custody of 2 teenaged children from a previous marriage

Review of Systems:

Height: 5'4"	Weight: 135#	BMI:	LMP:
BP 130/85	T 98.6	P 96	R 28

General: 40 year old Asian female, alert and cooperative, in general good health, c/o pelvic pain, slightly tense appearance while sitting for exam. Well groomed, communicates well, and expresses appropriate concern thought history.

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

Skin: Slightly sallow/pink complexion, soft, moist mucous membranes, tugor with instant recoil, no lesions, tenderness or edema, brisk capillary refill, hair with normal female distribution.

EENT: Head erect and midline, eyes clear with full visual fields, wears glasses for reading. No sinus congestion or discharge. Tongue is midline with no lesions. Lymph nodes non-palpable, with full range of motion of the neck.

Lungs: Muscle and respiratory effort symmetric without use of accessory muscles; I/E ratio is 1:1, resonant percussion throughout: without adventitious sounds; even, quiet breathing.

Cardiac: Regular rhythm, no heaves or lifts. S1 & S2 heard best at base, no visible pulsations, additional heart sounds or murmurs

Abdomen: Abdomen soft, rounded & non-tender, bowel sounds heard all quadrants. Mild pelvic distension & tenderness with palpation. Regular BM once daily in the morning.

Musculoskeletal: Joints to both hands with good mobility, no tenderness, swelling, heat or erythema noted. Remainder of muscles, spine and extremities are in good alignment. No problems noted.

	Hiroko Choy Mark Markam M.D. DOB 12/20/1970 MR# 123456

WBC	12.4	(4.8 – 10.8)	
RBC		(4.2 – 6.0)	
HGB	11.2	(12.0 – 16.0)	
HCT	32	(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	145	(150 –400)	
M PLAT CT		(7.4 – 10.4)	
AUTO DIFF %			
BANDS			
NEUT		(2.7-9.2)	
LYMP		(1.2-3.6)	
MONO		(0.11-0.59)	
EOS		(0.0-0.45)	
BASO		(0.0-0.15)	
PT		(10.5-13.0sec)	
INR			
PTT		(21-36sec)	

CHEMISTRY

NA	138	(135-153)	
K+	3.8	(3.6-5.4)	
CL-	100	(98-108)	
CO2	24	(23-33)	
ANION GAP		(7-19)	
OSM CA++		(275-300)	
CA++ BLD	9	(8.7-10.4)	
ALBUMIN			
SERUM PROTEINS			
GLU		(70-110)	
BUN	12	(7-29)	
CREAT	1.12	(0.5-1.4)	
BUN/CREAT		(10.0-20.0)	
GFR			
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**	**Hiroko Choy** Mark Markam M.D. DOB 12/20/1970 MR# 123456

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☐ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☐ Debriefing Guide	☐ Objectives	☐ Debriefing Points	☐ QSEN
QSEN Competencies to consider for debriefing scenarios			
☐ Patient Centered Care	☐ Teamwork/Collaboration	☐ Evidence-based Practice	
☐ Safety	☐ Quality Improvement	☐ Informatics	

Sample Questions for Debriefing

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: