



### **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 (CVSC), 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.californiasimulationalliance.org](http://www.californiasimulationalliance.org)

All scenarios have been validated 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](http://www.bayareanrc.org/rsc) and click documents. (Please send signed I.P. release forms to KT at [kt@cinhc.org](mailto: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

<b>Scenario Title:</b>	Adult Critical Care-Septic Shock
Original Scenario Developer(s):	Lindsay Shank, RN, MS, CNS, CCRN
Date - original scenario	12/31/07
Validation:	03/10/2008
Revision Dates:	transferred to new template 7/10 mm; 02/12/13 bld
Pilot testing:	Approved cok
QSEN revision:	02/12/13 Barbara Durham MSN, RN, CNE
<u>Estimated Scenario Time:</u> 15 minutes <u>Debriefing time:</u> 30 minutes	
<u>Target group:</u> Critical Care Nurse Training Program	
<u>Core case:</u> Septic Shock	
<u>QSEN Competencies:</u> Safety, Teamwork and Collaboration, Patient-centered care, Evidence-based Practice	
<u>Brief Summary of Case:</u>	
<p>Eileen Paul is a 54 year old female, diagnosis urospepsis, admitted to Med-Surg 3 days ago for treatment with IV antibiotics. She was transferred to the ICU yesterday evening after a RRT call for severe hypotension. Her previous medical history (PMH) includes: NIDDM. PSH: tonsillectomy 1960. Social history: Drinks 6-8 drinks per day. Nonsmoker. Lives with Domestic Partner. No children. Shortly after admission, the Intensivist decided to intubate the patient and place a CCombo pulmonary artery/SVO<sub>2</sub> line with to guide therapeutic interventions.</p>	
<p>Critical care scenario meant to practice and/or validate orientees' ability to synthesize and integrate knowledge presented in the Critical Care Training Program: sepsis, septic shock, interpret hemodynamic measurements and identify appropriate treatments.</p>	
<b>Key Contextual Details:</b>	
<p>It is 0415 in your unit and you enter Ms. Paul's room to obtain new hemodynamic/SVO<sub>2</sub> measurements and reassess her. Ms. Paul is lying quietly with her eyes closed. She does not arouse until you gently shake her and then she moans. You have an orientee working with you who is an experienced Telemetry nurse. There is also a charge and resource nurse present on your side of the CCU. The physician on call is not on the unit but is available by phone.</p>	

### EVIDENCE BASE / REFERENCES (APA Format)

Cronenwett et al. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55, 3, 122-131.

Dellinger, R. P. et al. (2013). Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2012. *Critical Care Medicine*, 41, 2, 580-637.

DOI:10.1097/CCM.0b013e31827e83af

The Surviving Sepsis Campaign Care Bundles. Society of Critical Care Medicine. Retrieved from survivingsepsis.org on March 8, 2013.

Casserly, B., Read, R., and Levy, M.M. (2011). Hemodynamic monitoring in Sepsis. *Critical Care Nurse Clinics of North America*, 23, 149-169. doi:10.1016/j.ccell.2010.12.009

