



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

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 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:	Adult Med-Surg/Tele: Smoke Inhalation-new onset chest pain
Original Scenario Developer(s):	Dorothy Nunn, MSN & Amy Flock, RN
Date - original scenario	08/15/07
Validation:	Cynthia Reid, RN 09/03/07
Pilot testing:	9/29/07, 3/02/08,
Revisions:	10/02/07, 12/2014 Marjorie A. Miller, MA, RN, CHSE; Melissa Punnoose, MSN, RN-BC, CHSE; Heidi Traxler, MSN, RN, CHSE
<u>Estimated Scenario Time:</u>	20 minutes
<u>Debriefing time:</u>	40 minutes
<u>Target group:</u>	Advanced medical-surgical nursing, new grads
<u>Core case:</u>	Smoke inhalation followed by new onset chest pain after admission
<u>Brief Summary of Case:</u>	<i>This is the first of 2 scenarios with this patient. Case A involves a new onset of chest pain and a transfer to tele; Case B involves a vfib arrest with recovery.</i>
<p>48 year old male patient who has been transferred to the medical-surgical unit post smoke inhalation received while performing duties as a fire fighter. He has a wife who will come in during the scenario. Due to his history, dehydration and decreased oxygen from the smoke inhalation he will develop chest pain of ischemic nature. This unanticipated change in condition needs to be assessed by the scenario participants followed by notification to primary care provider. Primary care provider will give telephone orders to cover the evolving situation.</p> <p>Medical/Surgical unit. The patient's wife will come in during the scenario and can be wired for prompting by the sim faculty. The scenario will end when orders are given, O₂ and NTG given. Charge nurse will pull the learners out of the room by having them give report to Telemetry where the patient will be transferred.</p>	
<u>QSEN Competencies</u>	
<input checked="" type="checkbox"/> Patient Centered Care <input checked="" type="checkbox"/> Patient Safety <input type="checkbox"/> Quality Improvement <input checked="" type="checkbox"/> Teamwork and Collaboration	

EVIDENCE BASE / REFERENCES (APA Format)

Ryland, P., Byrd MD, Mosenifar, Zab MD (2014). Respiratory Alkalosis Clinical Presentation. <i>Medscape</i> , Retrieved from http://emedicine.medscape.com/article
Berg, R.A., Hemphill, R., Abella, B. S., Aufderheide, T. P., Cave, D. M., Hazinski, M. F., Lerner, E. B., Rea, T. D., Sayre, M. R., and Swor, R. A. (2010). 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. <i>Circulation</i> , 2010; 122, pp. s685-s705.
Jneid, M., Anderson, J.L., Wright, R.S., Adams, C.D., Bridges, C. R., Casey, D. E., Jr., ...Zidar, J.P. (2012). ACC/AHA 2012 Focused Update of the Guidelines for the management of patients with unstable angina/non ST-elevation MI. A Report of the ACC/AHA Task Force on Practice Guidelines. <i>Circulation</i> , 2012; 126, pp876-910.
Dilansky M.A., Moore, S.M., (September 30, 2013) Quality and safety education for Nurses (QSEN) The Key is Systems Thinking. <i>Online Journal of Issues in Nursing</i> , 2013; Vol 18, No. 3, Manuscript 1.
Deglin, J.H. & Vallerand, A.H. (2011) Davis Drug Guide for Nurses. Philadelphia

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES

Learning Outcomes
1. Apply clinical decision making in interpreting and analyzing complex data in evolving situations.
2. Prioritize interventions based on accurate interpretation of assessment data.
3. Provide care to patient promoting safety and minimizing risk of error.
4. Independently communicates relevant data and collaborates with interprofessional team.
Specific Learning Objectives
1. Demonstrate accurate focused cardio-pulmonary assessment of patient with chest pain.
2. Differentiate causes of chest pain in identified patient and assess to narrow causes for intervention.
3. Recognize and interpret significant assessment findings requiring immediate reporting.
4. Effectively communicate assessment findings to interprofessional team; accurately taking orders using “read-back and verify” procedures.
5. Effectively communicate with patient and family member to keep informed and relieve anxiety.
6. Verify orders on EMR (if used); Administer medications following agency protocol, utilizing medication safety procedures.
Critical Learner Actions
1. Demonstrate focused cardiopulmonary assessment; differentiating causes of pain and recognizing new onset of chest pain of a cardiac nature.
2. Administer oxygen to maintain O2 sats, reposition for ventilation, verify IV access.
3. Primary nurse-delegates specific tasks to specific team members as they arrive in room; requesting “call-outs”, closed loop communication and continuous situation monitoring.
4. Call for assistance; place call to primary care provider of change in condition utilizing organized report format (SBAR).
5. Takes telephone orders following agency protocol (read back and verify) and communicates same to team.
6. Verifies orders on EMR (if used) prior to administering medications as ordered.
7. Assess patient for improvement following interventions
8. Monitor VS closely following administration of NTG.
9. Realistically reassure patient and family member regarding transfer to telemetry unit.

B. PRE-SCENARIO LEARNER ACTIVITIES

Prerequisite Competencies	
Knowledge	Skills/ Attitudes
<input type="checkbox"/> Chest pain protocols	<input type="checkbox"/> Cardiopulmonary assessment
<input type="checkbox"/> SBAR communication format	<input type="checkbox"/> Pain assessment; differentiate causes of pain
<input type="checkbox"/> Cardiopulmonary/pain assessment	<input type="checkbox"/> Administration of medications: IV, PO, SL, topical
<input type="checkbox"/> Therapeutic communication: patient/family	<input type="checkbox"/> Oxygen delivery systems, set-up
<input type="checkbox"/> Team STEPPS: teamwork & collaboration	<input type="checkbox"/> IV management
<input type="checkbox"/> Safe medication & oxygen administration	<input type="checkbox"/> Interprofessional communication
<input type="checkbox"/> Priority setting & clinical decision making	<input type="checkbox"/> Communication strategies for patient/family in escalating situations

SECTION III: SCENARIO SCRIPT

A. Case summary

(Summary – unfolding case – 1st case of 2)

48 year old male patient has been transferred to the medical-surgical unit post smoke inhalation received while performing duties as a fire fighter. He has a wife who will come in during the scenario. Due to his history, dehydration and decreased oxygen from the smoke inhalation he will develop chest pain of ischemic nature. Learners are expected to recognize and assess the unanticipated change in condition, reprioritize interventions, notify primary care provider and take telephone orders accurately and initiate interventions, including medications. Learners should communicate effectively with one another, with patient and family while performing interventions.

B. Key contextual details

Medical-Surgical Unit: The patient’s wife will come in during the scenario and can be wired for prompting by the sim faculty. (See script) The scenario will end when orders are taken, O₂ and NTG given. Scenario ends with charge nurse directing learners to give SBAR to telemetry nurse as patient is prepared for transfer.

C. Scenario Cast

Patient/ Client	<input checked="" 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/Actor (C/A) or Learner (L)
RN 1	Experienced staff nurse	Learner
RN 2	Orientee to med-surg unit	Learner
Charge Nurse	Comes in to end scenario	Actor/Confederate
Physician	Gives telephone orders	Actor/confederate
Patient’s wife	Comes in during scenario. Is concerned, but calm. Tells nurse that husband does not typically complain or mention symptoms. Is kind of a “macho man”.	Actor/confederate

D. Patient/Client Profile				
Last name:	Jones		First name:	Robert
Gender: Male	Age: 48	Ht: 5'10"	Wt: 220lbs	Code Status: Full
Spiritual Practice: None identified	Ethnicity: Caucasian		Primary Language spoken: English	
1. Past history				
<p>Robert Jones, is a mildly obese 48 year old white male, admitted to the medical-surgical floor for dehydration and smoke inhalation, developed while fighting a house fire. Mr. Jones became dizzy, fatigued and short of breath. Fire chief referred the patient to the hospital for check-up.</p> <p>On arrival to the ER, he was alert and oriented. VS: T. 37.8, RR 32, P 120, BP 102/62, O₂ Sat. 92% on room air.</p> <p>Past Medical History: untreated HTN, is a smoker, and has hyperlipidemia. He is currently being treated with Lipitor for the hyperlipidemia.</p> <p>Family History: Mother is living, she is 68 years old with no major medical problems. His father died at the age of 48 of a massive MI. no siblings.</p>				
Primary Medical Diagnosis	Dehydration, Smoke Inhalation			

2. Review of Systems	
CNS	Alert and oriented; PERL, symmetry intact, denies syncope or seizures, weakness or tremors, no recent loss of memory problems, depression or mood changes. Walking-gait with good balance. Visual acuity is intact.
Cardiovascular	Sinus tachycardia @ 120; no murmurs, thrills or ectopy . B/P 102/62; denies chest pain
Pulmonary	Smoker 30 pack years. RR-32, O ₂ sats 92% 2L /nc, c/o SOB, moderate wheezes throughout, occasional non-productive cough and no hemoptysis; denies orthopnea.
Renal/Hepatic	Voiding concentrated urine, no pain, frequency or nocturia
Gastrointestinal	Soft, non-tender. No history of bleeding reported.
Endocrine	No abnormalities. No hx of diabetes
Heme/Coag	Wnl
Musculoskeletal	Wnl
Integument	Wnl
Developmental Hx	Fire fighter for 25 years
Psychiatric Hx	None reported
Social Hx	Married firefighter lives with wife.
Alternative/ Complementary Medicine Hx	unknown

Medication allergies:	Morphine	Reaction:	Total body rash; dyspnea
Food/other allergies:	None reported	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Lipitor	20mg	PO	Daily
	ASA	325mg	PO	Daily
	Albuterol inhaler	2 puffs	inhaler	Q 1-4 hrs PRN resp distress

4. Laboratory, Diagnostic Study Results					
Na: 145	K: 4.0	Cl: 102	HCO ₃ : 24	BUN: 32	Cr: 1.8
Ca:	Mg:	Phos:	Glucose: 90	HgA1C:	
Hgb: 16.2	Hct: 47	Plt: 325	WBC: 12.3	ABO Blood Type:	
PT	PTT	INR	Troponin:	BNP:	
ABG-pH: 7.35	paO ₂ : 89%	paCO ₂ : 42	HCO ₃ /BE: 33/2	SaO ₂ :	
VDRL:	GBS:	Herpes:	HIV:		
CXR:	ECG: 12 lead-NSR				

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)			
1. Initial physical appearance			
Gender: Male		Attire: hospital gown	
<u>Alterations in appearance (moulage)</u> : Straight black/grey wig, grey mustache, pale skin			
X	ID band present, accurate	ID band present, inaccurate	ID band absent or not applicable
X	Allergy band present, accurate	Allergy band inaccurate	Allergy band absent or N/A

2. Initial Vital Signs Monitor display in simulation action room:					
No monitor display		Monitor on, but no data displayed		X Monitor on, data displayed	
BP: 152/92	HR: 92	RR: 20	T: 100	SpO ₂ : 94%	
CVP:	PAS:	PAD:	PCWP:	CO:	
AIRWAY:	ETCO ₂ :	FHR:			
Lungs: Sounds/mechanics	Left: wheezes throughout	Right: wheezes throughout			
Heart:	Sounds: S1 S2				
	ECG rhythm:				
	Other:				
Bowel sounds:	Active 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/20 mEq KCl	125mL/hr	
	Piggyback					
	IV #2	Site:		Fluid type:	Initial rate:	IV patent (Y/N)
	Main	RA				
	Piggyback					
4. Initial Non-invasive monitors set up						
X	NIBP			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:	
					.	
Environment, Equipment, Essential props						
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		Oral suction catheters	Chest tube kit
	Defibrillator		Code Cart	X	12-lead ECG	Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit	Dressing Δ equipment
X	IV fluid	D5/0.45 NS w/20 mEq KCl			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	X	Nebulizer tx kit		Flow meters (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		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
	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
2	Lipitor	20 mg	PO		2	Morphine	2mg/ml (carpuject)	IV
2	ASA	325 mg	PO		2	Dilaudid	1mg/ml q2-3hrs	IV
4	Nitroglycerin	0.4 ,g	SL		4	Saline Flushes		IV
1	Albuterol	2.5 mg	Inh			Solumedrol	20mg Q8hrs	IV
					2	Fentanyl	100mcg/2ml vial	IV

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES

Initiation of Scenario : *“Hand off” shift report from off going nurse.*

Mr. Robert Jones, who prefers to be called Bob, is a 48 year old patient of Dr. Mason. He was admitted this morning around 0400 from ED after developing dehydration and possible smoke inhalation while working a fire. He came in alert and oriented to the ED. He received a 500 mL bolus of NS, followed by a maintenance drip of D5 ½ NS w/20 mEq @ 125 mL/hr. Assessment in ED revealed inspiratory and expiratory wheezes throughout relieved with Albuterol nebulizer treatment.

Labs in ED: ABG’s – pH 7.35, PCO₂ 42, HCO₃ 33, BE -2, PO₂ 89%, COHb 4% - carbon monoxide level is consistent with smoke inhalation &/or long term smoking.

Bob has a history of untreated hypertension, hyperlipidemia, smoking and is allergic to Morphine. Currently he is comfortable, respirations are regular with mild wheezes that continue on end expiration, O₂ sats on O₂ 2L NC is 97%. Cardiac rhythm is regular; skin warm and dry and no other abnormal findings. Peripheral IV in right forearm is intact. He has been very thirsty and has taken in 2800 mL; voided 850 mL of concentrated urine. VS: T. 37.8°C., 100°F., RR 20, P 92, BP 152/94.

STATE / PATIENT STATUS	DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>1. Baseline</p> <p>Male voice, slightly hoarse. Awake, alert & oriented X3. Respiratory rate is 26, but breathing is slightly labored. Pt. states he is “ok, except for thirst and dry throat”. When asked, he reports that it is not an unusual feeling after fighting a fire.</p> <p>Cue: If learners do not identify themselves and their role, pt. asks who they are and what is going to happen.</p>	<p>Operator</p> <p>Monitor with VS on standby O₂ sat – 94% - RR – 26, occasional cough HR – 94 - NSR BP 154/92 Breath sounds: end expiratory wheezes bilaterally.</p> <p>Triggers: Learners complete Learner Actions within 5 minute</p>	<p>Learner Actions</p> <ol style="list-style-type: none"> 1. Performs hand hygiene 2. Introduces selves and role 3. Engage patient in plan of care 4. Begin initial assessment 5. Respond to patient’s concerns 6. Identify patient using 2 pt. identifiers 7. Reposition pt. for optimal ventilation 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. NPSG to minimize risk of error and infection. 2. Components of focused cardiopulmonary assessment. 3. Strategies for engaging patient in plan of care. 4. Role of information in decreasing anxiety.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>2.</p> <p>Patient begins to complain of “mild aching” in chest. When nurses question him, he states that it is “probably pulled a muscle from carrying firefighting equipment”.</p> <p>If nurses follow up on assessment of “mild aching” in his chest, patient responds that</p> <p>P – nothing provokes it</p> <p>Q -“pressure”type pain“,heavy ache”</p> <p>R - Located over left anterior thorax, radiating to neck and down left arm. Denies epigastric pain</p> <p>S – 7 on scale of 10</p> <p>T – just started</p>	<p>Operator:</p> <p>If taken, show VS O₂ sat - 92% Breath sounds - wheezing RR - 22 HR -103 BP – 162/98 T - 99.6°F.</p> <p>Triggers:</p> <p><input type="checkbox"/> Learner Actions completed within 8-10 minutes</p> <p><input type="checkbox"/> If not, proceed to next</p> <p>Cue: If learners do not respond to c/o chest ache, patient increases verbal distress and says “My chest is really hurting. “If learners do not adjust O2 levels, states “I’m having trouble breathing.”</p> <p>Cue: If learners do not follow up complaint of chest aching, wife enters room. Expresses concern and reports that patient rarely complains of pain “kind of a macho man.”</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Call for help. 2. Performs chest pain assessment, PQRST 3. Increase O2 per nasal cannula 4L/min 4. Performs focused cardio-pulmonary assessment 5. Repositions for optimal ventilation if not already done. 6. Check orders to see if patient can have Albuterol Rx; call RT to perform treatment; give SBAR to RT. 7. Reassess patient 8. Keep patient and family abreast of plan of care. 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Significance of chest pain in patient with recent/past history. 2. Clinical decision making with differential diagnosis: chest pain characteristics in pain of a cardiac vs. respiratory nature. 3. Interprofessional teamwork and collaboration. 4. Team <i>STEPPS</i> practices of situation awareness, call outs, closed loop communication 5. Strategies for keeping patient and family informed and calm in evolving situation.

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>3.</p> <p>Continued from previous frame (if asked...)</p> <p>See PQRST in previous frame</p> <p>Wife expresses increased concern as patient typically minimizes pain.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>MD orders after 12 lead results:</p> <ol style="list-style-type: none"> 1. Nitroglycerine 0.4 mg sublingual now, may repeat every 5 minutes x 3 if no relief 2. Aspirin 325 mg PO now 3. Dilaudid 1 mg IV if pain unrelieved by nitroglycerine 4. Oxygen 6 L/mask </div>	<p>Operator:</p> <p>If VS are taken: BP – 188/103 HR – 104 (sinus tach) RR – 26</p> <p>O₂ sat – 90%,</p> <p>Changes with interventions: If O₂ started – O₂ sat ↑ 97% If NTG given – BP ↓ 148/84 If CP reassessed after NTG – 2/10</p> <p>Cues: If students not moving forward, send charge nurse in to get SBAR, help learners focus tasks and suggest call to MD for orders</p> <p>Triggers: Performs action within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Recognize continued chest pain and suspect of cardiac nature 2. Confer with team members 3. ↑ O₂ flow rate to 6 L per simple mask 4. Notify physician of change in status using SBAR format – informs physician of morphine allergy 5. Request orders for 12 lead EKG 6. Writes, reads back and verifies orders (RAV) 7. Calls for stat 12 lead EKG 8. 12 lead EKG shows inferior wall MI. Notify MD with results informing MD of patient allergy to Morphine 9. RAV MD Chest pain orders. 10. Administers NTG, ASA, and Dilaudid following identification with 2 patient identifiers. 11. Monitors BP throughout care. 12. Reassesses pain after NTG 13. Keeps patient/family informed 	<p>Debriefing Points:</p> <ol style="list-style-type: none"> 1. Strategies for managing stress in escalating situations 2. Components of teamwork and communication to assure all important assessments/interventions are completed 3. Discuss appropriateness of call RRT 4. Discuss importance of 12 lead EKG to help determine nature of chest pain and interventions 5. MONA; O₂ protocols for CP 6. Legalities – telephone orders 7. Expected actions and side effects of NTG 8. Allergic reactions to Morphine 9. Compare additional options for pain management to Morphine: Fentanyl, Dilaudid re. onset and peak of response, pulmonary vasodilation

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
<p>4.</p> <p>If NTG is given, CP severity gradually decreases to 2/10</p> <p>Patient states that he is “much more comfortable” when asked. Wife remains at bedside, concerned but not disruptive.</p>	<p>Operator:</p> <p>BP: 156/92</p> <p>P 92</p> <p>R 24</p> <p>O2 sats – 94%</p> <p>Triggers: Learner Actions completed within 5 minutes</p>	<p>Learner Actions:</p> <ol style="list-style-type: none"> 1. Reassess chest pain 2. Reassess vital signs 3. Prepare patient for transfer to Telemetry unit 4. Communicate effectively with patient and wife regarding status and plan 5. Collect data to deliver effective “hand-off” report to telemetry nurse. 	<p>Debriefing Points</p> <ol style="list-style-type: none"> 1. Components of essential communication with patient and family. 2. Continued reassessment of CP and VS. 3. Role of nurse in change of status communication with patient and family. 4. Essential components of “hand-off” communication with telemetry team.
<p>Scenario End Point: Charge nurse will enter room and ask nurses to go out and give report to the telemetry nurse.</p>			
<p>Suggestions to <u>decrease</u> complexity: Charge nurse or rapid response team enter room and delegate interventions.</p> <p>Suggestions to <u>increase</u> complexity: Have learners follow-up with 12 lead EKG, initiate titratable medications, call for labs. Patient will not respond to NTG and further interventions are needed. See Case B for increased complexity.</p>			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Robert Jones DOB: 12/25/ Age: 48 MR#: 123456		Diagnosis: Smoke Inhalation/Dehydration
†No Known Allergies †Allergies & Sensitivities Morphine		
Date	Time	HEALTH CARE PROVIDER ORDERS AND SIGNATURE
		1. Admit to medical-surgical unit; diagnosis-Smoke Inhalation/Dehydration
		2. Peripheral IV with 18 gauge catheter
		3. 500 mL Normal Saline bolus now
		4. ABG's STAT
		5. Albuterol nebulizer 2.5 mg/3 mL now and QID while awake
		6. Oxygen protocol
		7. Portable chest x-ray now
		8. Transfer to Medical service Dr. Mason
		<i>Brian Whaley</i>
		Admissions Orders on Med-Surg Unit
		1. Transfer to Medical service Dr. Mason
		2. Regular diet
		3. Lipitor 20 mg PO daily
		4. ASA 325 mg daily
		5. IV D5 ½ NS with 20 mEq KCl @ 125 mL/hr
		6. Albuterol nebulizer 2.5 mg/3 mL QID while awake
		7. Oxygen per protocol to keep O ₂ sats equal to or greater than 92%
		8. Routine vital signs and Intake and Output
		9. Chemistry panel in AM
		<i>Patricia Mason, MD</i>
Signature		

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. 			
Notes for future sessions:			