**ALL DATA IN THIS SCENARIO IS FICTITIOUS**

## SECTION II: CURRICULUM INTEGRATION

<b>A. SCENARIO LEARNING OBJECTIVES</b>
<b>Learning Outcomes</b>
1. Apply nursing process and evidence based practice in clinical decision-making.
2. Implement critical thinking skills to interpret data and implement appropriate interventions.
3. Prioritize interventions based on accurate interpretation of data.
4. Integrate multiple dimensions of patient/family centered care
<b>Specific Learning Objectives</b>
1. Demonstrates situational awareness and acute changes in patient's condition/environment needing immediate attention.
2. Accurately anticipate, prioritize, and perform timely interventions required for the unstable patient with septic shock.
3. Recognize and initiate request for assistance and further orders appropriate to situation.
4. Use communication strategies to minimize risk associated with change of status reporting (SBAR).
5. Accurately interpret hemodynamic measurements and their effects on the components of cardiac output/index: heart rate, preload, afterload, contractility.
6. Make appropriate decisions regarding medication choices while administering medications safely and accurately.
7. Demonstrate team work and communication during emergency/stressful situations.
8. Evaluate effectiveness of interventions.
<b>Critical Learner Actions</b>
1. Perform hand hygiene, introduce self and role, identify patient using two patient identifiers.
2. Complete initial assessment pausing to deal with evolving situation
3. Recognize signs and symptoms of septic shock, hemodynamic instability and intervene appropriately.
4. Identifies and implements appropriate interventions in an optimal sequence per sepsis protocol.
5. Report change of status and pertinent data to health care team using standardized communication tool (SBAR) in a timely fashion
6. Implement interventions (nursing and medical) in an optimal sequence using 2 patient identifiers.
7. Reassesses EKG rhythm, vital signs, and O <sub>2</sub> sats for patient's response to medications.
8. Delivers accurate "handoff" report using SBAR to relieving nurse.

<b>B. PRE-SCENARIO LEARNER ACTIVITIES</b>	
<b>Prerequisite Competencies</b>	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> ECCO Septic Shock & PACEP Modules	<input type="checkbox"/> Pulmonary artery set-up and maintenance
<input type="checkbox"/> Interpretation of pulmonary artery and SVO <sub>2</sub> measurements	<input type="checkbox"/> Ability to obtain pulmonary artery measurements and hemodynamic calculations.
<input type="checkbox"/> Interprofessional team communication in changing status situations	<input type="checkbox"/> Strategies to enhance Interprofessional teamwork and collaboration
<input type="checkbox"/> SCCM Sepsis Bundle including EGDT	<input type="checkbox"/> Medication/titrating IV gtt administration
<input type="checkbox"/> SOPs: Arterial Line, Hemodynamic Monitoring, Pulmonary Artery, SVO <sub>2</sub> Monitoring, Vasoactive Drip, insulin intensive	<input type="checkbox"/> IV Therapy

### SECTION III: SCENARIO SCRIPT

#### A. Case summary

Eileen Paul is a 54-year-old female, diagnosis urospepsis, admitted to Med-Surg 3 days ago for treatment with IV Abx. She was transferred to the ICU yesterday evening after a RRT call for severe hypotension. Her previous medical history (PMH) includes: NIDDM. PSH: tonsillectomy 1960. Social history: Drinks 6-8 drinks per day. Nonsmoker. Lives with Domestic Partner. No children. Shortly after admission, the Intensivist decided to intubate the patient and place a CCombo pulmonary artery/SVO<sub>2</sub> line with to guide therapeutic interventions.

#### B. Key contextual details

It is 0415 in your unit and you enter Ms. Paul's room to obtain new hemodynamic/SVO<sub>2</sub> measurements and reassess her. Ms. Paul is lying quietly with her eyes closed. She does not arouse until you gently shake her and then she moans. You have an orientee working with you who is an experienced Telemetry nurse. There is also a charge and resource nurse present on your side of the CCU. The physician on call is not on the unit but is available by phone.

#### C. Scenario Cast

Patient/ Client	<input checked="" type="checkbox"/> X 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)
RN1	Primary	Learner
RN 2	Resource/helper/float	Learner
RN 3	Charge nurse	Learner
RN 4/SN	Orienteer	Optional/Learner
MD	Intensivist Available by phone. Orders 500 ml fluid bolus for patient	Confederate
RCP	Respiratory (if needed)	Confederate
Family	(if needed to address psychosocial aspect)	Confederate

D. Patient/Client Profile					
Last name:	Paul		First name:	Eileen	
Gender: Female	Age: 54	Ht: 66 in	Wt: 200 lbs / 90.1 kg	BMI: 32.3	Code Status: Full
Spiritual Practice: Catholic		Ethnicity: Caucasian		Primary Language spoken: English	
1. History of present illness					
Ms. Paul was transferred to ICU from Med-Surg last night after deteriorating. She had been in Med-Surg for 3 days receiving IV antibiotics. Ms. Paul is hypotensive, tachycardiac and confused. An arterial line and CCombo PA/SVO2 line were inserted last evening and she was intubated.					
Primary Medical Diagnosis			Urosepsis, septic shock		

2. Review of Systems	
CNS	Lethargic, responds to touch only. MAE spontaneously but not to command. Pupils, equal, round, sluggish but reactive to light. Does not speak, but moans to stimulus.
Cardiovascular	S <sub>1</sub> S <sub>2</sub> , no murmurs, bruits, or thrills, no JVD or pedal edema, peripheral pulses (radial & pedal) thready, capillary refill prolonged (5 seconds), skin, pale, cool, moist and intact. ECG shows sinus tachycardia (rate 132). Patient has PVCs.
Pulmonary	Respirations even. Lungs: bilateral fine crackles throughout all lung fields. Mechanically ventilated: Modes AC: Rate: 16, FiO <sub>2</sub> .40, PEEP 5, SpO <sub>2</sub> 92%. PCXR shows bilateral infiltrates scattered throughout both lungs
Renal/Hepatic	Foley catheter with small amount of cloudy, yellow urine.
Gastrointestinal	NPO
Endocrine	Last BS taken at 0312: 238; previous BS 226.
Heme/Coag	PT 30.7 seconds, aPTT 55.3 seconds, CBC: RBCs WNL, WBCs 15.7, HgB 10.4, HCT 39.3; Platelets: 89K
Musculoskeletal	Moves spontaneously
Integument	Skin, pale, cool, moist and intact.
Developmental Hx	wnl
Psychiatric Hx	None known
Social Hx	In long term relationship with domestic partner. No children. Drinks 6-8 alcoholic drinks per day.
Alternative/ Complementary Medicine Hx	None known

Medication allergies:	Penicillin	Reaction:	Rash
Food/other allergies:	NKFA	Reaction:	

	Drug	Dose	Route	Frequency
	Dopamine- Titrate to keep SBP> 100	10 mcg/kg/min	IV	Continuous gtt
	Insulin drip	3.5 units/hour	IV	Continuous gtt

#### 4. Laboratory, Diagnostic Study Results

Na: 142	K: 4.2	Cl: 101	HCO <sub>3</sub> : 20	BUN: 22	Cr: 1.6
Ca:	Mg: 2.2	Phos:	Glucose: 232	HgA1C:	
Hgb: 10.9	Hct: 39.3	Plt: 89K	WBC: 15.7	ABO Blood Type:	
PT: 30.7	PTT: 55.3	INR: 1.9	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate: 4.8	
ABG-pH:	paO <sub>2</sub> :	paCO <sub>2</sub> :	HCO <sub>3</sub> /BE:	SaO <sub>2</sub> :	
VDRL:	GBS:	Herpes:	HIV:		
CXR: Bilateral patchy infiltrates		ECG: ST w/ PVCs (rate 132)			
CT:		MRI:			
Other: ALT – 52; AST – 49;					

#### 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, (or clothes)				
Alterations in appearance (moulage): Patient is orally intubated. Vent settings: Mode: AC Rate 16 FiO <sub>2</sub> :.40; PEEP Simulate pale, cool and moist skin: Ice bags to arms, hands, chest and face for 15 minutes prior to scenario. Remove prior to scenario starting. Spray with glycerin and water immediately prior to beginning of scenario					
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 PCN	Allergy band absent or not applicable

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

	No monitor display		Monitor on, but no data displayed	X	Monitor on, standard display		
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BP: 92/47	HR: 132	RR: 16	T: 102.6F	SpO <sub>2</sub> : 92%
CVP: 6 mmHg	PAS: 31 mmHg	PAD: 17 mmHg	PCWP: 14 mmHg	CO: 2.76 L/min
AIRWAY: WNL	ETCO <sub>2</sub> :	FHR:	SVO <sub>2</sub> : 52 mmHg	
Lungs: Sounds/mechanics	Left: fine crackles		Right: fine crackles	
Heart:	Sounds:	S1, S2		
	ECG rhythm:	ST w/PVCs		
	Other:			
Bowel sounds:	Hypoactive	Other: CI 1.42, PVR 382, SVR 1899 RVSWI 5.9, LVSWI 33.7		

3. Initial Intravenous line set up							
	<b>Saline lock #1</b>	Site:				IV patent (Y/N)	
X	<b>IV #1</b>	Site:	RFA	Fluid type: D5 ½ NS	Initial rate: 150 ml/hr	X	IV patent (Y/N) YES
X	Main						
	Piggyback						
X	<b>IV #2</b>	Site:	RU cordis	Fluid type: Dopamine 10 mcg/kg/min 400 mg/250 ml D5W	Initial rate: 17ml/hr	X	IV patent (Y/N) YES
X	Main						
X	<b>IV #3</b>	Site:	RU PA port	Fluid type: Insulin 250 units/250 ml NS (1:1 concentration) 3.5 units/hr	Initial rate: 3.5 ml/hr	X	IV patent (Y/N) YES
X	Main						
4. Initial Non-invasive monitors set up							
x	NIBP	x	ECG First lead: II	ECG Second lead:			
x	Pulse oximeter	x	Temp monitor/type	Other:			
5. Initial Hemodynamic monitors set up							
x	A-line Site: R wrist	x	Catheter/tubing Patency ( /N)	CVP Site: RIJ	PAC Site: RIJ		
6. Other monitors/devices							
	Foley catheter – insertion kit	Amount: 150 ml	Appearance of urine: Yellow, slightly cloudy with sediments				
	Epidural catheter	X	Infusion pump: 3 channel	Pump settings: D5 ½ NS @ 150 ml/hr Dopamine 17ml/hr; Insulin 3.5 ml/hr	Ventilator: AC 16, FiO2 40%, Peep 5		
				CCOmbo/SVO2 Monitor			
	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)							
Intensive Care Unit							



<b>2. Equipment, supplies, monitors</b> (In simulation action room or available in adjacent core storage rooms)						
	Bedpan/ Urinal	x	Foley catheter kit		Straight cath. kit	Incentive spirometer
x	IV Infusion pump (3 channel)		Feeding pump	x	Pressure bag x2	x Wall suction
	Nasogastric tube	x	ETT suction catheters	x	Oral suction catheters	Chest tube insertion kit
x	Defibrillator	x	Code Cart/meds	x	12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump	x	Central line Insertion Kit with towel roll	Dressing Δ equipment
x	IV fluid Type:	NS 500 ml and 1000 ml	IV fluid additives: Primary and secondary IV tubing; drip chart		pressure lines for transducing CVP; strips for PAP, PAOP that are close to given parameters Ventilator	Blood product ABO Type: # of units:

<b>3. Respiratory therapy equipment/devices</b>						
x	Nasal cannula		Face tent		Simple Face Mask	x Non re-breather mask
x	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)	
x	Ventilator	x	Airway box/tray			

<b>4. Documentation and Order Forms</b>						
x	Health Care Provider orders	x	Med Admin Record	x	H & P	x Lab Results
x	Progress Notes		Graphic record		Anesthesia/PACU record	x ED Record
x	Medication reconciliation		Transfer orders	x	Standing (protocol) orders	ICU flow sheet
x	Nurses' Notes	x	Dx test reports		Code Record	Prenatal record
x	Actual medical record binder, constructed per institutional guidelines				Other Describe: lab reports, CXR CVP, PAOP, PAP & Hemodynamic numbers with same values from scenario.	

<b>5. Medications (to be available in sim action room)</b>							
#	Medication	Dosage	Route	#	Medication	Dosage	Route
1	Dopamine 400mg/250D5W	10 mcg/kg/min Rate=17ml/hr	IV	2	Insulin 250 units/250ml	3.5 ml/hr	IV
3	Phenylephrine		IV	4	Norepinephrine		IV
			IV				IV

Pt weight = 90kg

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
<p><b>Initiation of Scenario:</b> Report: Eileen Paul is a 54 year old female, diagnosis urospepsis, admitted to Med-Surg 3 days ago for treatment with IV antibiotics. She has a <b>past medical history</b> of NIDDM and <b>surgical history</b> of tonsillectomy. <b>Social history:</b> Drinks 6-8 drinks per day is a nonsmoker and lives with her Domestic Partner. She has no children.</p> <p>She was transferred to the ICU yesterday evening after a RRT call for severe hypotension. Shortly after admission, the Intensivist decided to place a CCOMbo pulmonary artery/SVO<sub>2</sub> line to guide therapeutic interventions. She is currently on a Dopamine drip at 10 mcg/kg/hour and Insulin at 3.5 units per hour. The physician's order is to titrate the Dopamine gtt to keep the SBP greater than 100 mmHg.</p> <p><b>It is change of shift and you enter Ms. Paul's room to obtain new hemodynamic/SVO2 measurements and reassess her.</b></p>			
STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>1. Baseline</b></p> <p>Ms. Paul is lying quietly with her eyes closed. She does not arouse until you gently shake her and then she moans.</p> <p>Neck veins flat Peripheral pulses thready Skin: moist, cool, pale. Lungs: fine crackles bilat,</p> <p><b>Cue:</b> HOB is slightly ↑ to 30° Patient has arterial line and CCOMbo with SVO2. Dopamine and Insulin gtts are infusing per MD order</p>	<p><b>Operator</b></p> <ul style="list-style-type: none"> <li>• O<sub>2</sub> sats 92% 40% FiO<sub>2</sub></li> <li>• EKG – sinus tach, 132</li> <li>• ABP –92/47 (MAP 62)</li> <li>• R 16</li> <li>• T – 102.6F</li> </ul> <p><b>Current hemodynamic display:</b> SVO<sub>2</sub>: 52 PAP 31/17; CVP 6, PAOP 14 CO 2.76 CI 1.42; PVR 382; SVR 1899; RVSWI 5.9, LVSWI 33.7</p> <p><b>Triggers:</b></p> <ul style="list-style-type: none"> <li>• Learner Actions complete within 5 minutes</li> </ul>	<p><b>Learner Actions</b></p> <ul style="list-style-type: none"> <li>• Perform hand hygiene, introduce self and role, identify patient using two patient identifiers.</li> <li>• Check vital signs and hemodynamic status (BP, HR, O<sub>2</sub> sats)</li> <li>• Focused assessment based on patient condition</li> <li>• Reposition patient to increase perfusion, lowers head of bed/flat</li> <li>• Confirms transducers are level with phlebostatic axis, performs square wave test, re-zeros transducer after repositioning patient</li> </ul>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>• Strategies for complying with NPSG's in acute situations</li> <li>• Rationale for positioning</li> <li>• Interpretation of hemodynamic values and significance of findings</li> <li>• Signs and symptoms of decreasing cardiac output</li> <li>• Strategies for communicating with patient to decrease own and patient anxiety</li> <li>• Decision points for priority setting nursing interventions (improve oxygenation)</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>2.</b> No change.</p>	<p><b>Operator:</b></p> <p>HR 138; EKG: ST RR 16; SpO2 94% if placed on &gt;50% FIO2 BP 80/50 (MAP 60) T 102.6F</p> <p><b>Hemodynamic readings</b> SVO2: 50; PAP 32/15; CVP 5, PAOP 12 CO 2.19; CI 1.11, PVR 358, SVR 1956, RVSWI 5.8, LVSWI 20.0</p> <p><b>Triggers:</b></p> <ul style="list-style-type: none"> <li>▪ Learner Actions complete within 6 minutes</li> <li>▪ If incomplete, gradually ↓ BP, ↑ HR, ↓ LOC</li> </ul>	<p><b>Learner Actions:</b></p> <ul style="list-style-type: none"> <li>• Obtain new set of hemodynamic numbers.</li> <li>• Identifies hemodynamic parameters that need to be manipulated in order to improve patient condition</li> <li>• Increases oxygen delivery method (face mask or NRB)</li> <li>• Identifies appropriate interventions based on EGDT algorithm and treatment for septic shock</li> <li>• Notify MD or Intensivist of patient's status using SBAR and anticipates orders to be received</li> </ul>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>▪ Decision points and rationale for priority setting immediate nursing interventions for patients in septic shock</li> <li>▪ Communication strategies to minimize risks of error when reporting change of status</li> <li>▪ Nurse's role in interpreting oxygenation/perfusion and hemodynamic status.</li> <li>▪ Importance of continued reassessment of unstable patient</li> <li>▪ Discuss key assessment parameters for a patient with a compromised hemodynamic status</li> <li>▪ Discuss purpose/benefits of EGDT</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p><b>3.</b> No change in patient condition</p> <p><b>Cue:</b></p>	<p><b>Operator:</b> HR 138 EKG: ST RR 16; SpO2 94%on 50% FiO2 BP 80/50 (MAP 60) T 102.6F</p> <p><b>Triggers:</b></p> <ul style="list-style-type: none"> <li>• Learner Actions completed within 8 minutes</li> <li>• Resident arrives-gives orders to perform all actions in listed in Learner Actions if learners had not already done them.</li> <li>• Gradually increase CVP to 8 mmHg with fluid bolus and increase BP to 100/60 with norepinephrine</li> </ul>	<p><b>Learner Actions:</b></p> <ul style="list-style-type: none"> <li>• Identify appropriate interventions per the sepsis bundle, early goal directed therapy (EGDT) <ul style="list-style-type: none"> <li>○ Obtain lactate level and blood cultures</li> <li>○ CVP <math>\geq</math> 8 mmHg (give fluid bolus 30 ml/kg to keep MAP &gt; 65</li> <li>○ Start Norepinephrine 5 mcg/min; titrate MAP&gt;65</li> <li>○ For SvO2 <math>\geq</math>70%, add Dobutamine 20 mcg/kg/min</li> </ul> </li> <li>• Obtains/verifies patient weight for dose calculation</li> <li>• Confirms two patient identifiers prior to administering medications</li> </ul>	<p><b>Debriefing Points:</b></p> <ul style="list-style-type: none"> <li>• Components of sepsis bundle and treatment for septic shock</li> <li>• Significance of CVP and MAP in the treatment of sepsis</li> <li>• Importance of continued reassessment of unstable patient</li> <li>• Correct drug/dose calculation</li> <li>• Ensuring 5 rights are confirmed prior to med admin</li> </ul>

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>No change</p>	<p><b>Operator:</b> HR 108 EKG: ST RR 16 BP 96/62</p> <p><b>Hemodynamic numbers: (after interventions)</b> SVO2: 68; PAP 26/12; CVP 10, PAOP 18 CO 3.24; CI 1.94, PVR 279, SVR 1733, RVSWI 8.3, LVSWI 49.6</p> <p><b>Triggers:</b> End scenario after 20 minutes and debrief.</p>	<p><b>Learner Actions:</b></p> <ul style="list-style-type: none"> <li>• Analyze SVO2 &amp; hemodynamic numbers to determine if interventions have been effective.</li> <li>• Revise the patient's plan of care</li> <li>• Suggest additional meds/ interventions needed to improve the patient's condition-</li> <li>• Report findings to MD</li> <li>• Communicate change of status to patient and family.</li> </ul>	<p><b>Debriefing Points</b></p> <ul style="list-style-type: none"> <li>• Evaluate effectiveness of interventions by reassessing critical parameters</li> <li>• Importance of continued reassessment of unstable patient</li> <li>• Consider next steps in patient's plan of care.</li> <li>• Strategies for communicating with physician to minimize risks of error during reporting change of status</li> <li>• Debate the differences between local practice and best practice according to evidence-based research.</li> </ul>
<p>Scenario End Point: End the scenario when treatment team (orientees) perform all of the actions that are listed or when RESIDENT orders them</p>			
<p>Suggestions to <u>decrease</u> complexity: Suggestions to <u>increase</u> complexity: This scenario requires knowledge synthesis and integration of content presented in the Critical Care Training Program. It is appropriate for CCU orientees and may be adapted for use with ADN/BSN/entry level Master's students if the content was covered.</p>			
<p>Normal Hemodynamic Values: CVP 0-8 mm Hg, CO 4-8 L/min, CI 2.5-4.5 L/min/m<sup>2</sup>, PAP 15-30/8-15 mmHg, PAOP (wedge) 8-12 mmHg, PVR 120-200 dynes, SVR 800-1200 dynes, SV 50-100 ml/beat, LVSWI 43-62 g/m/ m<sup>2</sup>, RVSWI 7-12 g/m/ m<sup>2</sup></p>			

**HEALTH CARE PROVIDER ORDERS**

<p><b>Patient Name: Eileen Paul</b></p> <p><b>DOB:</b></p> <p><b>Age: 54</b></p> <p><b>MR#:</b></p>	<p><b>Diagnosis:</b> Urosepsis, septic shock</p>
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No Known Allergies  
 Allergies & Sensitivities: Penicillin

Date	Time	<b>HEALTH CARE PROVIDER ORDERS AND SIGNATURE</b>
		Allergies: <b>PENICILLIN</b> Code Status: FULL
<b>Signature</b>		Dr. _____

<b>APPENDIX B: Digital images of manikin and/or scenario milieu</b>	
<b>Insert digital photo here</b>	<b>Insert digital photo here</b>
<b>Insert digital photo here</b>	<b>Insert digital photo here</b>

**APPENDIX C: DEBRIEFING GUIDE**

<b>General Debriefing Plan</b>			
<input type="checkbox"/> Individual	<input checked="" type="checkbox"/> Group	<input type="checkbox"/> With Video	<input type="checkbox"/> Without Video
<b>Debriefing Materials</b>			
<input checked="" type="checkbox"/> Debriefing Guide	<input checked="" type="checkbox"/> Objectives	<input checked="" type="checkbox"/> Debriefing Points	<input checked="" type="checkbox"/> QSEN
<b>QSEN Competencies to consider for debriefing scenarios</b>			
<input checked="" type="checkbox"/> Patient Centered Care	<input checked="" type="checkbox"/> Teamwork/Collaboration	<input type="checkbox"/> Evidence-based Practice	
<input checked="" type="checkbox"/> Safety	<input type="checkbox"/> Quality Improvement	<input type="checkbox"/> Informatics	
<b>Sample Questions for Debriefing</b>			
<ol style="list-style-type: none"> <li>1. Describe the experience of caring for this patient for you and the team?</li> <li>2. Did you have the knowledge and skills to meet the learning objectives of the scenario?</li> <li>3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?</li> <li>4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?</li> <li>5. How would you handle the scenario differently if you could?</li> <li>6. In what ways did you perform well?</li> <li>7. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?</li> <li>8. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?</li> <li>9. Consider potential safety risks and how to avoid them.</li> <li>10. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?</li> <li>11.</li> </ol>			
<b>Notes for future sessions:</b>			